Humana

SUMMARY PLAN DESCRIPTION

For the

SWORN EMPLOYEE HDHP MEDICAL AND PRESCRIPTION DRUG PLAN

Sponsored by

Kenosha County

Group Number: 574779

Package ID: SFKENC36

Effective: January 1, 2023

Important!

At Humana, it is important you are treated fairly.

Humana Inc. and its subsidiaries do not discriminate or exclude people because of their race, color, national origin, age, disability, sex, sexual orientation, gender, gender identity, ancestry, marital status or religion. Discrimination is against the law. Humana and its subsidiaries comply with applicable Federal Civil Rights laws. If you believe that you have been discriminated against by Humana or its subsidiaries, there are ways to get help.

- You may file a complaint, also known as a grievance:
  Discrimination Grievances, P.O. Box 14618,
  Lexington, KY 40512-4618
  If you need help filing a grievance, call the number on your ID card or if you use a **TTY**, call **711**.
- You can also file a civil rights complaint with the **U.S. Department of Health and Human Services**, Office for Civil Rights electronically through their complaint portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by at **U.S. Department of Health and Human Services**, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, DC 20201, **1-800-368-1019**, **800-537-7697 (TDD)**. Complaint forms are available at **https://www.hhs.gov/ocr/office/file/index.html**.
- **California residents:** You may also call California Department of Insurance toll-free hotline number: **1-800-927-HELP (4357)**, to file a grievance.

Auxiliary aids and services, free of charge, are available to you. Call the number on your ID card (TTY: 711)

Humana provides free auxiliary aids and services, such as qualified sign language interpreters, video remote interpretation, and written information in other formats to people with disabilities when such auxiliary aids and services are necessary to ensure an equal opportunity to participate.

Language assistance services, free of charge, are available to you. Call the number on your ID card (TTY: 711)

ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call the number on your ID card **(TTY: 711)**... ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al número que figura en su tarjeta de identificación **(TTY: 711)**... 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電會員卡上的電話號碼 **(TTY: 711)**... CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số điện thoại ghi trên thẻ ID của quý vị **(TTY: 711)**... 주의 : 한국어를 사용하시는 경우 , 언어 지원 서비스를 무료로 이용하실 수 있습니다 . ID 카드에 적혀 있는 번호로 전화해 주십시오 **(TTY: 711)**... PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tawagan ang numero na nasa iyong ID card **(TTY: 711)**... ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Наберите номер, указанный на вашей карточке-удостоверении **(телетайп: 711)**... ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele nimewo ki sou kat idantite manm ou **(TTY: 711)**... ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le numéro figurant sur votre carte de membre **(ATS: 711)**...UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Proszę zadzwonić pod numer podany na karcie identyfikacyjnej **(TTY: 711)**... ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para o número presente em seu cartão de identificação **(TTY: 711)**... ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero che appare sulla tessera identificativa **(TTY: 711)**... ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Wählen Sie die Nummer, die sich auf Ihrer Versicherungskarte befindet **(TTY: 711)**... 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。お手持ちの ID カードに記載されている電話番号までご連絡ください **(TTY: 711)**...

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با شماره تلفن روی کارت شناسایی تان تماس بگیرید **(TTY: 711)**...

Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, námboo ninaaltsoos yézhí, bee nééé ho'dólzin bikáá'ígíí bee hólne' **(TTY: 711)**...

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم الهاتف الموجود على بطاقة الهوية الخاصة بك **(TTY: 711)**.

NO SURPRISES ACT AMENDMENT

This amendment is made part of the Summary Plan Description to which it is attached.

All terms used in this amendment have the same meaning given to them in the Summary Plan Description, unless otherwise defined in this amendment. Except as modified below, all terms, conditions and limitations of the Summary Plan Description remain the same.

This amendment is effective for the Summary Plan Description issued or renewed on or after January 1, 2023.

No Surprises Act

The No Surprises Act (the Act) is a federal law that requires coverage of certain services received from a *non- network provider* at the *network provider* benefit level and protects *you* from balance billing when events described in this amendment occur.

Definitions

Air ambulance means a professionally operated helicopter or airplane, 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 *air ambulance* must be *medically necessary*. When transporting the sick or injured person from one medical facility to another, the *air ambulance* must be ordered by a *qualified provider*.

Ancillary services mean *covered expenses* that are:

- Items or *services* related to emergency medicine, anesthesiology, pathology; radiology; or neonatology;
- Provided by *assistant surgeons,* hospitalists or intensivists;
- Diagnostic laboratory or radiology *services*; or
- Items or *services* provided by a *non- network provider* when a *network provider* is not available to provide the *services* at the *network facility*.

Emergency care means services provided in an emergency facility for an *emergency medical condition*. *Emergency care* does not mean services for the convenience of the *covered person* or the provider of treatment or services.

Emergency medical condition means a *bodily injury* or *sickness* manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of that individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment of bodily functions; or
- Serious dysfunction of any bodily organ or part.

Network facility means a *hospital*, *hospital* outpatient department or *ambulatory surgical center* that has been designated as such or has signed an agreement with Humana as an independent contractor, or has been designated by Humana to provide *services* to all *covered persons*. *Network facility* designation by Humana may be limited to specified *services*.

Post-stabilization services means *services you* receive in *observation status* or during an inpatient or outpatient stay in a *network facility* related to an *emergency medical condition* after *you* are stabilized.

Recognized amount means the reimbursement rate as determined by:

- An applicable state All Payer Model Agreement under the Social Security Act;
- An applicable state law; or
- The qualifying payment amount as defined by the Act.

Emergency and non-emergency services

We will apply the *network provider* benefit level and *you* will only be responsible to pay the *network provider copayment*, *deductible* and/or *coinsurance* based on the *recognized amount* for *covered expenses* when *you* receive the following *services* from a *non- network provider*:

- *Air ambulance services*;
- *Emergency care*;
- *Ancillary services* when *you* are at a *network facility*;
- *Services* that are not considered *ancillary services* when *you* are at a *network facility* and *you* did not consent to the *non- network provider* to obtain such *services*; or
- *Post-stabilization services* when *you* did not consent to the *non- network provider* to obtain such *services* due to *your emergency medical condition*.

The protections of the Act do not apply if *you* consent to a *non- network provider* to receive the following *services*:

- Those that are not considered *ancillary services*; or
- *Post-stabilization services*.

Continuity of care

You may be eligible to elect continuity of care if *you* are a continuing care patient, as defined in the Act, as of the date any of the following events occur:

- *Your qualified provider* terminates as a *network provider*;
- The terms of a *network provider's* participation in the network changes in a manner that terminates a benefit for a service *you* are receiving as a continuing care patient; or
- The Plan terminates.

If *you* elect continuity of care, *we* will apply the *network provider* benefit level to *covered expenses* related to *your* treatment as a continuing care patient. *You* may contact Humana's customer service department at the telephone number shown on *your* ID card to determine if you are eligible for continuity of care.

External Review

You may file a request for an *external review* of an *adverse benefit determination* or *final internal adverse benefit determination* notice that involves compliance with the cost-sharing and surprise billing protections.

Humana

INTRODUCTION

THE SUMMARY PLAN DESCRIPTION – YOUR HEALTH CARE PLAN GUIDE

Welcome to *your employer*-sponsored health care plan (Plan) administered by Humana Insurance Company (Humana). *Your employer* has provided *you* with this *Summary Plan Description* (*SPD*), which outlines *your* benefits, as well as *your* rights and responsibilities under this Plan.

This *SPD* is *your* guide to the benefits, provisions and programs offered by this Plan. *Services* are subject to all provisions of this Plan, including the limitations and exclusions. Please read this *SPD* carefully, paying special attention to the "Medical Schedule of Benefits," "Medical Covered Expenses," and "Limitations and Exclusions" sections to better understand how *your* benefits work. If *you* are unable to find the information *you* need, please contact Humana at the toll-free customer service telephone number listed on *your* Humana ID card or visit Humana's website at www.humana.com.

This *SPD* presents an overview of *your* benefits. In the event of any discrepancy between this *SPD* and the official Plan Document, the Plan Document shall govern.

DEFINED TERMS

Italicized terms throughout this *SPD* are defined in the "Definitions" section. An italicized word may have a different meaning in the context of this *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 *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 toll-free customer service telephone number.

Website: *You* can access Humana's online services at www.humana.com.

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

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SECTION 1

HEALTH RESOURCES AND PREAUTHORIZATION

HEALTH RESOURCES

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

Each Health Resources program is tailored to meet different health care needs, from those who want to stay well when they are healthy, to those who 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*.

All Health Resources programs are subject to change without notice. For additional information or questions regarding any of these programs, visit Humana's website at www.humana.com or call the toll-free customer service telephone number listed on *your* Humana ID card.

WELLNESS PROGRAMS

From time to time this Plan may offer directly, or enter into agreements with third parties who administer participatory or health-contingent wellness programs to *you*.

"Participatory" wellness programs do not require *you* to meet a standard related to a health factor. Examples of participatory wellness programs may include, but are not limited to, membership in a fitness center, certain preventive testing, or attending a no-cost health education seminar.

"Health-contingent" wellness programs require *you* to attain certain wellness goals that are related to a health factor. Examples of health contingent wellness programs may include, but are not limited to, completing a 5k event, lowering blood pressure or ceasing the use of tobacco.

The rewards may include, but are not limited to, payment for all or a portion of a participatory wellness program, merchandise, gift cards, debit cards, discounts or contributions to *your* health spending account, if applicable. This Plan is not responsible for any rewards provided by third parties that are non-Plan benefits or for *your* receipt of such reward(s).

The rewards may also include, but are not limited to, discounts or credits toward premium or a reduction in *copayments*, *deductibles* or *coinsurance*, as permitted under applicable state and federal laws. Such insurance premium or benefit rewards may be made available at the individual or the Plan level.

The rewards may be taxable income. *You* may consult a tax advisor for further guidance.

This Plan's agreement with any third party does not eliminate any of *your* obligations under this Plan or change any of the terms of this Plan. This Plan's agreement with the third parties and the program may be terminated at any time, although insurance benefits will be subject to applicable state and federal laws.

This Plan is committed to helping *you* achieve *your* best health. Some wellness programs may be offered only to *covered persons* with particular health factors. If *you* think *you* might be unable to meet a standard for a reward under a health-contingent wellness program, *you* might qualify for an opportunity to earn the same reward by different means. Contact this Plan at the number listed on *your* ID card or in the marketing literature issued by the wellness program administrator for more information.

The wellness program administrator or this Plan may require proof in writing from *your qualified provider* that *your* medical condition prevents *you* from taking part in the available activities.

The decision to participate in wellness program activities is voluntary and if eligible, *you* may decide to participate anytime during the year. Refer to the marketing literature issued by the wellness program administrator for their program's eligibility, rules and limitations.

PREAUTHORIZATION

Humana will provide *preauthorization* as required by this Plan. The list of services and supplies that require *preauthorization* is available by calling the customer service telephone number on *your* ID card. The list of services and supplies that require *preauthorization* is subject to change. Coverage provided in the past for services or supplies that did not receive or require *preauthorization*, is not a guarantee of future coverage of the same services or supplies. Benefits are not paid at all for services or supplies that are not *covered expenses*.

Your network health care practitioner is responsible for obtaining the appropriate *preauthorization* for services or supplies to be provided by a *network provider*.

You are responsible for informing *your health care practitioner* of the *preauthorization* requirements for services or supplies to be provided by a *non-network provider*. *You* or *your health care practitioner* must contact Humana by telephone, *electronic mail* or in writing to request the appropriate *preauthorization*.

After *you* or *your health care practitioner* have contacted Humana and provided *your* diagnosis and treatment plan, Humana will:

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

- Conduct *concurrent review* as necessary.

If *your admission* is *preauthorized*, benefits are subject to all Plan provisions. 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.

The following *services* require *preauthorization*:

INPATIENT MEDICAL AND SURGICAL ADMISSIONS (INCLUDES ACUTE HOSPITAL, LONG TERM ACUTE CARE, REHABILITATION FACILITY, SKILLED NURSING FACILITY AND INPATIENT HOSPICE)

Humana must be notified in advance of an inpatient *admission*. If the *admission* is on an *emergency* basis, notification must be received following the *emergency admission*.

INPATIENT TRANSPLANTS AND IMMUNE EFFECTOR CELL THERAPY

Humana must be notified prior to receiving inpatient transplant *services* and *immune effector cell therapy*. If the *admission* is on an *emergency* basis, notification must be received following the *emergency admission*.

DURABLE MEDICAL EQUIPMENT (DME) AND PROSTHETICS

Humana must be notified if the purchase or rental of *durable medical equipment* or prosthetics is expected to be $1,000 or more.

GENETIC MOLECULAR TESTING

Humana must be notified prior to receiving genetic molecular testing.

ADDITIONAL MEDICAL PROCEDURES

Humana must be notified prior to receiving any of the following services: Plastic Surgery/Cosmetic: Abdominoplasty, Blepharoplasty, Breast Procedures, Otoplasty, Penile Implant or Rhinoplasty

INPATIENT BEHAVIORAL HEALTH

Humana must be notified in advance of an inpatient *behavioral health admission*.

PREAUTHORIZATION PENALTY

If *preauthorization* is not received, for inpatient benefits will be subject to a $75 penalty.

Penalties do not apply to any applicable Plan *copayments*, *deductibles* and/or *coinsurance* or *out-of-pocket limits*.

PREDETERMINATION OF BENEFITS

You or *your qualified provider* 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 than 180 days after the date treatment is authorized, Humana will require *you* to submit another treatment plan.

SECTION 2

MEDICAL BENEFITS

NETWORK AND NON-NETWORK PROVIDERS

This Plan has two (2) levels of benefits – *network provider* benefits and *non-network provider* benefits, payable as shown in the "Medical Schedule of Benefits" section. *You* may select any provider to provide *your* medical care.

NETWORK AND NON-NETWORK PROVIDERS - POINT OF SERVICE (POS) PLAN

A Point of Service (POS) Plan combines the features of an HMO and a PPO. A POS Plan network consists of a group of *hospitals*, *qualified providers* and other providers called *network providers*, that have contractual arrangements with Humana. *You* may select any provider to provide *your* medical care. Benefits are payable as shown in the "Medical Schedule of Benefits" section.

In most cases, if *you* receive *services* from a *network provider*, this Plan will pay a higher percentage of benefits and *you* will have lower out-of-pocket costs. *You* are responsible for any applicable *deductibles*, *coinsurance* amounts and/or *copayments*.

If *you* receive *services* from a *Non-network provider*, this Plan will pay benefits at a lower percentage and *you* will pay a larger share of the costs. Since *Non-network providers* do not have contractual arrangements with Humana to accept discounted or negotiated fees, they may bill *you* for charges in excess of the *maximum allowable fee*. *You* are responsible for charges in excess of the *maximum allowable fee* in addition to any applicable *deductibles*, *coinsurance* amounts and/or *copayments*. Any amount *you* pay to the provider in excess of *your coinsurance* or *copayment* will not apply to *your out-of-pocket limit* or *deductible*.

Not all *qualified providers* including pathologists, radiologists, anesthesiologists, and emergency room physicians who provide *services* at *network hospitals* are *network qualified providers*. If *services* are provided to *you* by such *Non-network qualified providers* at a *network hospital*, this Plan will pay for those *services* at the *network provider* benefit percentage *Non-network qualified providers* may require payment from *you* for any amount not paid by this Plan. If possible, *you* may want to verify whether *services* are available from a *network qualified provider*.

However, *we* will apply the *network provider* benefit level and *you* will only be responsible to pay the *network provider copayment*, *deductible* and/or *coinsurance*, based on the *qualified payment amount*, for *covered expenses* when *you* receive the following services from a *non-network provider*:

- *Emergency care* and *air ambulance* services;
- Ancillary *services* while *you* are at a *network facility*;
- Services that are not considered *ancillary services* while *you* are at a *network facility*, and *you* do not consent to the *non-network provider* to obtain such services; and
- *Post-stabilization services* when:
    - The attending *qualified provider* determines *you* are not able to travel by non-medical transportation to obtain services from a *network provider*; and
    - *You* do not consent to the *non-network provider* to obtain such services.

In the event that a specific medical *service* cannot be provided by or through a *network provider*, a *covered person* is entitled to coverage for *medically necessary covered expenses* obtained through a *Non-network provider* when approved by this Plan on a case by case basis.

