HUMANA.
Guidance when you need it most

Appendix A

Description of Plan Benefits
Humana Health Plan

Humana Group No. 751374
Package IDS SFDCHA02
SFDCHR02

Effective January 1, 2014
This document supersedes any earlier version of Appendix A for the Humana Health Plan

APPENDIX A TO THE SPD

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INTRODUCTION

APPENDIX A TO THE SPD

This Appendix A outlines the benefits, provisions and limitations of the Humana Health Plan, and is an integral part of the SPD. If there is a conflict between the terms and/or provisions of this Appendix A and the SPD Wrapper or plan document for The Dow Chemical Company Medical Care Program or The Dow Chemical Company Retiree Medical Care Program ("Plan Documents"), the SPD Wrapper and Plan Documents will supersede this Appendix A.

DEFINED TERMS

Italicized terms throughout this *Appendix A to the SPD* are defined in the Definitions section. An italicized word may have a different meaning in the context of this *Appendix A to the SPD* than it does in general usage. Referring to the Definitions section as *you* read through this document will help *you* have a clearer understanding of this *Appendix A to the SPD*.

PRIVACY

Humana understands the importance of keeping *your protected health information* private. *Protected health information* includes both medical information and individually identifiable information, such as *your* name, address, telephone number or Social Security number. Humana is required by applicable federal law to maintain the privacy of *your protected health information*.

CONTACT INFORMATION

Customer Service Telephone Number:

Please refer to *your* Humana ID card for the applicable phone number.

Claims Submittal Address:

Humana Claims Office
P.O. Box 14601
Lexington, KY 40512-4601

Claims Appeal Address:

Humana Grievance and Appeals
P.O. Box 14546
Lexington, KY 40512-4546

TABLE OF CONTENTS

Page Number

SECTION 1

HEALTH RESOURCES AND PRECERTIFICATION

HEALTH RESOURCES

Health Resources is a comprehensive set of clinical programs and services available to help *covered persons* better understand their health care benefits and how to use them, navigate the health care system when they need it, understand treatment options and choices, reduce their costs and enhance the quality of life.

Each Health Resources program is tailored to meet different health care needs, from those that want to stay well when they are healthy, to those that are at risk for an illness, to those who are at chronic or acute stages of illness. Health Resources offer a wide range of assistance including online educational tools, interventions, health assessments and personal discussions with registered nurses.

Below is a brief description of this Plan's Health Resources programs. For additional information or questions regarding any of these programs, please contact the customer service telephone number on the back of *your* ID card.

*MY*HUMANA

Go to www.humana.com and click on "log in or register" to receive step by step instructions on how to set up *your My*Humana page. After *you* have set up *your* page, log on anytime to find a *participating provider*, look up *your* Plan benefits or check the status of a claim. *You* can also find *prescription* drug information, information on specific health conditions, financial tools to help with budgeting for health care and more.

*My*Humana Mobile allows *you* quick access to important information using *your* mobile device's browser. If *you* log in to *My*Humana Mobile, using *your* existing *My*Humana login and password, *you* can access:

- The urgent care center finder;
- *Your* member ID card detail information; and
- *Your* spending account balance and transaction information (if *you* have a Humana spending account).

HUMANA HEALTH ASSESSMENT

Go to www.humana.com and register for *My*Humana. Once *you* have registered and logged on to *My*Humana, click on the "Health Assessment" link. The Humana Health Assessment is a confidential, online health survey that provides *you* with an overall assessment of *your* health. Upon completion of the assessment, *you* will receive an individualized health score and an action plan on how *you* can improve *your* health. Responses may also result in a referral to another Health Resources program

TRANSPLANT MANAGEMENT

The Transplant Management team provides hands-on support to *covered persons* in need of organ and tissue transplants. They guide *covered persons* to Humana's National Transplant Network (NTN), designed to deliver a superior transplant experience. They review coverage, coordinate benefits, facilitate services and follow the transplant recipient's progress from initial referral through treatment and recovery.

To contact the Transplant Management team, call 1-866-421-5663.

BARIATRIC MANAGEMENT

The Bariatric Management team, made up of a dedicated team of bariatric specialists, is available to explain *your morbid obesity* and *bariatric surgery* benefits and *medical necessity* criteria. They guide *you* to facilities and *qualified practitioners* designated by Humana as approved *bariatric services* providers and provide *you* access to pre-surgical online educational video modules. Bariatric Registered Nurses provide Utilization Management by guiding eligible *covered persons* through the *bariatric surgery* pre-determination process and coordinating care. They provide Bariatric Case Management during the *surgery* process (both inpatient and outpatient *surgeries*) through 6 months after *surgery*, which includes discharge planning and post-surgery home health needs. Support for life long lifestyle change is provided, and access is given, to post-surgical education online video modules.

To contact the Bariatric Management team, call 1-866-486-5295.

UTILIZATION MANAGEMENT

Utilization management is designed to assist *covered persons* in making informed medical care decisions resulting in the delivery of appropriate levels of Plan benefits for each proposed course of treatment. These decisions are based on the medical information provided by the patient and the patient's physician. The patient and his or her physician determine the course of treatment. The assistance provided through these services does not constitute the practice of medicine. Payment of Plan benefits is not determined through these processes.

Precertification and Concurrent Review

Utilization review may include *precertification* and *concurrent review*.

This provision will not provide benefits to cover a *confinement* or *service* which is not *medically necessary* or otherwise would not be covered under this Plan. *Precertification* is not a guarantee of coverage.

If *you* or *your* covered *dependent* are to receive a *service* which requires *precertification*, *you* or *your qualified practitioner* must contact Humana by telephone or in writing. *Precertification* for *emergency services* is not required. Refer to the Precertification section for time requirements.

After *you* or *your qualified practitioner* have provided Humana with *your* diagnosis and treatment plan, Humana will:

1. Advise *you* by telephone, electronically, or in writing if the proposed treatment plan is *medically necessary*; and

2. Conduct *concurrent review* as necessary.

If *your admission* is *precertified*, benefits are subject to all Plan provisions and are payable as shown on the Medical Schedule of Benefits.

If it is determined at any time *your* proposed treatment plan, either partially or totally, is not a *covered expense* under the terms and provisions of this Plan, benefits for *services* may be reduced or *services* may not be covered.

Penalty for Not Obtaining Precertification

If *you* do not obtain *precertification* for *services* being rendered, *your* benefits may be reduced. Refer to the Precertification section for the applicable penalty. Penalties do not apply to *emergency services*.

CASE MANAGEMENT

The Case Management program provides a higher level of management and involvement for the seriously ill or injured who need intensive, hands-on support. Case Managers, averaging 18 years of experience in nursing, are there to provide condition-specific education, individual assessment, coordination of *services*, benefit plan guidance, communication with the patient's support system, personal support and counseling, and facilitation of discharge planning. Their goal is to contribute to the patient's sense of well-being, address their quality of life, ease the physical and emotional burdens associated with a major medical event and promote the most positive clinical outcomes possible.

Participants for Case Management are identified through a variety of methods, including referrals from other Health Resources programs and services (e.g. a *covered person* is referred to a Case Manager by their Personal Nurse).

Case Management is based on the individual's needs, and may include the following:

- Onsite nurse support at facilities with a high volume of Humana *admissions*;
- Telephone support for persons admitted to facilities where onsite coverage is not provided;
- Post-discharge follow-up for ongoing needs;
- Assistance in finding options and alternatives, such as community resources, social services, *Medicare*/Medicaid, pharmaceutical medication programs, etc.;
- Catastrophic Case Management that focuses on high-dollar, high-complexity, catastrophic type illnesses such as trauma, complex *surgery*, automobile *accidents* and burn injuries.

TRANSITION OF CARE

Changing health care plans can be stressful, especially for those who are going through intense medical treatment, such as chemotherapy. Humana understands this and does not want to hinder progress or interfere with the doctor-patient relationship. The transition of care process helps *covered persons* make a smooth transition to Humana from their current health care plan with the least amount of disruption to their care.

CONTINUITY OF CARE

If *you* are receiving treatment from a *participating provider* and that *provider's contract* to provide *medically necessary services* terminates for reasons other than medical competence or professional behavior, *you* may be entitled to continue treatment with that terminating *participating provider* if at the time of the *participating provider's* termination *you* are: a) undergoing active treatment for a chronic or acute medical condition; or b) *you* are in the 2nd or 3rd trimester of *your* pregnancy. If this Plan agrees to the continued treatment, *medically necessary services* provided to *you* by the terminating *participating provider* will continue to be payable at the *participating provider* benefit level. The maximum duration of continued treatment under this provision may not exceed: a) 90 days from the date of termination of the *provider's contract*; or b) through the delivery of a child, including immediate post-partum care and the follow-up visit within the first six weeks of delivery, in the case of *you* being in the 2nd or 3rd trimester of pregnancy.

HUMANA HEALTH ALERTS

PREVENTIVE REMINDERS

Humana encourages preventive healthcare and may send *you* wellness messages and reminders via a phone call (live and voice activated), mail, email or text message. Humana's messaging campaigns may include, but are not limited to:

- Flu vaccination reminders, targeted to those most at risk;
- Cancer screenings – breast, cervical and colorectal;
- Adolescent vaccination reminders.

GAPS IN CARE

Humana's clinical rules engine leverages expert medical opinions to identify gaps in care that address potential medical errors and instances of sub-optimal medical treatment.

The established clinical rules compare a patients' pharmacy, laboratory and claims data to industry standard Quality of Care guidelines in order to identify patients at risk of highly specific patient-centric problems. Examples include: a misdiagnosis, a flawed surgical treatment or medical management, and lack of follow-up care or preventive treatment. In addition, a variety of preventive and pharmacy rules are included such as drug-to-drug interactions and drug-to-disease interactions.

When gaps in care, drug to drug interaction, drug to disease interaction or a preventive reminder is identified, an alert and a message, if appropriate, are generated to communicate the findings through physician and member messaging.

HUMANAFIRST® NURSE ADVICE LINE

HumanaFirst® is a toll-free, 24-hour medical information line, staffed by registered nurses who are available to answer *your* health-related questions and help *you* decide where to best seek treatment. HumanaFirst® offers two lines to support *your* needs:

Immediate Medical Concerns: HumanaFirst® registered nurses can be of service when *you* are thinking about taking *your* child to the *hospital* for a fever in the middle of the night or deciding if a reaction to a new medication is normal. They can also help with "how-to" questions, like how to change a bandage or how to prepare for lab tests.

Health Planning and Support: When planning a future medical procedure, registered nurses are available to help *you* understand *your* options, choose providers and use *your* health benefits wisely. When additional clinical support is needed, the nurses will connect *you* with specialty programs to address *your* unique needs.

To contact the Nurse Advice Line, call 1-800-622-9529, choose "Nurse Advice" and then "Immediate Medical Concerns" or "Health Planning and Support".

CHRONIC CONDITION MANAGEMENT

The chronic condition management programs support the physician/patient relationship and care plan, emphasize education, promote self-management, evaluate outcomes to improve *your* overall health and offer nurse support.

Humana will contact *you* if *you* are eligible for a Chronic Condition Management program. If *you* have not received a phone call and *you* need support, *you* can contact Humana at 1-800-622-9529, select "nurse advice" and then "health planning and support."

DISEASE MANAGEMENT

Disease management programs have been developed to help *covered persons* manage specific chronic medical conditions. Clinicians are available 24 hours a day to provide individual guidance through coaching, support and service coordination, to help lessen the day-to-day impact of chronic illnesses.

This Plan's disease management programs include:

- **Asthma**: This program provides participants with education to help them better understand their disease and to take a more active role in controlling it. The program helps participants adhere to the treatment plan prescribed by their physician, helps them increase their self-monitoring skills and promotes compliance with controller medications.

- **Cancer (active treatment only)**: The cancer management program offers support and educational services to adults with cancer who have begun or are planning to undergo *surgery*, chemotherapy, radiation therapy or biological therapy, those that have a history of cancer that has recurred and those that have declined further therapy but require supportive management. The program's oncology care managers have an average of 10 years of professional experience in understanding cancer, its symptoms, side effects and treatments.

- **Chronic Obstructive Pulmonary Disease**: This program focuses on adherence to physicians' treatment plan, as well as education and goal development. Main focus areas include smoking cessation, diet and exercise, and lung health. Ongoing clinician support also discusses symptoms and warning signs education.

- **Congestive Heart Failure**: This program focuses on those with moderate to severe heart failure and is delivered primarily through clinicians who assist participants through a combination of intervention, monitoring and education.

- **Coronary Artery Disease**: This program helps participants adhere to their physicians' prescription and treatment plan, monitor their health status for complications and decrease cardiovascular risks. Ongoing guidance and education is provided, focusing on clinical and behavioral issues such as high blood pressure, elevated lipid levels, smoking and lack of exercise.

- **Diabetes:** This program provides ongoing education about disease management and monitoring in the areas of diet, exercise and lifestyle. Clinicians who have received additional training in diabetes disease management are available to answer questions.

- **End Stage Renal Disease (ESRD)**: The end-stage renal disease program provides support designed to address quality-of-life issues of those with ESRD and late-stage Chronic Kidney Disease. ESRD staff work closely with participants, local nephrologists and dialysis centers to coordinate services and monitor medical management.

- **Rare Diseases (Amyotrophic Lateral Sclerosis, or Lou Gehrig's Disease; Chronic Inflammatory Demyelinating Polyradiculoneuropathy Disease (CIDP); Cystic Fibrosis; Dermatomyositis; Hemophilia; Multiple Sclerosis; Myasthenia Gravis; Parkinson's Disease; Polymyositis; Rheumatoid Arthritis; Scleroderma; Sickle Cell Disease; and Systemic Lupus)**: Participants receive information tailored to their individual situation. Each program addresses the individual's medical, educational and psychological needs by providing disease-specific online tools and resources, service coordination and education via telephone contact and access to specially trained clinicians.

Specific programs may change at Humana's sole discretion. Some of the disease management programs may not be available in all areas.

PERSONAL NURSE®

In addition to disease-specific programs, Humana also offers Personal Nurse, which supports members with long-term, ongoing health needs and/or any chronic condition. Personal Nurses offers *covered persons* dealing with a condition or illness, following treatment plans, or needing continued guidance in reaching their long-term health goals, the opportunity to develop a long-term partnership with an experienced registered nurse. Personal Nurses provide both personalized education and guidance to resources to help participants better understand their condition or illness and effectively use their benefits. They also teach the benefits of wellness, prevention and disease avoidance, help identify roadblocks to improved health, motivate and support participants' efforts to meet goals and refer participants to other Health Resource programs that may meet their needs.

Participants will speak with the same Personal Nurse every time – whether the call is initiated by the nurse or the *covered person*. Personal Nurses work flexible hours and will provide participants with their direct telephone number. Participants can stay with their Personal Nurse for as long as they remain a member of this Plan.

HUMANA*BEGINNINGS*®

The Humana*Beginnings*® program educates and guides expectant mothers to make the best choices to achieve a healthy pregnancy and, ultimately, a healthy baby. Participants are offered guidance by phone from the time Humana is notified of the pregnancy through baby's first months. Participation is not limited to those *covered persons* with high-risk pregnancies – it is designed as a resource for all expectant mothers covered under the Plan.

Humana*Beginnings*® includes:

- Education, support and encouragement toward healthy behaviors and decisions related to pregnancy, such as nutrition, exercise, smoking and depression screening. Participants learn more about their pregnancy, their baby's development and how to practice healthy habits during pregnancy.
- Educational materials.
- Guidance for managing health concerns and complications.
- Awareness about premature birth. Women are educated about risk factors, preventive measures and the symptoms of preterm labor.
- Experienced registered nurses who specialize in prenatal care who can address questions and concerns.

A nurse reaches the expectant mother and begins discussions centered on her pregnancy and general health. They plan dates and times for future conversations and follow-up after delivery. Along with scheduled calls, the nurse is available as needed for contact throughout the pregnancy and the postpartum period.

Covered persons can enroll themselves at any time during their pregnancy, but are encouraged to enroll early in their pregnancy in order to get the most from the program. *Covered persons* can enroll in two ways:

- Online at *My*Humana (www.myhumana.com); or
- Calling toll-free 1-888-847-9960.

NEONATAL INTENSIVE CARE UNIT (NICU) MANAGEMENT

Specially trained case managers promote the highest standards of care for Neonatal Intensive Care Unit (NICU) infants and they work with *you* and *your* family throughout the NICU stay to help *you* prepare for a smooth transition home.

The Neonatal Case Management program includes:

- Registered nurses experienced in neonatal care.
- Coordination of home health needs.
- Transitional services.
- Parent education.
- Case management services.
- Discharge planning and follow-up.

To contact a NICU program representative, call 1-800-622-9529.

RADIOLOGY REVIEW SERVICES

Radiology Review Services convenient scheduling of imaging procedures (CT, CTA, MRI, MRA and PET scans). Radiology Review Services are designed to help avoid issues such as inappropriate or unnecessary imaging studies that are costly and inconvenient to the patient, by educating ordering physicians on imaging procedures and best practice guidelines before the procedure is scheduled.

Your qualified practitioner should call Humana at the toll-free customer service number on the back of *your* Humana ID card to initiate the consultation and schedule any imaging procedures.

PRECERTIFICATION

Humana will provide *precertification* as required by this Plan. It is recommended that *you* call the toll-free customer service phone number on the back of *your* ID card as soon as possible to receive proper *precertification*. *Precertification* for *emergency services* is not required.

Visit Humana's website or call the toll-free customer service phone number on the back of *your* ID card to obtain a list of *services* that require *precertification*. This list is subject to change. Coverage provided in the past for *services* that did not receive or require *precertification*, is not a guarantee of future coverage of the same *services*.

Please follow the directions below when accessing Humana's website:

1. Go to www.humana.com and sign in with *your* username and password, or register as a new user if *you* haven't already;

2. Go to the bottom of the page, and click on "Member Guidelines" under the "Member Support" heading;

3. Click on the "Medical Authorizations" tab along the left-hand side of the page;

4. Under the "How to find out if a service requires preauthorization" heading, click the "Commercial Preauthorization and Notification List"* with the most current date for a list of the *services* that require *precertification*.

5. *Please note, even though this Plan is a self-insured plan (also known as an ASO plan), this Plan is utilizing Humana's standard *precertification* and notification list which has the same *precertification* requirements as a commercial fully insured plan. All *precertification* requirements outlined on the list apply to this Plan, **unless** it specifically states that the requirement does not apply to ASO or is not available for ASO groups.

PRECERTIFICATION PENALTY

If *precertification* is not received, benefits will not be covered.

Penalties do not apply to any applicable Plan *deductibles* or *out-of-pocket limits*

Penalties do not apply to *emergency services*.

PREDETERMINATION OF BENEFITS

You or *your qualified practitioner* may submit a written request for a *predetermination of benefits*. The written request should contain the treatment plan, specific diagnostic and procedure codes, as well as the expected charges. Humana will provide a written response advising if the *services* are a *covered* or non-*covered expense* under this Plan, what the applicable Plan benefits are and if the expected charges are within the *maximum allowable fee*. The *predetermination of benefits* is not a guarantee of benefits. *Services* will be subject to all terms and provisions of this Plan applicable at the time treatment is provided.

If treatment is to commence more 180 days after the date treatment is authorized, Humana will require *you* to submit another treatment plan.

SECTION 2

MEDICAL BENEFITS

UNDERSTANDING YOUR COVERAGE

PARTICIPATING PROVIDERS

This Plan has one (1) level of benefits – *participating provider* benefits, payable as shown in the Medical Schedule of Benefits section. *You* are responsible for any applicable *copayments* and/or *deductible* amounts.

When receiving *services*, *you* should make sure the provider is a *participating provider* for this Plan. Humana may designate limited panels of *participating providers* from which certain kinds of *services* must be obtained. If these *services* are not obtained from the designated *participating providers*, benefits for these *services* may be reduced or denied. Humana reserves the right, at their discretion, to make changes to the list of *participating providers* at any time.

PARTICIPATING PROVIDER DIRECTORY

Your employer will automatically provide, without charge, information to *you* about how *you* can access a directory of *participating providers* appropriate to *your service area*. An online directory of *participating providers* is available to *you* and accessible via Humana's website at www.humana.com. This directory is subject to change. Due to the possibility of *participating providers* changing status, please check the online directory of *participating providers* prior to obtaining *services*. If *you* do not have access to the online directory, contact Humana at the customer service number on the back of *your* identification (ID) card prior to *services* being rendered or to request a directory.