NETWORK PROVIDER DIRECTORY

Your employer will automatically provide, without charge, information to *you* about how *you* can access a directory of *network providers* appropriate to *your* service area. An online directory of *network 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 *network providers* changing status, please check the online directory of *network providers* prior to obtaining *services*. If *you* do not have access to the online directory, call Humana at the toll-free customer service telephone number listed on *your* Humana ID card prior to *services* being rendered or to request a directory.

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 *network provider* or a *Non-network provider*, *you* are responsible for making the full payment to the provider. The fact that a provider 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.

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 *you* make a smooth transition to Humana from *your* current health care plan with the least amount of disruption to *your* care.

CONTINUITY OF CARE

You may be eligible to elect continuity of care if *you* are a continuing care patient as of the date any of the following events occur:

- *Your qualified provider* terminates as a *network provider*;
- The terms of a *network provider's* participation in the network changes in a manner that terminates a benefit for a service *you* are receiving as a continuing care patient; or
- The Plan terminates.

You must be in a course of treatment with the *qualified provider* as a continuing care patient the day before *you* are eligible to elect continuity of care.

If *you* elect continuity of care, *we* will apply the *network provider* benefit level to *covered expenses* related to *your* treatment as a continuing care patient. *You* will be responsible for the *network provider copayment, deductible* and/or *coinsurance* until the earlier of:

- 90 days from the date *we* notify *you* the *qualified provider* is no longer a *network provider*;
- 90 days from the date *we* notify *you* the terms of a *network provider's* participation in the network changes in a manner that terminates a benefit for a service *you* are receiving as a continuing care patient;
- 90 days from the date *we* notify *you* this Plan terminates; or
- The date *you* are no longer a continuing care patient.

For the purposes of this "Continuity of care" provision, continuing care patient means at the time continuity of care becomes available, *you* are undergoing treatment from the *network provider* for:

- An acute *sickness* or *bodily injury* that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm;
- A chronic sickness or *bodily injury* that is a life-threatening condition, degenerative, potentially disabling, or is a *congenital anomaly* and requires specialized medical care over a prolonged period of time;
- Inpatient care;
- A scheduled non-elective *surgery* and any related post-surgical care;
- A pregnancy; or
- A terminal illness.

For the purposes of this "Continuity of Care" provision, a terminal illness means you have a medical prognosis with a life expectancy of 6 months or less.

Continuity of care is not available if:

- The *qualified provider's* participation in *our* network is terminated due to failure to meet applicable quality standards or fraud;
- You transition to another *qualified provider*;
- The services *you* receive are not related to *your* treatment as a continuing care patient;
- This "Continuity of Care" provision is exhausted; or
- *Your* coverage terminates, however the Plan remains in effect.

All terms and provisions of the Plan are applicable to this "Continuity of Care" provision.

MEDICAL SCHEDULE OF BENEFITS

IMPORTANT INFORMATION ABOUT PLAN BENEFITS

Plan benefits and limits (i.e. visit or dollar limits) are applicable per *calendar year*, unless specifically stated otherwise.

When Plan benefit limits apply (i.e. visit or dollar limits), *network* and *non-network provider* benefits accumulate together, unless specifically stated otherwise.

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 AND PRESCRIPTION DRUG DEDUCTIBLES, COINSURANCE AND OUT-OF-POCKET LIMITS		
BENEFIT FEATURES	**NETWORK PROVIDER BENEFIT (In Network)**	**NON-NETWORK PROVIDER BENEFIT (Out of Network)**
Both medical and *prescription* drug *covered expenses* apply towards the medical and *prescription* drug *deductibles* and medical and *prescription* drug *out-of-pocket limits* outlined below. Please see the "Prescription Drug Benefits" section of this *SPD* for a detailed description of *your prescription* drug coverage.		
Single Medical and Prescription Drug *Deductible*	$2,400 per *covered person*	$4,800 per *covered person*
Family Medical and Prescription Drug *Deductible*	$4,800 per covered family	$9,600 per covered family
Medical and Prescription Drug *Coinsurance*	The Plan pays 100%, *you* pay 0%.	The Plan pays 70%, *you* pay 30%.
Single Medical and Prescription Drug *Out-of-Pocket Limit*	$3,400 per *covered person*	$6,950 per *covered person*
Family Medical and Prescription Drug *Out-of-Pocket Limit*	$6,800 per covered family	$13,650 per covered family

MEDICAL AND PRESCRIPTION DRUG DEDUCTIBLES, COINSURANCE AND OUT-OF-POCKET LIMITS		
BENEFIT FEATURES	**NETWORK PROVIDER BENEFIT (In Network)**	**NON-NETWORK PROVIDER BENEFIT (Out of Network)**
Lifetime Maximum Benefit	Unlimited	Unlimited
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 clinic*. A specialist would be all other *qualified providers*.		

ROUTINE/PREVENTIVE CHILD CARE SERVICES BIRTH TO AGE 18 (*Services* Received at a Clinic or Outpatient *Hospital*)		
MEDICAL SERVICES	**NETWORK PROVIDER BENEFIT (In Network)**	**NON-NETWORK PROVIDER BENEFIT (Out of Network)**
Routine/Preventive Child Care Examination	100%	70% after *deductible*
Routine/Preventive Child Care Hearing Screening.	100%	70% after *deductible*
Routine/Preventive Child Care Vision Screening	100%	70% after *deductible*
Routine/Preventive Child Care Laboratory	100%	70% after *deductible*
Routine/Preventive Child Care X-ray	100%	70% after *deductible*

ROUTINE/PREVENTIVE CHILD CARE SERVICES BIRTH TO AGE 18 (*Services* Received at a Clinic or Outpatient *Hospital*)		
MEDICAL SERVICES	**NETWORK PROVIDER BENEFIT (In Network)**	**NON-NETWORK PROVIDER BENEFIT (Out of Network)**
Routine/Preventive Child Care 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 (www.cdc.gov)	100%	70% after *deductible*
Routine/Preventive Child Care Flu/Pneumonia Immunizations	100%	70% after *deductible*

ROUTINE/PREVENTIVE ADULT CARE SERVICES AGE 18 AND OVER (*Services* Received at a Clinic or Outpatient *Hospital*)		
MEDICAL SERVICES	**NETWORK PROVIDER BENEFIT (In Network)**	**NON-NETWORK PROVIDER BENEFIT (Out of Network)**
Routine/Preventive Adult Care Examination	100%	70% after *deductible*
Routine/Preventive Adult Care Hearing Screening	100%	70% after *deductible*

ROUTINE/PREVENTIVE ADULT CARE SERVICES AGE 18 AND OVER (*Services* Received at a Clinic or Outpatient *Hospital*)		
MEDICAL SERVICES	**NETWORK PROVIDER BENEFIT (In Network)**	**NON-NETWORK PROVIDER BENEFIT (Out of Network)**
Routine/Preventive Adult Care Vision Screening	100%	70% after *deductible*
Routine/Preventive Adult Care Laboratory and X-ray	100%	70% after *deductible*
Routine/Preventive Adult Care 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 (www.cdc.gov)	100%	70% after *deductible*
Routine/Preventive Adult Care Flu/Pneumonia Immunizations	100%	70% after *deductible*
Routine/Preventive Adult Care Mammograms Routine Mammograms do not apply to child or adult age limits.	100%	70% after *deductible*

ROUTINE/PREVENTIVE ADULT CARE SERVICES AGE 18 AND OVER (*Services* Received at a Clinic or Outpatient *Hospital*)		
MEDICAL SERVICES	**NETWORK PROVIDER BENEFIT (In Network)**	**NON-NETWORK PROVIDER BENEFIT (Out of Network)**
Routine/Preventive Adult Care Pap Smears Routine Pap Smears do not apply to child or adult age limits.	100%	70% after *deductible*
Routine/Preventive Child Care and Adult Care Colonoscopy, Proctosigmoidoscopy and Sigmoidoscopy Screenings (including related *services*) i.e. anesthesia (performed at an outpatient facility, *ambulatory surgical center* or clinic location) Colonoscopy, Proctosigmoidoscopy and Sigmoidoscopy Screenings are payable under this Routine/Preventive Adult Care Benefit when billed by the *qualified provider* with a routine diagnosis.	100%	70% after *deductible*
Routine/Preventive Adult Care Prostate Specific Antigen (PSA) Testing	100%	70% after *deductible*
Breast Feeding Counseling	100%	100%
Breast Feeding Support and Supplies	100%	70% after *deductible*

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

MEDICAL SERVICES	NETWORK PROVIDER BENEFIT (In Network)	NON-NETWORK PROVIDER BENEFIT (Out of Network)
Contraceptive Methods - contraceptive devices (e.g. IUD or diaphragms), injections, implant insertion/removal, emergency contraceptives, tubal ligation, and tubal sterilization.	100%	70% after *deductible*
Male Sterilization	100%	70% after *deductible*
Male Contraceptives	Not covered	Not covered

Note: If *services* are not to prevent pregnancy, then they will be payable the same as any other *sickness*.

Note: Excludes birth control pills/patches and spermicide - refer to the Pharmacy Benefit for coverage for these and for *prescription* drug coverage for emergency contraceptives.

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, male sterilization and male contraceptives.

ROUTINE VISION SERVICES		
MEDICAL SERVICES	**NETWORK PROVIDER BENEFIT (In Network)**	**NON-NETWORK PROVIDER BENEFIT (Out of Network)**
Routine Vision Examination	Not Covered	Not Covered
Routine Vision Refraction	Not Covered	Not Covered
Eyeglass Frames and Lenses and Contact Lenses	Not Covered	Not Covered

HEARING SERVICES		
MEDICAL SERVICES	**NETWORK PROVIDER BENEFIT (In Network)**	**NON-NETWORK PROVIDER BENEFIT (Out of Network)**
Routine Hearing Examination	Not Covered	Not Covered
Routine Hearing Testing	Not Covered	Not Covered
Hearing Aids and Fitting Cost of treatment and Cochlear Implants/Device implantation for children ages 0 through 17	Payable the same as any other condition.	Payable the same as any other condition.
Hearing Aids and Fitting Limits	One hearing aid, per hearing impaired ear, once every three years for *covered persons* through age 17.	

QUALIFIED PROVIDER SERVICES (Non-Routine/Non-Preventive Care *Services*)		
MEDICAL SERVICES	**NETWORK PROVIDER BENEFIT (In Network)**	**NON-NETWORK PROVIDER BENEFIT (Out of Network)**
Diagnostic Office Examination at a Clinic, including Second Surgical Opinion – *Qualified Provider* Primary Care Physician	100% after *deductible*	70% after *deductible*
Diagnostic Office Examination at a Clinic, including Second Surgical Opinion - *Qualified Provider* Specialist	100% after *deductible*	70% after *deductible*
Telemedicine	100% after *deductible*	70% after *deductible*
If an office examination is billed from an outpatient location, the *services* will be payable the same as an office examination at a clinic.		
Diagnostic Laboratory and X-ray at a Clinic (other than *advanced imaging*)	100% after *deductible*	70% after *deductible*
Office exam-at Retail/Minute Clinic- Location-including Second Surgical Opinion	100% after *deductible*	70% after *deductible*
Independent Laboratory	Payable the same as diagnostic laboratory and x-ray.	Payable the same as diagnostic laboratory and x-ray.
Advanced Imaging at a Clinic	100% after *deductible*	70% after *deductible*
Allergy Testing at a Clinic	100% after *deductible*	70% after *deductible*

QUALIFIED PROVIDER SERVICES (Non-Routine/Non-Preventive Care *Services*)		
MEDICAL SERVICES	**NETWORK PROVIDER BENEFIT (In Network)**	**NON-NETWORK PROVIDER BENEFIT (Out of Network)**
Allergy Serum/Vials at a Clinic	100% after *deductible*	70% after *deductible*
Allergy Injections at a Clinic	100% after *deductible*	70% after *deductible*
Injections at a Clinic (other than routine immunizations, contraceptive injections for birth control reasons and allergy injections)	100% after *deductible*	70% after *deductible*
Anesthesia at a Clinic	100% after *deductible*	70% after *deductible*
Surgery at a Clinic (including *Qualified Provider*, *Assistant Surgeon* and Physician Assistant)	100% after *deductible*	70% after *deductible*
Medical and Surgical Supplies	100% after *deductible*	70% after *deductible*
Eyeglasses or Contact Lenses after Cataract *Surgery* (initial pair only)	100% after *deductible*	70% after *deductible*
Diabetic Nutritional Counseling (*Diabetes Self-Management Training*) (all places of *service*)	100% after *deductible*	70% after *deductible*

QUALIFIED PROVIDER SERVICES (Non-Routine/Non-Preventive Care *Services*)		
MEDICAL SERVICES	**NETWORK PROVIDER BENEFIT (In Network)**	**NON-NETWORK PROVIDER BENEFIT (Out of Network)**
Diabetic Nutritional Counseling Yearly Limits	No limitations for children with PKU, subject to *medical necessity*. Six (6) visits then pend for medical necessity.	
Diabetes Supplies	Payable under the *prescription* drug benefits.	Payable under the *prescription* drug benefits.
Autism Spectrum Disorders	Payable the same as any other condition.	Payable the same as any other condition.

DENTAL/ORAL SURGERIES COVERED UNDER THE MEDICAL PLAN		
MEDICAL SERVICES	**NETWORK PROVIDER BENEFIT (In Network)**	**NON-NETWORK PROVIDER BENEFIT (Out of Network)**
Dental/Oral *Surgeries*	Payable the same as any other condition.	Payable the same as any other condition.
Dental/Oral *Surgeries* Lifetime Limit	$25,000 per lifetime on paid amount In Network and Out of Network functional osteotomies only	
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.		

REVERSAL OF STERILIZATION AND ABORTIONS		
MEDICAL SERVICES	**NETWORK PROVIDER BENEFIT (In Network)**	**NON-NETWORK PROVIDER BENEFIT (Out of Network)**
Reversal of Sterilization	Not Covered	Not Covered
Life Threatening Abortions	Payable the same as any other condition	Payable the same as any other condition
Elective Abortions	Not Covered	Not Covered

MATERNITY (Normal, C-Section and Complications)		
MEDICAL SERVICES	**NETWORK PROVIDER BENEFIT (In Network)**	**NON-NETWORK PROVIDER BENEFIT (Out of Network)**
Inpatient *Hospital Room and Board* and Ancillary Facility *Services*	Payable the same as any other condition.	Payable the same as any other condition.
Birthing Center *Room and Board* and Ancillary *Services*	Payable the same as any other condition.	Payable the same as any other condition.
Qualified Provider Services	Payable the same as any other condition.	Payable the same as any other condition.
Dependent Daughter Maternity	Payable the same as any other condition.	Payable the same as any other condition.
Newborn Inpatient *Qualified Provider Services*	100% after *deductible*	70% after *deductible*

MATERNITY (Normal, C-Section and Complications)		
MEDICAL SERVICES	**NETWORK PROVIDER BENEFIT (In Network)**	**NON-NETWORK PROVIDER BENEFIT (Out of Network)**
Newborn Inpatient Facility *Services*	100% after *deductible*	70% after *deductible*

INPATIENT SERVICES		
MEDICAL SERVICES	**NETWORK PROVIDER BENEFIT (In Network)**	**NON-NETWORK PROVIDER BENEFIT (Out of Network)**
Inpatient *Hospital Room and Board* and Ancillary Facility *Services*	100% after *deductible*	70% after *deductible*
Qualified Provider Inpatient *Hospital* Visit	100% after *deductible*	70% after *deductible*
Qualified Provider Inpatient *Surgery* and Anesthesia	100% after *deductible*	70% after *deductible*
Qualified Provider Inpatient Pathology and Radiology	100% after *deductible*	70% after *deductible*
Private Duty Nursing (inpatient *hospital* only)	Not covered	Not covered
NOTE: Hospitalist services rendered by a non-PPO physician, but performed at a PPO facility are to be paid at the in-plan level of benefits.		

SKILLED NURSING SERVICES		
MEDICAL SERVICES	**NETWORK PROVIDER BENEFIT (In Network)**	**NON-NETWORK PROVIDER BENEFIT (Out of Network)**
Skilled Nursing *Room and Board* and Ancillary Facility *Services*	100% after *deductible*	70% after *deductible*
Skilled Nursing Facility Yearly Limits	180 days per *covered person* per *admission*.	
Skilled Nursing *Qualified Provider* Visit	100% after *deductible*	70% after *deductible*

OUTPATIENT AND AMBULATORY SURGICAL CENTER SERVICES		
MEDICAL SERVICES	**NETWORK PROVIDER BENEFIT (In Network)**	**NON-NETWORK PROVIDER BENEFIT (Out of Network)**
Ambulatory Surgical Center Facility *Services*	100% after *deductible*	70% after *deductible*
Ambulatory Surgical Center Ancillary *Services*	100% after *deductible*	70% after *deductible*
Outpatient *Hospital* Facility Surgical *Services*	100% after *deductible*	70% after *deductible*
Outpatient *Hospital* Facility Non-Surgical *Services* (e.g. observation)	100% after *deductible*	70% after *deductible*

OUTPATIENT AND AMBULATORY SURGICAL CENTER SERVICES		
MEDICAL SERVICES	**NETWORK PROVIDER BENEFIT (In Network)**	**NON-NETWORK PROVIDER BENEFIT (Out of Network)**
Outpatient *Hospital* Surgical and Non-Surgical Ancillary *Services* (e.g. supplies; medication; anesthesia)	100% after *deductible*	70% after *deductible*
Outpatient *Hospital* Facility Diagnostic Laboratory and X-ray (other than *advanced imaging*)	100% after *deductible*	70% after *deductible*
Outpatient *Hospital* Facility *Advanced Imaging*	100% after *deductible*	70% after *deductible*
Outpatient *Hospital* and *Ambulatory Surgical Center Qualified Provider* Visit	100% after *deductible*	70% after *deductible*
Outpatient *Hospital* and *Ambulatory Surgical Center Surgery* (including surgeon; *assistant surgeon*; and physician assistant) and Anesthesia	100% after *deductible*	70% after *deductible*
Outpatient *Hospital* and *Ambulatory Surgical Center* Pathology and Radiology	100% after *deductible*	70% after *deductible*

EMERGENCY AND URGENT CARE SERVICES		
MEDICAL SERVICES	**NETWORK PROVIDER BENEFIT (In Network)**	**NON-NETWORK PROVIDER BENEFIT (Out of Network)**
Emergency Room Facility and Ancillary *Services* (*emergency care*)	100% after *deductible*	Same as *Network Provider* Benefit
Emergency Room All Physician *Services* (including Emergency Room Physician, Radiologist, Pathologist, Anesthesiologist and ancillary *services* billed by an Emergency Room Physician) (*emergency care*)	100% after *deductible*	Same as *Network Provider* Benefit
Emergency Room Facility and Ancillary *Services* (non-emergency)	100% after *deductible*	70% after *deductible*
Emergency Room All Physician *Services* (including Emergency Room Physician, Radiologist, Pathologist, Anesthesiologist and ancillary *services* billed by an Emergency Room Physician) (non-emergency)	100% after *deductible*	70% after *deductible*
Urgent Care Center (facility, ancillary *services* and *Qualified Provider services*)	100% after *deductible*	70% after *deductible*

HOSPICE SERVICES		
MEDICAL SERVICES	**NETWORK PROVIDER BENEFIT (In Network)**	**NON-NETWORK PROVIDER BENEFIT (Out of Network)**
Hospice Inpatient *Room and Board* and Ancillary *Services*	100% after *deductible*	70% after *deductible*
Hospice Outpatient (including hospice home visits)	100% after *deductible*	70% after *deductible*
Hospice *Qualified Provider* Visit	100% after *deductible*	70% after *deductible*

HOME HEALTH CARE SERVICES		
MEDICAL SERVICES	**NETWORK PROVIDER BENEFIT (In Network)**	**NON-NETWORK PROVIDER BENEFIT (Out of Network)**
Home Health Care *Services*	100% after *deductible*	70% after *deductible*
Home therapy benefits will be reimbursed under the home health care benefit. If therapies are done in the home (such as physical or occupational therapy), these therapy *services* will apply to the home health care limits. If therapies and home health visits are done on the same day the *services* will track as one visit per day.		
Home Health Care Ancillary *Services* (excluding *durable medical equipment*, prosthetics and private duty nursing)	100% after *deductible*	70% after *deductible*

DURABLE MEDICAL EQUIPMENT (DME)		
MEDICAL SERVICES	**NETWORK PROVIDER BENEFIT (In Network)**	**NON-NETWORK PROVIDER BENEFIT (Out of Network)**
Durable Medical Equipment (DME)	100% after *deductible*	70% after *deductible*
Orthotics CPTs Codes: L3000, L3001, L3002, L3003, L3020, L3030, L3031, L3010, L3070, L3080, L3090.	100% after deductible	70% after deductible
Prosthesis	100% after *deductible*	70% after *deductible*
Wigs for cancer patients with hair loss resulting from chemotherapy and/or radiation therapy	100% after *deductible*	70% after *deductible*
Wig Limits	One wig per *covered person* per lifetime	

SPECIALTY DRUGS		
MEDICAL SERVICES	**NETWORK PROVIDER BENEFIT**	**NON-NETWORK PROVIDER BENEFIT**
Specialty Drugs (*Qualified Provider's* Office Visit, Home Health Care, Freestanding Facility and *(Urgent Care Center*)	100% after *deductible*	70% after *deductible*
Specialty Drugs (Home Health Care)	100% after *deductible*	70% after *deductible*
Humana Pharmacy Home Health Care	100% after *deductible*	70% after *deductible*
Other Home Health Care	100% after *deductible*	70% after *deductible*
Specialty Drugs (Emergency Room, *Ambulance*, Inpatient *Hospital*, Outpatient *Hospital* and Skilled Nursing Facility)	100% after *deductible*	70% after *deductible*

AMBULANCE SERVICES		
MEDICAL SERVICES	**NETWORK PROVIDER BENEFIT (In Network)**	**NON-NETWORK PROVIDER BENEFIT (Out of Network)**
Ground *Ambulance* (only *medically necessary* transports) Only medically necessary transports-for SPD only	100% after *deductible*	Same as *network Provider* Benefit
Air *Ambulance* (only *medically necessary* transports) Only medically necessary transports-for SPD only	100% after *deductible*	Same as *network Provider* Benefit

OBESITY SERVICES		
MEDICAL SERVICES	**NETWORK PROVIDER BENEFIT**	**NON-NETWORK PROVIDER BENEFIT**
Obesity	Payable the same as any other *sickness*.	Payable the same as any other *sickness*.

MORBID OBESITY SERVICES		
MEDICAL SERVICES	**NETWORK PROVIDER BENEFIT**	**NON-NETWORK PROVIDER BENEFIT**
Morbid Obesity	Not covered	Not covered

TEMPOROMANDIBULAR JOINT DYSFUNCTION (TMJ)		
MEDICAL SERVICES	**NETWORK PROVIDER BENEFIT (In Network)**	**NON-NETWORK PROVIDER BENEFIT (Out of Network)**
Temporomandibular Joint Dysfunction (TMJ) (Other than Splint/Appliances)	100% after *deductible*	70% after *deductible*
Temporomandibular Joint Dysfunction (TMJ) Splint/Appliances	100% after *deductible*	70% after *deductible*

DENTAL INJURY SERVICES		
MEDICAL SERVICES	**NETWORK PROVIDER BENEFIT (In Network)**	**NON-NETWORK PROVIDER BENEFIT (Out of Network)**
Dental Injuries	Payable the same as any other condition.	Payable the same as any other condition.
Please see the "Medical Covered Expenses" section, Dental Injury, for benefit details.		

INFERTILITY SERVICES		
MEDICAL SERVICES	**NETWORK PROVIDER BENEFIT (In Network)**	**NON-NETWORK PROVIDER BENEFIT (Out of Network)**
Infertility Counseling and Treatment	Not Covered	Not Covered

INFERTILITY SERVICES		
MEDICAL SERVICES	**NETWORK PROVIDER BENEFIT (In Network)**	**NON-NETWORK PROVIDER BENEFIT (Out of Network)**
Artificial Means of Achieving Pregnancy	Not Covered	Not Covered
Sexual Dysfunction/Impotence	Payable the same as any other condition.	Not Covered
Sexual Dysfunction/Impotence related to a *Mental* Disorder	Payable the same as any other condition.	Payable the same as any other condition.

THERAPY SERVICES		
MEDICAL SERVICES	**NETWORK PROVIDER BENEFIT (In Network)**	**NON-NETWORK PROVIDER BENEFIT (Out of Network)**
Chiropractic Examinations	100% after *deductible*	70% after *deductible*
Chiropractic Laboratory	100% after *deductible*	70% after *deductible*
Chiropractic X-ray	100% after *deductible*	70% after *deductible*
Chiropractic Manipulations	100% after *deductible*	70% after *deductible*
Chiropractic Therapy	100% after *deductible*	70% after *deductible*
Physical Therapy (Clinic and Outpatient)	100% after *deductible*	70% after *deductible*

THERAPY SERVICES		
MEDICAL SERVICES	**NETWORK PROVIDER BENEFIT (In Network)**	**NON-NETWORK PROVIDER BENEFIT (Out of Network)**
Occupational Therapy (Clinic and Outpatient)	100% after *deductible*	70% after *deductible*
Speech Therapy (Clinic and Outpatient)	100% after *deductible*	70% after *deductible*
Cognitive Therapy (Clinic and Outpatient)	100% after *deductible*	70% after *deductible*
Therapy Limits	*Medical necessity* needed after 15 visits	
Chiropractic, physical, occupational, speech and cognitive therapies are combined and track toward the Therapy Limits.		
Acupuncture	Not Covered	Not Covered
Respiratory Therapy and Pulmonary Therapy (Clinic and Outpatient)	100% after *deductible*	70% after *deductible*
Vision Therapy (eye exercises to strengthen the muscles of the eye) (Clinic and Outpatient)	Not Covered	Not Covered
Chemotherapy (Clinic and Outpatient)	100% after *deductible*	70% after *deductible*
Radiation Therapy (Clinic and Outpatient)	100% after *deductible*	70% after *deductible*

THERAPY SERVICES		
MEDICAL SERVICES	**NETWORK PROVIDER BENEFIT (In Network)**	**NON-NETWORK PROVIDER BENEFIT (Out of Network)**
Cardiac Rehabilitation (Phase II) Phase I is covered under the inpatient facility benefits. Phase III, an unsupervised exercise program, is not covered.	100% after *deductible*	70% after *deductible*

TRANSPLANT SERVICES AND IMMUNE EFFECTOR CELL THERAPY

Preauthorization* is required, if *preauthorization* is not received, organ transplant *services* and *immune effector cell therapy. Failure to do so could result in reduced benefits.

MEDICAL SERVICES	NETWORK PROVIDER BENEFIT (In Network)	NON-NETWORK PROVIDER BENEFIT (Out of Network)
Organ Transplant Medical *Services* and *Immune Effector Cell Therapy*	Payable the same as any other condition	Payable the same as any other condition
Non-Medical *Services* - Lodging and Transportation	100%	70% after *deductible*
Organ Transplant Medical *Services* Limits	None	None
Non-Medical *Services* - Lodging and Transportation Combined Limits	$10,000 per covered transplant	Not applicable – lodging and transportation are not covered for a *Non- network* provider

Please refer to the "Medical Covered Expenses" Transplant Services for more information regarding the Transplant Rider with TMHCC.

BEHAVIORAL HEALTH INPATIENT SERVICES		
MEDICAL SERVICES	**NETWORK PROVIDER BENEFIT (In Network)**	**NON-NETWORK PROVIDER BENEFIT (Out of Network)**
Inpatient *Behavioral Health Room and Board* and Ancillary *Services*	Payable the same as medical inpatient *hospital services*.	Payable the same as medical inpatient *hospital services*.
Inpatient *Behavioral Health* Professional *Services*	Payable the same as medical inpatient *qualified Provider services*.	Payable the same as medical inpatient *qualified Provider services*.
Behavioral Health Partial Hospitalization	Payable the same as medical outpatient non-surgical *hospital services*.	Payable the same as medical outpatient non-surgical *hospital services*.
Inpatient Nutritional Counseling for eating disorders	Payable the same as medical inpatient Physician	Payable the same as medical inpatient Physician
Behavioral Health Residential Treatment Facility Services	Not Covered	Not Covered
Behavioral Health Half-way House *Services*	Same as inpatient if a licensed Facility	Same as inpatient if a licensed Facility

BEHAVIORAL HEALTH CLINIC, OUTPATIENT AND INTENSIVE OUTPATIENT SERVICES		
MEDICAL SERVICES	**NETWORK PROVIDER BENEFIT (In Network)**	**NON-NETWORK PROVIDER BENEFIT (Out of Network)**
Behavioral Health Therapy *Services* (Clinic, Outpatient, *Intensive Outpatient* and *Virtual visit*)	Payable the same as medical *qualified provider* office visit.	Payable the same as medical *qualified provider* office visit.
Prescription drug expenses for the treatment of *behavioral health services* are covered under the Prescription Drug Benefit.		
Diagnostic Examination (Clinic)	Payable the same as any other condition.	Payable the same as any other condition.
Laboratory and X-ray (Clinic and Outpatient)	Payable the same as any other condition.	Payable the same as any other condition.
Nutritional Counseling for eating disorders	Payable the same as a primary care physician office visit.	Payable the same as a primary care physician office visit.
Intensive Outpatient	Payable the same as any other *sickness*.	Payable the same as any other *sickness*.
Applied Behavioral Analysis (ABA) Therapy	Payable the same as any other condition.	Payable the same as any other condition.
Residential Treatment Outpatient Services	Payable the same as any other condition.	Payable the same as any other condition.
Outpatient Facility MRI, MRA, PET, CAT, SPECT Scans	Payable the same as any other condition.	Payable the same as any other condition.

BEHAVIORAL HEALTH CLINIC, OUTPATIENT AND INTENSIVE OUTPATIENT SERVICES		
MEDICAL SERVICES	**NETWORK PROVIDER BENEFIT (In Network)**	**NON-NETWORK PROVIDER BENEFIT (Out of Network)**
Clinic injections, other than routine immunizations, flu or pneumonia, contraceptive for birth control reasons and allergy injections	Payable the same as any other condition.	Payable the same as any other condition.
Autism (excludes *ABA therapy*)	Payable the same as any other condition.	Payable the same as any other condition.
Outpatient *Hospital* Services	Payable the same as any other condition.	Payable the same as any other condition.

BEHAVIORAL HEALTH SKILLED NURSING SERVICES		
MEDICAL SERVICES	**NETWORK PROVIDER BENEFIT**	**NON-NETWORK PROVIDER BENEFIT**
Skilled Nursing Room & Board and Ancillary Facility Services	Payable the same as any other condition.	Payable the same as any other condition.
Skilled Nursing *Qualified Provider* visit	Payable the same as any other condition.	Payable the same as any other condition.

BEHAVIORAL HEALTH EMERGENCY AND URGENT CARE SERVICES		
MEDICAL SERVICES	**NETWORK PROVIDER BENEFIT**	**NON-NETWORK PROVIDER BENEFIT**
Emergency Room MRI, MRA, PET, CAT, SPECT scans	Payable the same as any other condition.	Payable the same as any other condition.
Urgent Care Facility, Ancillary and *Qualified Provider* services	Payable the same as any other condition.	Payable the same as any other condition.

BEHAVIORAL HEALTH HOME HEALTH SERVICES		
MEDICAL SERVICES	**NETWORK PROVIDER BENEFIT**	**NON-NETWORK PROVIDER BENEFIT**
Home Health Care	Payable the same as any other condition.	Payable the same as any other condition.
Home Health Care Ancillary Services (excluding DME, Prosthesis and Private duty Nursing)	Payable the same as any other condition.	Payable the same as any other condition.

BEHAVIORAL HEALTH SPECIALTY DRUG MEDICAL BENEFIT		
MEDICAL SERVICES	**NETWORK PROVIDER BENEFIT**	**NON-NETWORK PROVIDER BENEFIT**
Specialty drugs administered at a *qualified provider* office visit, freestanding facility or urgent care facility	Payable the same as any other condition.	Payable the same as any other condition.
Specialty drugs administered for home health care	Payable the same as any other condition.	Payable the same as any other condition.
Specialty drugs administered in an emergency room, ambulance, inpatient *hospital*, skilled nursing facility or outpatient *hospital*.	Payable the same as any other condition.	Payable the same as any other condition.
To obtain a list of *our specialty drugs*, log onto *our* unsecured website at www.humana.com and use the "drug list search" tool or on the secured website at www.myhumana.com to use the "drug pricing" tool and search for *your* drug.		