PRIMARY CARE PHYSICIAN

A *primary care physician* is responsible for providing primary medical care and helping to guide any care *you* receive from other medical care providers, including *specialists*. *You* must select a *primary care physician* who is a *participating provider*, for *yourself* and for each covered *dependent*. *You* have the right to designate any *primary care physician* who is a *participating provider* and who is available to accept *you* and *your* covered *dependents*. A physician who is a *participating provider* specializing in pediatrics is permitted to be selected as the *primary care physician* for a covered *dependent* child. When *your primary care physician* is unavailable, *you* may need to obtain *services* from the back-up *participating provider* designated by *your primary care physician*. Please be sure to discuss these back-up arrangements with *your primary care physician*.

You should discuss all of *your* medical needs with *your primary care physician*. If *you* and *your primary care physician* determine *you* need to see a *specialist*, *your primary care physician* may refer *you* to one. A referral from *your primary care physician* is required to see a *specialist*. *You* will receive a referral for a period of time or a specific number of visits. The *primary care physician* referral is valid only for the *covered expenses* authorized by the *primary care physician*. A female *covered person* is permitted to receive *services* for obstetrical or gynecological care from a *participating provider* specializing in obstetrics or gynecology without a referral from her *primary care physician*. *Services* received from, or ordered by a *participating provider* for obstetrical or gynecological *services*, are considered authorization from the *primary care physician*.

If *you* have a chronic, disabling or life threatening *sickness*, *you* may apply to Humana to utilize a *specialist* who is a *participating provider* as *your* primary care provider.

For information on how to select a *primary care physician*, and for a list of *participating providers*, contact Humana at the customer service number on the back of *your* identification (ID) card or visit our website at www.humana.com.

SEEKING EMERGENCY CARE

When seeking *emergency* care, *you* should do the following:

1. If *your* medical condition permits, proceed to the nearest *emergency* care *participating provider* in this Plan.

2. If *your* medical condition does not permit going to a *participating provider*, *you* should go to the nearest *emergency* care medical facility. If *you* are admitted to a *non-participating hospital* for *emergency* care, *you* (or someone acting for *you*) must contact Humana within forty-eight (48) hours of *your admission*, or if this is not possible, as soon as *your* medical condition permits.

3. *You* may call 911 or *your* local *emergency* telephone number when *you* need on-site *emergency* assistance or *ambulance services*.

4. If *you* are admitted to a *non-participating hospital* for *emergency* care, Humana may require *you* be transferred to a *participating hospital* in the *service area* when *your* condition has been stabilized.

5. *You* must receive any follow-up *services* from *your primary care physician*.

SEEKING URGENT CARE

The steps for seeking urgent care are as follows:

1. *You* may go to an urgent care center that is a *participating provider* under this Plan.

2. If *you* are outside the *service area* and cannot reasonably return to the *service area* for urgent care *services*, *you* may receive the urgent care *services* from a *non-participating provider*. Notify Humana within forty-eight (48) hours after the urgent care *services* were received.

3. *You* must receive any follow-up *services* from *your primary care physician*.

4. *You* must pay the required *copayment*, if any, for urgent care.

COVERED AND NON-COVERED EXPENSES

Benefits are payable only if *services* are considered to be a *covered expense* and are subject to the specific conditions, limitations and applicable maximums of this Plan. The benefit payable for *covered expenses* will not exceed the *maximum allowable fee(s)*.

A *covered expense* is deemed to be incurred on the date a covered *service* is received. The bill submitted by the provider, if any, will determine which benefit provision is applicable for payment of *covered expenses*.

If *you* incur non-covered expenses, whether from a *participating provider* or a *non-participating provider*, *you* are responsible for making the full payment to the provider. The fact that a *qualified practitioner* has performed or prescribed a medically appropriate procedure, treatment, or supply, or the fact that it may be the only available treatment for a *bodily injury* or *sickness*, does not mean that the procedure, treatment or supply is covered under this Plan.

Please refer to the "Medical Schedule of Benefits", "Medical Covered Expenses" and the "Limitations and Exclusions" sections of this *Summary Plan Description* for more information about *covered expenses* and non-covered expenses.

COVERAGE OF OUT-OF-AREA DEPENDENTS

Dependents who reside outside of the *service area* because they are enrolled in an educational institution on a full-time basis may be covered under this Plan. Outside the *service area*, only *emergency* and urgent care medical conditions are covered. Payment of those *services* will be made in accordance with the "Seeking Emergency Care" and "Seeking Urgent Care" sections. Non-emergency *services* will be covered only if rendered by *participating providers*.

When an out-of-area *dependent* enters the *service area* on a temporary basis, coverage will be provided under the same terms and conditions as *covered persons* who reside in the *service area*. If the *dependent* moves into the *service area*, or if the *service area* is changed to include the *dependent's* residence, the *dependent* will immediately cease to be considered out-of-area.

MEDICAL SCHEDULE OF BENEFITS

IMPORTANT INFORMATION ABOUT PLAN BENEFITS

Plan benefits and limits (i.e. visit or dollar limits) are applicable per *plan year,* unless specifically stated otherwise. Annual limits do not apply to essential health benefits.

This schedule provides an overview of the medical Plan benefits. For a more detailed description of this Plan's medical benefits, refer to the "Medical Covered Expenses" section.

MEDICAL OUT-OF-POCKET LIMITS AND MEDICAL OFFICE VISIT COPAYMENTS	
Primary Care Physician (PCP) Office Visit *Copayment*	$20
Specialist Office Visit *Copayment*	$35
Primary Care Physician (PCP) is defined as a family practice physician, pediatrician, doctor of internal medicine, general practitioner, nurse practitioner, physician assistant, registered nurse and retail/minute clinic. A specialist would be all other *qualified practitioners*. This Plan applies the *copayment* based on the primary specialty of the *qualified practitioner*, for example, if a *qualified practitioner* is a nurse practitioner at a cardiologist's office, the specialist office visit *copayment* may apply. One *copayment* will be taken per visit per servicing provider, unless otherwise indicated in this Schedule.	
Single Medical *Out-of-Pocket Limit*	$2,500 per *covered person*
Family Medical *Out-of-Pocket Limit*	$7,500 per covered family
Lifetime Maximum Benefit	Unlimited

MEDICAL AND PRESCRIPTION DRUG PLAN MAXIMUM OUT-OF-POCKET LIMIT	
BENEFIT FEATURES	**PARTICIPATING PROVIDER BENEFIT**
Single *Plan Maximum Out-of-Pocket Limit*	$6,350 per *covered person*
Family *Plan Maximum Out-of-Pocket Limit*	$12,700 per covered family

ROUTINE/PREVENTIVE CHILD CARE SERVICES
BIRTH TO AGE 18
(*Services* Received at a Clinic or Outpatient *Hospital*)

MEDICAL SERVICES	PARTICIPATING PROVIDER BENEFIT
Routine/Preventive Child Care Examination	100%
Routine/Preventive Child Care Vision Screening	100%
Routine/Preventive Child Care Hearing Screening	100%
Routine/Preventive Child Care Laboratory	100%
Routine/Preventive Child Care X-ray	100%
Routine/Preventive Child Care Immunizations (includes school immunizations) (e.g. HPV Vaccine, Meningitis Vaccine, etc.) Immunizations are covered based on the recommendations by the Department of Health and Human Services - Centers for Disease Control and Prevention	100%
Routine/Preventive Child Care Flu/Pneumonia Immunizations	100%

ROUTINE/PREVENTIVE ADULT CARE SERVICES AGE 18 AND OVER (*Services* Received at a Clinic or Outpatient *Hospital*)	
MEDICAL SERVICES	**PARTICIPATING PROVIDER BENEFIT**
Routine/Preventive Adult Care Examination	100%
Routine/Preventive Adult Care Vision Screening	100%
Routine/Preventive Adult Care Hearing Screening	Payable the same as any other *sickness*.
Routine/Preventive Adult Care Laboratory	100%
Routine/Preventive Adult Care X-ray	100%
Routine/Preventive Adult Care Immunizations (includes school immunizations) (e.g. Shingles Vaccine, Meningitis Vaccine, HPV Vaccine, etc.) Immunizations are covered based on the recommendations by the Department of Health and Human Services - Centers for Disease Control and Prevention	100%
Routine/Preventive Adult Care Flu/Pneumonia Immunizations	100%
Routine/Preventive Mammograms	100%

ROUTINE/PREVENTIVE ADULT CARE SERVICES AGE 18 AND OVER (*Services* Received at a Clinic or Outpatient *Hospital*)

MEDICAL SERVICES	PARTICIPATING PROVIDER BENEFIT
Routine/Preventive Pap Smears	100%
Routine/Preventive Adult Care Colonoscopy, Proctosigmoidoscopy and Sigmoidoscopy Screenings (including related *services*) (performed at an outpatient facility, *ambulatory surgical center* or clinic location)	100%
Routine/Preventive Adult Care Prostate Specific Antigen (PSA) Testing	100%
Breast Feeding Counseling	100%
Breast Feeding Support and Supplies	100%
Contraceptive Methods - devices (e.g. IUD or diaphragms), injections, implant insertion/removal, the morning after pill and condoms; Sterilization - tubal ligation and vasectomy For information on *prescription* drug coverage for birth control pills/patches, abortifacients, the morning after pill, condoms and spermicide, please see *your prescription* drug benefits.	100%

Note: To the extent required by the Affordable Care Act, age limits do not apply to breast feeding counseling, breast feeding support and supplies, contraceptive methods and sterilization.

ROUTINE VISION SERVICES	
MEDICAL SERVICES	**PARTICIPATING PROVIDER BENEFIT**
Routine Vision Examination	Not covered
Routine Vision Refraction	100% after a $20 *copayment*
Aphakia (Vision)	100%
Eyeglass Frames and Lenses and Contact Lenses	Not covered
Routine Vision Refraction Visit Limit	One (1) visit per *covered person* (based on diagnosis)

ROUTINE HEARING SERVICES	
MEDICAL SERVICES	**PARTICIPATING PROVIDER BENEFIT**
Routine Hearing Examination	Payable the same as any other *sickness*.
Routine Hearing Testing	Not covered
Hearing Aids and Fitting	80%, for ages 17 and younger, coverage for non-disposable aids, up to $1,400 per hearing aid, every 36th months.
Hearing Impaired Interpreter Expenses (covers qualified interpreter/translator)	100%

QUALIFIED PRACTITIONER SERVICES (Non-Routine/Non-Preventive Care *Services*)	
MEDICAL SERVICES	**PARTICIPATING PROVIDER BENEFIT**
Diagnostic Office Examination at a Clinic, including Second and Third Surgical Opinion – *Primary Care Physician*	100% after a $20 *copayment*
Diagnostic Office Examination at a Clinic, including Second and Third Surgical Opinion - *Qualified Practitioner Specialist*	100% after a $35 *copayment*
If an office examination is billed from an outpatient location, the *services* will be payable the same as outpatient *services*.	
Diagnostic Laboratory and X-ray at a Clinic (other than *advanced imaging*)	100%
Independent Laboratory	100%
Advanced Imaging at a Clinic	100%
Allergy Testing at a Clinic	100%
Allergy Serum/Vials at a Clinic	100%
Allergy Injections at a Clinic	100%
Injections at a Clinic (other than routine immunizations, contraceptive injections for birth control reasons and allergy injections)	100%

QUALIFIED PRACTITIONER SERVICES (Non-Routine/Non-Preventive Care *Services*)	
MEDICAL SERVICES	**PARTICIPATING PROVIDER BENEFIT**
Anesthesia at a Clinic	100%
Surgery at a Clinic (including *Qualified Practitioner*, Assistant Surgeon and Physician Assistant) • *Primary Care Physician* • *Qualified Practitioner Specialist* • Assistant Surgeon	 100% after a $20 *copayment* 100% after a $35 *copayment* 100%
Multiple Surgical Procedures • Outpatient • In an Office Setting	 100% Subject to applicable office visit *copayment*
Medical and Surgical Supplies	100%
Eyeglasses or Contact Lenses after Cataract *Surgery* (initial pair only)	Not covered
Diabetic Counseling and Diabetic Nutritional Counseling (*Diabetes Self-Management Training*) (all places of *service*)	Payable the same as any other *sickness*.
Diabetes Supplies	75% (or covered under pharmacy)

DENTAL/ORAL SURGERIES COVERED UNDER THE MEDICAL PLAN	
MEDICAL SERVICES	**PARTICIPATING PROVIDER BENEFIT**
Dental/Oral *Surgeries* in office visit • *Primary Care Physician* • *Qualified Practitioner Specialist* Dental/Oral *Surgeries* Outpatient	 100% after a $20 *copayment* 100% after a $35 *copayment* 100%
Please refer to the Medical Covered Expenses section, Dental/Oral Surgeries Covered Under the Medical Plan, for a list of oral surgeries covered under this benefit.	

FAMILY PLANNING	
MEDICAL SERVICES	**PARTICIPATING PROVIDER BENEFIT**
Birth Control Pills and Patches	Not covered (Covered under pharmacy)
Contraceptive Devices (e.g. IUD; Diaphragms) – for *services* other than to prevent pregnancy Over-the-counter contraceptive devices are not covered.	50%. Office visit *copayment* will apply if there is an office visit. If obtained at the pharmacy, the pharmacy *copayment* will apply.
Contraceptive Injections– for *services* other than to prevent pregnancy	50%. Office visit *copayment* will apply if there is an office visit. If obtained at the pharmacy, the pharmacy *copayment* will apply.
Contraceptive Implant Systems (e.g. Norplant) – Insertion and Removal – for *services* other than to prevent pregnancy	50%. Office visit *copayment* will apply if there is an office visit. If obtained at the pharmacy, the pharmacy *copayment* will apply.

FAMILY PLANNING	
MEDICAL SERVICES	**PARTICIPATING PROVIDER BENEFIT**
Sterilization Vasectomy • *Primary Care Physician* • *Qualified Practitioner Specialist* Tubal Ligation, Hysterectomy	 100% after a $20 *copayment* 100% after a $35 *copayment* Payable the same as any other *sickness*.
Life Threatening Abortions	Payable the same as any other *sickness*.

MATERNITY (Normal, C-Section and Complications)	
MEDICAL SERVICES	**PARTICIPATING PROVIDER BENEFIT**
Inpatient *Hospital* Room and Board and Ancillary Facility *Services*	100% after a $50 one-time charge at delivery
Birthing Center Room and Board and Ancillary *Services*	100% after a $50 one-time charge at delivery
Qualified Practitioner Services	100% after a $50 one-time charge at delivery
Pre-natal Provider Visits	100%
Dependent Daughter Maternity	100% after a $50 one-time charge at delivery

MATERNITY (Normal, C-Section and Complications)	
MEDICAL SERVICES	**PARTICIPATING PROVIDER BENEFIT**
Newborn Well/Sick Baby (these benefits apply for the first year of life)	100%
Newborn Inpatient *Qualified Practitioner Services*	100%
Newborn Inpatient Facility *Services* • Well newborn • Sick newborn	 100% 100% after a $200 *copayment* per day up to a maximum of $600 per *admission.*

INPATIENT SERVICES	
MEDICAL SERVICES	**PARTICIPATING PROVIDER BENEFIT**
Inpatient *Hospital* Room and Board and Ancillary Facility *Services*	100% after a $200 *copayment* per day up to a maximum of $600 per *admission*
Qualified Practitioner Inpatient *Hospital* Visit	100%
Qualified Practitioner Inpatient *Surgery* and Anesthesia	100%
Qualified Practitioner Inpatient Pathology and Radiology	100%
Inpatient Physical Rehabilitation	100% after a $200 *copayment* per day up to a maximum of $600 per *admission*

INPATIENT SERVICES	
MEDICAL SERVICES	**PARTICIPATING PROVIDER BENEFIT**
Inpatient Physical Rehabilitation Limits	60 days per *covered person*
Private Duty Nursing	Not covered

SKILLED NURSING SERVICES	
MEDICAL SERVICES	**PARTICIPATING PROVIDER BENEFIT**
Skilled Nursing Room and Board and Ancillary Facility *Services*	100% after a $200 *copayment* per day up to a maximum of $600 per *admission*
Skilled Nursing Facility Yearly Limits	90 day(s) per *covered person*
Skilled Nursing *Qualified Practitioner* Visit	100%

OUTPATIENT AND AMBULATORY SURGICAL CENTER SERVICES	
MEDICAL SERVICES	**PARTICIPATING PROVIDER BENEFIT**
Ambulatory Surgical Center Facility *Services*	100% after a $200 *copayment* per admission
Ambulatory Surgical Center Ancillary *Services*	100%
Outpatient *Hospital* Facility Surgical *Services*	100% after a $200 *copayment* per admission

OUTPATIENT AND AMBULATORY SURGICAL CENTER SERVICES	
MEDICAL SERVICES	**PARTICIPATING PROVIDER BENEFIT**
Outpatient *Hospital* Facility Non-Surgical *Services* (e.g. clinic facility *services*; observation)	100%
Outpatient *Hospital* Surgical and Non-Surgical Ancillary *Services* (e.g. supplies; medication; anesthesia)	100%
Outpatient *Hospital* Facility Diagnostic Laboratory and X-ray (other than *advanced imaging*)	100%
Pre-Admission/Pre-Surgical Testing	100%
Outpatient *Hospital* Facility *Advanced Imaging*	100%
Outpatient *Hospital* and *Ambulatory Surgical Center Qualified Practitioner* Visit	100%
Outpatient *Hospital* and *Ambulatory Surgical Center Surgery* (including surgeon; assistant surgeon; and physician assistant) and Anesthesia	100%
Outpatient *Hospital* and *Ambulatory Surgical Center* Pathology and Radiology	100%

EMERGENCY AND URGENT CARE SERVICES	
MEDICAL SERVICES	**PARTICIPATING PROVIDER BENEFIT**
Emergency Room Facility *Services* (true *emergency*) If *you* are admitted to the *hospital*, the *copayment* will be waived.	100% after a $150 *copayment*
Emergency Room Ancillary *Services* (e.g. laboratory; x-ray; supplies) (true *emergency*)	100%
Emergency Room All Physician *Services* (including Radiologist, Pathologist, Anesthesiologist and ancillary *services* billed by an Emergency Room Physician) (true *emergency*)	100%
Emergency Room Facility *Services* (non-emergency) If *you* are admitted to the *hospital*, the *copayment* will be waived.	Not covered
Emergency Room Ancillary *Services* (e.g. laboratory; x-ray; supplies) (non-emergency)	Not covered
Emergency Room All Physician *Services* (including Radiologist, Pathologist, Anesthesiologist and ancillary *services* billed by an Emergency Room Physician) (non-emergency)	Not covered

EMERGENCY AND URGENT CARE SERVICES	
MEDICAL SERVICES	**PARTICIPATING PROVIDER BENEFIT**
Urgent Care Center (facility and ancillary *services*) Urgent Care Center (*qualified practitioner services)* • *Primary Care Physician* • *Qualified Practitioner Specialist* Only one *copayment* will be taken per day.	100% 100% after a $20 *copayment* 100% after a $35 *copayment*

HOSPICE SERVICES	
MEDICAL SERVICES	**PARTICIPATING PROVIDER BENEFIT**
Hospice Inpatient Room and Board and Ancillary *Services*	100%
Hospice Inpatient Limits	180 day(s) per *covered person*
Hospice Outpatient (including hospice home visits)	100%
Hospice Outpatient Limits	180 day(s) per *covered person*
The inpatient and outpatient hospice limits are combined.	
Hospice *Qualified Practitioner* Visit	100%

HOME HEALTH CARE SERVICES	
MEDICAL SERVICES	**PARTICIPATING PROVIDER BENEFIT**
Home Health Care *Services*	100%
Home Health Care Yearly Limits	60 visit(s) per *covered person*
Home Health Care Ancillary *Services* (excluding *durable medical equipment*, prosthetics and private duty nursing)	100%

DURABLE MEDICAL EQUIPMENT (DME)	
MEDICAL SERVICES	**PARTICIPATING PROVIDER BENEFIT**
Durable Medical Equipment (DME)	80%
Prosthesis	80%
Wigs for cancer patients with hair loss resulting from chemotherapy and/or radiation therapy	80%, subject to *medical necessity*

SPECIALTY DRUGS		
MEDICAL SERVICES	**PARTICIPATING PROVIDER BENEFIT**	
Specialty Drugs (*Qualified Practitioner's* Office Visit, Home Health Care, Freestanding Facility and Urgent Care)	Payable the same as any other *sickness.*	
Specialty Drugs (Emergency Room, *Ambulance*, Inpatient *Hospital*, Outpatient *Hospital* and Skilled Nursing Facility)	Payable the same as any other *sickness.*	

AMBULANCE SERVICES	
MEDICAL SERVICES	**PARTICIPATING PROVIDER BENEFIT**
Ground *Ambulance*	100%
Air *Ambulance*	100%

MORBID OBESITY SERVICES	
MEDICAL SERVICES	**FACILITIES/QUALIFIED PRACTITIONERS DESIGNATED BY HUMANA AS APPROVED BARIATRIC SERVICES PROVIDERS**
Precertification: Humana must be notified prior to receiving *bariatric services*. If *precertification* is not received, benefits will not be covered.	
The following *services* will be covered under the *morbid obesity* benefit: examinations/*qualified practitioner* visits; laboratory and x-ray and other diagnostic testing; *bariatric surgery*; inpatient facility *services*; outpatient facility *services*; *durable medical equipment* and nutritional counseling..	
Morbid Obesity	Payable the same as any other *sickness*

TEMPOROMANDIBULAR JOINT DYSFUNCTION (TMJ)	
MEDICAL SERVICES	**PARTICIPATING PROVIDER BENEFIT**
Temporomandibular Joint Dysfunction (TMJ) (Other than Splint/Appliances)	Payable the same as any other *sickness*
Temporomandibular Joint Dysfunction (TMJ) Splint/Appliances	Not covered

DENTAL INJURY SERVICES	
MEDICAL SERVICES	**PARTICIPATING PROVIDER BENEFIT**
Dental Injuries	100%. Office visit *copayment* may apply.
Please see the Medical Covered Expenses section, Dental Injury, for benefit details.	