BEHAVIORAL HEALTH THERAPY SERVICES		
MEDICAL SERVICES	**NETWORK PROVIDER BENEFIT**	**NON-NETWORK PROVIDER BENEFIT**
Physical therapy (clinical and outpatient)	Payable the same as any other condition.	Payable the same as any other condition.
Occupational therapy (clinical and outpatient)	Payable the same as any other condition.	Payable the same as any other condition.
Speech therapy (clinical and outpatient	Payable the same as any other condition.	Payable the same as any other condition.
Cognitive therapy (clinical and outpatient)	Payable the same as any other condition.	Payable the same as any other condition.
Audiology therapy (clinical and outpatient)	Payable the same as any other condition.	Payable the same as any other condition.

OTHER COVERED EXPENSES		
MEDICAL SERVICES	**NETWORK PROVIDER BENEFIT (In Network)**	**NON-NETWORK PROVIDER BENEFIT (Out of Network)**
Other Covered Expenses	Payable the same as any other condition.	Payable the same as any other condition.

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*. 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* and *out-of-pocket limit* amounts, medical *services* and medical *service* limits are stated on the Medical Schedule of Benefits.

DEDUCTIBLE

A *deductible* is a specified dollar amount *you* must pay for *covered expenses*, per *plan year* before any applicable *coinsurance* applies and most benefits are paid under this Plan. Only amounts paid by *you* apply to the *deductibles*. There are individual and family *network provider deductibles*. The individual and family *deductible* amounts are stated on the Schedule of Benefits.

Single Deductible

The single *deductible* applies to each *covered person* each *calendar year*. Once a *covered person* meets their single *deductible*, this Plan will begin to pay benefits for that *covered person*.

The single *deductible* only applies if *you* have single coverage under this Plan. If *you* have elected to cover *your dependents* under this Plan, the family *deductible* must be satisfied before benefits will be payable for any *covered person*.

Family Deductible

The family *deductible* is the total *deductible* applied to all *covered persons* in one family in a *calendar year*. Once *you* and/or *your* covered *dependents* meet the family *deductible*, any remaining *deductible* for a *covered person* in the family will be waived for that year and this Plan will begin to pay benefits for all *covered persons* in the family.

The family *deductible* is the total *deductible* applied to all *covered persons* in one family in a *calendar year*. Once *you* and/or *your* covered *dependents* meet the family *deductible*, any remaining *deductible* for a *covered person* in the family will be waived for that year and this Plan will begin to pay benefits for all *covered persons* in the family.

If *you* have elected to cover *your dependents* under this Plan, the family *deductible* must be satisfied before benefits will be payable for any *covered person*.

Network and Non- Network Deductible Accumulation

If *you* and/or *your* covered *dependents* use a combination of *network* and *Non-network providers*, the *network* and *Non-network deductibles* will not reduce each other and will not reduce the *out-of-pocket limits.*

COINSURANCE

Coinsurance means the shared financial responsibility for *covered expenses* between the *covered person* and this Plan.

Covered expenses are payable at the applicable *coinsurance* percentage rate shown on the Medical Schedule of Benefits after the *deductible*, if any, is satisfied each *calendar year*, subject to any *calendar year* maximum.

OUT-OF-POCKET LIMIT

The *out-of-pocket limit* is the amount of *copayments*, *deductibles* and/or *coinsurance* for *covered expenses* you must pay either individually or combined as a covered family per *plan year* before a benefit percentage for *covered expenses* is increased. The single and family *out-of-pocket limits* are stated on the Medical Schedule of Benefits.

You must meet the *network provider out-of-pocket limits* for *covered expenses* to be payable by the Plan at 100% for the rest of the *year* for services *you* receive from a *network provider* or for services *you* receive from a *non-network provider* that are subject to the *qualified payment amount*. *You* must meet the *non-network out-of-pocket limits* for *covered expenses* to be payable by the Plan at 100% for the rest of the *year* for all other services *you* receive from a *non-network provider*, unless otherwise specified by the Plan.

Any amount *you* pay a *non-network provider* exceeding the *maximum allowable fee* is not applied to the *out-of-pocket limits*. Once the individual or family *non-network provider out-of-pocket limit* is met, *you* will continue to be responsible to pay a *non-network provider* any amount exceeding the *maximum allowable fee* for *covered expenses* other than those subject to the *qualified payment amount*.

Only amounts paid by *you* for *covered expenses* apply to the *out-of-pocket limits*. Any amount waived by a *qualified provider* is not applied to any *out-of-pocket limit*.

Single Out-of-Pocket Limits

Once a *covered person* satisfies the separate single *deductible* and *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 and annual maximum benefits.*

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. If *you* have elected to cover *your dependents* under this Plan, the family *out-of-pocket limit* must be satisfied before the benefit percentage will be increased for any *covered person*.

Network and Non-Network Out-of-Pocket Limit Accumulation

If *you* and/or *your* covered *dependents* use a combination of *network* and *non-network providers*, the *out-of-pocket limits* will not reduce each other.

Penalties do not apply to the *out-of-pocket limits*.

ROUTINE/PREVENTIVE SERVICES

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

- Services with an A or B rating in the current recommendations of the U. S. Preventive Services Task Force (USPSTF).
- Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC).
- Preventive care for infants, children and adolescents provided in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA).
- 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 www.healthcare.gov website or call the toll free customer service telephone number listed on *your* Humana ID 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.

HEARING SERVICES

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 *services*.

No benefits are payable under this 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 PROVIDER SERVICES

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

Second Surgical Opinion

If *you* obtain a second surgical opinion, the *qualified providers* 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 provider* 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 during the same day, the *surgeries* will be paid according to the *provider contract* for a *network provider* When a *non-network provider* is utilized, the *surgery* with the highest monetary *maximum allowable fee* amount will be allowed at 100% of the *maximum* monetary *allowable fee.* For each additional *surgery* for a *non-network provider* the amount allowed will be: a) 50% of the *maximum allowable fee* for the *surgery* with the second highest monetary *maximum allowable fee* amount; and b) 25% of the *maximum allowable fee* for all the other surgeries.

Assistant Surgeon

Services for an *assistant surgeon*. The *assistant surgeon* will be paid according to the *provider contract* if they are a *network provider*. This Plan will allow the *assistant surgeon* 16% of the *maximum allowable fee* for the *surgery* that would apply if the *assistant surgeon* were the primary surgeon.

Physician Assistant

Services for a physician assistant (P.A.). The P.A will be paid according to the *provider contrac*t if they are a *network provider*. This Plan will allow the P.A., at 10% of the *maximum allowable fee* for the *surgery* that would apply if the P.A. were the primary surgeon.

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:

- Excision of partially or completely unerupted impacted teeth;
- Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof/floor of the mouth in conjunction with a pathological examination;
- Surgical procedures required to correct accidental injuries of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
- Reduction of fractures and dislocations of the jaw;
- External incision and drainage of cellulitis;
- Incision of accessory sinuses, salivary glands or ducts;

- Frenectomy (the cutting of the tissue in the midline of the tongue);
- Functional Dental osteotomies;
- Apicoectomy, Gingivectomy, Osseous Surgery, Removal of residual root, Alveoloplasty, and Vestibuloplasty.

REVERSAL OF STERILIZATION AND ABORTIONS

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 an uncomplicated vaginal delivery and 96 hours following an uncomplicated 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 *nurse*ry *room and board* and miscellaneous *services*, *qualified provider's* expenses for circumcision and *qualified provider'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

Expenses incurred in a *birthing center* are payable as shown on the Medical Schedule of Benefits.

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 *confined*.

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*:

- Occurs while *you* or an eligible *dependent* are covered under this Plan;
- Begins after discharge from a *hospital confinement* or a prior covered skilled nursing facility *confinement*;
- Is necessary for care or treatment of the same *bodily injury* or *sickness* which caused the prior *confinement*; and
- Occurs while *you* or an eligible *dependent* are under the regular care of a physician.

OUTPATIENT AND AMBULATORY SURGICAL CENTER

Covered expenses incurred by *you* for services provided in an *ambulatory surgical center* for the utilization of the facility and ancillary services in connection with *outpatient surgery* are payable as shown on the Schedule of Benefits.

EMERGENCY SERVICES

Benefits for *covered expenses* incurred by *you* for *emergency care*, including the treatment and stabilization of an *emergency medical condition* are payable as shown on the Schedule of Benefits.

Emergency care provided by *non-network providers* will be covered at the *network provider* benefit level, as specified in the "Emergency services" benefit in the Schedule of Benefits. However, *you* will only be responsible to pay the *network provider copayment*, *deductible* and/or *coinsurance* to the *non-network provider* for *emergency care* based on the *qualified payment amount*.

Benefits under this "Emergency services" provision are not available if the services provided are not for an *emergency medical condition*.

URGENT CARE SERVICES

Benefits for *urgent care covered expenses* incurred by *you* for charges made by an *urgent care center* or an *urgent care qualified provider* are payable as shown on the Schedule of Benefits.

HOSPICE SERVICES

Benefits for *covered expenses* incurred by *you* for a *hospice care program* are payable as shown on the Schedule of Benefits. A *health care practitioner* must certify that the *covered person* is terminally ill with a life expectancy of 18 months or less.

If the above criteria is not met, no benefits will be payable under the Plan.

Hospice care benefits are payable for the following hospice services:

- *Room and board* at a hospice, when it is for management of acute pain or for an acute phase of chronic symptom management;
- Part-time nursing care provided by or supervised by a registered nurse (R.N.) for up to eight hours in any one day;
- Counseling for the terminally ill *covered person* and his/her immediate covered *family members* by a licensed:

    - Clinical social worker; or
    - Pastoral counselor.

- Medical social services provided to the terminally ill *covered person* or his/her immediate covered *family members* under the direction of a *health care practitioner*, including:

    - Assessment of social, emotional and medical needs, and the home and family situation; and
    - Identification of the community resources available.

- Psychological and dietary counseling;
- Physical therapy;
- Part-time home health aide services for up to eight hours in any one day; and
- Medical supplies, drugs and medicines for *palliative care*.

Hospice care *covered expenses* do not include:

- A *confinement* not required for acute pain control or other treatment for an acute phase of chronic symptom management;
- Services by volunteers or persons who do not regularly charge for their services;
- Services by a licensed pastoral counselor to a member of his or her congregation. These are services in the course of the duties to which he or she is called as a pastor or minister; and
- Bereavement counseling services for *family members* not covered under the Plan.

HOME HEALTH CARE

The Plan will pay benefits for *covered expenses* incurred by *you* in connection with a *home health care plan* provided by a *home health care agency*. All home health care services and supplies must be provided on a part-time or intermittent basis to *you* in conjunction with the approved *home health care plan*.

The Schedule of Benefits shows the maximum number of visits allowed by a representative of a *home health care agency*, if any. A visit by any representative of a *home health care agency* of two hours or less will be counted as one visit. Each additional two hours or less is considered an additional visit.

Home health care *covered expenses* are limited to:

- Care provided by a *nurse*;
- Physical, occupational, respiratory, or speech therapy;
- Medical social work and nutrition services;
- Medical supplies, except for *durable medical equipment*; and
- Laboratory services.

Home health care *covered expenses* do not include:

- Charges for mileage or travel time to and from the *covered person's* home;
- Wage or shift differentials for any representative of a *home health care agency*;
- Charges for supervision of *home health care agencies*;
- Charges for services of a home health aide;
- *Custodial care*; or
- The provision or administration of *self-administered injectable drugs*, unless otherwise determined by Humana.

DURABLE MEDICAL EQUIPMENT (DME)

The Plan will pay benefits for *covered expenses* incurred by *you* for *durable medical equipment* and *diabetes equipment*.

At the Plan's option, *covered expense* includes the purchase or rental of *durable medical equipment* or *diabetes equipment*. If the cost of renting the equipment is more than *you* would pay to buy it, only the purchase price is considered a *covered expense*. In either case, total *covered expenses* for *durable medical equipment* or *diabetes equipment* shall not exceed its purchase price. In the event the Plan determines to purchase the *durable medical equipment* or *diabetes equipment*, any amount paid as rent for such equipment will be credited toward the purchase price.

Repair and maintenance of purchased *durable medical equipment* and *diabetes equipment* is a *covered expense* if:

- Manufacturer's warranty is expired; and
- Repair or maintenance is not a result of misuse or abuse; and
- Maintenance is not more frequent than every 6 months; and
- Repair cost is less than replacement cost.

Replacement of purchased *durable medical equipment* and *diabetes equipment* is a *covered expense* if:

- Manufacturer's warranty is expired; and
- Replacement cost is less than repair cost; and
- Replacement is not due to lost or stolen equipment, or misuse or abuse of the equipment; or
- Replacement is required due to a change in *your* condition that makes the current equipment non-functional.

SPECIALTY DRUG MEDICAL BENEFIT

Specialty drugs are payable as shown on the Medical Schedule of Benefits. For more information regarding the specific *specialty drugs* covered under this Plan, benefits may vary depending on place of service. Please call the toll-free customer service telephone number listed on *your* Humana ID card for Humana or Serve You RX or visit Humana's website at www.humana.com or Serve You Rx website at www.serveyourx.com to clarify. Coverage for certain *specialty drugs* administered to you by a *qualified provider* in a *hospital's* outpatient department may only be granted when preauthorized and subject to the "Retail Pharmacy and Specialty Pharmacy" section of this plan.

AMBULANCE

Benefits for *covered expenses* incurred by *you* for licensed *ambulance* and *air ambulance* services to, from or between medical facilities for an *emergency medical condition* are payable as shown on the Schedule of Benefits.

Ambulance and *air ambulance* services for an *emergency medical condition* provided by a *non-network provider* will be covered at the *network provider* benefit level, as specified in the "Ambulance Services" benefit in the Schedule of Benefits. *You* may be required to pay the *non-network provider* any amount not paid by the Plan, as follows:

- For *ambulance* services, *you* will be responsible to pay the *network provider copayment, deductible* and/or *coinsurance*. *You* may also be responsible to pay any amount over the *maximum allowable fee* to a non-*network provider*. *Non-network providers* have not agreed to accept discounted or negotiated fees, and may bill *you* for charges in excess of the *maximum allowable fee*; and

- For *air ambulance* services, *you* will only be responsible to pay the *network provider copayment*, deductible and/or *coinsurance* based on the *qualified payment amount*.

OBESITY

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

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 initial extraction and initial replacement.

Services for teeth injured as a result of chewing are not covered. Biting or chewing injuries as a result of an act of domestic violence or a medical condition (including both physical and mental health conditions) are a *covered expense.*

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.

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 AND IMMUNE EFFECTOR CELL THERAPY

This Plan will pay benefits for the expense of a transplant and *immune effector cell therapies* approved by the United States Food and Drug Administration, including but not limited to Chimeric Antigen Receptor Therapy (CAR-T). The transplant *services* and *immune effector cell therapy* must be approved by Humana in advance subject to those terms, conditions and limitations described below and contained in this Plan. Please call the toll-free customer service telephone number listed on *your* Humana ID card when in need of these *services*.

Preauthorization

Pre-authorization of transplant services and *immune effector cell therapy* is required prior to seeing a transplant provider for a consult and/or evaluation. Failure to do so could result in reduced benefits.

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 integral chemotherapy and associated *services*, post-discharge *services* and treatment of complications after transplantation for or in connection with only the following procedures:

- Heart;
- Lung(s);
- Liver;
- Kidney;
- *Stem cell;*
- *Bone Marrow*
- Intestine;
- Pancreas;
- Auto islet cell;
- Any combination of the above listed transplants; and;
- Any transplant not listed above required by state or federal law.

Multiple solid organ transplants performed simultaneously are considered one transplant *surgery*. Multiple *stem cell* or *immune effector cell therapy* infusions occurring as part of one treatment plan is considered one event.

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

The following are *covered expenses* for an approved transplant or *immune effector cell therapy* and all related complications:

- *Hospital* and health *care practitioner* services.

- Acquisition of cell therapy products for *immune effector cell therapy*, acquisition of *stem cells* or solid organs for transplants and associated donor costs, including pre-transplant or *immune effector cell therapy* services, the acquisition procedure, and any complications resulting from the harvest and/or acquisition. Donor costs for post-discharge services and treatment of complications will not exceed the treatment period of 365 days from the date of discharge following harvest and/or acquisition.

- Non-medical travel and lodging costs for:

  - The *covered person* receiving the transplant or *immune effector cell therapy*, if the *covered person* lives more than 100 miles from the transplant or *immune effector cell therapy* facility designated by Humana; and

  - One caregiver or support person (two, when the *covered person* receiving the transplant or *immune effector cell therapy* is under 18 years of age) if the caregiver or support person lives more than 100 miles from the transplant or *immune effector cell therapy* facility designated by Humana.

- Non-medical travel and lodging costs include:

  - Transportation to and from the designated transplant or *immune effector cell therapy* facility where the transplant or *immune effector cell therapy* is performed; and
  - Temporary lodging at a prearranged location when requested by the designated transplant or immune *effector cell therapy* facility and approved by Humana.

All non-medical travel and lodging costs for transplant and *immune effector cell therapy* are payable as specified in the "Schedule of Benefits" section in this Summary Plan Description.

Covered expenses for post-discharge services and treatment of complications for or in connection with an approved transplant or *immune effector cell therapy* are limited to the treatment period of 365 days from the date of discharge following transplantation of an approved transplant received while *you* were covered by the Plan. After this transplant treatment period, regular plan benefits and other provisions of the Plan are applicable.

NOTICE- Transplant Network

Transplant Benefits:

You have organ and tissue transplant coverage under a separate insurance policy provided by Tokio Marine HCC – Stop Loss Group (TMHCC) and issued by HCC Life Insurance Company. Such coverage pays benefits for certain organ and tissue transplants without regard to any benefits that may or may not be provided by this major medical plan. Please contact TMHCC's Transplant Unit toll-free at 1-888-449-2377 for benefit information, pre-authorization of transplant services, and transplant network provider access.

Pre-Authorization of Transplant Services

Pre-authorization of transplant services is required prior to seeing a transplant provider for a consult and/or evaluation. Failure to do so could result in reduced benefits.

NOTICE- Transplant Network

In order to obtain 100% in-network benefits, you must use providers in a transplant network approved by and accessed through TMHCC's Transplant Unit. Expenses billed by the transplant network provider that are not covered by the TMHCC policy are subject to this medical plan's benefits and the payment terms and conditions of the transplant network provider's contracted rates.

For more information, contact your medical plan administrator and or human resources department.
NOTE: Humana (the claims administrator) does not administer the benefits within this provision. Please contact the TMHCC Transplant Unit, Humana Customer Service, or your employer with any questions related to this coverage and assistance in being referred to the TMHCC Transplant Unit. As noted above, failure to do so could result in reduced or no transplant benefits.

This health Plan document includes benefits for human organ and tissue transplantation, which are fully explained in the applicable Organ & Tissue Transplant Group Policy Human organ or tissue transplant services for eligible Employees are covered under this separate policy, according to its terms and conditions. Benefits under the applicable Organ & Tissue Transplant Group Policy continues up to the 365th day after the transplant, and includes the transplant procedure itself, evaluation, search and registry, certain donor services, and anti-rejection drugs. Certain terms, conditions and exclusions may reduce the post-transplant benefit period.

Transplant-related health services received before or after the benefit period, or while a participant is fulfilling a pre-existing condition waiting period, will remain covered under the terms and conditions of health coverage under this health Plan document as well as any health care services received at any time that are not covered transplant services under the applicable Organ & Tissue Transplant Group Policy.

Benefits offered for human organ and tissue transplants are subject to the following conditions:

- Eligibility – the Employee and any Dependent(s) must be eligible for medical benefits under the group's Plan document.
- Policy terms – the Employee and any Dependent(s) must meet all the terms and conditions stated in the applicable Organ & Tissue Transplant Group Policy.

Insured Transplant Benefits: Benefits received under the applicable Organ & Tissue Transplant Group Policy are hereby incorporated by reference into this SPD. Covered Persons are not entitled to double benefits under both the Organ & Tissue Transplant Group Policy and this SPD.

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 the following locations:

- *Qualified provider's office*;
- *Free-standing facility*;
- *Urgent care center*;
- A home;
- *Hospital;*
- *Skilled nursing facility;*
- *Ambulance;* and
- Emergency Room.

Coverage for certain *specialty drugs* administered to you by a *qualified provider* in a *hospital's* outpatient department may only be granted when preauthorized and subject to the "Retail Pharmacy and Specialty Pharmacy" section of this plan.

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.

VIRTUAL VISIT SERVICES

Expenses incurred by *you* for *virtual visits* for the diagnosis and treatment of a *sickness* or *bodily injury* are payable as shown on the Medical Schedule of Benefits. *Virtual visits* must be services that would otherwise be a *covered expense* if provided during a face-to-face consultation between a *covered person* and a *qualified provider*.

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.

Residential treatment facilities are NOT covered except when the following criteria are met:

- The alternative treatment suggested is prudent and satisfies *medical necessity.*
- The alternative treatment is fiscally prudent and less costly than maintaining an inpatient protocol or re-admission.
- The alternative treatment is approved by Lifesynch as meeting criteria #1 and #2.

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

OTHER COVERED EXPENSES

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

- 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;

- Casts, trusses, crutches, *orthotics*, splints and braces. *Orthotics* must be custom made or custom fitted, made of rigid or semi-rigid material, prescribed by a *Qualified Provider* and be *medically necessary* 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*;

- 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*;\

- Reconstructive *services* following a covered mastectomy, including but not limited to:
  - Reconstruction of the breast on which the mastectomy was performed;
  - *Surgery* and reconstruction of the other breast to achieve symmetrical appearance
  - Prosthesis; and
  - Treatment of physical complications of all stages of the mastectomy, including lymphedemas;

- Routine costs associated with clinical trials, when approved by this Plan. For additional details, go to www.humana.com or call the toll-free customer service telephone number listed on *your* Humana ID card;

- Cranial banding, when approved by this Plan. For additional details, go to www.humana.com or call the toll-free customer service telephone number listed on *your* Humana ID card.

LIMITATIONS AND EXCLUSIONS

These limitations and exclusions apply even if a *health care practitioner* has performed or prescribed a medically appropriate procedure, treatment or supply. This does not prevent *your health care practitioner* from providing or performing the procedure, treatment or supply. However, the procedure, treatment or supply will not be a *covered expense*.

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

- Treatments, services, supplies, or *surgeries* that are not *medically necessary*, except *preventive services*.

- A *sickness* or *bodily injury* arising out of, or in the course of, any employment for wage, gain or profit. This exclusion applies whether or not *you* have Workers' Compensation coverage.

- Care and treatment given in a *hospital* owned, or run, by any government entity, unless *you* are legally required to pay for such care and treatment. However, care and treatment provided by military *hospitals* to *covered persons* who are armed services retirees and their *dependents* are not excluded.

- Any service furnished while *you* are *confined* in a *hospital* or institution owned or operated by the United States government or any of its agencies for any military service-connected *sickness* or *bodily injury*.

- Services, or any portion of a service, for which no charge is made.

- Services, or any portion of a service, *you* would not be required to pay for, or would not have been charged for, in the absence of this coverage.

- Any portion of the amount the Plan determines *you* owe for a service that the provider waives, rebates or discounts, including *your copayment*, *deductible* or *coinsurance*.

- *Sickness* or *bodily injury* for which *you* are in any way paid or entitled to payment or care and treatment by or through a government program.

- Any service not ordered by a *health care practitioner*.

- Private duty nursing.

- Services rendered by a standby physician, *surgical assistant* or *assistant surgeon* unless *medically necessary*

- Any service not rendered by the billing provider.

- Any service not substantiated in the medical records of the billing provider.

- Any amount billed for a professional component of an automated:
  - Laboratory service; or
  - Pathology service.

- Expenses for services, *prescriptions*, equipment, or supplies received outside the United States or from a foreign provider, unless:

  - For emergency *care*;

  - The *employee* is traveling outside the United States due to employment with the *employer* sponsoring the Plan and the services are not covered under any Workers' Compensation or similar law; or

  - The employee and *dependents* live outside the United States and the *employee* is in *active status* with the *employer* sponsoring the Plan.

- Education or training, except for *diabetes self-management training* and *habilitative services*.

- 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;

- *Services* provided to *you* if *you* do not comply with this Plan's requirements. These include services:

  - Not provided by a *network provider*, unless required for *emergency care*;
  - Received in an emergency room, unless required because of *emergency care*;
  - Which require *preauthorization* if *preauthorization* was not obtained;
  - Which require a *primary care physician* referral if a referral was not obtained.

- *Services* provided by a *covered person's family member*.

- *Ambulance* and *air ambulance* services for routine transportation to, from or between medical facilities and/or a *health care* practitioner's office.

- Any drug, *biological* product, device, medical treatment, or procedure which is *experimental, investigational or for research purposes*.

- Vitamins, except for *preventive services* with a *prescription* from a *health care practitioner*, 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);

- Over-the-counter, non-prescription medications, unless for drugs, medicines or medications or supplies on the Preventive Medication Coverage *drug list* with a *prescription* from a *health care practitioner*.

- Over-the-counter medical items or supplies that can be provided or prescribed by a *health care practitioner* but are also available without a written order or *prescription,* except for preventive *services*;

- Growth hormones, except as otherwise specified in the pharmacy services sections of this *SPD*;

- *Prescription* drugs and *self-administered injectable* drugs, except as specified in the "Covered Expenses – Pharmacy Services" section in this *SPD* or unless administered to *you*:
  - While an *inpatient* in a *hospital*, *skilled nursing facility*, *health care treatment facility* or *residential treatment facility*;
  - By the following, when deemed appropriate by this Plan:
  - A *health care practitioner*:
  - During an office visit; or
  - While an *outpatient*; or
  - A *home health care agency* as part of a covered *home health care plan*.

- Services received in an emergency room, unless required because of *emergency care*.

- 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 Provider* when there is no cause for an *emergency care admission* and the *covered person* receives no *surgery* or therapeutic treatment until the following Monday;

- *Hospital* inpatient *services* when *you* are in *observation status* unless otherwise determined by this Plan;

- In vitro fertilization regardless of the reason for treatment.

- Contraceptive pills and patches and spermicide (see the Prescription Drug Benefit for coverage);

- Services for or in connection with a transplant or *immune effector cell therapy* if:
  - The expense relates to storage of cord blood and s*tem cells*, unless it is an integral part of a transplant approved by this Plan.
  - Not approved by Humana, based on their established criteria.
  - 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.
  - The expense relates to the transplantation of any non-human organ or tissue, unless otherwise stated in the *SPD.*
  - The expense relates to the donation or acquisition of an organ or tissue for a recipient who is not covered by this Plan.
  - The expense relates to a transplant or *immune effector cell therapy* performed outside of the United States and any care resulting from that transplant or *immune effector cell therapy*. This exclusion applies even if the *employee* and *dependents* live outside the United States and the *employee* is in *active status* with the *employer.*

- Services provided for:
  - Immunotherapy for recurrent abortion;
  - Chemonucleolysis;
  - Sleep therapy;
  - Light treatments for Seasonal Affective Disorder (S.A.D.);
  - Immunotherapy for food allergy;
  - Prolotherapy; or
  - Sensory integration therapy.

- *Cosmetic surgery* and cosmetic services or devices.

- Hair prosthesis, hair transplants or implants.

- Dental services, appliances or supplies for treatment of the teeth, gums, jaws, or alveolar processes, including but not limited to, any *oral surgery*, *endodontic services* or *periodontics*, implants and related procedures, orthodontic procedures, and any dental services related to a *bodily injury* or *sickness* unless otherwise stated in this *SPD.*

- The following types of care of the feet:
  - Shock wave therapy of the feet;
  - The treatment of weak, strained, flat, unstable, or unbalanced feet;
  - Hygienic care, and the treatment of superficial lesions of the feet, such as corns, calluses or hyperkeratosis;
  - The treatment of tarsalgia, metatarsalgia or bunion, except surgically;
  - The cutting of toenails, except the removal of the nail matrix;
  - Heel wedges, lifts or shoe inserts; and
  - Arch supports (foot orthotics) or orthopedic shoes, except for diabetes or hammer toe.

- *Custodial care* and *maintenance care*.

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

- Services relating to a *sickness* or *bodily injury* as a result of:
  - Engagement in an illegal profession or occupation; or
  - Commission of or an attempt to commit a criminal act.

This exclusion does not apply to any *sickness* or *bodily injury* resulting from an act of domestic violence or a medical condition (including both physical and mental health conditions).

- Expenses for any membership fees or program fees, including but not limited to, health clubs, health spas, aerobic and strength conditioning, work-hardening programs and weight loss or surgical programs and any materials or products related to these programs.

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

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

- Duplicate or similar rentals or purchases of *durable medical equipment* or *diabetes equipment*.

- 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 tests and/or treatment <u>unless</u> such therapy or testing is approved by:
  - The American Academy of Allergy and Immunology; or
  - The Department of Health and Human Services or any of its offices or agencies.

- Lodging accommodations or transportation,
- Communications or travel time;
- Bariatric *surgery*, any services or complications related to bariatric *surgery*, and other weight loss products or services
- *Sickness* or bodily *injury* for which no-fault medical payment or expense coverage benefits are paid or payable under any automobile, homeowners, premises or any other similar coverage.
- Elective medical or surgical abortion: unless:
  - The pregnancy would endanger the life of the mother; or
  - The pregnancy is a result of rape or incest; or
- *Alternative medicine*.
- Acupuncture, unless:
  - The treatment is *medically necessary*, appropriate and is provided within the scope of the acupuncturist's license; and
  - *You* are directed to the acupuncturist for treatment by a licensed physician.
- Services rendered in a premenstrual syndrome clinic or holistic medicine clinic.
- Services of a midwife unless the midwife is licensed.
- Vision examinations or testing for the purposes of prescribing corrective lenses.
- Orthoptic/vision training (eye exercises).
- Radial keratotomy, refractive keratoplasty or any other *surgery* or procedure to correct myopia, hyperopia or stigmatic error.
- The purchase or fitting of eyeglasses or contact lenses, except as the result of an *accident* or following cataract *surgery* as stated in this *SPD*.
- Services and supplies which are:
  - Rendered in connection with mental illnesses not classified in the International Classification of Diseases of the U.S. Department of Health and Human Services; or
  - Extended beyond the period necessary for evaluation and diagnosis of learning and behavioral disabilities or for mental retardation.
- Marriage counseling.

- Expenses for:
  - Employment;
  - School;
  - Sport;
  - Camp;
  - Travel; or
  - The purposes of obtaining insurance.

- Expenses for care and treatment of non-covered procedures or services.

- Expenses for treatment of complications of non-covered procedures or services.

- Expenses incurred for services prior to the *effective date* or after the termination date of *your* coverage under the Plan, except as specifically described in this *SPD.*

- *Pre-surgical/procedural testing* duplicated during a *hospital confinement*

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 or dental coverage. *Prescription* drug coverage under the *prescription* drug benefit, if applicable, is not subject to these coordination provisions and will therefore only be coordinated with other *prescription* drug 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:

- Employer, trustee, union, employee benefit, or other association; or
- 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:

- The plan has no coordination of benefits provision;
- The plan covers the person as *an employee*;
- 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 bullet3, then the gender rule will be followed to determine which plan is primary.

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

- 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 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.

GENERAL COORDINATION OF BENEFITS WITH MEDICARE

If *you* are covered under both *Medicare* and this Plan, federal law mandates that *Medicare* is the secondary plan in most situations. When permitted by law, this Plan is the secondary plan. In all cases, coordination of benefits with *Medicare* will conform to federal statutes and regulations. If *you* are enrolled in *Medicare*, *your* benefits under this Plan will be coordinated to the extent benefits are payable under *Medicare*, as allowed by federal statutes and regulations.

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:

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

- 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* Humana ID 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. Claims must be filed as soon as reasonably possible after they are incurred, and in no event later than 24 months after the date the claim was incurred for *Non-network provider* claims, except if *you* were legally incapacitated. Claims should be submitted by a *network provider* in accordance with the timely filing period outlined in that *provider's contract* with Humana (typically 180 days for physicians and 90 days for facilities and ancillary providers, however, a provider's contractual timely filing period may vary). 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:
  - The name of the *covered person* who incurred the *covered expense*;
  - The name and address of the health care provider;
  - The diagnosis of the condition;
  - The procedure or nature of the treatment;
  - The date of and place where the procedure or treatment has been or will be provided;
  - The amount billed and the amount of the *covered expense* not paid through coverage other than Plan coverage, as appropriate;
  - 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 Serve You Rx.

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*.