INFERTILITY SERVICES	
MEDICAL SERVICES	**PARTICIPATING PROVIDER BENEFIT**
Infertility (Diagnosis) • *Primary Care Physician* • *Qualified Practitioner Specialist*	 100% after a $20 *copayment* Not covered
Infertility (Treatment)	50% (In-Network only)
Infertility Counseling and Treatment Yearly Limits	Two year maximum limit
Artificial Means of Achieving Pregnancy	Please refer to the Medical Covered Expenses section of this *Appendix A to the SPD*.
Sexual Dysfunction/Impotence	Payable the same as any other *sickness.*
Sexual Dysfunction/Impotence related to a *Mental Health* Disorder	Not covered

THERAPY SERVICES	
MEDICAL SERVICES	**PARTICIPATING PROVIDER BENEFIT**
Therapy *copayments* apply to therapy *services*, regardless of provider specialty (for example, if a Podiatrist is performing physical therapy, the physical therapy *copayment* will apply).	
Chiropractic Examinations	100% after a $20 *copayment*
Chiropractic Laboratory and X-ray	100%
Chiropractic Manipulations	100% after a $20 *copayment*
Chiropractic Therapy	100% after a $20 *copayment*
If *copayments* apply to multiple chiropractic *services*, one *copayment* will apply per day per servicing provider.	
Physical Therapy (Clinic and Outpatient)	100% after a $35 *copayment*
Physical Therapy and Occupational Therapy Limits	20 visit(s) per *covered person* No limits apply to age 18 for diagnosis of autism)
Occupational Therapy (Clinic and Outpatient)	100% after a $35 *copayment*
Speech Therapy (Clinic and Outpatient) (Only covered for illness or injury)	100% after a $35 *copayment*
Speech Therapy Limits	20 visit(s) per *covered person* No limits apply to age 18 for diagnosis of autism)
Cognitive Therapy (Clinic and Outpatient)	100%

THERAPY SERVICES	
MEDICAL SERVICES	**PARTICIPATING PROVIDER BENEFIT**
Acupuncture	Not covered
Respiratory Therapy and Pulmonary Therapy (Clinic and Outpatient)	100%
Vision Therapy (eye exercises to strengthen the muscles of the eye) (Clinic and Outpatient)	Not covered
Chemotherapy (Clinic and Outpatient)	100%
Radiation Therapy (Clinic and Outpatient)	100%
Cardiac Rehabilitation (Phase II) Phase I is covered under the inpatient facility benefits. Phase III, an unsupervised exercise program, is not covered.	70%
Cardiac Rehabilitation Limits	48 visit(s) per *covered person*

TRANSPLANT SERVICES

Precertification **is required, if** ***precertification*** **is not received, organ transplant** ***services*** **will not be covered.**

MEDICAL SERVICES	HUMANA NATIONAL TRANSPLANT NETWORK (NTN) FACILITY
Organ Transplant Lifetime Maximum	$1,000,000
Organ Transplant Medical *Services* • Inpatient *Hospital* • Physician *Services* (Clinic) • Physician *Services* (Inpatient/Outpatient)	 100% Subject to applicable office visit *copayment* 100%
Non-Medical *Services* - Lodging and Transportation	100%
Non-Medical *Services* - Lodging Limits	$50 per day
Immunosuppressant Drugs (applies to transplant lifetime maximum)	Covered under pharmacy

BEHAVIORAL HEALTH INPATIENT SERVICES

MEDICAL SERVICES	PARTICIPATING PROVIDER BENEFIT
Inpatient *Behavioral Health* Room and Board and Ancillary *Services*	100% after a $200 *copayment* per day up to a maximum of $600 per *admission*

BEHAVIORAL HEALTH INPATIENT SERVICES	
MEDICAL SERVICES	**PARTICIPATING PROVIDER BENEFIT**
Inpatient *Behavioral Health* Professional *Services*	100%
Behavioral Health Partial Hospitalization	100%
Behavioral Health Outpatient *Services*	100%
Behavioral Health Outpatient Therapy	100% after a $35 *copayment*
Behavioral Health Residential Treatment Facility Services	Not covered
Behavioral Health Half-way House *Services*	Not covered

BEHAVIORAL HEALTH CLINIC, OUTPATIENT AND INTENSIVE OUTPATIENT SERVICES	
MEDICAL SERVICES	**PARTICIPATING PROVIDER BENEFIT**
Behavioral Health Therapy *Services* (Clinic, Outpatient and Intensive Outpatient)	100% after a $35 *copayment*
Diagnostic Examination (Clinic)	100% after a $35 *copayment*
Pharmacological *Services*	100% after a $35 *copayment*

BEHAVIORAL HEALTH CLINIC, OUTPATIENT AND INTENSIVE OUTPATIENT SERVICES	
MEDICAL SERVICES	**PARTICIPATING PROVIDER BENEFIT**
Laboratory and X-ray (Clinic and Outpatient)	100%
The clinic, outpatient and intensive outpatient *behavioral health coinsurance* amounts will reduce the Plan *copayment limits*.	

DETOXIFICATION SERVICES	
MEDICAL SERVICES	**PARTICIPATING PROVIDER BENEFIT**
Detoxification	100% after a $200 *copayment* per day up to a maximum of $600 per *admission*

TRANSGENDER SERVICES	
MEDICAL SERVICES	**PARTICIPATING PROVIDER BENEFIT**
Transgender Services	Payable the same as any other *sickness*.

*Transgender *services* are covered only for active *employees*. *Services* are not covered for *retirees*.

OTHER COVERED EXPENSES	
MEDICAL SERVICES	**PARTICIPATING PROVIDER BENEFIT**
Other Covered Expenses	Payable the same as any other *sickness*.
Low Protein Food Products and Medical Foods for the Treatment of Metabolical Diseases	100%, up to $200 per month
ADD/Hyperactivity (Diagnosis and Treatment)	Payable the same as any other *sickness*.
Bone Mass Measurement	Payable the same as any other *sickness*.
Cleft Lip and Cleft Palate (Treatment and Correction)	Payable the same as any other *sickness*.
Pain Management Programs	Payable the same as any other *sickness*.
Sleep Studies	Payable the same as any other *sickness*.
Telemedicine (Provider)	100%
Health Education (Lamaze, Diabetic Education and Smoking Cessation)	100%

HOW BENEFITS PAY

This Plan may require *you* to satisfy *deductible(s)* before this Plan begins to share the cost of most medical *services*. If a *deductible* is required to be met before benefits are payable under this Plan, when it is satisfied, this Plan will share the cost of *covered expenses* at the *coinsurance* percentage until *you* have reached any applicable *out-of-pocket limit* or the *Plan maximum out-of-pocket limit*, whichever comes first. After *you* have met the *out-of-pocket limit*, if any, this Plan will pay *covered expenses* at 100% for the rest of the *calendar year*, subject to the *maximum allowable fee(s)*, any *maximum benefits* and all other terms, provisions, limitations and exclusions of this Plan. Any applicable *deductible*, *coinsurance*, *out-of-pocket limit* amounts, *Plan maximum out-of-pocket limit* amounts, medical *services* and medical *service* limits are stated on the Medical Schedule of Benefits.

OUT-OF-POCKET LIMIT

An *out-of-pocket limit* is a specified dollar amount that must be satisfied, either individually or combined as a covered family, per *calendar year* before a benefit percentage will be increased. The single and family *out-of-pocket limits* are stated on the Medical Schedule of Benefits.

Single Out-of-Pocket Limits

Once a *covered person* satisfies the single *out-of-pocket limits*, this Plan will pay 100% of *covered expenses* for the remainder of the *calendar year* for that *covered person*, unless specifically indicated, subject to any *calendar year* maximums. The single *out-of-pocket limits* include the *deductible* and *participating provider copayments*.

Family Out-of-Pocket Limit

Once the family *out-of-pocket limit* is met by a combination of *you* and/or *your* covered *dependents*, this Plan will pay 100% of *covered expenses* for the remainder of the *calendar year* for the family, unless specifically indicated, subject to any *calendar year* maximums. The family *out-of-pocket limits* include the *deductible* and *participating provider copayments.*

Penalties, *copayments* and organ transplants performed at a facility that is not a Humana National Transplant Network facility do not apply to the *out-of-pocket limits*.

PLAN MAXIMUM OUT-OF-POCKET LIMIT

The *Plan maximum out-of-pocket limit* is the maximum amount of any *participating provider covered expenses*, including *deductibles*, *coinsurance* amounts and *copayments* and *prescription* drug *copayments*, that must be paid by *you*, either individually or combined as a covered family, per *calendar year* before a benefit percentage for *participating provider covered expenses* will be increased. The *participating provider* medical *out-of-pocket limit* and the *prescription drug out-of-pocket limit* apply toward the *Plan maximum out-of-pocket limit*. Once the *Plan maximum out-of-pocket limit* is met, any remaining *participating provider* medical *out-of-pocket limit* or *prescription drug out-of-pocket limit* will be waived for the remainder of the *year*. Any applicable *precertification* penalties do not apply to the *Plan maximum out-of-pocket limit*.

ROUTINE/PREVENTIVE SERVICES

Covered expenses are payable as shown on the Medical Schedule of Benefits and include the preventive *services* recommended by the U.S. Department of Health and Human Services (HHS) for *your plan year* as follows:

1. Services with an A or B rating in the current recommendations of the U. S. Preventive Services Task Force (USPSTF). The recommendations by the USPSTF for breast cancer screenings, mammography and preventions issued prior to November 2009 will be considered current.

2. Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC).

3. Preventive care for infants, children and adolescents provided in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA).

4. Preventive care for women provided in the comprehensive guidelines supported by HRSA.

For the recommended preventive *services* that apply to *your plan year*, refer to the U.S. Department of Health and Human Services (HHS) website at www.Healthcare.gov or call the customer service telephone number on *your* identification card.

The exclusion for *services* which are not *medically necessary* does not apply to routine/preventive care *services*.

No benefits are payable under this routine/preventive care benefit for a medical examination for a *bodily injury* or *sickness*, a medical examination caused by or resulting from pregnancy, or a dental examination.

ROUTINE VISION SERVICES

Routine vision *services* are payable as shown on the Medical Schedule of Benefits.

The exclusion for *services* which are not *medically necessary* does not apply to routine vision refraction.

No benefits are payable under this routine vision benefit for repair, maintenance or supplies for eyeglass frames and lenses and contact lenses, a medical examination for a *bodily injury* or *sickness*, or medical and/or surgical treatment of the eye.

ROUTINE HEARING SERVICES

Routine hearing *services* are payable as shown on the Medical Schedule of Benefits.

The exclusion for *services* which are not *medically necessary* does not apply to routine hearing examinations.

No benefits are payable under this routine hearing benefit for repair, maintenance or supplies for hearing aids, a medical examination for a *bodily injury* or *sickness*, or medical and/or surgical treatment of the ear.

QUALIFIED PRACTITIONER SERVICES

Qualified practitioner services are payable as shown on the Medical Schedule of Benefits.

Second Surgical Opinion

If *you* obtain a second surgical opinion, the *qualified practitioners* providing the surgical opinions MUST NOT be in the same group practice or clinic. If the two opinions disagree, *you* may obtain a third opinion. Benefits for the third opinion are payable the same as for the second opinion. The *qualified practitioner* providing the second or third surgical opinion may confirm the need for *surgery* or present other treatment options. The decision whether or not to have the *surgery* is always *yours*.

Multiple Surgical Procedures

If multiple or bilateral surgical procedures are performed at one operative session, the amount payable for these procedures will be limited to the *maximum allowable fee* for the primary surgical procedure. When a *participating provider* is utilized, subsequent procedures will be paid in accordance with the *provider contract*. When a *non-participating provider* is utilized, the amount payable will be: a) 50% of the *maximum allowable fee* for the secondary procedure; and b) 25% of the *maximum allowable fee* for the third and subsequent procedures. No benefits will be payable for incidental procedures.

Surgical Assistant/Assistant Surgeon

Surgical assistants and/or assistant surgeon will be paid at 20% of the *covered expense* for *surgery*.

Physician Assistant

Physician assistants will be paid at 20% of the *covered expense* for *surgery*.

DENTAL/ORAL SURGERIES COVERED UNDER THE MEDICAL PLAN

Oral surgical operations due to a *bodily injury* or *sickness* are payable as shown on the Medical Schedule of Benefits and include the following procedures:

1. Excision of oral lesions;

2. Treatment of TMJ caused by arthritis or trauma.

FAMILY PLANNING

Family planning *services* are payable as shown on the Medical Schedule of Benefits.

The exclusion for *services* which are not *medically necessary* does not apply to family planning *services*, except life-threatening abortions.

MATERNITY

Maternity *services*, including normal maternity, c-section and complications, are payable as shown on the Medical Schedule of Benefits.

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any *hospital* length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). An attending provider is defined as an individual who is licensed under applicable state law to provide maternal or pediatric care and who is directly responsible for providing such care to a mother or newborn child. The definition of attending provider does not include a plan, *hospital*, managed care organization or other issuer. In any case, plans may not, under Federal law, require that a provider obtain authorization from the Plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Newborns

Covered expenses incurred during a newborn child's initial inpatient *hospital confinement* include *hospital* expenses for nursery room and board and miscellaneous *services*, *qualified practitioner's* expenses for circumcision and *qualified practitioner's* expenses for routine examination before release from the *hospital*. *Covered expenses* also include *services* for the treatment of a *bodily injury* or *sickness*, care or treatment for premature birth and medically diagnosed birth defects and abnormalities.

Please refer to the Eligibility and Effective Date of Coverage section regarding newborn eligibility and enrollment.

Birthing Centers

A birthing center is a free standing facility, licensed by the state, which provides prenatal care, delivery, immediate postpartum care and care of the newborn child. *Services* are payable when incurred within 48 hours after *confinement* in a birthing center for *services* and supplies furnished for prenatal care and delivery.

INPATIENT HOSPITAL

Inpatient *hospital services* are payable as shown on the Medical Schedule of Benefits, and include charges made by a *hospital* for daily semi-private, ward, intensive care or coronary care room and board charges for each day of *confinement* and *services* furnished for *your* treatment during *confinement*. Benefits for a private or single-bed room are limited to the *maximum allowable fee* charged for a semi-private room in the *hospital* while a registered bed patient.

SKILLED NURSING FACILITY

Expenses incurred for daily room and board and general nursing *services* for each day of *confinement* in a skilled nursing facility are payable as shown on the Medical Schedule of Benefits. The daily rate will not exceed the maximum daily rate established for licensed skilled nursing care facilities by the Department of Health and Social Services.

Covered expenses for a skilled nursing facility *confinement* are payable when the *confinement*:

1. Begins while *you* or an eligible *dependent* are covered under this Plan;

2. Begins after discharge from a *hospital confinement* or a prior covered skilled nursing facility *confinement*;

3. Is necessary for care or treatment of the same *bodily injury* or *sickness* which caused the prior *confinement*; and

4. Occurs while *you* or an eligible *dependent* are under the regular care of a physician.

Skilled nursing facility means only an institution licensed as a skilled nursing facility and lawfully operated in the jurisdiction where located. It must maintain and provide:

1. Permanent and full-time bed care facilities for resident patients;

2. A physician's *services* available at all times;

3. 24-hour-a-day skilled nursing *services* under the full-time supervision of a physician or registered nurse (R.N.);

4. A daily record for each patient;

5. Continuous skilled nursing care for sick or injured persons during their convalescence from *sickness* or *bodily injury*; and

6. A utilization review plan.

A skilled nursing facility is not except by incident, a rest home, a home for care of the aged, or engaged in the care and treatment of *mental health* or *substance abuse*.

OUTPATIENT AND AMBULATORY SURGICAL CENTER

Outpatient facility and *ambulatory surgical center services* are payable as shown on the Medical Schedule of Benefits.

EMERGENCY AND URGENT CARE SERVICES

Emergency and urgent care *services* are payable as shown on the Medical Schedule of Benefits.

HOSPICE SERVICES

Hospice *services* are payable as shown on the Medical Schedule of Benefits, and must be furnished in a hospice facility or in *your* home. A *qualified practitioner* must certify *you* are terminally ill with a life expectancy of six months or less.

For hospice *services* only, *your* immediate family is considered to be *your* parent, spouse, children or step-children.

Covered expenses are payable for the following hospice *services*:

1. Room and board and other *services* and supplies;

2. Part-time nursing care by, or supervised by, a registered nurse for up to 8 hours per day;

3. Counseling *services* by a *qualified practitioner* for the hospice patient and the immediate family;

4. Medical social *services* provided to *you* or *your* immediate family under the direction of a *qualified practitioner,* which include the following:
   a. Assessment of social, emotional and medical needs, and the home and family situation;
   b. Identification of the community resources available; and
   c. Assistance in obtaining those resources;

5. Nutritional counseling;

6. Physical or occupational therapy;

7. Part-time home health aide service for up to 8 hours in any one day;

8. Medical supplies, drugs and medicines prescribed by a *qualified practitioner*.

Hospice care benefits do NOT include:

1. Private duty nursing *services* when *confined* in a hospice facility;

2. A *confinement* not required for pain control or other acute chronic symptom management;

3. Funeral arrangements;

4. Financial or legal counseling, including estate planning or drafting of a will;

5. Homemaker or caretaker *services,* including a sitter or companion *services*;

6. Housecleaning and household maintenance;

7. *Services* of a social worker other than a licensed clinical social worker;

8. *Services* by volunteers or persons who do not regularly charge for their *services*; or

9. *Services* by a licensed pastoral counselor to a member of his or her congregation when *services* are in the course of the duties to which he or she is called as a pastor or minister.

Hospice care program means a written plan of hospice care, established and reviewed by the *qualified practitioner* attending the patient and the hospice care agency, for providing palliative and supportive care to hospice patients. It offers supportive care to the families of hospice patients, an assessment of the hospice patient's medical and social needs, and a description of the care to meet those needs.

Hospice facility means a licensed facility or part of a facility which principally provides hospice care, keeps medical records of each patient, has an ongoing quality assurance program and has a physician on call at all times. A hospice facility provides 24-hour-a-day nursing *services* under the direction of a R.N. and has a full-time administrator.

Hospice care agency means an agency which has the primary purpose of providing hospice *services* to hospice patients. It must be licensed and operated according to the laws of the state in which it is located and meets all of these requirements: (1) has obtained any required certificate of need; (2) provides 24-hours a day, 7 day-a-week service supervised by a *qualified practitioner*; (3) has a full-time coordinator; (4) keeps written records of *services* provided to each patient; (5) has a nurse coordinator who is a R.N., who has four years of full-time clinical experience, of which at least two involved caring for terminally ill patients; and, (6) has a licensed social service coordinator.

A hospice care agency will establish policies for the provision of hospice care, assess the patient's medical and social needs and develop a program to meet those needs. It will provide an ongoing quality assurance program, permit area medical personnel to use its *services* for their patients, and use volunteers trained in care of, and *services* for, non-medical needs.

HOME HEALTH CARE

Expenses incurred for home health care are payable as shown on the Medical Schedule of Benefits. The maximum weekly benefit for such coverage may not exceed the maximum allowable weekly cost for care in a skilled nursing facility.

Each visit by a home health care provider for evaluating the need for, developing a plan, or providing *services* under a home health care plan will be considered one home health care visit. Up to 4 consecutive hours of service in a 24-hour period is considered one home health care visit. A visit by a home health care provider of 4 hours or more is considered one visit for every 4 hours or part thereof.