OTHER PROGRAMS AND PROCEDURES

This Plan may introduce new programs and procedures that apply to *your* coverage. This Plan may also introduce limited pilot or test programs including, but not limited to, disease management, care management, expanded accessibility, or wellness initiatives.

This Plan reserves the right to discontinue or modify a program or procedure at any time.

CLAIMS PROCESSING EDITS

Payment of *covered expenses* for *services* rendered by a *qualified provider* is subject to this Plan's claims processing edits, as determined by this Plan. The amount determined to be payable after this Plan applies claims processing edits depends on the existence and interaction of several factors. Because the mix of these factors may be different for every claim, the amount paid for a *covered expense* may vary depending on the circumstances. Accordingly, it is not feasible to provide an exhaustive description of the claims processing edits that will be used to determine the amount payable for a *covered expense*, but examples of the most commonly used factors are:

- The intensity and complexity of a *service*;
- Whether a *service* is one of multiple *services* performed at the same *service* session such that the cost of the *service* to the *qualified provider* is less than if the *service* had been provided in a separate *service* session. For example:
  - Two or more *surgeries* during the same *service* session; or
  - Two or more radiologic imaging views performed during the same session;
- Whether an *assistant surgeon*, physician assistant, registered *nurse*, certified operating room technician or any other *qualified provider*, who is billing independently is involved;
- When a charge includes more than one claim line, whether any *service* is part of or incidental to the primary *service* that was provided, or if these *services* cannot be performed together;
- If the *service* is reasonably expected to be provided for the diagnosis reported;
- Whether a *service* was performed specifically for *you*; or
- Whether *services* can be billed as a complete set of *services* under one billing code.

This Plan develops claims processing edits in this Plan's sole discretion based on review of one or more of the following sources, including but not limited to:

- *Medicare* laws, regulations, manuals and other related guidance;
- Appropriate billing practices;
- National Uniform Billing Committee (NUBC);
- American Medical Association (AMA)/Current Procedural Terminology (CPT);
- Centers for Medicare and Medicaid Services (CMS)/Healthcare Common Procedure Coding System (HCPCS);
- UB-04 Data Specifications Manual, and any successor manuals;
- International Classification of Diseases of the U.S. Department of Health and Human Services and the Diagnostic and Statistical Manual of Mental Disorders;
- Medical and surgical specialty societies and associations;
- This Plan's medical and pharmacy coverage policies; or
- Generally accepted standards of medical, behavioral health and dental practice based on credible scientific evidence recognized in published peer reviewed medical or dental literature.

Changes to any one of the sources may or may not lead this Plan to modify current or adopt new claims processing edits.

Subject to applicable law, *qualified providers* who are *non-network providers* may bill *you* for any amount this Plan does not pay even if such amount exceeds the allowed amount after these claims processing edits. Any such amount paid by *you* will not apply to *your deductible*, *out-of-pocket limit* or *network provider*. *Plan maximum out-of-pocket limit*, if applicable. *You* will also be responsible for any applicable *deductible*, *copayment*, or *coinsurance*.

Your qualified provider may access this Plan's claims processing edits and medical and pharmacy coverage policies at the "For Providers" link at www.humana.com. *You* or *your qualified provider* may also call the toll-free customer service number listed on *your* ID card to obtain a copy of a policy. *You* should discuss these policies and their availability with any *qualified provider*, who are *non- network providers*, prior to receiving any *services*.

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 made by the *covered person* on Humana's Appointment of Representative (AOR) Form. The date of the *covered person's* signature must be on or after the denial of the disputed claims, approvals, or authorization. An assignment of benefits does not constitute designation of an authorized representative.

- Humana's AOR Form must be submitted to Humana at the time or prior to the date 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.

- 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:

    - This Plan's receipt of the specified information; or

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

Concurrent Care Decisions

Humana will notify a *claimant* of a *concurrent care decision* 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 an *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:

- The date of service;
- The health care provider;
- The claim amount, if applicable;

- 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;

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

- 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.

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). With the exception of *urgent care claims* and *concurrent care decisions*, this Plan uses a two level *appeals* process for all *adverse benefit determinations*. Humana will make the determination on the first level of *appeal*. If the *claimant* is dissatisfied with the decision on this first level of *appeal*, or if Humana fails to make a decision within the time frame indicated below, the *claimant* may *appeal* again to Humana. *Urgent care claims* and *concurrent care decisions* (expedited *internal appeals*) are subject to a single level *appeal* process only, with Humana making the determination.

A first level and second level *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

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

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

If the claims denial being appealed is based in whole, or in part, upon 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 Periods for Decisions on Appeal -- First Level

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

Urgent Care Claims	As soon as possible, but not later than 72 hours after Humana receives the *appeal* request. If oral notification is given, written notification will follow in hard copy or electronic format within the next 3 days.
Pre-Service Claims	Within a reasonable period, but not later than 15 days after Humana receives the *appeal* request.
Post-Service Claims	Within a reasonable period, but no later than 30 days after Humana receives the *appeal* request.
Concurrent Care Decisions	Within the time periods specified above, depending upon the type of claim involved.

Time Periods for Decisions on Appeal -- Second Level

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

Pre-Service Claims	Within a reasonable period, but not later than 15 days after Humana receives the *appeal* request.
Post-Service Claims	Within a reasonable period, but no later than 30 days after Humana receives the *appeal* request.

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 convey 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. 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:

- Relied on in making the determination;
- Submitted, considered or generated in the course of making the benefit determination;
- That demonstrates compliance with the administrative processes and safeguards required with respect to such determinations;
- 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 allows.

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. 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 the 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*, the Humana must complete a preliminary review of the request to determine the following:

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

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

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

- 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, the Humana must provide written notification to the *claimant* of the following:

- 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 Health and Human Services Health Insurance Assistance Team (HIAT), including this number: 1-888-393-2789.

- 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:
    - The initial 4-month filing period; or
    - 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:

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

- 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.

- 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.

- 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*.

- 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:
  - The *claimant's* medical records;
  - The attending health care professional's recommendation;
  - Reports from the appropriate health care professional(s) and other documents submitted by Humana, *claimant*, or *claimant's* treating provider;
  - The terms of the *claimant's* plan to ensure the *IRO's* decision is not contrary, unless the terms are inconsistent with applicable law;
  - 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;
  - Any applicable clinical review criteria developed and used by this Plan, unless inconsistent with the terms of this Plan or with applicable law; and
  - 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.

- 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 general description of the reason an *external review* was requested, including information sufficient to identify the claim including:
    - The date(s) of service;
    - The health care provider;
    - The claim amount (if applicable); and
    - The reason for the previous denial.
  - The date the *IRO* received assignment to conduct the *external review* and the date of the *IRO* decision;

- References to the evidence or documentation considered in reaching the decision, including the specific coverage provisions and evidence-based standards;
- A discussion of the principal reason(s) for its decision, including the rationale and any evidence-based standards relied on in making the decision;
- 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*;
- A statement that judicial review may be available to the *claimant*; and
- Current contact information, including telephone number, for any applicable office of health insurance consumer assistance or ombudsman established under PPACA (*section 2793 of PHSA, as amended*).

- 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:

- 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

- A *final internal adverse benefit determination* involving a medical condition where:
  - 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
  - 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 Department of Health and Human Services Health Insurance Assistance Team (HIAT) at 1-888-393-2789.

SECTION 3

ELIGIBILITY AND EFFECTIVE DATE OF COVERAGE

ELIGIBILITY AND EFFECTIVE DATE OF COVERAGE

OPEN ENROLLMENT

Once annually *you* will have a choice of enrolling *yourself* and *your* eligible *dependents* in this Plan. *You* will be notified in advance when the Open Enrollment Period is to begin and how long it will last. If *you* decline coverage for *yourself* or *your dependents* at the time *you* are initially eligible for coverage, *you* will be able to enroll *yourself* and/or eligible *dependents* during the Open Enrollment Period.

EMPLOYEE ELIGIBILITY

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

- *You* are an *employee* who meets the eligibility requirements of the *employer*; (See Employee Handbook) and
- *You* satisfy an eligibility period of 30 calendar days of full-time or part-time employment.
- *You* are in *active status*.

Your eligibility date is the first of the month following *your* completion of the eligibility period.

EMPLOYEE EFFECTIVE DATE OF COVERAGE

You must enroll in a manner acceptable to *your employer* and Humana.

- If *your* completed enrollment is received by Humana before *your eligibility date* or within 31 days after *your eligibility date*, *your* coverage is effective on *your eligibility date*;
- If *your* completed enrollment is received by Humana more than 31 days after *your* eligibility date, *you* are a *late applicant*. *Your* coverage will be effective the first of the month following receipt of *your* completed enrollment.

DEPENDENT ELIGIBILITY

Each *dependent* is eligible for coverage on:

- The date the *employee* is eligible for coverage, if he or she has *dependents* who may be covered on that date; or
- The date of the *employee 's* marriage for any *dependent* acquired on that date; or
- The date of birth of the *employee's* natural-born child; or
- The date a child is placed for adoption under the *employee's* legal guardianship, or the date which the *employee* incurs a legal obligation for total or partial support in anticipation of adoption; or
- The date a covered *employee's* child is determined to be eligible as an alternate recipient under the terms of a medical child support order.

The covered *employee* may cover *dependents* only if the *employee* is also covered. Check with *your employer* immediately on how to enroll for *dependent* coverage.

DEPENDENT EFFECTIVE DATE OF COVERAGE

Check with *your employer* immediately on how to enroll for enroll for dependent coverage. *Dependent* effective date of coverage as determined your employer:

- If the completed enrollment is received by Humana before the *dependent's* eligibility date or within 31 days after the *dependent's* eligibility date, that *dependent* is covered on the date he or she is eligible.

- If the completed enrollment is received by Humana more than 31 days after the *dependent's eligibility date*, the *dependent* is a *late applicant*. The *dependent's* coverage will be effective the first of the month following receipt of the *dependent's* completed enrollment.

No *dependent's* effective date will be prior to the covered *employee's* effective date of coverage. If *your dependent* child becomes an eligible *employee* of the *employer*, he or she cannot be covered both as *your dependent* and as an eligible *employee*.

MEDICAL CHILD SUPPORT ORDERS

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

A QMCSO is a state court order or judgment, including approval of a settlement agreement that: (a) provides for support of a covered *employee's* child; (b) provides for health care coverage for that child; (c) is made under state domestic relations law (including a community property law); (d) relates to benefits under this Plan; and (e) is "qualified" in that it meets the technical requirements of applicable law. QMCSO also means a state court order or judgment that enforces a state Medicaid law regarding medical child support required by Social Security Act §1908 (as added by Omnibus Budget Reconciliation Act of 1993).

An NMSN is a notice issued by an appropriate agency of a state or local government that is similar to a QMCSO that requires coverage under this Plan for the *dependent* child of a non-custodial parent who is (or will become) a *covered person* by a domestic relations order that provides for health care coverage.

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

SPECIAL PROVISIONS

If *your employer* continues to pay required contributions and does not terminate the Plan, *your* coverage will remain in force for a period of time as determined by *your employer* for a layoff, during an approved medical leave of absence (other than FMLA), during a period of *total disability*, during an approved non-medical leave of absence, during an approved military leave of absence (other than USERRA) or during part-time status (less than the required full-time hours per week).

REINSTATEMENT OF COVERAGE

If *your* coverage under this Plan was terminated after a period of layoff, *total disability*, approved medical leave of absence (other than FMLA), approved non-medical leave of absence, approved military leave of absence (other than USERRA) or during part-time status (now working required full-time hours), and *you* are now returning to work, *your* coverage is effective immediately on the day *you* return to work.

The eligibility period requirement with respect to the reinstatement of *your* coverage will be waived.

If *your* coverage under the Plan was terminated due to a period of service in the uniformed services covered under the Uniformed Services Employment and Reemployment Rights Act of 1994, *your* coverage is effective immediately on the day *you* return to work. Eligibility waiting periods will be imposed only to the extent they were applicable prior to the period of service in the uniformed services.

FAMILY AND MEDICAL LEAVE ACT (FMLA)

If *you* are granted a leave of absence (Leave) by the *employer* as required by the Federal Family and Medical Leave Act, *you* may continue to be covered under this Plan for the duration of the Leave under the same conditions as other *employees* covered by this Plan. If *you* choose to terminate coverage during the Leave, or if coverage terminates as a result of nonpayment of any required contribution, coverage may be reinstated on the date immediately following the end of the Leave. Charges incurred after the date of reinstatement will be paid as if *you* had been continuously covered.

EXTENDED BENEFITS

If, on the date *your* coverage terminates under this Plan, *you* or *your* covered *dependents* are *totally disabled* as a result of a covered *bodily injury* or *sickness* or hospital confined, this Plan will continue to provide medical benefits until the earliest of the following:

- The end of twelve consecutive months immediately following the date of *your* termination of coverage. This period of time is measured from the date *your* coverage is terminated under this Plan, to the same calendar day of the next succeeding months.

The Extended Benefits provision applies only to *covered expenses* for the disabling condition which existed on the date *your* coverage terminated. This Plan must remain in effect.

RETIREE COVERAGE

Please see *your employer* for more details.

SURVIVORSHIP COVERAGE

Please see *your employer* for more details.

SPECIAL ENROLLMENT

If *you* previously declined coverage under this Plan for *yourself* or any eligible *dependents*, due to the existence of other health coverage (including COBRA), and that coverage is now lost, this Plan permits *you*, *your dependent* spouse, and any eligible *dependents* to be enrolled for medical benefits under this Plan due to any of the following qualifying events:

- Loss of eligibility for the coverage due to any of the following:
  - Legal separation;
  - Divorce;
  - Cessation of *dependent* status (such as attaining the limiting age);
  - Death;
  - Termination of employment;
  - Reduction in the number of hours of employment;
  - Plan no longer offering benefits to a class of similarly situated individuals, which includes the *employee*;
  - Any loss of eligibility after a period that is measured by reference to any of the foregoing.

  However, loss of eligibility does not include a loss due to failure of the individual or the participant to pay premiums on a timely basis or termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan).

- Employer contributions towards the other coverage have been terminated. Employer contributions include contributions by any current or former employer (of the individual or another person) that was contributing to coverage for the individual.

- COBRA coverage under the other plan has since been exhausted.

The previously listed qualifying events apply only if *you* stated in writing at the previous enrollment the other health coverage was the reason for declining enrollment, but only if *your employer* requires a written waiver of coverage which includes a warning of the penalties imposed on late enrollees.

If *you* are a covered *employee* or an otherwise eligible *employee***,** who either did not enroll or did not enroll *dependents* when eligible, *you* now have the opportunity to enroll *yourself* and/or any previously eligible *dependents* or any newly acquired *dependents* when due to any of the following changes:

- Marriage;

- Birth; or

- Adoption or placement for adoption;

- Loss of eligibility due to termination of Medicaid or State Children's Health Insurance Program (SCHIP) coverage; or

- Eligibility for premium assistance subsidy under Medicaid or SCHIP.

You may elect coverage under this Plan and will be considered a *timely applicant* provided completed enrollment is received within 31 days from the qualifying event or 60 days from such event as identified in #4 and #5 above. *You* MUST provide proof that the qualifying event has occurred due to one of the reasons listed before coverage under this Plan will be effective. Coverage under this Plan will be effective the date immediately following the date of the qualifying event, unless otherwise specified in this section.

In the case of a *dependent's* birth, enrollment is effective on the date of such birth.

In the case of a *dependent's* adoption or placement for adoption, enrollment is effective on the date of such adoption or placement for adoption.

If *you* apply more than 31 days after a qualifying event or 60 days from such event as identified in #4 and #5 above, *you* are considered a *late applicant*.

Please see *your employer* for more details.

TERMINATION OF COVERAGE

Coverage terminates on the earliest of the following:

- The date this Plan terminates;
- The end of the period for which any required contribution was due and not paid;
- For all *employees* or *dependent* spouses as determined by *your employer* when they enter full-time military, naval or air service, except coverage may continue during an approved military leave of absence for an *employee* as indicated in the Special Provisions;
- The date determined by *your employer*, when *you* fail to be in an eligible class of persons according to the eligibility requirements of the *employer*;
- For all *employees*, as determined by *your employer*, following termination of employment with the *employer*;
- For all *employees*, as determined by *your employer*, following *your* retirement;
- As determined by *your employer* when *you* request termination of coverage to be effective for *yourself*;
- For any benefit, the date the benefit is removed from this Plan;
- For *your dependents*, the date *your* coverage terminates;
- For a *dependent* spouse as determined by *your employer*, when such *covered person* no longer meets the definition of *dependent*;
- For a *dependent* child, the end of the birth month they meet the limiting age as indicted in the *dependent* definition.

If *you* or any of *your* covered *dependents* no longer meet the eligibility requirements, *you* and *your employer* are responsible for notifying Humana of the change in status. Coverage will not continue beyond the last date of eligibility even if notice has not been given to Humana.

SECTION 4

GENERAL PROVISIONS AND REIMBURSEMENT/ SUBROGATION

GENERAL PROVISIONS

The following provisions are to protect *your* legal rights and the legal rights of this Plan.

PLAN ADMINISTRATION

The *Plan Sponsor* has established and continues to maintain this Plan for the benefit of its *employees* and their eligible *dependents* as provided in this document.

Benefits under this Plan are provided on a self-insured basis, which means that payment for benefits is ultimately the sole financial responsibility of the *Plan Sponsor*. Certain administrative services with respect to this Plan, such as claims processing, are provided under a services agreement. Humana is not responsible, nor will it assume responsibility, for benefits payable under this Plan.

Any changes to this Plan, as presented in this *Summary Plan Description* must be properly adopted by the *Plan Sponsor*, and material modifications must be timely disclosed in writing and included in or attached to this document. A verbal modification of this Plan or promise having the same effect made by any person will not be binding with respect to this Plan.

RESCISSION

This Plan will rescind coverage only due to fraud or an intentional misrepresentation of a material fact. Rescission is a cancellation or discontinuance of coverage that has a retroactive effect. A cancellation or discontinuance is not a rescission if the cancellation or discontinuance of coverage has only a prospective effect, or 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.

CONTESTABILITY

This Plan has the right to contest the validity of *your* coverage under the Plan at any time.

RIGHT TO REQUEST OVERPAYMENTS

This Plan reserves the right to recover any payments made by this Plan that were:

- Made in error; or
- Made to *you* or any party on *your* behalf where this Plan determines the payment to *you* or any party is greater than the amount payable under this Plan.

This Plan has the right to recover against *you* if this Plan has paid *you* or any other party on *your* behalf.

WORKERS' COMPENSATION NOT AFFECTED

This Plan is not issued in lieu of, nor does it affect any requirement for coverage by any Workers' Compensation or Occupational Disease Act or Law.

WORKERS' COMPENSATION

If benefits are paid by this Plan and this Plan determines *you* received Workers' Compensation for the same incident, this Plan has the right to recover as described under the Reimbursement/Subrogation provision. This Plan will exercise its right to recover against *you* even though:

- The Workers' Compensation benefits are in dispute or are made by means of settlement or compromise;
- No final determination is made that *bodily injury* or *sickness* was sustained in the course of, or resulted from, *your* employment;
- The amount of Workers' Compensation due to medical or health care is not agreed upon or defined by *you* or the Workers' Compensation carrier;
- The medical or health care benefits are specifically excluded from the Workers' Compensation settlement or compromise.

You hereby agree that, in consideration for the coverage provided by this Plan, *you* will notify Humana of any Workers' Compensation claim *you* make, and that *you* agree to reimburse this Plan as described above.

MEDICAID

This Plan will not take into account the fact that an *employee* or *dependent* is eligible for medical assistance or Medicaid under state law with respect to enrollment, determining eligibility for benefits, or paying claims.

If payment for Medicaid benefits has been made under a state Medicaid plan for which payment would otherwise be due under this Plan, payment of benefits under this Plan will be made in accordance with a state law which provides that the state has acquired the rights with respect to a covered *employee* to the benefits payment.

CONSTRUCTION OF PLAN TERMS

This Plan has the sole right to construe and prescribe the meaning, scope and application of each and all of the terms of this Plan, including, without limitation, the benefits provided thereunder, the obligations of the *beneficiary* and the recovery rights of this Plan; such construction and prescription by this Plan shall be final and uncontestable.

REIMBURSEMENT/SUBROGATION

The *beneficiary* agrees that by accepting and in return for the payment of *covered expenses* by this Plan in accordance with the terms of this Plan:

- This Plan shall be repaid the full amount of the *covered expenses* it pays from any amount received from others for the *bodily injuries* or losses which necessitated such *covered expenses*. Without limitation, "amounts received from others" specifically includes, but is not limited to, liability insurance, worker's 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.

- This Plan's right to repayment is, and shall be, prior and superior to the right of any other person or entity, including the *beneficiary*.

- The right to recover amounts from others for the injuries or losses which necessitate *covered expenses* is jointly owned by this Plan and the *beneficiary*. This Plan is subrogated to the *beneficiary's* rights to that extent. Regardless of who pursues those rights, the funds recovered shall be used to reimburse this Plan as prescribed above; this Plan has no obligation to pursue the rights for an amount greater than the amount that it has paid, or may pay in the future. The rights to which this Plan is subrogated are, and shall be, prior and superior to the rights of any other person or entity, including the *beneficiary*.

- The *beneficiary* will cooperate with this Plan in any effort to recover from others for the *bodily injuries* and losses which necessitate *covered expense* payments by this Plan. The *beneficiary* will notify this Plan immediately of any claim asserted and any settlement entered into, and will do nothing at any time to prejudice the rights and interests of this Plan. Neither this Plan nor the *beneficiary* shall be entitled to costs or attorney fees from the other for the prosecution of the claim.

RIGHT TO COLLECT NEEDED INFORMATION

You must cooperate with Humana and when asked, assist Humana by:

- Authorizing the release of medical information including the names of all providers from whom *you* received medical attention;

- Obtaining medical information and/or records from any provider as requested by Humana;

- Providing information regarding the circumstances of *your sickness* or *bodily injury*;

- Providing information about other insurance coverage and benefits, including information related to any *bodily injury* or *sickness* for which another party may be liable to pay compensation or benefits; and

- Providing information Humana requests to administer this Plan.

Failure to provide the necessary information will result in denial of any pending or subsequent claims, pertaining to a *bodily injury* or *sickness* for which the information is sought, until the necessary information is satisfactorily provided.

DUTY TO COOPERATE IN GOOD FAITH

You are obliged to cooperate with Humana in order to protect this Plan's recovery rights. Cooperation includes promptly notifying Humana that *you* may have a claim, providing Humana relevant information, and signing and delivering such documents as Humana reasonably requests to secure this Plan's recovery rights. *You* agree to obtain this Plan's consent before releasing any party from liability for payment of medical expenses. *You* agree to provide Humana with a copy of any summons, complaint or any other process serviced in any lawsuit in which *you* seek to recover compensation for *your bodily injury* or *sickness* and its treatment.

You will do whatever is necessary to enable Humana to enforce this Plan's recovery rights and will do nothing after loss to prejudice this Plan's recovery rights.

You agree that *you* will not attempt to avoid this Plan's recovery rights by designating all (or any disproportionate part) of any recovery as exclusively for pain and suffering.

Failure of the *covered person* to provide Humana such notice or cooperation, or any action by the *covered person* resulting in prejudice to this Plan's rights will be a material breach of this Plan and will result in the *covered person* being personally responsible to make repayment. In such an event, this Plan may deduct from any pending or subsequent claim made under this Plan any amounts the *covered person* owes this Plan until such time as cooperation is provided and the prejudice ceases.

SECTION 5

NOTICES

IMPORTANT NOTICES FOR EMPLOYEES AND SPOUSES AGE 65 AND OVER

Federal law may affect *your* coverage under this Plan. The *Medicare* as Secondary Payer rules were enacted by an amendment to the Social Security Act. Also, additional rules which specifically affect how a large group health plan provides coverage to employees (or their spouses) over age 65 were added to the Social Security Act and to the Internal Revenue Code.

Generally, the health care plan of an employer that has at least 20 employees must operate in compliance with these rules in providing plan coverage to plan participants who have "current employment status" and are *Medicare* beneficiaries, age 65 and over.

Persons who have "current employment status" with an employer are generally employees who are actively working and also persons who are NOT actively working as follows:

- Individuals receiving disability benefits from an employer for up to 6 months; or
- Individuals who retain employment rights and have not been terminated by the employer and for whom the employer continues to provide coverage under this Plan. (For example, employees who are on an approved leave of absence).

If *you* are a person with "current employment status" who is age 65 and over (or the dependent spouse age 65 and over of an *employee* of any age), *your* coverage under this Plan will be provided on the same terms and conditions as are applicable to *employees* (or dependent spouses) who are under the age of 65. *Your* rights under this Plan do not change because *you* (or *your* dependent spouse) are eligible for *Medicare* coverage on the basis of age, as long as *you* have "current employment status" with *your employer*.

You have the option to reject plan coverage offered by *your employer*, as does any eligible *employee*. If *you* reject coverage under *your employer's* Plan, coverage is terminated and *your employer* is not permitted to offer *you* coverage that supplements *Medicare* covered services.

If *you* (or *your* dependent spouse) obtain *Medicare* coverage on the basis of age, and not due to disability or end-stage renal disease, this Plan will consider its coverage to be primary to *Medicare* when *you* have elected coverage under this Plan and have "current employment status".

If *you* have any questions about how coverage under this Plan relates to *Medicare* coverage, please contact *your employer*.

PRIVACY OF PROTECTED HEALTH INFORMATION

This Plan is required by law to maintain the privacy of *your protected health information* in all forms including written, oral and electronically maintained, stored and transmitted information and to provide individuals with notice of this Plan's legal duties and privacy practices with respect to *protected health information*.

This Plan has policies and procedures specifically designed to protect *your* health information when it is in electronic format. This includes administrative, physical and technical safeguards to ensure that *your* health information cannot be inappropriately accessed while it is stored and transmitted to Humana and others that support this Plan.

In order for this Plan to operate, it may be necessary from time to time for health care professionals, the *Plan Administrator*, individuals who perform Plan-related functions under the auspices of the *Plan Administrator*, Humana and other service providers that have been engaged to assist this Plan in discharging its obligations with respect to delivery of benefits, to have access to what is referred to as *protected health information*.

A *covered person* will be deemed to have consented to use of *protected health information* about him or her for the sole purpose of health care operations by virtue of enrollment in this Plan. This Plan must obtain authorization from a *covered person* to use *protected health information* for any other purpose.

Individually identifiable health information will only be used or disclosed for purposes of Plan operation or benefits delivery. In that regard, only the minimum necessary disclosure will be allowed. The *Plan Administrator*, Humana, and other entities given access to *protected health information*, as permitted by applicable law, will safeguard *protected health information* to ensure that the information is not improperly disclosed.

Disclosure of *protected health information* is improper if it is not allowed by law or if it is made for any purpose other than Plan operation or benefits delivery without authorization. Disclosure for Plan purposes to persons authorized to receive *protected health information* may be proper, so long as the disclosure is allowed by law and appropriate under the circumstances. Improper disclosure includes disclosure to the *employer* for employment purposes, *employee* representatives, consultants, attorneys, relatives, etc. who have not executed appropriate agreements effective to authorize such disclosure.

Humana will afford access to *protected health information* in its possession only as necessary to discharge its obligations as a service provider, within the restrictions noted above. Information received by Humana is information received on behalf of this Plan.

Humana will afford access to *protected health information* as reasonably directed in writing by the *Plan Administrator*, which shall only be made with due regard for confidentiality. In that regard, Humana has been directed that disclosure of *protected health information* may be made to the person(s) identified by the *Plan Administrator*.

Individuals who have access to *protected health information* in connection with their performance of Plan-related functions under the auspices of the *Plan Administrator* will be trained in these privacy policies and relevant procedures prior to being granted any access to *protected health information*. Humana and other Plan service providers will be required to safeguard *protected health information* against improper disclosure through contractual arrangements.

In addition, *you* should know that the *employer*/*Plan Sponsor* may legally have access, on an as-needed basis, to limited health information for the purpose of determining Plan costs, contributions, Plan design, and whether Plan modifications are warranted. In addition, federal regulators such as the Department of Health and Human Services and the Department of Labor may legally require access to *protected health information* to police federal legal requirements about privacy.

Covered persons may have access to *protected health information* about them that is in the possession of this Plan, and they may make changes to correct errors. *Covered persons* are also entitled to an accounting of all disclosures that may be made by any person who acquires access to *protected health information* concerning them and uses it other than for Plan operation or benefits delivery. In this regard, please contact the *Plan Administrator*.

Covered persons are urged to contact the originating health care professional with respect to medical information that may have been acquired from them, as those items of information are relevant to medical care and treatment. And finally, *covered persons* may consent to disclosure of *protected health information*, as they please.

THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1986 (COBRA)

CONTINUATION OF BENEFITS

On April 7, 1986, the Consolidated Omnibus Budget Reconciliation Act (COBRA) was signed into law. This federal law applies to employers with 20 or more employees. The law requires that employers offer employees and/or their dependents continuation of medical coverage at group rates in certain instances where there is a loss of group insurance coverage.

ELIGIBILITY

A qualified beneficiary under COBRA law means an *employee*, *employee's* spouse or *dependent* child covered by this Plan on the day before a qualifying event. A qualified beneficiary under COBRA law also includes a child born to the *employee* during the coverage period or a child placed for adoption with the *employee* during the coverage period.

EMPLOYEE: An *employee* covered by the *employer's* Plan has the right to elect continuation coverage if coverage is lost due to one of the following qualifying events:

- Termination (for reasons other than gross misconduct, as defined by *your employer*) of the *employee's* employment or reduction in the hours of *employee's* employment; or
- Termination of retiree coverage when the former *employer* discontinues retiree coverage within one year before or one year after filing for Chapter 11 bankruptcy.

SPOUSE: A spouse covered by the *employer's* Plan has the right to elect continuation coverage if the group coverage is lost due to one of the following qualifying events:

- The death of the *employee*;
- Termination of the *employee's* employment (for reasons other than gross misconduct, as defined by *your employer*) or reduction of the *employee's* hours of employment with the *employer*;
- Divorce or legal separation from the *employee*;
- The *employee* becomes entitled to *Medicare* benefits; or
- Termination of a retiree spouse's coverage when the former *employer* discontinues retiree coverage within one year before or one year after filing for Chapter 11 bankruptcy.

DEPENDENT CHILD: A *dependent* child covered by the *employer's* Plan has the right to continuation coverage if group coverage is lost due to one of the following qualifying events:

- The death of the *employee* parent;
- The termination of the *employee* parent's employment (for reasons other than gross misconduct, as defined by *your employer*) or reduction in the *employee* parent's hours of employment with the *employer*;
- The *employee* parent's divorce or legal separation;

- Ceasing to be a "*dependent* child" under this Plan;
- The *employee* parent becomes entitled to *Medicare* benefits; or
- Termination of the retiree parent's coverage when the former *employer* discontinues retiree coverage within one year before or one year after filing for Chapter 11 bankruptcy.

LOSS OF COVERAGE

Coverage is lost in connection with the foregoing qualified events, when a covered *employee*, spouse or *dependent* child ceases to be covered under the same Plan terms and conditions as in effect immediately before the qualifying event (such as an increase in the premium or contribution that must be paid for *employee*, spouse or *dependent* child coverage).

If coverage is reduced or eliminated in anticipation of an event (for example, an *employer* eliminating an *employee's* coverage in anticipation of the termination of the *employee's* employment, or an *employee* eliminating the coverage of the *employee's* spouse in anticipation of a divorce or legal separation), the reduction or elimination is disregarded in determining whether the event causes a loss of coverage.

A loss of coverage need not occur immediately after the event, so long as it occurs before the end of the Maximum Coverage Period.

NOTICES AND ELECTION

This Plan provides that coverage terminates for a spouse due to legal separation or divorce or for a child when that child loses *dependent* status. Under the law, the *employee* or qualified beneficiary has the responsibility to inform the *Plan Administrator* (see Plan Description Information) if one of the above events has occurred. The qualified beneficiary must give this notice within 60 days after the event occurs. (For example, an ex-spouse should make sure that the *Plan Administrator* is notified of his or her divorce, whether or not his or her coverage was reduced or eliminated in anticipation of the event). When the *Plan Administrator* is notified that one of these events has happened, it is the *Plan Administrator's* responsibility to notify the *COBRA Service Provider*, who will in turn notify the qualified beneficiary of the right to elect continuation coverage.