Home health care provider means an agency licensed by the proper authority as a home health agency or *Medicare* approved as a home health agency.

Home health care will not be reimbursed unless this Plan determines:

1. Hospitalization or *confinement* in a skilled nursing facility would otherwise be required if home care were not provided;

2. Necessary care and treatment are not available from a *family member* or other persons residing with *you*; and

3. The home health care *services* will be provided or coordinated by a state-licensed or *Medicare*-certified home health agency or certified rehabilitation agency.

The home health care plan must be reviewed and approved by the *qualified practitioner* under whose care *you* are currently receiving treatment for the *bodily injury* or *sickness* which requires the home health care.

The home health care plan consists of:

1. Care by or under the supervision of a registered nurse (R.N.);

2. Physical, speech, occupational, cognitive and respiratory therapy and home health aide *services*; and

3. Medical supplies, laboratory *services* and nutritional counseling, if such *services* and supplies would have been covered if *you* were *hospital confined*.

Home health care benefits do not include:

1. Charges for mileage or travel time to and from the *covered person's* home;

2. Wage or shift differentials for home health care providers;

3. Charges for supervision of home health care providers;

4. Private duty nursing;

5. *Durable medical equipment* and prosthetics.

DURABLE MEDICAL EQUIPMENT (DME)

Durable medical equipment (DME) is payable as shown on the Medical Schedule of Benefits and includes *DME* provided within a *covered person's* home. Rental is allowed up to, but not to exceed, the total purchase price of the *durable medical equipment (DME)*. This Plan, at its option, may authorize the purchase of *DME* in lieu of its rental, if the rental price is projected to exceed the purchase price. Oxygen and rental of equipment for its administration and insulin infusion pumps in the treatment of diabetes are considered *DME*. Repair or maintenance of *DME* is covered if such replacement meets the OHP-approved repair and replacement criteria. Duplicate *DME* is not covered.

Prosthetics and Orthotics

Initial prosthetic devices or supplies, including but not limited to, limbs and eyes are payable as shown on the Medical Schedule of Benefits. Coverage will be provided for prosthetic devices necessary to restore minimal basic function. Replacement is a *covered expense* if due to pathological changes. Repair or maintenance of prosthetics or orthotics is covered if such replacement meets the OHP-approved repair and replacement criteria.

SPECIALTY DRUG MEDICAL BENEFIT

Specialty drugs are payable as shown on the Medical Schedule of Benefits.

For more information regarding *specialty drugs*, call the toll-free customer service telephone number on *your* ID card or log-in or register at www.humana.com. Once *you* have logged in to www.human.com, under "Coverage and Claims", "Viewing", select *your* Prescription Drug Plan and click "Go". Under "Related links", click "Printable drug list and forms". Select the Drug List and the *specialty drugs* will be indicated within that list.

AMBULANCE

Local professional ground or air *ambulance* service to the nearest *hospital* equipped to provide the necessary treatment is covered as shown on the Medical Schedule of Benefits. *Ambulance* service must not be provided primarily for the convenience of the patient or the *qualified practitioner*.

MORBID OBESITY

Morbid obesity services are payable as shown on the Medical Schedule of Benefits section.

Bariatric Services

When in need of *bariatric services* and to obtain a list of covered *bariatric surgeries*, please contact the Bariatric Management Team at:

Telephone Number: (866) 486-5295
Fax Number: (502) 508-0049
Email: bariatrics@humana.com

The list of covered *bariatric surgeries* is subject to change without notice.

Precertification is required for *bariatric services*. If *precertification* is not received, benefits will not be covered. *You* or *your qualified practitioner* must notify Humana of *your* need for *bariatric services* in advance of receiving *your* initial evaluation for *bariatric surgery*. Humana must be given a reasonable opportunity to review the clinical results of the *bariatric surgery* evaluation before determining if the *bariatric surgery* will be covered. Humana will advise *your qualified practitioner* of its determination.

Covered persons are eligible for *bariatric surgery* ONLY if:

1. The patient is age 18 or older; and

2. The patient meets the definition of *morbid obesity* as defined in the Definitions section; and

3. The patient has been previously unsuccessful with medical treatment for obesity; and

4. The patient has had a recent (within 12 months prior to planned surgical intervention) psychological evaluation in which they are evaluated to rule out psychiatric disorders (e.g. schizophrenia, major depression, chemical dependency) that interfere with adherence to a new lifestyle and are cleared for *surgery*; and

5. The patient utilizes a Humana preferred facility for the *bariatric surgery.*

Benefits are payable only if the *bariatric services* are approved by Humana.

Direct, non-medical costs for the *covered person* receiving *bariatric services* and one designated caregiver or support person will be paid as shown on the Medical Schedule of Benefits, for: (a) transportation to and from the *bariatric services* facility where the *bariatric services* are performed; and (b) temporary lodging at a prearranged location when requested by the *bariatric services* facility and approved by Humana. These direct, non-medical costs are only available if the *covered person* lives more than 100 miles from the *bariatric services* facility and are only available to the caregiver or support person, if he or she lives more than 100 miles from the *bariatric services* facility.

TEMPOROMANDIBULAR JOINT DYSFUNCTION (TMJ)

Covered expenses are payable as shown on the Medical Schedule of Benefits for any jaw joint problem including any temporomandibular joint disorder, craniomaxillary, craniomandibular disorder or other conditions of the joint linking the jaw bone and skull and treatment of the facial muscles used in expression and mastication functions, for symptoms including but not limited to, headaches. These expenses do not include charges for orthodontic *services*.

DENTAL INJURY

Dental injury services are payable as shown on the Medical Schedule of Benefits and include charges for *services* for the treatment of a *dental injury* to a *sound natural tooth*, including but not limited to extraction and initial replacement.

Services for teeth injured as a result of chewing are covered.

Services must begin within 30 days after the date of the *dental injury*. *Services* must be completed within one year after the date of the *dental injury*.

Benefits will be paid only for *expenses incurred* for the least expensive *service* that will produce a professionally adequate result as determined by this Plan.

INFERTILITY

Infertility *services* are payable for *you* or *your* covered *dependent* spouse as shown on the Medical Schedule of Benefits.

Artificial Means of Achieving Pregnancy

Services performed to achieve pregnancy or ovulation by artificial means include artificial insemination and in vitro fertilization. Gamete intra fallopian transfer (GIFT), zygote intra fallopian transfer (ZIFT), reversal of surgical sterilization, embryo transplantation and extracorporeal insemination are not covered.

THERAPY SERVICES

Therapy *services* are payable as shown on the Medical Schedule of Benefits.

Chiropractic Care

Chiropractic care for the treatment of a *bodily injury* or *sickness* is payable as shown on the Medical Schedule of Benefits.

TRANSPLANT SERVICES

This Plan will pay benefits for the expense of a transplant as defined below for a *covered person* when approved in advance by Humana, subject to those terms, conditions and limitations described below and contained in this Plan. Please call the customer service phone number listed on the back of *your* ID card when in need of these *services*.

Precertification

Precertification is required. If *precertification* is not received, transplant *services* will not be covered.

Covered Organ Transplant

Only the *services*, care and treatment received for, or in connection with, the pre-approved transplant of the organs identified hereafter, which are determined by Humana to be *medically necessary services* and which are not *experimental, investigational or for research purposes* will be covered by this Plan. The transplant includes: pre-transplant *services*, transplant inclusive of any chemotherapy and associated *services*, post-discharge *services* and treatment of complications after transplantation of the following organs or procedures only:

1. Heart;

2. Lung(s);

3. Liver;

4. Kidney;

5. Bone Marrow*;

6. Intestine;

7. Pancreas;

8. Auto islet cell;

9. Multivisceral;

10. Any combination of the above listed organs;

11. Any organ not listed above required by federal law.

*The term bone marrow refers to the transplant of human blood precursor cells which are administered to a patient following high-dose, ablative or myelosuppresive chemotherapy. Such cells may be derived from bone marrow, circulating blood, or a combination of bone marrow and circulating blood obtained from the patient in an autologous transplant or from a matched related or unrelated donor or cord blood. If chemotherapy is an integral part of the treatment involving a transplant of bone marrow, the term bone marrow includes the harvesting, the transplantation and the chemotherapy components. Storage of cord blood and stem cells will not be covered unless as an integral part of a transplant of bone marrow approved by Humana.

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

For a transplant to be considered fully approved, prior written approval from Humana is required in advance of the transplant. *You* or *your qualified practitioner* must notify Humana in advance of *your* need for an initial transplant evaluation in order for Humana to determine if the transplant will be covered. For approval of the transplant itself, Humana must be given a reasonable opportunity to review the clinical results of the evaluation before rendering a determination.

Once the transplant is approved, Humana will advise the *covered person's qualified practitioner*. Benefits are payable only if the pre-transplant *services*, the transplant and post-discharge *services* are approved by Humana.

Exclusions

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

1. It is *experimental, investigational or for research purposes* as defined in the Definitions section;

2. Humana is not contacted for authorization prior to referral for evaluation of the transplant;

3. Humana does not approve coverage for the transplant, based on its established criteria;

4. Expenses are eligible to be paid under any private or public research fund, government program, except Medicaid, or another funding program, whether or not such funding was applied for or received;

5. The expense relates to the transplantation of any non-human organ or tissue, unless otherwise stated in this Plan;

6. The expense relates to the donation or acquisition of an organ for a recipient who is not covered by this Plan;

7. A denied transplant is performed; this includes the pre-transplant evaluation, pre-transplant *services*, the transplant procedure, post-discharge *services*, immunosuppressive drugs and complications of such transplant;

8. The *covered person* for whom a transplant is requested has not met pre-transplant criteria as established by Humana.

Covered Services

For approved transplants, and all related complications, this Plan will cover only the following expenses:

1. *Hospital* and *qualified practitioner services*, payable as shown on the Medical Schedule of Benefits. If *services* are rendered at a Humana National Transplant Network (NTN) facility, *covered expenses* are paid in accordance to the NTN contracted rates;

2. Organ acquisition and donor costs. Except for bone marrow transplants, donor costs are not payable under this Plan if they are payable in whole or in part by any other group plan, insurance company, organization or person other than the donor's family or estate. Coverage for bone marrow transplants procedures will include costs associated with the donor-patient to the same extent and limitations associated with the *covered person;*

3. Direct, non-medical costs for the *covered person*, when the transplant is performed at a Humana National Transplant Network facility, will be paid as shown on the Medical Schedule of Benefits, for: (a) transportation to and from the *hospital* where the transplant is performed; and (b) temporary lodging up to $50 per day at a prearranged location when requested by the *hospital* and approved by Humana. These direct, non-medical costs are only available if the *covered person* lives more than 100 miles from the transplant facility;

4. Direct, non-medical costs for one support person of the *covered person* (two persons if the patient is under age 18 years), when the transplant is performed at a Humana National Transplant Network facility, will be paid as shown on the Medical Schedule of Benefits, for: (a) transportation to and from the approved facility where the transplant is performed; and (b) temporary lodging up to $50 per day at a prearranged location during the *covered person's confinement* in the *hospital*. These direct, non-medical costs are only available if the *covered person's* support person(s) live more than 100 miles from the transplant facility.

   Non-medical costs are not covered if a transplant is performed at a facility that is not a Humana National Transplant Network facility.

BEHAVIORAL HEALTH SERVICES

Expense incurred by *you* during a plan of treatment for *behavioral health* is payable as shown on the Medical Schedule of Benefits for:

1. Charges made by a *qualified practitioner*;

2. Charges made by a *hospital*;

3. Charges made by a *qualified treatment facility*;

4. Charges for x-ray and laboratory expenses.

Inpatient Services

Covered expenses while *confined* as a registered bed patient in a *hospital* or *qualified treatment facility* are payable as shown on the Medical Schedule of Benefits.

Outpatient Services

Covered expenses for outpatient treatment received while not *confined* in a *hospital* or *qualified treatment facility* are payable as shown on the Medical Schedule of Benefits.

Limitations

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

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

SEX REASSIGNMENT SURGERY

Sex reassignment *surgery* is considered *medically necessary* when all of the following criteria are met:

1. *Covered person* is at least 18 years old; **and**

2. *Covered person* has met criteria for the diagnosis of "true" transsexualism, including:
   a. A sense of estrangement from one's own body, so that any evidence of one's own biological sex is regarded as repugnant; and
   b. A stable transsexual orientation evidenced by a desire to be rid of one's genitals and to live in society as a member of the other sex for at least 2 years, that is, not limited to periods of stress; and
   c. Absence of physical inter-sex of genetic abnormality; and
   d. Does not gain sexual arousal from cross-dressing; and
   e. Life-long sense of belonging to the opposite sex and of having been born into the wrong sex, often since childhood; and
   f. Not due to another biological, chromosomal or associated psychiatric disorder, such as schizophrenia; and
   g. Wishes to make his or her body as congruent as possible with the preferred sex through *surgery* and hormone treatment; **and**

3. *Covered person* is at least 18 years old; **and**

4. *Covered person* has met criteria for the diagnosis of "true" transsexualism, including:
   a. A sense of estrangement from one's own body, so that any evidence of one's own biological sex is regarded as repugnant; and
   b. A stable transsexual orientation evidenced by a desire to be rid of one's genitals and to live in society as a member of the other sex for at least 2 years, that is, not limited to periods of stress; and
   c. Absence of physical inter-sex of genetic abnormality; and
   d. Does not gain sexual arousal from cross-dressing; and
   e. Life-long sense of belonging to the opposite sex and of having been born into the wrong sex, often since childhood; and
   f. Not due to another biological, chromosomal or associated psychiatric disorder, such as schizophrenia; and
   g. Wishes to make his or her body as congruent as possible with the preferred sex through *surgery* and hormone treatment; **and**

5. *Covered person* has completed a recognized program of transgender identity treatment as evidenced by all of the following:
   a. A qualified *mental health* professional* who has been acquainted with the *covered person* for at least 18 months recommends sex reassignment *surgery* documented in the form of a written comprehensive evaluation; and
   b. For genital surgical sex reassignment, a second concurring recommendation by another qualified *mental health* professional * must be documented in the form of a written expert opinion**; and
   c. For genital surgical sex reassignment, *covered person* has undergone a urological examination for the purpose of identifying and perhaps treating abnormalities of the genitourinary tract, since genital surgical sex reassignment includes the invasion of, and the alteration of, the genitourinary tract (urological examination is not required for persons not undergoing genital reassignment); and
   d. C*overed person* has demonstrated an understanding of the proposed male-to-female or female-to-male sex reassignment *surgery* with its attendant costs, required lengths of hospitalization, likely complications, and post-surgical rehabilitation requirements of the planned *surgery*; and
   e. Psychotherapy is not an absolute requirement for *surgery* unless the *mental health* professional's initial assessment leads to a recommendation for psychotherapy that specifies the goals of treatment, estimates its frequency and duration throughout the real life experience (usually a minimum of 3 months); and
   f. The *covered person* has successfully lived and worked within the desired gender role full-time for at least 12 months (so-called real-life experience), without periods of returning to the original gender; and
   g. Unless medically contraindicated, *covered person* has received at least 12 months of continuous hormonal sex reassignment therapy recommended by a *mental health* professional and carried out by an endocrinologist (which can be simultaneous with the real-life experience).

* At least one of the two clinical behavioral scientists making the favorable recommendation for surgical (genital) sex reassignment must possess a doctoral degree (e.g., Ph.D., Ed.D., D.Sc., D.S.W., Psy.D., or M.D.). Note: Evaluation of candidacy for sex reassignment *surgery* by a *mental health* professional is covered under the *covered person's* medical benefit, unless the services of a *mental health* professional are necessary to evaluate and treat a *covered person's* problem, in which case the *mental health* professional's *services* are covered under the *covered person's behavioral health* benefit. Please check benefit plan descriptions.

** Either two separate letters or one letter with two signatures is acceptable.

Note: Rhinoplasty, face-lifting, lip enhancement, facial bone reduction, blepharoplasty, liposuction of the waist, reduction thyroid chondroplasty, laryngoplasty or shortening of the vocal cords, which have been used in feminization, are considered cosmetic. Similarly, chin implants, nose implants, and lip reduction, which have been used to assist masculinization, are considered cosmetic.

Note on gender specific services for transgender persons:

Gender-specific services may be *medically necessary* for transgender persons appropriate to their anatomy. Examples include:

1. Breast cancer screening may be *medically necessary* for female to male transgender persons who have not undergone a mastectomy;

2. Prostate cancer screening may be *medically necessary* for male to female transgender individuals who have retained their prostate.

OTHER COVERED EXPENSES

The following are other *covered expenses* payable as shown on the Medical Schedule of Benefits:

1. Blood and blood plasma are payable as long as it is NOT replaced by donation, and administration of blood and blood products including blood extracts or derivatives;

2. Casts, trusses, crutches, *orthotics*, splints and braces. *Orthotics* must be custom made or custom fitted, made of rigid or semi-rigid material. Oral or dental splints and appliances must be custom made and for the treatment of documented obstructive sleep apnea. Unless specifically stated otherwise, fabric supports, replacement *orthotics* and braces, oral splints and appliances, dental splints and appliances, and dental braces are not a *covered expense*;

3. Reconstructive *surgery* due to *bodily injury*, infection or other disease of the involved part or congenital disease or anomaly of a covered *dependent* child which resulted in a *functional impairment*;

4. Reconstructive *services* following a covered mastectomy, including but not limited to:
   a. Reconstruction of the breast on which the mastectomy was performed;
   b. Reconstruction of the other breast to achieve symmetry;
   c. Prosthesis; and
   d. Treatment of physical complications of all stages of the mastectomy, including lymphedemas;

5. Routine costs associated with clinical trials, when approved by this Plan in accordance with the requirements of the Affordable Care Act. For additional details, go to www.humana.com, click on "Humana Websites for Providers" along the left hand side of the page, then click "Medical Coverage Policies" under Critical Topics, then click "Medical Coverage Policies" and search for Clinical Trials.

6. Cranial banding, when approved by this Plan. For additional details, go to www.humana.com, and follow the instructions below:
   a. Click on the "Providers" tab at the top of the page, then
   b. Click "Medical and pharmacy coverage policies" under the "Resources" box at the bottom of the page, then
   c. Type "cranial orthotics" in the "Search By Keyword" box; then
   d. Open the "Cranial Orthotics (Cranial Banding, Soft-Shell Helmets)" policy.

LIMITATIONS AND EXCLUSIONS

This Plan does not provide benefits for:

1. *Services*:
   a. Not furnished by a *qualified practitioner* or *qualified treatment facility*;
   b. Not authorized or prescribed by a *qualified practitioner*;
   c. Not specifically covered by this Plan whether or not prescribed by a *qualified practitioner*;
   d. Which are not provided;
   e. For which no charge is made, or for which *you* would not be required to pay if *you* were not covered under this Plan unless charges are received from and reimbursable to the United States Government or any of its agencies as required by law;
   f. Furnished by or payable under any plan or law through any government or any political subdivision (this does not include *Medicare* or Medicaid);
   g. Furnished for a military service connected *sickness* or *bodily injury* by or under an agreement with a department or agency of the United States Government, including the Department of Veterans Affairs;
   h. Performed in association with a *service* that is not covered under this Plan.

2. Immunizations required for travel and vocational;

3. Radial keratotomy, refractive keratoplasty or any other *surgery* to correct myopia, hyperopia or stigmatic error;

4. *Services* related to gender change;

5. *Cosmetic surgery* and cosmetic *services* or devices, unless for reconstructive *surgery*:
   a. Resulting from a *bodily injury*, infection or other disease of the involved part, when *functional impairment* is present; or
   b. Resulting from a congenital disease or anomaly of a covered *dependent* child which resulted in a *functional impairment*.

   Expense incurred for reconstructive *surgery* performed due to the presence of a psychological condition is not covered, unless the condition(s) described above are also met;

6. Hair prosthesis, hair transplants or hair implants;

7. Dental *services* or appliances for the treatment of the teeth, gums, jaws or alveolar processes, including but not limited to, implants and related procedures, routine dental extractions (including removal of impacted wisdom teeth) and orthodontic procedures, unless specifically provided under this Plan;

8. *Services* which are:
   a. Rendered in connection with a *mental health* disorder not classified in the International Classification of Diseases of the U.S. Department of Health and Human Services;
   b. Extended beyond the period necessary for evaluation and diagnosis of learning and behavioral disabilities or for mental retardation.

9. Marriage counseling;

10. Education or training, unless otherwise specified in this Plan;

11. Educational or vocational therapy, testing, services or schools, including therapeutic boarding schools and other therapeutic environments. Educational or vocational videos, tapes, books and similar materials are also excluded;

12. Expenses for *services* that are primarily and customarily used for environmental control or enhancement (whether or not prescribed by a *qualified practitioner*) and certain medical devices including, but not limited to:
    a. Common household items including air conditioners, air purifiers, water purifiers, vacuum cleaners, waterbeds, hypoallergenic mattresses or pillows or exercise equipment;
    b. Motorized transportation equipment (e.g. scooters), escalators, elevators, ramps or modifications or additions to living/working quarters or transportation vehicles;
    c. Personal hygiene equipment including bath/shower chairs and transfer equipment or supplies;
    d. Personal comfort items including cervical pillows, gravity lumbar reduction chairs, swimming pools, whirlpools, spas or saunas;
    e. Medical equipment including blood pressure monitoring devices, PUVA lights and stethoscopes;
    f. Communication system, telephone, television or computer systems and related equipment or similar items or equipment;
    g. Communication devices, except after surgical removal of the larynx or a diagnosis of permanent lack of function of the larynx.

13. Any medical treatment, procedure, drug, biological product or device which is *experimental, investigational or for research purposes*, unless otherwise specified in this Plan;

14. *Services* that are not *medically necessary*, except routine/preventive *services*;

15. Charges in excess of the *maximum allowable fee* for the *service*;

16. *Services* provided by a person who ordinarily resides in *your* home or who is a *family member*;

17. Any *expense incurred* prior to *your* effective date under this Plan or after the date *your* coverage under this Plan terminates, except as specifically described in this Plan;

18. *Expenses incurred* for which *you* are entitled to receive benefits under *your* previous dental or medical plan;

19. Any expense due to the *covered person's*:
    a. Engaging in an illegal occupation; or
    b. Commission of or an attempt to commit a criminal act.

20. Any loss caused by or contributed to:
    a. War or any act of war, whether declared or not;
    b. Insurrection; or
    c. Any act of armed conflict, or any conflict involving armed forces of any authority.

21. Any *expense incurred* for *services* received outside of the United States, except for *emergency* care *services*, unless otherwise determined by this Plan;

22. Treatment of nicotine habit or addiction, including, but not limited to hypnosis, smoking cessation products or tapes, unless otherwise determined by this Plan;

23. Vitamins, dietary supplements and dietary formulas except enteral formulas, nutritional supplements or low protein modified food products for the treatment of an inherited metabolic disease, e.g. phenylketonuria (PKU);

24. *Prescription* drugs and *self-administered injectable drugs*, unless administered to *you*:
    a. While inpatient in a *hospital*, *qualified treatment facility* or skilled nursing facility;
    b. By the following, when deemed appropriate by this Plan: a *qualified practitioner*, during an office visit, while outpatient, or at a home health care agency as part of a covered home health care plan approved by this Plan.

25. Any drug prescribed, except:
    a. FDA approved drugs utilized for FDA approved indications; or
    b. FDA approved drugs utilized for *off-label drug indications* recognized in at least one compendia reference or peer-reviewed medical literature deemed acceptable to this Plan.

26. *Off-evidence drug indications*;

27. Over-the-counter, non-prescription medications, unless for drugs, medicines or medications on the Women's Healthcare Drug List with a *prescription* from a *qualified practitioner.* See the Prescription Drug Benefit;

28. Over-the-counter medical items or supplies that can be provided or prescribed by a *qualified practitioner* but are also available without a written order or *prescription*, except for preventive *services* (with a *prescription* from a *qualified practitioner*);

29. Growth hormones (medications, drugs or hormones to stimulate growth);

30. Therapy and testing for treatment of allergies including, but not limited to, *services* related to clinical ecology, environmental allergy and allergic immune system dysregulation and sublingual antigen(s), extracts, neutralization test and/or treatment UNLESS such therapy or testing is approved by:
    a. The American Academy of Allergy and Immunology, or
    b. The Department of Health and Human Services or any of its offices or agencies.

31. Professional pathology or radiology charges, including but not limited to, blood counts, multi-channel testing, and other clinical chemistry tests, when:
    a. The *services* do not require a professional interpretation, or
    b. The *qualified practitioner* did not provide a specific professional interpretation of the test results of the *covered person*.

32. *Services* that are billed incorrectly or billed separately, but are an integral part of another billed *service*;

33. Expenses for health clubs or health spas, aerobic and strength conditioning, work-hardening programs or weight loss or similar programs, and all related material and product for these programs;

34. *Alternative medicine*;

35. *Services* rendered in a premenstrual syndrome clinic or holistic medicine clinic;

36. *Services* of a midwife, unless provided by a Certified Nurse Midwife;

37. The following types of care of the feet:
    a. Shock wave therapy of the feet.
    b. The treatment of weak, strained, flat, unstable or unbalanced feet.
    c. Hygienic care, and the treatment of superficial lesions of the feet, such as corns, calluses or hyperkeratosis.
    d. The treatment of tarsalgia, metatarsalgia, or bunion, except surgically.
    e. The cutting of toenails, except the removal of the nail matrix.
    f. The provision of heel wedges, lifts or shoe inserts.
    g. The provision of arch supports or orthopedic shoes. Arch supports and orthopedic shoes are covered if *medically necessary* because of diabetes or hammertoe.

38. *Custodial care* and *maintenance care*;

39. Weekend non-emergency *hospital admissions*, specifically *admissions* to a *hospital* on a Friday or Saturday at the convenience of the *covered person* or his or her *qualified practitioner* when there is no cause for an *emergency admission* and the *covered person* receives no *surgery* or therapeutic treatment until the following Monday;

40. *Hospital* inpatient *services* when *you* are in observation status;

41. *Services* rendered by a standby physician, surgical assistant, assistant surgeon, physician assistant, registered nurse or certified operating room technician unless *medically necessary*;

42. *Ambulance services* for routine transportation to, from or between medical facilities and/or a *qualified practitioner's* office;

43. *Preadmission testing*/procedural testing duplicated during a *hospital confinement*;

44. Lodging accommodations or transportation, unless specifically provided under this Plan;

45. Communications or travel time;

46. No benefits will be provided for the following, unless otherwise determined by this Plan:
    a. Immunotherapy for recurrent abortion;
    b. Chemonucleolysis;
    c. Biliary lithotripsy;
    d. Home uterine activity monitoring;
    e. Sleep therapy;
    f. Light treatments for Seasonal Affective Disorder (S.A.D.);
    g. Immunotherapy for food allergy;
    h. Prolotherapy;
    i. Hyperhidrosis *surgery*;
    j. Lactation therapy; or
    k. Sensory integration therapy;

47. Any *covered expenses* to the extent of any amount received from others for the *bodily injuries* or losses which necessitate such benefits. Without limitation, "amounts received from others" specifically includes, but is not limited to, liability insurance, workers' compensation, uninsured motorists, underinsured motorists, "no-fault" and automobile med-pay payments or recovery from any identifiable fund regardless of whether the *beneficiary* was made whole;

48. Surrogate parenting;

49. Any *bodily injury* or *sickness* arising from or sustained in the course of any occupation or employment for compensation, profit or gain for which:
    a. Benefits are provided or payable under any Workers' Compensation or Occupational Disease Act or Law, or
    b. Coverage was available under any Workers' Compensation or Occupational Disease Act or Law regardless of whether such coverage was actually purchased;

50. Routine physical examinations and related *services* for occupation, employment, school, sports, camp, travel, purchase of insurance or premarital tests or examinations, unless specifically provided under this Plan;

51. The purchase, fitting or repair of eyeglass frames and lenses or contact lenses, unless specifically provided under this Plan;

52. Routine vision examinations;

53. Vision therapy;

54. Routine hearing examinations;

55. Routine hearing testing;

56. Elective medical or surgical abortion, unless:
    a. The pregnancy would endanger the life of the mother; or
    b. The pregnancy is a result of rape or incest; or
    c. The fetus has been diagnosed with a lethal or otherwise significant abnormality;

57. *Services* for a reversal of sterilization;

58. Contraceptive pills and patches, abortifacients and spermicide (see the Prescription Drug Benefit for coverage);

59. Private duty nursing.

60. Wigs, except for cancer patients with hair loss resulting from chemotherapy and/or radiation therapy;

61. *Morbid obesity services* other than the covered *services* listed on the Medical Schedule of Benefits;

62. Surgical procedures for the removal of excess skin and/or fat in conjunction with or resulting from weight loss or weight loss *surgery*;

63. No benefits will be provided for, or on account of, the following items:

    a. Expenses for a *bariatric surgery* that are *experimental, investigational or for research purposes*;
    b. *Bariatric services* not approved by this Plan;
    c. *Bariatric services* for a *bariatric surgery* denied by this Plan, based on this Plan's established criteria;
    d. *Bariatric services* for which *you* have not met criteria as established by this Plan;
    e. Expenses for *bariatric surgery* performed outside of the United States;
    f. Any care resulting from a non-covered *bariatric surgery*.

64. Dental osteotomies;

65. Artificial means to achieve pregnancy or ovulation, including, but not limited to, gamete intra fallopian transfer (GIFT), zygote intra fallopian transfer (ZIFT), reversal of surgical sterilization, embryo transplantation and extracorporeal insemination;

66. *Services* related to the treatment and/or diagnosis of sexual dysfunction/impotence, if related to a mental health diagnosis;

67. Acupuncture;

68. Bras for breast prosthesis;

69. Dental implants;

70. Fitness programs;

71. Oral splints;

72. Disposable medical supplies;

73. Light weight and sport wheelchairs;

74. *Hospital* beds;

75. *Residential treatment facilities*;

76. Halfway-house *services*.

NOTE: These limitations and exclusions apply even if a *qualified practitioner* has performed or prescribed a *medically necessary* procedure, treatment or supply. This does not prevent *your qualified practitioner* from providing or performing the procedure, treatment or supply, however, the procedure, treatment or supply will not be a *covered expense*.

COORDINATION OF BENEFITS

BENEFITS SUBJECT TO THIS PROVISION

Benefits described in this Plan are coordinated with benefits provided by other plans under which *you* are also covered. This is to prevent duplication of coverage and a resulting increase in the cost of medical coverage.

For this purpose, a plan is one which covers medical or dental expenses and provides benefits or *services* by group, franchise or blanket insurance coverage. This includes group-type contracts not available to the general public, obtained and maintained only because of the *covered person's* membership in, or connection with, a particular organization or group, whether or not designated as franchise, blanket, or in some other fashion. Plan also includes any coverage provided through the following:

1. Employer, trustee, union, employee benefit, or other association; or

2. Governmental programs, programs mandated by state statute, or sponsored or provided by an educational institution.

This Coordination of Benefits provision does not apply to any individual policies or Blanket Student Accident Insurance provided by, or through, an educational institution. Allowable expense means any eligible expense, a portion of which is covered under one of the plans covering the person for whom claim is made. Each plan will determine what is an allowable expense according to the provisions of the respective plan. When a plan provides benefits in the form of *services* rather than cash payments, the reasonable cash value of each *service* rendered will be deemed to be both an allowable expense and a benefit paid.

EFFECT ON BENEFITS

One of the plans involved will pay benefits first. This is called the primary plan. All other plans are called secondary plans.

When this Plan is the secondary plan, the sum of the benefit payable will not exceed 100% of the total allowable expenses incurred under this Plan and any other plans included under this provision.

ORDER OF BENEFIT DETERMINATION

In order to pay claims, it must be determined which plan is primary and which plan(s) are secondary. A plan will pay benefits first if it meets one of the following conditions:

1. The plan has no coordination of benefits provision;

2. The plan covers the person as an *employee*;

3. For a child who is covered under both parents' plans, the plan covering the parent whose birthday (month and day) occurs first in the *calendar year* pays before the plan covering the other parent. If the birthdates of both parents are the same, the plan which has covered the person for the longer period of time will be determined the primary plan;

   If a plan other than this Plan does not include provision 3, then the gender rule will be followed to determine which plan is primary.

4. In the case of *dependent* children covered under the plans of divorced or separated parents, the following rules apply:
   a. The plan of a parent who has custody will pay the benefits first;
   b. The plan of a step-parent who has custody will pay benefits next;
   c. The plan of a parent who does not have custody will pay benefits next;
   d. The plan of a step-parent who does not have custody will pay benefits next.

   There may be a court decree which gives one parent financial responsibility for the medical or dental expenses of the *dependent* children. If there is a court decree, the rules stated above will not apply if they conflict with the court decree. Instead, the plan of the parent with financial responsibility will pay benefits first.

5. If a person is laid off or is retired or is a *dependent* of such person, that plan covers after the plan covering such person as an active *employee* or *dependent* of such *employee*. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule will be ignored.

If the above rules do not apply or cannot be determined, then the plan that covered the person for the longest period of time will pay first.

COORDINATION OF BENEFITS WITH MEDICARE

When an employer employs 100 or more persons, the benefits of this Plan will be payable first for a *covered person* who is under age 65 and eligible for *Medicare*. The benefits of *Medicare* will be payable second.

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

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

For the purposes of determining benefits payable for any *covered person* who is eligible to enroll for *Medicare* Part B, but does not, Humana assumes the amount payable under *Medicare* Part B to be the amount the *covered person* would have received if he or she enrolled for it. A *covered person* is considered to be eligible for *Medicare* on the earliest date coverage under *Medicare* could become effective for him or her.

OPTIONS

Federal Law allows this Plan's actively working covered *employees* age 65 or older and their covered spouses who are eligible for *Medicare* to choose one of the following options:

OPTION 1 - The benefits of this Plan will be payable first and the benefits of *Medicare* will be payable second.

OPTION 2 - *Medicare* benefits only. The *covered person* and his or her *dependents*, if any, will not be covered by this Plan.

Each covered *employee* and each covered spouse will be provided with the choice to elect one of these options at least one month before the covered *employee* or the covered spouse becomes age 65. All new covered *employees* and newly covered spouses age 65 or older will also be offered these options. If Option 1 is chosen, its issue is subject to the same requirements as for a covered *employee* or *dependent* who is under age 65.

Under Federal law, there are two categories of persons eligible for *Medicare*. The calculation and payments of benefits by this Plan differs for each category.

CATEGORY 1 - *Medicare* Eligibles are actively working covered *employees* age 65 or older and their age 65 or older covered spouses, and age 65 or older covered spouses of actively working covered *employees* who are under age 65.

CATEGORY 2 - *Medicare* Eligibles are any other *covered persons* entitled to *Medicare*, whether or not they enrolled for it. This category includes, but is not limited to, retired covered *employees* and their spouses or covered *dependents* of a covered *employee* other than his or her spouse.

CALCULATION AND PAYMENT OF BENEFITS

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

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

RIGHT OF RECOVERY

This Plan reserves the right to recover benefit payments made for an allowable expense under this Plan in the amount which exceeds the maximum amount this Plan is required to pay under these provisions. This right of recovery applies to this Plan against:

1. Any person(s) to, for or with respect to whom, such payments were made; or

2. Any other insurance companies, or organizations which according to these provisions, owe benefits due for the same allowable expense under any other plan.

This Plan alone will determine against whom this right of recovery will be exercised.

CLAIM PROCEDURES

SUBMITTING A CLAIM

This section describes what a *covered person* (or his or her authorized representative) must do to file a claim for Plan benefits.

- A claim must be filed with Humana in writing and delivered to Humana by mail, postage prepaid. However, a submission to obtain preauthorization may also be filed with Humana by telephone;

- Claims must be submitted to Humana at the address indicated in the documents describing this Plan or *claimant's* identification card. Claims will not be deemed submitted for purposes of these procedures unless and until received at the correct address;

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

- Claims submissions must be timely. All claims must be filed in the same *calendar year* that the *service* was rendered, or during the following *calendar year*. The deadline for filing a claim that *you* were overcharged for coverage is the end of the year following the year for which the premium was paid. Failure to file a claim within the deadline will result in denial of the claim. Plan benefits are only available for claims that are incurred by a *covered person* during the period that he or she is covered under this Plan;

- Claims submissions must be complete. They must contain, at a minimum:
  a. The name of the *covered person* who incurred the *covered expense*;
  b. The name and address of the health care provider;
  c. The diagnosis of the condition;
  d. The procedure or nature of the treatment;
  e. The date of and place where the procedure or treatment has been or will be provided;
  f. The amount billed and the amount of the *covered expense* not paid through coverage other than Plan coverage, as appropriate;
  g. Evidence that substantiates the nature, amount, and timeliness of each *covered expense* in a format that is acceptable according to industry standards and in compliance with applicable law.

Presentation of a *prescription* to a *pharmacy* does not constitute a claim. If a *covered person* is required to pay the cost of a covered *prescription* drug, however, he or she may submit a claim based on that amount to Humana.

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

Mail medical claims and correspondence to:

Humana Claims Office
P.O. Box 14601
Lexington, KY 40512-4601

MISCELLANEOUS MEDICAL CHARGES

If *you* accumulate bills for medical items *you* purchase or rent *yourself*, send them to Humana at least once every three months during the year (quarterly). The receipts must include the patient name, name of the item, date item was purchased or rented and name of the provider of *service*.

PROCEDURAL DEFECTS

If a *pre-service claim* submission is not made in accordance with this Plan's procedural requirements, Humana will notify the *claimant* of the procedural deficiency and how it may be cured no later than within five (5) days (or within 24 hours, in the case of an *urgent care claim*) following the failure. A *post-service claim* that is not submitted in accordance with these claims procedures will be returned to the submitter.

ASSIGNMENTS AND REPRESENTATIVES

A *covered person* may assign his or her right to receive Plan benefits to a health care provider only with the consent of Humana, in its sole discretion, except as may be required by applicable law. Assignments must be in writing. If a document is not sufficient to constitute an assignment, as determined by Humana, then this Plan will not consider an assignment to have been made. An assignment is not binding on this Plan until Humana receives and acknowledges in writing the original or copy of the assignment before payment of the benefit.

If benefits are assigned in accordance with the foregoing paragraph and a health care provider submits claims on behalf of a *covered person*, benefits will be paid to that health care provider.

In addition, a *covered person* may designate an authorized representative to act on his or her behalf in pursuing a benefit claim or *appeal*. The designation must be explicitly stated in writing and it must authorize disclosure of *protected health information* with respect to the claim by this Plan, Humana and the authorized representative to one another. If a document is not sufficient to constitute a designation of an authorized representative, as determined by Humana, then this Plan will not consider a designation to have been made. An assignment of benefits does not constitute designation of an authorized representative.

- Any document designating an authorized representative must be submitted to Humana in advance, or at the time an authorized representative commences a course of action on behalf of a *claimant*. At the same time, the authorized representative should also provide notice of commencement of the action on behalf of the *claimant* to the *claimant*, which Humana may verify with the *claimant* prior to recognizing the authorized representative status.

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

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

CLAIMS DECISIONS

After submission of a claim by a *claimant*, Humana will notify the *claimant* within a reasonable time, as follows:

Pre-Service Claims

Humana will notify the *claimant* of a favorable or *adverse benefit determination* within a reasonable time appropriate to the medical circumstances, but no later than 15 days after receipt of the claim by this Plan.

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

If the reason for the extension is because of the *claimant's* failure to submit information necessary to decide the claim, the notice of extension will describe the required information. The *claimant* will have at least 45 days from the date the notice is received to provide the specified information.

Urgent Care Claims

Humana will determine whether a claim is an *urgent care claim*. This determination will be made on the basis of information furnished by or on behalf of a *claimant*. In making this determination, Humana will exercise its judgment, with deference to the judgment of a physician with knowledge of the *claimant's* condition. Accordingly, Humana may require a *claimant* to clarify the medical urgency and circumstances that support the *urgent care claim* for expedited decision-making.

Humana will notify the *claimant* of a favorable or *adverse benefit determination* as soon as possible, taking into account the medical urgency particular to the *claimant's* situation, but not later than 72 hours after receipt of the *urgent care claim* by this Plan.

However, if a claim is submitted that does not provide sufficient information to determine whether, or to what extent, expenses are covered or payable under this Plan, notice will be provided by Humana as soon as possible, but not more than 24 hours after receipt of the *urgent care claim* by this Plan. The notice will describe the specific information necessary to complete the claim.

- The *claimant* will have a reasonable amount of time, taking into account his or her circumstances, to provide the necessary information but not less than 48 hours.

- Humana will notify the *claimant* of this Plan's *urgent care claim* determination as soon as possible, but in no event more than 48 hours after the earlier of:

    1. This Plan's receipt of the specified information; or

    2. The end of the period afforded the *claimant* to provide the specified additional information.

Concurrent Care Decisions

Humana will notify a *claimant* of a *concurrent care decision* that involves a reduction in or termination of benefits that have been pre-authorized. Humana will provide the notice sufficiently in advance of the reduction or termination to allow the *claimant* to *appeal* and obtain a determination on review of the *adverse benefit determination* before the benefit is reduced or terminated.

A request by a *claimant* to extend a course of treatment beyond the period of time or number of treatments that is a claim involving urgent care will be decided by Humana as soon as possible, taking into account the medical urgency. Humana will notify a *claimant* of the benefit determination, whether adverse or not within 24 hours after receipt of the claim by this Plan, provided that the claim is submitted to this Plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

Post-Service Claims

Humana will notify the *claimant* of a favorable or *adverse benefit determination* within a reasonable time, but not later than 30 days after receipt of the claim by this Plan.

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

If the reason for the extension is because of the *claimant's* failure to submit information necessary to decide the claim, the notice of extension will describe the required information. The *claimant* will have at least 45 days from the date the notice is received to provide the specified information. Humana will make a decision no later than 15 days after the earlier of the date on which the information provided by the *claimant* is received by this Plan or the expiration of the time allowed for submission of the additional information.

TIMES FOR DECISIONS

The periods of time for claims decisions presented above begin when a claim is received by this Plan, in accordance with these claims procedures.

PAYMENT OF CLAIMS

Many health care providers will request an assignment of benefits as a matter of convenience to both provider and patient. Also as a matter of convenience, Humana will, in its sole discretion, assume that an assignment of benefits has been made to certain Network Providers. In those instances, Humana will make direct payment to the *hospital*, clinic or physician's office, unless Humana is advised in writing that *you* have already paid the bill. If *you* have paid the bill, please indicate on the original statement, "paid by *employee*," and send it directly to Humana. *You* will receive a written explanation of *adverse benefit determination*. Humana reserves the right to request any information required to determine benefits or process a claim. *You* or the provider of *services* will be contacted if additional information is needed to process *your* claim.

When an *employee's* child is subject to a medical child support order, Humana will make reimbursement of eligible expenses paid by *you*, the child, the child's non-employee custodial parent, or legal guardian, to that child or the child's custodial parent, or legal guardian, or as provided in the medical child support order.

Payment of benefits under this Plan will be made in accordance with an assignment of rights for *you* and *your dependents* as required under state Medicaid law.

Benefits payable on behalf of *you* or *your* covered *dependent* after death will be paid, at this Plan's option, to any *family member(s)* or *your* estate.

Humana will rely upon an affidavit to determine benefit payment, unless it receives written notice of valid claim before payment is made. The affidavit will release this Plan from further liability.

Any payment made by Humana in good faith will fully discharge it to the extent of such payment.

Payments due under this Plan will be paid upon receipt of written proof of loss.

NOTICES – GENERAL INFORMATION

A notice of an *adverse benefit determination* or *final internal adverse benefit determination* will include information that sufficiently identifies the claim involved, including:

1. The date of service;

2. The health care provider;

3. The claim amount, if applicable;

4. The reason(s) for the *adverse benefit determination* or *final internal adverse benefit determination* to include the denial code (e.g. CARC) and its corresponding meaning as well as a description of this Plan's standard (if any) that was used in denying the claim. For a *final internal adverse benefit determination*, this description must include a discussion of the decision;

5. A description of available *internal appeals* and *external review* processes, including information on how to initiate an *appeal*; and

6. Disclosure of the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman to assist individuals with internal claims and *appeals*, and *external review* processes.

The *claimant* may request the diagnosis code(s) (e.g. ICD-9) and/or the treatment code(s) (e.g. CPT) that apply to the claim involved with the *adverse benefit determination* or *final internal adverse benefit determination* notice. A request for this information, in itself, will not be considered a request for an *appeal* or *external review*.

INITIAL DENIAL NOTICES

Notice of a claim denial (including a partial denial) will be provided to *claimants* by mail, postage prepaid, within the time frames noted above.

However, notices of adverse decisions involving *urgent care claims* may be provided to a *claimant* orally within the time frames noted above for expedited *urgent care claim* decisions. If oral notice is given, written notification will be provided to the *claimant* no later than 3 days after the oral notification.

A claims denial notice will state the specific reason or reasons for the *adverse benefit determination*, the specific Plan provisions on which the determination is based, and a description of this Plan's review procedures and associated timeline. The notice will also include a description of any additional material or information necessary for the *claimant* to perfect the claim and an explanation of why such material or information is necessary.

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

The notice will also disclose any internal Plan rule, protocol or similar criterion that was relied on to deny the claim. A copy of the rule, protocol or similar criterion relied upon will be provided to a *claimant* free of charge upon request.

If the *adverse benefit determination* is based on *medical necessity, experimental, investigational or for research purposes,* or similar exclusion or limit, the notice will provide either an explanation of the scientific or clinical judgment for the determination, applying the terms of this Plan to the *claimant's* medical circumstances, or a statement that such explanation will be provided free of charge upon request.

In the case of an adverse decision of an *urgent care claim*, the notice will provide a description of this Plan's expedited review procedures applicable to such claims.

APPEALS OF ADVERSE BENEFIT DETERMINATIONS

A *claimant* must *appeal* an *adverse benefit determination* within 180 days after receiving written notice of the denial (or partial denial). This Plan uses a one level *appeal* process for all *adverse benefit determinations.* Humana will make the final determination on the *appeal.*

An *appeal* must be made by a *claimant* by means of written application, in person, or by mail (postage prepaid), addressed to:

Humana Grievance and Appeals
P.O. Box 14546
Lexington, KY 40512-4546

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

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

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

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

TIME PERIOD FOR DECISIONS ON APPEAL

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

Urgent Care Claims	As soon as possible, but not later than 72 hours after Humana has received the *appeal* request. If oral notification is given, written notification will follow in hard copy or electronic format within the next three days.
Pre-Service Claims	Within a reasonable period, but not later than 30 days after Humana has received *appeal* request.
Post-Service Claims	Within a reasonable period, but not later than 60 days after Humana has received the *appeal* request.
Concurrent Care Decisions	Within the time periods specified above, depending on the type of claim involved.

APPEAL DENIAL NOTICES

Notice of a benefit determination on *appeal* will be provided to *claimants* by mail, postage prepaid, within the time frames noted above.

A notice that a claim *appeal* has been denied will state the specific reason or reasons for the *adverse benefit determination* and the specific Plan provisions on which the determination is based.

The notice will also disclose any internal Plan rule, protocol or similar criterion that was relied on to deny the claim on *appeal*. A copy of the rule, protocol or similar criterion relied upon will be provided to a *claimant* free of charge upon request.

If the *adverse benefit determination* is based on *medical necessity, experimental, investigational or for research purposes* or similar exclusion or limit, the notice will provide either an explanation of the scientific or clinical judgment for the determination, applying the terms of this Plan to the *claimant's* medical circumstances, or a statement that such explanation will be provided free of charge upon request.

In the event of a denial of an appealed claim, the *claimant* on *appeal* will be entitled to receive upon request and without charge, reasonable access to and copies of any document, record or other information:

1. relied on in making the determination;

2. Submitted, considered or generated in the course of making the benefit determination;

3. That demonstrates compliance with the administrative processes and safeguards required with respect to such determinations;

4. That constitutes a statement of policy or guidance with respect to this Plan concerning the denied treatment without regard to whether the statement was relied on.

FULL AND FAIR REVIEW

As part of providing an opportunity for a full and fair review, this Plan shall provide the *claimant*, free of charge, with any new or additional evidence considered, relied upon, or generated by this Plan (or at the direction of this Plan) in connection with the claim. Such evidence shall be provided as soon as possible and sufficiently in advance of the date on which the notice of *final internal adverse benefit determination* is required to be provided to give the *claimant* a reasonable opportunity to respond prior to that date.

Before a *final internal adverse benefit determination* is made based on a new or additional rationale, this Plan shall provide the *claimant*, free of charge, with the rationale. The rationale shall be provided as soon as possible and sufficiently in advance of the date on which the notice of *final internal adverse benefit determination* is required to be provided to give the *claimant* a reasonable opportunity to respond prior to that date.

RIGHT TO REQUIRE MEDICAL EXAMINATIONS

This Plan has the right to require that a medical examination be performed on any *claimant* for whom a claim is pending as often as may be reasonably required. If this Plan requires a medical examination, it will be performed at this Plan’s expense. This Plan also has a right to request an autopsy in the case of death, if state law so allow.

EXHAUSTION

Upon completion of the *appeals* process under this section, a *claimant* will have exhausted his or her administrative remedies under this Plan. If Humana fails to complete a claim determination or *appeal* within the time limits set forth above, the *claimant* may treat the claim or *appeal* as having been denied, and the *claimant* may proceed to the next level in the review process. After exhaustion, a *claimant* may pursue any other legal remedies available to him or her which may include bringing a civil action under ERISA § 502(a) for judicial review of this Plan's determinations. Additional information may be available from a local U.S. Department of Labor Office.

A *claimant* may seek immediate *external review* of an *adverse benefit determination* if Humana fails to strictly adhere to the requirements for internal claims and *appeals* processes set forth by the federal regulations, unless the violation was: a) Minor; b) Non-prejudicial; c) Attributable to good cause or matters beyond the Plan's control; d) In the context of an ongoing good-faith exchange of information; and e) Not reflective of a pattern or practice of non-compliance. The *claimant* is entitled, upon written request, to an explanation of the Plan's basis for asserting that it meets the standard, so the *claimant* can make an informed judgment about whether to seek immediate *external review*. If the external reviewer or the court rejects the *claimant's* request for immediate review on the basis that the Plan met this standard, the *claimant* has the right to resubmit and pursue the internal appeal of the claim.

LEGAL ACTIONS AND LIMITATIONS

No action at law or inequity may be brought with respect to Plan benefits until all remedies under this Plan have been exhausted and then prior to the expiration of the applicable limitations period under applicable law.

STANDARD EXTERNAL REVIEW

Request for an External Review

A *claimant* may file a request for an *external review* with Humana at the address listed below, within 4 months after the date the *claimant* received an *adverse benefit determination* or *final internal adverse benefit determination* notice that involves a medical judgment (excluding those that involve only contractual or legal interpretation without any use of medical judgment, as determined by the external reviewer) or a rescission of coverage. If there is no corresponding date 4 months after the notice date, the request must be filed by the first day of the 5th month following receipt of the notice. If the last filing date falls on a Saturday, Sunday or federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday or federal holiday.

A request for an *external review* must be made by a *claimant* by means of written application, by mail (postage prepaid), addressed to:

Humana Grievance and Appeals
P.O. Box 14546
Lexington, KY 40512-4546

Preliminary Review

Within 5 business days following receipt of a request for *external review*, Humana must complete a preliminary review of the request to determine the following:

1. If the *claimant* is, or was, covered under this Plan at the time the health care item or *service* was requested or provided;

2. If the *adverse benefit determination* or *final internal adverse benefit determination* relates to the *claimant's* failure to meet this Plan's eligibility requirements;

3. If the *claimant* has exhausted this Plan's *internal appeals* process, when required; and

4. If the *claimant* has provided all the information and forms required to process an *external review*.

Within 1 business day after completion of the preliminary review, Humana must provide written notification to the *claimant* of the following:

1. If the request is complete but not eligible for *external review*. The notice must include the reason(s) for its ineligibility and contact information for the Department of Labor (DOL) Employee Benefits Security Administration (EBSA), including this toll-free number: 1-866-444-EBSA (3272) and this email address: www.askebsa.dol.gov.

2. If the request is not complete. The notice must describe the information or materials needed to make it complete, and Humana must allow the *claimant* to perfect the *external review* request within whichever of the following two options is later:
   a. The initial 4-month filing period; or
   b. The 48-hour period following receipt of the notification.

Referral to an Independent Review Organization (IRO)

Humana must assign an independent *IRO* that is accredited by URAC, or another nationally-recognized accreditation organization to conduct the *external review*. Humana must attempt to prevent bias by contracting with at least 3 *IROs* for assignments and rotate claims assignments among them, or incorporate some other independent method for *IRO* selection (such as random selection). The *IRO* may not be eligible for financial incentives based on the likelihood that the *IRO* will support the denial of benefits.

The contract between Humana and the *IRO* must provide for the following:

1. The assigned *IRO* will use legal experts where appropriate to make coverage determinations.

2. The assigned *IRO* will timely provide the *claimant* with written notification of the request's eligibility and acceptance of the request for *external review*. This written notice must inform the *claimant* that he/she may submit, in writing, additional information that the *IRO* must consider when conducting the *external review* to the *IRO* within 10 business days following the date the notice is received by the *claimant*. The *IRO* may accept and consider additional information submitted after 10 business days.

3. Humana must provide the *IRO* the documents and any information considered in making the *adverse benefit determination* or *final internal adverse benefit determination* within 5 business days after assigning the *IRO*. Failure to timely provide this information must not delay the conduct of the *external review* - the assigned *IRO* may terminate the *external review* and make a decision to reverse the *adverse benefit determination* or *final internal adverse benefit determination* if this Plan fails to timely provide this information. The *IRO* must notify the *claimant* and Humana within 1 business day of making the decision.

4. If the *IRO* receives any information from the *claimant*, the *IRO* must forward it to Humana within 1 business day. After receiving this information, Humana may reconsider its *adverse benefit determination* or *final internal adverse benefit determination*. If Humana reverses or changes its original determination, Humana must notify the *claimant* and the *IRO*, in writing, within 1 business day. The assigned *IRO* will then terminate the *external review*.

5. The *IRO* will review all information and documents timely received. In reaching a decision, the *IRO* will not be bound by any decisions or conclusions reached during Humana's internal claims and *appeals* process. The *IRO*, to the extent the information or documents are available and the *IRO* considers them appropriate, will consider the following when reaching a determination:
   a. The *claimant's* medical records;
   b. The attending health care professional's recommendation;
   c. Reports from the appropriate health care professional(s) and other documents submitted by Humana, *claimant*, or *claimant's* treating provider;
   d. The terms of the *claimant's* plan to ensure the *IRO's* decision is not contrary, unless the terms are inconsistent with applicable law;
   e. Appropriate practice guidelines, including applicable evidence-based standards that may include practice guidelines developed by the federal government, national or professional medical societies, boards, and associations;
   f. Any applicable clinical review criteria developed and used by this Plan, unless inconsistent with the terms of this Plan or with applicable law; and
   g. The opinion of the *IRO's* clinical reviewer(s) after considering the information described above to the extent the information or documents are available and the reviewer(s) consider them appropriate.

6. The assigned *IRO* must provide written notice of the *final external review decision* within 45 days after receiving the *external review* request to the *claimant* and Humana. The decision notice must contain the following:
   a. A general description of the reason an *external review* was requested, including information sufficient to identify the claim including:
      (1) The date(s) of service;
      (2) The health care provider;
      (3) The claim amount (if applicable); and
      (4) The reason for the previous denial.
   b. The date the *IRO* received assignment to conduct the *external review* and the date of the *IRO* decision;
   c. References to the evidence or documentation considered in reaching the decision, including the specific coverage provisions and evidence-based standards;
   d. A discussion of the principal reason(s) for its decision, including the rationale and any evidence-based standards relied on in making the decision;

e. A statement that the determination is binding except to the extent that other remedies may be available under state or federal law to either Humana or the *claimant*;
f. A statement that judicial review may be available to the *claimant*; and
g. Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under PPACA (*section 2793 of PHSA, as amended*).

7. After a *final external review decision*, the *IRO* must maintain records of all claims and notices associated with the *external review* process for 6 years. An *IRO* must make such records available for examination by the *claimant*, Humana, or state/federal oversight agency upon request, except where such disclosure would violate state or federal privacy laws.

Reversal of this Plan's Decision

If Humana receives notice of a *final external review decision* that reverses the *adverse benefit determination* or *final internal adverse benefit determination*, it must immediately provide coverage or payment for the affected claim(s). This includes authorizing or paying benefits.

EXPEDITED EXTERNAL REVIEW

Request for an Expedited External Review

Expedited *external reviews* are subject to a single level *appeal* process only.

Humana must allow a *claimant* to make a request for an expedited *external review* at the time the *claimant* receives:

1. An *adverse benefit determination* involving a medical condition of the *claimant* for which the time frame for completion of an expedited *internal appeal* under the interim final regulations would seriously jeopardize the life or health of the *claimant*, or would jeopardize the *claimant's* ability to regain maximum function and the *claimant* has filed a request for an expedited *external review*; or

2. A *final internal adverse benefit determination* involving a medical condition where:
   a. The time frame for completion of a standard *external review* would seriously jeopardize the life or health of the *claimant*, or would jeopardize the *claimant's* ability to regain maximum function; or
   b. The *final internal adverse benefit determination* concerns an *admission*, availability of care, continued stay, or health care item or *service* for which the *claimant* received *emergency services*, but has not be discharged from the facility.

A request for an expedited *external review* must be made by a *claimant* by means of written application, by mail (postage prepaid), addressed to:

Humana Grievance and Appeals
P.O. Box 14546
Lexington, KY 40512-4546

Preliminary Review

Humana must determine whether the request meets the reviewability requirements for a standard *external review* immediately upon receiving the request for an expedited *external review*. Humana must immediately send a notice of its eligibility determination regarding the *external review* request that meets the requirements under the Standard External Review, Preliminary Review section.

Referral to an Independent Review Organization (IRO)

If Humana determines that the request is eligible for *external review*, Humana will assign an *IRO* as required under the Standard External Review, Referral to an Independent Review Organization (IRO) section. Humana must provide or transmit all necessary documents and information considered when making the *adverse benefit determination* or *final internal adverse benefit determination* to the assigned *IRO* electronically, by telephone/fax, or any other expeditious method.

The assigned *IRO*, to the extent the information is available and the *IRO* considers it appropriate, must consider the information or documents as outlined for the procedures for standard *external review* described in the Standard External Review, Referral to an Independent Review Organization (IRO) section. The assigned *IRO* is not bound by any decisions or conclusions reached during this Plan's internal claims and *appeals* process when reaching its decision.

Notice of Final External Review Decision

The *IRO* must provide notice of the *final external review decision* as expeditiously as the *claimant's* medical condition or circumstances require, but no more than 72 hours after the *IRO* receives the request for an expedited *external review*, following the notice requirements outlined in the Standard External Review, Referral to an Independent Review Organization (IRO) section. If the notice is not in writing, written confirmation of the decision must be provided within 48 hours to the *claimant* and Humana.

IF YOU HAVE QUESTIONS ON INTERNAL CLAIMS AND APPEALS AND EXTERNAL REVIEW RIGHTS

For more information on *your* internal claims and appeals and external review rights, *you* can contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) at 1-866-444-EBSA or at www.askebsa.dol.gov.

STATE CONSUMER ASSISTANCE OR OMBUDSMAN TO ASSIST YOU WITH INTERNAL CLAIMS AND APPEALS AND EXTERNAL REVIEW PROCESSES

A state office of consumer assistance or ombudsman is available to assist *you* with internal claims and appeals and external review processes. The contact information is as follows:

California Department of Managed Health Care Help Center
980 9th Street, Suite 500
Sacramento, CA 95814
(888) 466-2219
http://www.healthhelp.ca.gov
helpline@dmhc.ca.gov

SECTION 3

DEFINITIONS

DEFINITIONS

Italicized terms throughout this *Appendix A to the SPD* have the meaning indicated below. Defined terms are italicized wherever found in this *Appendix A to the SPD*.

A

Accident means a sudden event that results in a *bodily injury* and is exact as to time and place of occurrence.

Admission means entry into a facility as a registered bed patient according to the rules and regulations of that facility. An *admission* ends when *you* are discharged, or released, from the facility and *you* are no longer registered as a bed patient.

Advanced imaging, for the purpose of this definition, means Magnetic Resonance Imaging (MRI), Magnetic Resonance Angiography (MRA), Positron Emission Tomography (PET), Single Photon Emission Computed Tomography (SPECT) and Computed Tomography (CT) imaging.

Adverse benefit determination means a denial, reduction, or termination, or failure to provide or make payment (in whole or in part) for a benefit, including:

1. A determination based on a *covered person's* eligibility to participate in this Plan;

2. A determination that a benefit is not a covered benefit;

3. The imposition of a *pre-existing condition* exclusion, source-of-injury exclusion, network exclusion, or other limitation on otherwise covered benefits; or

4. A determination resulting from the application of any utilization review, such as the failure to cover an item or *service* because it is determined to be experimental/investigational or not *medically necessary*.

An *adverse benefit determination* includes any rescission of coverage (whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at that time). Rescission is a cancellation or discontinuance of coverage that has retroactive effect. A cancellation or discontinuance is not a rescission if:

1. The cancellation or discontinuance of coverage has only a prospective effect; or

2. The cancellation or discontinuance of coverage is effective retroactively, to the extent it is attributable to a failure to timely pay premium or costs of coverage.

Alternative medicine means an approach to medical diagnosis, treatment or therapy that has been developed or practiced NOT using the generally accepted scientific methods in the United States of America. For purposes of this definition, *alternative medicine* shall include, but is not limited to: acupressure, aromatherapy, ayurveda, biofeedback, faith healing, guided mental imagery, herbal medicine, holistic medicine, homeopathy, hypnosis, macrobiotics, naturopathy, ozone therapy, reflexotherapy, relaxation response, rolfing, shiatsu and yoga.

Ambulance means a professionally operated vehicle, provided by a licensed *ambulance* service, equipped for the transportation of a sick or injured person to or from the nearest medical facility qualified to treat the person's *sickness* or *bodily injury*. Use of the *ambulance* must be *medically necessary* and/or ordered by a *qualified practitioner*.

Ambulatory surgical center means an institution which meets all of the following requirements:

1. It must be staffed by physicians and a medical staff which includes registered nurses;

2. It must have permanent facilities and equipment for the primary purpose of performing *surgery*;

3. It must provide continuous physicians' *services* on an outpatient basis;

4. It must admit and discharge patients from the facility within a 24-hour period;

5. It must be licensed in accordance with the laws of the jurisdiction where it is located. It must be operated as an *ambulatory surgical center* as defined by those laws;

6. It must not be used for the primary purpose of terminating pregnancies, or as an office or clinic for the private practice of any physician or dentist.

Appeal (or ***internal appeal***) means review by this Plan of an *adverse benefit determination*.

B

Bariatric services means the *bariatric surgery* and the post-discharge *services* and expenses related to complications following an approved *bariatric surgery*.

Bariatric surgery means gastrointestinal *surgery* to promote weight loss for the treatment of *morbid obesity*.

Bariatric surgery treatment period means six months from the date of discharge from the *hospital* following an approved *bariatric surgery* received while *you* were covered by this Plan.

Behavioral health means *mental health services* and *substance abuse services*.

Beneficiary means *you* and *your* covered *dependent(s)*, or legal representative of either, and anyone to whom the rights of *you* or *your* covered *dependent(s)* may pass.

Bodily injury means bodily damage other than a *sickness*, including all related conditions and recurrent symptoms. However, bodily damage resulting from infection or muscle strain due to athletic or physical activity is considered a *sickness* and not a *bodily injury*.

C

Calendar year means a period of time beginning on January 1 and ending on December 31.

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

Complications of pregnancy means:

1. Conditions whose diagnoses are distinct from pregnancy but adversely affected by pregnancy or caused by pregnancy. Such conditions include: acute nephritis, nephrosis, cardiac decompensation, hyperemesis gravidarum, puerperal infection, toxemia, eclampsia and missed abortion;

2. A non-elective cesarean section surgical procedure;

3. Terminated ectopic pregnancy; or

4. Spontaneous termination of pregnancy which occurs during a period of gestation in which a viable birth is not possible.

Complications of pregnancy do not mean:

1. False labor;

2. Occasional spotting;

3. Prescribed rest during the period of pregnancy;

4. Conditions associated with the management of a difficult pregnancy but which do not constitute distinct *complications of pregnancy*; or

5. An elective cesarean section.

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

Concurrent review means the process of assessing the continuing *medical necessity*, appropriateness, or utility of additional days of *hospital confinement*, outpatient care, and other health care *services*.

Confinement or ***confined*** means *you* are admitted as a registered bed patient in a *hospital* or a *qualified treatment facility* as the result of a *qualified practitioner's* recommendation. It does not mean detainment in *observation status*.

Copayment means the specified dollar amount that *you* must pay to a provider for certain medical *covered expenses* regardless of any amounts that may be paid by this Plan as shown in the Medical Schedule of Benefits section.

Copayment limit means the amount of *copayments* that must be paid by a *covered person*, either individually or combined as a covered family, per year before *copayments* are no longer required for the remainder of that year.

Cosmetic surgery means *surgery* performed to reshape structures of the body in order to change *your* appearance or improve self-esteem.

Court-ordered means involuntary placement in *behavioral health* treatment as a result of a judicial directive.

Covered expense means *medically necessary services* incurred by *you* or *your* covered *dependents* for which benefits may be available under this Plan, subject to any *maximum benefit* and all other terms, provisions, limitations and exclusions of this Plan.

Covered person means the *employee* or any of the *employee's* covered *dependents* enrolled for benefits provided under this Plan.

Custodial care means *services* provided to assist in the activities of daily living which are not likely to improve *your* condition. Examples include, but are not limited to, assistance with dressing, bathing, preparation and feeding of special diets, transferring, walking, taking medication, getting in and out bed and maintaining continence. These *services* are considered *custodial care* regardless if a *qualified practitioner* or provider has prescribed, recommended or performed the *services*.

D

Deductible means a specified dollar amount that must be satisfied, either individually or combined as a covered family, per *plan year* before this Plan pays benefits for certain specified *services*.

Dental injury means an injury to a *sound natural tooth* caused by a sudden, violent, and external force that could not be predicted in advance and could not be avoided.

Diabetes equipment means blood glucose monitors, including monitors designed to be used by blind individuals, insulin infusion pumps and associated accessories, insulin infusion devices and podiatric appliances for the prevention of complications associated with diabetes.

Diabetes self-management training means the training provided to a *covered person* after the initial diagnosis of diabetes for care and management of the condition including nutritional counseling and use of *diabetes equipment* and supplies. It also includes training when changes are required to the self-management regime and when new techniques and treatments are developed.

Diabetes supplies means test strips for blood glucose monitors, visual reading and urine test strips, lancets and lancet devices, insulin and insulin analogs, injection aids, syringes, prescriptive and non-prescriptive oral agents for controlling blood sugar levels, glucagon emergency kits and alcohol swabs.

Durable medical equipment (DME) means equipment that is *medically necessary* and able to withstand repeated use. It must also be primarily and customarily used to serve a medical purpose and not be generally useful to a person except for the treatment of a *bodily injury* or *sickness*.

E

Emergency **(true)** means an acute, sudden onset of a *sickness* or *bodily injury* which is life threatening or will significantly worsen without immediate medical or surgical treatment.

Expense incurred means the fee charged for *services* provided to *you*. The date a *service* is provided is the *expense incurred* date.

Experimental, investigational or for research purposes means a drug, biological product, device, treatment or procedure that meets any one of the following criteria, as determined by this Plan in accordance with the requirements of the Affordable Care Act:

1. Cannot be lawfully marketed without the final approval of the United States Food and Drug Administration (FDA) and which lacks such final FDA approval for the use or proposed use, unless:

    a. Found to be accepted for that use in the most recently published edition of Clinical Pharmacology, Micromedex DrugDex, National Comprehensive Cancer Network Drugs and Biologics Compendium, and the American Hospital Formulary Service (AHFS) Drug Information for drugs used to treat cancer, and is determined to be covered by this Plan (for additional details, go to www.humana.com, click on "Humana Websites for Providers" along the left hand side of the page, then click "Medical Coverage Policies" under Critical Topics, then click "Medical Coverage Policies" and search for Clinical Trials and Off-Label and Off-Evidence); or

    b. Found to be accepted for that use in the most recently published edition of the Micromedex DrugDex or AHFS Drug Information for non-cancer drugs, and is determined to be covered by this Plan (for additional details, go to www.humana.com, click on "Humana Websites for Providers" along the left hand side of the page, then click "Medical Coverage Policies" under Critical Topics, then click "Medical Coverage Policies" and search for Clinical Trials and Off-Label and Off-Evidence); or

    c. Identified by this Plan as safe, widely used and generally accepted as effective for that use as reported in nationally recognized peer reviewed medical literature published in the English language as of the date of service;

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

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

4. Is the subject of a National Institute of Health (NIH) Phase I, II or III trial or a treatment protocol comparable to a NIH Phase I, II or III trial, or any trial not recognized by NIH regardless of phase, except for:

    a. Clinical trials approved by this Plan (for additional details, go to www.humana.com, click on "Humana Websites for Providers" along the left hand side of the page, then click "Medical Coverage Policies" under Critical Topics, then click "Medical Coverage Policies" and search for Clinical Trials and Off-Label and Off-Evidence); or

    b. Transplants, in which case this Plan would approve requests for *services* that are the subject of a NIH Phase II, Phase III or higher when transplant *services* are appropriate for the treatment of the underlying disease;

5. Is identified as not covered by the Centers for Medicare and Medicaid Services (CMS) Medicare Coverage Issues Manual, a CMS Operational Policy Letter or a CMS National Coverage Decision, except as required by federal law and excluding transplants.

External review means a review of an *adverse benefit determination* (including a *final internal adverse benefit determination*) conducted pursuant to the federal *external review* process or an applicable state *external review* process.

F

Family member means *you* or *your* spouse, or *you* or *your* spouse's child, brother, sister, parent, grandchild or grandparent.

Final external review decision means a determination by an *independent review organization* at the conclusion of an *external review*.

Final internal adverse benefit determination means an *adverse benefit determination* that has been upheld by this Plan at the completion of the *internal appeals* process (or an *adverse benefit determination* with respect to which the internal appeals process has been exhausted under the deemed exhaustion rules).

Functional impairment means a direct and measurable reduction in physical performance of an organ or body part.

H

Hospital means an institution which:

1. Maintains permanent full-time facilities for bed care of resident patients;

2. Has a physician and surgeon in regular attendance;

3. Provides continuous 24 hour a day nursing *services*;

4. Is primarily engaged in providing diagnostic and therapeutic facilities for medical or surgical care of sick or injured persons;

5. Is legally operated in the jurisdiction where located; and

6. Has surgical facilities on its premises or has a contractual agreement for surgical *services* with an institution having a valid license to provide such surgical *services*; or

7. Is a lawfully operated *qualified treatment facility* certified by the First Church of Christ Scientist, Boston, Massachusetts.

Hospital does not include an institution which is principally a rest home, skilled nursing facility, convalescent home or home for the aged. *Hospital* does not include a place principally for the treatment of *mental health* or *substance abuse*.

I

Independent review organization (or IRO) means an entity that conducts independent *external reviews* of *adverse benefit determinations* and *final internal adverse benefit determinations*.

Intensive outpatient means outpatient *services* providing:

1. Group therapeutic sessions greater than one hour a day, three days a week;

2. *Behavioral health* therapeutic focus;

3. Group sessions centered on cognitive behavioral constructs, social/occupational/educational skills development and family interaction;

4. Additional emphasis on recovery strategies, monitoring of participation in 12-step programs and random drug screenings for the treatment of *substance abuse*; and

5. *Qualified practitioner* availability for medical and medication management.

Intensive outpatient program does not include services that are for:

1. *Custodial care*; or

2. Day care.

L

Lifetime maximum benefit means the maximum amount of benefits available while *you* are covered under this Plan.

M

Maintenance care means any *service* or activity which seeks to prevent *bodily injury* or *sickness*, prolong life, promote health or prevent deterioration of a *covered person* who has reached the maximum level of improvement or whose condition is resolved or stable.

Maximum allowable fee for a *covered expense* is the lesser of:

1. The fee charged by the provider for the *services*;

2. The fee that has been negotiated with the provider whether directly or through one or more intermediaries or shared savings contracts for the *services*;

3. The fee established by this Plan by comparing rates from one or more regional or national databases or schedules for the same or similar *services* from a geographical area determined by this Plan;

4. The fee based upon rates negotiated by this Plan or other payors with one or more *participating providers* in a geographic area determined by this Plan for the same or similar *services*;

5. The fee based upon the provider's cost for providing the same or similar *services* as reported by such provider in its most recent publicly available *Medicare* cost report submitted to the Centers for Medicare and Medicaid Services (CMS) annually; or

6. The fee based on a percentage determined by this Plan of the fee *Medicare* allows for the same or similar *services* provided in the same geographic area.

Note: The bill *you* receive for *services* from *non-participating providers* may be significantly higher than the *maximum allowable fee*. In addition to *deductibles, copayments* and *coinsurance, you* are responsible for the difference between the *maximum allowable fee* and the amount the provider bills *you* for the *services*. Any amount *you* pay to the provider in excess of the *maximum allowable fee* will not apply to *your out-of-pocket limit* or *deductible*.

Maximum benefit means the maximum amount that may be payable for each *covered person*, for *expense incurred*. The applicable *maximum benefit* is shown in the Medical Schedule of Benefits section. No further benefits are payable once the *maximum benefit* is reached.

Medically necessary or medical necessity means the extent of *services* required to diagnose or treat a *bodily injury* or *sickness* which is known to be safe and effective by the majority of *qualified practitioners* who are licensed to diagnose or treat that *bodily injury* or *sickness*. Such *services* must be:

1. Performed in the least costly setting required by *your* condition;

2. Not provided primarily for the convenience of the patient or the *qualified practitioner*;

3. Appropriate for and consistent with *your* symptoms or diagnosis of the *sickness* or *bodily injury* under treatment;

4. Furnished for an appropriate duration and frequency in accordance with accepted medical practices, and which are appropriate for *your* symptoms, diagnosis, *sickness* or *bodily injury*; and

5. Substantiated by the records and documentation maintained by the provider of *service*.

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

Mental health means a mental, nervous, or emotional disease or disorder of any type as classified in the Diagnostic and Statistical Manual of Mental Disorders, regardless of the cause or causes of the disease or disorder.

Morbid obesity (clinically severe obesity) means a body mass index (BMI) as determined by a *qualified practitioner* as of the date of *service* of:

1. 40 kilograms or greater per meter squared (kg/m^2); or

2. 35 kilograms or greater per meter squared (kg/m^2) with an associated comorbid condition such as hypertension, type II diabetes, life-threatening cardiopulmonary conditions; or joint disease that is treatable, if not for the obesity.

N

Non-participating provider means a *hospital*, *qualified treatment facility*, *qualified practitioner* or any other health *services* provider who has not entered into an agreement with the *Plan Manager* to provide *participating provider services* or has not been designated by the *Plan Manager* as a *participating provider*.

O

Off-evidence drug indications mean indications for which there is a lack of sufficient evidence for safety and/or efficacy for a particular medication.

Off-label drug indications mean prescribing of an FDA-approved medication for a use or at a dose that is not included in the product indications or labeling. This term specifically refers to drugs or dosages used for diagnoses that are not approved by the FDA and may or may not have adequate medical evidence supporting safety and efficacy. Off-label prescribing of traditional drugs is a common clinical practice and many off-label uses are effective, well documented in peer reviewed literature and widely employed as standard of care treatments.

Orthotic means a custom-fitted or custom-made braces, splints, casts, supports and other devices used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body when prescribed by a *qualified practitioner*.

Out-of-pocket limit is a specified dollar amount that must be satisfied, either individually or combined as a covered family, per *calendar year* before a benefit percentage will be increased.

P

Partial hospitalization means *services* provided by a *hospital* or *qualified treatment facility* in which patients do not reside for a full 24-hour period:

1. For a comprehensive and intensive interdisciplinary psychiatric treatment for minimum of 5 hours a day, 5 days per week;

2. That provides for social, psychological and rehabilitative training programs with a focus on reintegration back into the community and admits children and adolescents who must have a treatment program designed to meet the special needs of that age range; and

3. That has physicians and appropriately licensed *mental health* and *substance abuse* practitioners readily available for the emergent and urgent care needs of the patients.

The *partial hospitalization* program must be accredited by the Joint Commission of the Accreditation of Hospitals or in compliance with an equivalent standard.

Licensed drug abuse rehabilitation programs and alcohol rehabilitation programs accredited by the Joint Commission on the Accreditation of Health Care Organizations or approved by the appropriate state agency are also considered to be *partial hospitalization services*.

Partial hospitalization does not include *services* that are for *custodial care* or day care.

Participating provider means a *hospital*, *qualified treatment facility*, *qualified practitioner* or any other health *services* provider who has entered into an agreement with, or has been designated by, Humana to provide specified *services* to all *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*.

Plan Administrator means U.S. Health and Welfare Leader for The Dow Chemical Company.

Plan Manager means Humana Insurance Company (HIC). The *Plan Manager* provides services to the *Plan Administrator*, as defined under the Plan Management Agreement. The *Plan Manager* is not the *Plan Administrator* or the *Plan Sponsor*. The *Plan Manager* has the same meaning as Claims Administrator with respect to Claims for a Plan Benefit and Appeals Administrator with respect to Claims for a Plan Benefit, as those terms are defined in the body of this Summary Plan Description.

Plan Maximum Out-of-Pocket Limit means the maximum amount of any *participating provider covered expenses*, including medical *deductibles*, *coinsurance* amounts and *copayments* and *prescription* drug *copayments*, that must be paid by *you*, either individually or combined as a covered family, per *calendar year* before a benefit percentage for *participating provider covered expenses* will be increased. The *participating provider out-of-pocket limit* and the *prescription drug out-of-pocket limit* apply toward the *Plan maximum out-of-pocket limit*. Once the *Plan maximum out-of-pocket limit* is met, any remaining *participating provider* medical *out-of-pocket limit* or *prescription drug out-of-pocket limit* will be waived for the remainder of the *year*. Any applicable *precertification* penalties do not apply to the *Plan maximum out-of-pocket limit*.

Plan Sponsor means The Dow Chemical Company.

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

Preadmission testing means only those outpatient x-ray and laboratory tests made within seven days before *admission* as a registered bed patient in a *hospital*. The tests must be for the same *bodily injury* or *sickness* causing the patient to be *hospital confined*. The tests must be accepted by the *hospital* in lieu of like tests made during *confinement*. *Preadmission testing* does not mean tests for a routine physical check-up.

Precertification (also known as "*preauthorization*") means the process of assessing the *medical necessity*, appropriateness, or utility of proposed non-emergency *hospital admission*s, surgical procedures, outpatient care, and other health care *services*.

Predetermination of benefits means a review by Humana of a *qualified practitioner's* treatment plan, specific diagnostic and procedure codes and expected charges prior to the rendering of *services*.

Prescription means a direct order for the preparation and use of a drug, medicine or medication. The drug, medicine or medication must be obtainable only by *prescription*. The *prescription* must be given to a *pharmacist* verbally, electronically or in writing by a *qualified practitioner* for the benefit of and use by a *covered person*. The *prescription* must include at least:

1. The name and address of the *covered person* for whom the *prescription* is intended;

2. The type and quantity of the drug, medicine or medication prescribed, and the directions for its use;

3. The date the *prescription* was prescribed; and

4. The name and address of the prescribing *qualified practitioner*.

Pre-service claim means a claim with respect to which the terms of the Plan condition receipt of a Plan benefit, in whole or in part, on approval of the benefit by Humana in advance of obtaining medical care.

Primary Care Physician (PCP) means a *participating provider* who is a family practice physician, pediatrician, doctor of internal medicine or general practitioner. The *primary care physician* is responsible for providing initial and primary care *services* to *covered persons*, maintaining the continuity of medical care and helping to direct *covered persons* to a *specialist*.

Protected health information means individually identifiable health information about a *covered person*, including: (a) patient records, which includes but is not limited to all health records, physician and provider notes and bills and claims with respect to a *covered person*; (b) patient information, which includes patient records and all written and oral information received about a *covered person*; and (c) any other individually identifiable health information about *covered persons*.

Provider contract means a legally binding agreement between Humana and a *participating provider* that includes a provider payment arrangement.

Q

Qualified practitioner means a practitioner, professionally licensed by the appropriate state agency to diagnose or treat a *bodily injury* or *sickness*, and who provides *services* within the scope of that license.

Qualified treatment facility means only a facility, institution or clinic duly licensed by the appropriate state agency, and is primarily established and operating within the scope of its license.

R

Residential treatment facility means an institution which:

1. Is licensed as a 24-hour residential facility for *mental health* and *substance abuse* treatment, although not licensed as a *hospital*;

2. Provides a multidisciplinary treatment plan in a controlled environment, with periodic supervision of a physician or a Ph.D. psychologist; and

3. Provides programs such as social, psychological and rehabilitative training, age appropriate for the special needs of the age group of patients, with focus on reintegration back into the community.

Residential treatment is utilized to provide structure, support and reinforcement of the treatment required to reverse the course of behavioral deterioration.

S

Services mean procedures, surgeries, examinations, consultations, advice, diagnosis, referrals, treatment, tests, supplies, drugs, devices or technologies.

Service area means the geographic area designated by Humana, or as otherwise agreed upon between the *Plan Sponsor* and Humana. A description of the *service area* is provided in the provider directories.

Sickness means a disturbance in function or structure of *your* body which causes physical signs or symptoms and which, if left untreated, will result in a deterioration of the health state of the structure or system(s) of *your* body.

Sound natural tooth means a tooth that:

1. Is organic and formed by the natural development of the body (not manufactured);

2. Has not been extensively restored;

3. Has not become extensively decayed or involved in periodontal disease; and

4. Is not more susceptible to injury than a whole natural tooth.

Specialist means a *qualified practitioner* who has received training in a specific medical field other than those listed as primary care.

Specialty drug means a drug, medicine or medication used as a specialized therapy developed for chronic, complex *sicknesses* or *bodily injuries*. *Specialty drugs* may:

1. Require nursing services or special programs to support patient compliance;

2. Require disease-specific treatment programs;

3. Have limited distribution requirements; or

Have special handling, storage or shipping requirements.

Substance abuse means the abuse of, or psychological or physical dependence on, or addiction to alcohol or a controlled substance.

Surgery means excision or incision of the skin or mucosal tissues, or insertion for exploratory purposes into a natural body opening. This includes insertion of instruments into any body opening, natural or otherwise, done for diagnostic or other therapeutic purposes.

T

Total disability *or* ***totally disabled*** means:

1. During the first twelve months of disability *you* or *your* employed covered spouse are at all times prevented by *bodily injury* or *sickness* from performing each and every material duty of *your* respective job or occupation;

2. After the first twelve months, *total disability* or *totally disabled* means that *you* or *your* employed covered spouse are at all times prevented by *bodily injury* or *sickness* from engaging in any job or occupation for wage or profit for which *you* or *your* employed covered spouse are reasonably qualified by education, training or experience;

3. For a non-employed spouse or a child, *total disability* or *totally disabled* means the inability to perform the normal activities of a person of similar age and gender.

A *totally disabled* person also may not engage in any job or occupation for wage or profit.

U

Urgent care claim means any claim for medical care or treatment when the time periods for making non-urgent care determinations:

1. Could seriously jeopardize the life or health of the *claimant* or the ability of the *claimant* to regain maximum function; or

2. In the opinion of the physician with knowledge of the *claimant's* medical condition, would subject the *claimant* to severe pain that cannot be adequately managed without the care or treatment recommended.

Utilization review means the process of assessing the *medical necessity*, appropriateness, or utility of *hospital admissions*, surgical procedures, outpatient care, and other health care *services*. *Utilization review* includes *precertification* and *concurrent review*.

Y

You and your means *you* as the *employee* and any of *your* covered *dependents*, unless otherwise indicated.

SECTION 4

PRESCRIPTION DRUG BENEFIT

PRESCRIPTION DRUG BENEFIT

All defined terms used in this Prescription Drug Benefit section have the same meaning given to them in Section 3 of this *Appendix A to the SPD*, unless otherwise specifically defined below.

DEFINITIONS

The following definitions are used in this Prescription Drug Benefit section:

Copayment (*prescription* drug) means the amount to be paid by *you* toward the cost of each separate *prescription* or refill of a covered *prescription* drug when dispensed by a *pharmacy*.

Cost share means any *copayment* and/or percentage amount that *you* must pay per *prescription* drug or refill.

Dispensing limit means the monthly drug dosage limit and/or the number of months the drug usage is usually needed to treat a particular condition, as determined by Humana.

Drug list means a list of *prescription* drugs, medicines, medications and supplies specified by Humana. This list identifies drugs as *Level 1, Level 2, Level 3* or *Level 4* and indicates applicable *dispensing limits* and/or any *prior authorization* or *step therapy* requirements. There is also a Women's Healthcare Drug List. Visit Humana's Website at www.humana.com or call the customer service telephone number on *your* identification card to obtain the *drug lists*. The *drug lists* are subject to change without notice. This list is subject to change without notice. Drugs may move between levels and may be subject to specific time constraints. There may be times when a level contains no drugs at all or a drug may be subject to multiple levels.

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

Level 1 drugs mean a category of *prescription* drugs, medicines or medications within the *drug list* that are designated by Humana as *Level 1 drugs*.

Level 2 drugs means a category of *prescription* drugs, medicines or medications within the *drug list* that are designated by Humana as *Level 2 drugs*.

Level 3 drugs means a category of *prescription* drugs, medicines or medications within the *drug list* that are designated by Humana as *Level 3 drugs*.

Level 4 drugs means a category of *prescription* drugs, medicines or medications within the *drug list* that are designated by Humana as *Level 4 drugs*.

Mail order pharmacy means a *pharmacy* that provides covered *mail order pharmacy* services, as defined by Humana, and delivers covered *prescriptions* or refills through the mail to *covered persons*.

Non-participating pharmacy means a *pharmacy* that has NOT signed a direct agreement with Humana or has NOT been designated by Humana to provide covered *pharmacy services*, or covered *specialty pharmacy* services or covered *mail order pharmacy* services to *covered persons*, including covered *prescriptions* or refills delivered to *your* home.

Off-evidence drug indications mean indications for which there is a lack of sufficient evidence for safety and/or efficacy for a particular medication.

Off-label drug indications mean prescribing of an FDA-approved medication for a use or at a dose that is not included in the product indications or labeling. This term specifically refers to drugs or dosages used for diagnoses that are not approved by the FDA and may or may not have adequate medical evidence supporting safety and efficacy. Off-label prescribing of traditional drugs is a common clinical practice and many off-label uses are effective, well documented in peer reviewed literature and widely employed as standard of care treatments.

Orphan drug means a drug or biological used for the diagnosis, treatment, or prevention of rare diseases or conditions, which:

1. Affects less than 200,000 persons in the United States; or

2. Affects more than 200,000 persons in the United States, however, there is no reasonable expectation that the cost of developing the drug and making it available in the United States will be recovered from the sales of that drug in the United States.

Participating pharmacy means a *pharmacy* that has signed a direct agreement with Humana or has been designated by Humana to provide covered *pharmacy services*, covered *specialty pharmacy* services or covered *mail order pharmacy* services, as defined by Humana, to *covered persons,* including covered *prescriptions* or refills delivered to *your* home.

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*.

Prescription means a direct order for the preparation and use of a drug, medicine or medication. The *prescription* must be given by a *qualified practitioner* to a *pharmacist* for *your* benefit and used for the treatment of a *sickness* or *bodily injury* which is covered under this plan or for drugs, medicines or medications on the Women's Healthcare Drug List. The drug, medicine or medication must be obtainable only by *prescription* or must be obtained by *prescription* for drugs, medicines or medications on the Women's Healthcare Drug List. The *prescription* must be given to a *pharmacist* verbally, electronically or in writing by a *qualified practitioner*. The *prescription* must include at least:

1. *Your* name;

2. The type and quantity of the drug, medicine or medication prescribed, and the directions for its use;

3. The date the *prescription* was prescribed; and

4. The name and address of the prescribing *qualified practitioner.*

Prior authorization means the required prior approval from Humana for the coverage of *prescription* drugs, medicines and medications, including the dosage, quantity and duration, as appropriate for the *covered person's* diagnosis, age and sex. Certain *prescription* drugs, medicines or medications may require *prior authorization*. Visit Humana's Website at www.humana.com or call the customer service telephone number on *your* identification card to obtain a list of *prescription* drugs, medicines and medications that require *prior authorization*

Self-administered injectable drug means an FDA approved medication which a person may administer to himself/herself by means of intramuscular, intravenous, or subcutaneous injection, and is intended for use by *you*.

Specialty drug means a drug, medicine, medication or biological used as a specialized therapy developed for chronic, complex *sicknesses* or *bodily injuries*. *Specialty drugs* may:

1. Require nursing services or special programs to support patient compliance;

2. Require disease-specific treatment programs;

3. Have limited distribution requirements; or

4. Have special handling, storage or shipping requirements.

Specialty pharmacy means a *pharmacy* that provides covered *specialty pharmacy* services, as defined by Humana, to *covered persons*.

Step therapy means type of *prior authorization*. Humana may require *you* to follow certain steps prior to coverage of some high-cost drugs, medicines or medications. Humana may require *you* to try a similar drug, medicine or medication that has been determined to be safe, effective and less costly for most people with *your* condition. Alternatives may include over-the-counter drugs, *generic medications* and *brand name medications*.

SCHEDULE OF PRESCRIPTION DRUG BENEFITS

Additional drug information can be obtained by accessing Humana's website at www.humana.com or calling the toll-free customer service number on the back *your* ID card.
You are responsible for the following:

RETAIL PHARMACY AND SPECIALTY PHARMACY	
Level 1 Drugs	$10 *copayment* per *prescription* or refill per 30 day supply
Level 2 Drugs	$30 *copayment* per *prescription* or refill per 30 day supply
Level 3 Drugs	$50 *copayment* per *prescription* or refill per 30 day supply
Level 4 Drugs	25% *copayment* per *prescription* or refill per 30 day supply
Flu and Pneumonia Immunizations	No *cost share* (Retail Only)
Drugs, Medicines or Medications on the Women's Healthcare Drug List (with a *prescription* from a *qualified practitioner*)	No *cost share*
Glucometers	No *cost share*
Non-Insulin Needles and Syringes	No *cost share*
Non-Oral Contraceptives	No *cost share*

Mandatory Mail Order: Following the initial fill and one refill of a covered *prescription* drug or therapeutic equivalent medication prescribed by one or more *qualified practitioners* and dispensed by one or more retail or *specialty pharmacies*, all subsequent refills must be obtained through a *mail order pharmacy*.

This plan features Humana's RightSourceRx Preferred Mandatory Mail Order Program. Members are allowed up to two, thirty day retail fills of a maintenance medication. The third and subsequent retail fills of any one maintenance medication, will apply double the applicable member *cost share*.

MAIL ORDER PHARMACY	
Up to a 90 day supply of a *prescription* or refill received from a *mail order pharmacy* *Self-administered injectable drugs* and *specialty drugs* received from a *mail order pharmacy* may be limited to a 30 day supply, as determined by this Plan.	Two and a half (2.5) times the applicable *copayments* outlined under Retail Pharmacy and Specialty Pharmacy. *Level 4 drugs* are not covered.
Drugs, Medicines or Medications on the Women's Healthcare Drug List (with a *prescription* from a *qualified practitioner*)	No *cost share*

OFFICE-ADMINISTERED SPECIALTY DRUGS	
Up to a 30 day supply of a *prescription* or refill for office administered *specialty drugs*, dispensed directly to the *qualified practitioner's* office through Humana's preferred *specialty pharmacy* vendor *Specialty drugs* administered in a *qualified practitioner's* office do not include *self-administered injectable drugs.*	No *cost share*

ADDITIONAL PRESCRIPTION DRUG BENEFIT INFORMATION

If an *employee*/eligible *dependent* purchases a *brand name medication*, and an equivalent *generic medication* is available, the *employee*/eligible *dependent* must pay the difference between the *brand name medication* and the *generic medication* plus any applicable *generic medication copayment*. If the *qualified practitioner* indicates on the *prescription* "dispense as written", the drug will be dispensed as such, and the *employee*/eligible *dependent* will only be responsible for the *brand name medication copayment*.

Participating Pharmacy

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

Non-participating Pharmacy

If *you* received the *prescription* at a *non-participating pharmacy*, the *prescription* is NOT eligible for coverage.

Mail *pharmacy* receipts to:

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

PRIOR AUTHORIZATION

Some *prescription drugs* are subject to *prior authorization*. To verify if a *prescription* drug requires *prior authorization*, call the toll free customer service phone number on the back of *your* ID card or visit Humana's website at www.humana.com.

STEP THERAPY

Some *prescription* drugs may be subject to the *step therapy* process. Call the toll-free customer service phone number on the back of *your* ID card or visit Humana's website at www.humana.com for more information.

DISPENSING LIMITS

Some *prescription* drugs may be subject to *dispensing limits*. To verify if a *prescription* drug has *dispensing limits*, call the toll free customer service phone number on the back of *your* ID card or visit Humana's website at www.humana.com.

RETAIL PHARMACY AND SPECIALTY PHARMACY

Your Plan provisions include a retail *prescription* drug benefit. *You* will receive an identification (ID) card which includes *your* name, group number and *your* effective date.

Present *your* ID card at a *participating pharmacy* when purchasing a *prescription*. *Prescriptions* dispensed at a retail *pharmacy* or *specialty pharmacy* are limited to the day supply per *prescription* or refill as shown on the Schedule of Prescription Drug Benefits.

Following the initial fill and one refill of a covered *prescription* drug or therapeutic equivalent medication prescribed by one or more *qualified practitioners* and dispensed by one or more retail *pharmacies* or *specialty pharmacies*, all subsequent refills must be obtained through a *mail order pharmacy*.

MAIL ORDER PHARMACY

Your prescription drug coverage also includes *mail order pharmacy* benefits, allowing participants an easy and convenient way to obtain *prescription* drugs.

Mail order pharmacy prescriptions will only be filled with the quantity prescribed by *your qualified practitioner* and are limited to the day supply per *prescription* or refill as shown on the Schedule of Prescription Drug Benefits.

Additional *mail order pharmacy* information can be obtained by calling the toll free customer service phone number on the back of *your* ID card or visit Humana's website at www.humana.com.

OFFICE-ADMINISTERED SPECIALTY DRUGS

Your qualified practitioner has access to *specialty drugs* used to treat chronic conditions. These drugs can be ordered by *your qualified practitioner* specifically for *you* through Humana's preferred *specialty pharmacy* vendor for administration in his/her office setting. This allows *your qualified practitioner* a cost effective and convenient way to obtain high cost, high tech specialty medications and injectables. Additional information can be obtained by calling the toll-free customer service phone number on the back of *your* ID card or visit Humana's website at www.humana.com.

MAXIMIZE YOUR BENEFIT

You may receive "Maximize Your Benefit" notifications from Humana regarding possible lower-cost, but equally effective medication alternatives for *you* to discuss with *your* doctor.

PRESCRIPTION DRUG COST SHARING

Prescription drug benefits are payable for covered *prescription expenses incurred* by *you* and *your* covered *dependents*. Benefits for expenses made by a *pharmacy* are payable as shown on the Schedule of Prescription Drug Benefits.

You are responsible for payment of:

-
- Any and all *cost share*, when applicable;
- The cost of medication not covered under this Prescription Drug Benefit Plan;
- The cost of any quantity of medication dispensed in excess of the day supply noted on the Schedule of Prescription Drug Benefits.

If the dispensing *pharmacy's* charge is less than the *copayment*, *you* will be responsible for the lesser amount. The amount paid by this Plan to the dispensing *pharmacy* may not reflect the ultimate cost to this Plan for the drug. *Your cost share* is made on a per *prescription* or refill basis and will not be adjusted this Plan receives any retrospective volume discounts or *prescription* drug rebates.

PRESCRIPTION DRUG COVERAGE

Because Humana's *drug list* is continually updated with *prescription* drugs approved or not approved for coverage, *you* must call the toll-free customer service phone number on the back of *your* ID card or visit Humana's website at www.humana.com to verify whether a *prescription* drug is covered or not covered under this Prescription Drug Benefit Plan.

Please follow the directions below when accessing Humana's website:

1. Go to Humana's website (www.humana.com) and log-in as a Registered Member;

2. Click on the "Doctors & RX" drop down box located at the top of the page;

3. Click "Pharmacy Tools";

4. Click "Prescription Benefits" to get details about the *prescription* drug benefits under *your* Plan, including specific out-of-pocket costs; OR

5. Click "Printable Drug Lists and Forms" to view or download *your drug list*; OR

6. Click "Drug Pricing" and search for a drug by name, health condition or alphabetically to receive an estimated retail or mail order *pharmacy* drug price.

Covered *prescription* drugs, medicine or medications must:

1. Be prescribed by a *qualified practitioner* for the treatment of a *sickness* or *bodily injury*; and

2. Be dispensed by a *pharmacist*.

Prescription drug expenses covered under this Prescription Drug Benefit are not covered under any other provisions of the Plan. Any amount in excess of the maximum amount provided under the Prescription Drug Benefit is not covered under any other provision of the Plan.

Any *expenses incurred* under provisions of this Prescription Drug Benefit section, when received by a *participating pharmacy* apply towards the *Plan maximum out-of-pocket limit* outlined in the Medical Schedule of Benefits section. Any *expenses incurred* under provisions of this Prescription Drug Benefit section are not covered under any medical benefits. Any *expenses incurred* under *your* medical benefits are not covered under any *prescription drug* benefits.

Humana may decline coverage of a specific *prescription* or, if applicable, *drug list* inclusion of any and all drugs, medicines or medications until the conclusion of a review period not to exceed six (6) months following FDA approval for the use and release of the drug, medicine or medication into the market.

PRESCRIPTION DRUG LIMITATIONS

Expense incurred will not be payable for the following, unless specifically provided by this Prescription Drug Benefit Plan:

1. Any drug, medicine, medication or supply not approved for coverage under this Prescription Drug Benefit Plan (call the toll free customer service phone number on the back of *your* ID card or visit Humana's website at www.humana.com to verify whether a *prescription* drug is covered or not covered under this Prescription Drug Benefit Plan). A discount card is available for use on *prescription* drugs not covered under this Plan;

2. *Legend drugs* which are not deemed *medically necessary* by a *qualified practitioner*;

3. Charges for the administration or injection of any drug;

4. Any drug, medicine or medication labeled "Caution-limited by federal law to investigational use," or any drug, medicine or medication that is *experimental, investigational or for research purposes*, even though a charge is made to *you*;

5. Any drug, medicine or medication that is consumed or injected at the place where the *prescription* is given, or dispensed by the *qualified practitioner*;

6. *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 facility where drugs are ordinarily provided by the facility on an inpatient basis. Inpatient facilities include, but are not limited to:
   a. *Hospital*;
   b. Skilled nursing facility; or
   c. Hospice facility;

7. Any drug prescribed, except:
   a. FDA approved drugs utilized for FDA approved indications; or
   b. FDA approved drugs utilized for *off-label drug indications* recognized in at least one compendia reference or peer-reviewed medical literature deemed acceptable to this Plan;

8. *Prescription* refills:
   a. In excess of the number specified by the *qualified practitioner*; or
   b. Dispensed more than one year from the date of the original order;

9. *Off-evidence drug indications*;

10. Any drug for which a charge is customarily not made;

11. Therapeutic devices or appliances, including, but not limited to: hypodermic needles and syringes (except needles and syringes for use with insulin and covered *self-administered injectable drugs*, whose coverage is approved by this Plan); support garments; test reagents; mechanical pumps for delivery of medications; and other non-medical substances;

12. Dietary supplements (except enteral formulas and nutritional supplements for the treatment of phenylketonuria (PKU) or other inherited metabolic disease) nutritional products; fluoride supplements; minerals; herbs; and vitamins (except pre-natal vitamins, including greater than one milligram of folic acid, and pediatric multi-vitamins with fluoride);

13. Drug delivery implants;

14. Injectable drugs, including but not limited to: immunizing agents; biological sera; blood; blood plasma; or *self-administered injectable drugs* or *specialty drugs* not covered under this Prescription Drug Benefit Plan;

15. Any drug prescribed for a *sickness* or *bodily injury* not covered under this Plan;

16. Any portion of a *prescription* or refill that exceeds the day supply as shown on the Schedule of Prescription Drug Benefits;

17. Any drug, medicine or medication received by the *covered person*:
    a. Before becoming covered under this Plan; or
    b. After the date the *covered person's* coverage under this Plan has ended;

18. Any costs related to the mailing, sending, or delivery of *prescription* drugs;

19. Any intentional misuse of this benefit including *prescriptions* purchased for consumption by someone other than the *covered person*;

20. Any *prescription* or refill for drugs, medicines, or medications that are lost, stolen, spilled, spoiled, or damaged;

21. Repackaged drugs;

22. Any drug or medicine that is:
    a. Lawfully obtainable without a *prescription* (over the counter drugs), except insulin; or
    b. Available in *prescription* strength without a *prescription*;

23. Any drug or biological that has received designation as an *orphan drug*, unless approved by this Plan;

24. Any amount *you* paid for a *prescription* that has been filled, regardless of whether the *prescription* is revoked or changed due to adverse reaction or change in dosage or *prescription*;

25. Any portion of a *prescription* or refill that exceeds the drug specific *dispensing limit*, is dispensed to a *covered person* whose age is outside the drug specific age limits, is refilled early or exceeds the duration-specific *dispensing limit*, if applicable;

26. Any drug for which *prior authorization* or *step therapy* is required and not obtained;

27. Based on the dosage schedule prescribed by the *qualified practitioner*, more than one *prescription* or refill for the same drug or therapeutic equivalent medication prescribed by one or more *qualified practitioners* and dispensed by one or more *pharmacies* until *you* have used, or should have used, at least 75% of the previous *prescription* or refill. If the drug or therapeutic equivalent medication is purchased through a *mail order pharmacy*, until *you* have used, or should have used, at least 66% of the previous *prescription* or refill;

28. *Prescriptions* filled at a *non-participating pharmacy*.

Administered by:

HUMANA.
Guidance when you need it most

Humana Insurance Company
500 West Main Street
Louisville, KY 40202