For a qualified beneficiary who is determined under the Social Security Act to be disabled at any time during the first 60 days of COBRA coverage, the continuation coverage period may be extended 11 additional months. The disability that extends the 18-month coverage period must be determined under Title II (Old Age, Survivors, and Disability Insurance) or Title XVI (Supplemental Security Income) of the Social Security Act. To be entitled to the extended coverage period, the disabled qualified beneficiary must provide notice to the *COBRA Service Provider* and *Plan Administrator* within the initial 18 month coverage period and within 60 days after the date of the determination of disability under the Social Security Act. Failure to provide this notice will result in the loss of the right to extend the COBRA continuation period.

For termination of employment, reduction in work hours, the death of the *employee*, the *employee* becoming covered by *Medicare* or loss of retiree benefits due to bankruptcy, it is the *Plan Administrator's* responsibility to notify the *COBRA Service Provider*, who will in turn notify the qualified beneficiary of the right to elect continuation coverage.

Under the law, continuation coverage must be elected within 60 days after Plan coverage ends, or if later, 60 days after the date of the notice of the right to elect continuation coverage. If continuation coverage is not elected within the 60 day period, the right to elect coverage under this Plan will end.

A covered *employee* or the spouse of the covered *employee* may elect continuation coverage for all covered *dependents*, even if the covered *employee* or spouse of the covered *employee* or all covered *dependents* are covered under another group health plan (as an employee or otherwise) prior to the election. The covered *employee*, his or her spouse and *dependent* child, however, each have an independent right to elect continuation coverage. Thus a spouse or *dependent* child may elect continuation coverage even if the covered *employee* does not elect it.

Coverage will not be provided during the election period. However, if the individual makes a timely election, coverage will be provided from the date that coverage would otherwise have been lost. If coverage is waived before the end of the 60 day election period and the waiver revoked before the end of the 60 day election period, coverage will be effective on the date the election of coverage is sent to the *COBRA Service Provider* or *Plan Administrator*.

On August 6, 2002, The Trade Act of 2002 (TAA), was signed into law. Workers whose employment is adversely affected by international trade (increased import or shift in production to another country) may become eligible to receive TAA. TAA provides a second 60-day COBRA election period for those who become eligible for assistance under TAA. Pursuant to the Trade Act of 1974, an individual who is either an eligible TAA recipient or an eligible alternative TAA recipient and who did not elect continuation coverage during the 60-day COBRA election period that was a direct consequence of the TAA-related loss of coverage, may elect continuation coverage during a 60-day period that begins on the first day of the month in which he or she is determined to be TAA-eligible individual, provided such election is made not later than 6 months after the date of the TAA-related loss of coverage. Any continuation coverage elected during the second election period will begin with the first day of the second election period and not on the date on which coverage originally lapsed.

TAA created a new tax credit for certain individuals who became eligible for trade adjustment assistance (eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. If *you* have questions about these new tax provisions, *you* may call the Health Care Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282.

The *Plan Administrator* shall require documentation evidencing eligibility of TAA benefits. The Plan need not require every available document to establish evidence of TAA. The burden for evidencing TAA eligibility is that of the individual applying for coverage under this Plan.

MAXIMUM COVERAGE PERIOD

Coverage may continue up to:

- 18 months for an *employee* and/or *dependent* whose group coverage ended due to termination of the *employee's* employment or reduction in hours of employment;

- 36 months for a spouse whose coverage ended due to the death of the *employee* or retiree, divorce, or the *employee* becoming entitled to *Medicare* at the time of the initial qualifying event;

- 36 months for a *dependent* child whose coverage ended due to the divorce of the *employee* parent, the *employee* becoming entitled to *Medicare* at the time of the initial qualifying event, the death of the *employee*, or the child ceasing to be a *dependent* under this Plan;

- For the retiree, until the date of death of the retiree who is on continuation due to loss of coverage within one year before or one year after the *employer* filed Chapter 11 bankruptcy.

DISABILITY

An 11-month extension of coverage may be available if any of the qualified beneficiaries are determined by the Social Security Administration (SSA) to be disabled. The disability has to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. The qualified beneficiary must provide notice of such determination prior to the end of the initial 18-month continuation period to be entitled to the additional 11 months of coverage. Each qualified beneficiary who has elected continuation coverage will be entitled to the 11-month disability extension if one of them qualifies. If a qualified beneficiary is determined by SSA to no longer be disabled, *you* must notify this Plan of that fact within 30 days after SSA's determination.

SECOND QUALIFYING EVENT

An 18-month extension of coverage will be available to spouses and *dependent* children who elect continuation coverage if a second qualifying event occurs during the first 18 months of continuation coverage. The maximum amount of continuation coverage available when a second qualifying event occurs is 36 months. Such second qualifying event may include the death of a covered *employee*, divorce or separation from the covered *employee*, the covered *employee's* becoming entitled to *Medicare* benefits (under Part A, Part B, or both), or a *dependent* child's ceasing to be eligible for coverage as a *dependent* under this Plan. These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under this Plan if the first qualifying event had not occurred. *You* must notify this Plan within 60 days after the second qualifying event occurs if *you* want to extend *your* continuation coverage.

TERMINATION BEFORE THE END OF MAXIMUM COVERAGE PERIOD

Continuation coverage will terminate before the end of the maximum coverage period for any of the following reasons:

- The *employer* no longer provides group health coverage to any of its *employees*;
- The premium for continuation is not paid timely;
- The individual on continuation becomes covered under another group health plan (as an *employee* or otherwise);
- The individual on continuation becomes entitled to *Medicare* benefits;
- If there is a final determination under Title II or XVI of the Social Security Act that an individual is no longer disabled; however, continuation coverage will not end until the month that begins more than 30 days after the determination;
- The occurrence of any event (e.g. submission of a fraudulent claim) permitting termination of coverage for cause under this Plan.

TYPE OF COVERAGE; PREMIUM PAYMENT

The initial premium payment for continuation coverage is due by the 45th day after coverage is elected. The initial premium includes charges back to the date the continuation coverage began. All other premiums are due on the first of the month for which the premium is paid, subject to a 31 day grace period. The *employer* or *COBRA Service Provider* must provide the individual with a quote of the total monthly premium.

Premium for continuation coverage may be increased, however, the premium may not be increased more than once in any determination period. The determination period is a 12 month period which is established by this Plan.

The monthly premium payment to this Plan for continuing coverage must be submitted directly to the *employer* or *COBRA Service Provider*. This monthly premium may include the *employee's* share and any portion previously paid by the *employer*. The monthly premium must be a reasonable estimate of the cost of providing coverage under this Plan for similarly situated non-COBRA beneficiaries. The premium for COBRA continuation coverage may include a 2% administration charge. However, for qualified beneficiaries who are receiving up to 11 months additional coverage (beyond the first 18 months) due to disability extension (and not a second qualifying event), the premium for COBRA continuation coverage may be up to 150% of the applicable premium for the additional months. Qualified beneficiaries who do not take the additional 11 months of special coverage will pay up to 102% of the premium cost.

OTHER INFORMATION

Additional information regarding rights and obligations under this Plan and under federal law may be obtained by contacting the *Plan Administrator* or Humana.

It is important for the *covered person* or qualified beneficiary to keep the *Plan Administrator* and Humana informed of any changes in marital status, or a change of address.

PLAN CONTACT INFORMATION

WEX Health Inc.
4321 20th Ave S,
Fargo ND 58103
Telephone: **(**866-451-3399)

Humana Insurance Company
Billing/Enrollment Department
101 E. Main Street
Louisville, KY 40202
Toll-Free: 1-800-872-7207

THE UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994 (USERRA)

CONTINUATION OF BENEFITS

Effective October 13, 1994 federal law requires that health plans must offer to continue coverage for *employees* who are absent due to service in the uniformed services and/or their *dependents*. Coverage may continue for up to twenty-four (24) months after the date the *employee* is first absent due to uniformed service.

ELIGIBILITY

An *employee* is eligible for continuation under USERRA if absent from employment because of voluntary or involuntary performance of duty in the Armed Forces, Army National Guard, Air National Guard, the commissioned corps of the Public Health Service or any other category of persons designated by the President of the United States of America in a time of war or national emergency. Duty includes absence for active duty, active duty for training, initial active duty for training, inactive duty training, full-time National Guard duty and for the purpose of an examination to determine fitness for duty.

An *employee's dependent* who has coverage under this Plan immediately prior to the date of the *employee's* covered absence are eligible to elect continuation under USERRA.

PREMIUM PAYMENT

If continuation of Plan coverage is elected under USERRA, the *employee* or *dependent* is responsible for payment of the applicable cost of coverage. If the *employee* is absent for 30 days or less, the cost will be the amount the *employee* would otherwise pay for coverage. For absences exceeding 30 days, the cost may be up to 102% of the cost of coverage under this Plan. This includes the *employee's* share and any portion previously paid by the *employer*.

DURATION OF COVERAGE

Elected continuation coverage under USERRA will continue until the earlier of:

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

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

OTHER INFORMATION

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

THE WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998 (WHCRA)

If *you* have had or are going to have a mastectomy, *you* may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the covered mastectomy was performed;
- *Surgery* and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

Contact *your employer* if *you* would like more information on WHCRA benefits.

THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996

The Newborns' and Mothers' Health Protection Act of 1996 provides that 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).

Contact *your employer* if *you* would like more information on The Newborns' and Mothers' Health Protection Act.

PLAN DESCRIPTION INFORMATION

- Proper Name of Plan: Kenosha County Medical and Pharmacy Plan

- *Plan Sponsor*: Kenosha County
  1010 56th St.
  Kenosha, WI 53140
  262-653-2800

- *Employer* Kenosha County
  1010 56th St.
  Kenosha, WI 53140
  262-653-2800

- *Plan Administrator* and Named Fiduciary;

  Humana Insurance Company
  500 West Main Street
  Louisville, KY 40202
  Telephone: Refer to *your* ID card

- *Employer* Identification Number: 39-6005707

- This Plan provides medical and *prescription* drug benefits for participating *employees* and their enrolled *dependents*.

- Plan benefits described in this booklet are effective July 1, 2023.

- The *Plan year* is January 1 through December 31 of each year.

- The fiscal year is January 1 through December 31 of each year.

- Service of legal process may be served upon the *Plan Administrator* as shown above or the following agent for service of legal process:

  Humana Insurance Company
  500 West Main Street
  Louisville, KY 40202
  Telephone: Refer to *your* ID card

- The *Plan Manager* is responsible for performing certain delegated administrative duties, including the processing of claims. The *Plan Manager* and Claim Fiduciary is:

  Humana Insurance Company
  500 West Main Street
  Louisville, KY 40202
  Telephone: Refer to *your* ID card

- This is a self-insured and self-administered health benefit plan. The cost of this Plan is paid by the *employer*. Benefits under this Plan are provided from the general assets of the *employer* and are used to fund payment of covered claims under this Plan plus administrative expenses. Please see *your employer* for the method of calculating contributions and the funding mechanism used for the accumulation of assets through which benefits are provided under this Plan.

- Each *employee* of the *employer* who participates in this Plan receives a *Summary Plan Description*, which is this booklet. This booklet will be provided to *employees* by the *employer*. It contains information regarding eligibility requirements, termination provisions, a description of the benefits provided and other Plan information.

- This Plan's benefits and/or contributions may be modified or amended from time to time, or may be terminated at any time by the *Plan Sponsor*. Significant changes to this Plan, including termination, will be communicated to participants as required by applicable law.

- Upon termination of this Plan, the rights of the participants to benefits are limited to claims incurred and payable by this Plan up to the date of termination. Plan assets, if any, will be allocated and disposed of for the exclusive benefit of the participating *employees* and their *dependents* covered by this Plan, except that any taxes and administration expenses may be made from this Plan's assets.

- This Plan does not constitute a contract between the *employer* and any *covered person* and will not be considered as an inducement or condition of the employment of any *employee*. Nothing in this Plan will give any *employee* the right to be retained in the service of the *employer*, or for the *employer* to discharge any *employee* at any time. It is provided, however, that the foregoing will not modify the provisions of any collective bargaining agreement which may be made by the *employer* with the bargaining representative of any *employees*. A copy of the collective bargaining agreement will be made available by the *employer* for review, upon written request.

- This Plan is not in lieu of and does not affect any requirement for coverage by workers' compensation insurance.

SECTION 6

DEFINITIONS

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

- A determination based on a *covered person's* eligibility to participate in this Plan;
- A determination that a benefit is not a covered benefit;
- The imposition of a source-of-injury exclusion, network exclusion, or other limitation on otherwise covered benefits; or
- 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:

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

Air ambulance means a professionally operated helicopter or airplane, 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 *air ambulance* must be *medically necessary*. When transporting the sick or injured person from one medical facility to another, the *air ambulance* must be ordered by a *health care practitioner*.

Alternative medicine means for purposes of this definition, *alternative medicine* shall include, but is not limited to: acupressure, aromatherapy, ayurveda, biofeedback, faith healing, guided mental imagery, herbal supplements and medicine, holistic medicine, homeopathy, hypnosis, macrobiotics, massage therapy, naturopathy, ozone therapy, reflexotherapy, relaxation response, rolfing, shiatsu and yoga and chelation therapy.

Ambulance means a professionally operated ground 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 qualified provider*. When transporting the sick or injured person from one medical facility to another, the *ambulance* must be ordered by a *health care practitioner*.

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

- It must be staffed by physicians and a medical staff which includes registered *nurse*s;
- It must have permanent facilities and equipment for the primary purpose of performing *surgery*;
- It must provide continuous physicians' *services* on an outpatient basis;
- It must admit and discharge patients from the facility within a 24-hour period;
- 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;
- 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.

Ancillary services mean *covered expenses* that are:

- Items or services related to emergency medicine, anesthesiology, pathology; radiology; or neonatology;
- Provided by *assistant surgeons*, hospitalists or intensivists;
- Diagnostic laboratory or radiology services; or
- Items or services provided by a *non-network provider* when a *network provider* is not available to provide the services at the *network facility.*

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

Applied behavioral analysis (ABA) therapy is an intensive behavioral treatment program that attempts to improve cognitive and social functioning.

Assistant surgeon means a *qualified provider* who assists at *surgery* and is a Doctor of Medicine (MD), Doctor of Osteopathic Medicine (DO), Doctor of Podiatric Medicine (DPM) or where state law requires a specific *qualified provider* be treated and reimbursed the same as an MD, DO or DPM.

B

Behavioral health means *mental health services* and *chemical dependency 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.

Birthing center means a *free-standing facility* that is specifically licensed to perform uncomplicated pregnancy care, delivery and immediate care after delivery for a *covered person*.

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.

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

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

Coinsurance means the amount expressed as a percentage of the *covered expense* that *you* must pay.

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 a registered bed patient in a *hospital* or a *qualified treatment facility* as the result of a *health care practitioner's* recommendation. It does not mean detainment in *observation status*.

Congenital anomaly means an abnormality of the body that is present from the time of birth.

Copayment means the specified dollar amount that *you* must pay to a provider for *covered expenses*, regardless of any amounts that may be paid by this Plan.

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

Co-surgeon means one of two or more *health care practitioners* furnishing a single *surgery* which requires the skill of multiple surgeons each in a different specialty, performing parts of the same *surgery* simultaneously.

Covered expense means:

- *Medically necessary* services to treat a *sickness* or *bodily injury*, such as:
    - Procedures;
    - Surgeries;
    - Consultations;
    - Advice;
    - Diagnosis;
    - Referrals;
    - Treatment;
    - Supplies;
    - Drugs, including *prescription* and *specialty drugs*;
    - Devices; or
    - Technologies;
- *Preventive services*.

To be considered a *covered expense*, services must be:

- Ordered by a *qualified provider*;
- Authorized or prescribed by a *qualified provider*;
- Provided or furnished by a *qualified provider*;
- For the benefits described herein, subject to any maximum benefit and all other terms, provisions, limitations, and exclusions of the Plan; and
- Incurred when *you* are eligible for that benefit under the Plan on the date that the service is rendered.

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

Custodial care means services given to *you* if:

- *You* need services including, but not limited to, assistance with dressing, bathing, preparation and feeding of special diets, walking, supervision of medication which is ordinarily self-administered, getting in and out of bed, and maintaining continence;
- The services *you* require are primarily to maintain, and not likely to improve, *your* condition; or
- The services involve the use of skills which can be taught to a layperson and do not require the technical skills of a *nurse*.

Services may still be considered *custodial care* by this Plan even if:

- *You* are under the care of a *qualified provider*;
- The *qualified provider* prescribed services are to support or maintain *your* condition; or
- Services are being provided by a *nurse*.

D

Deductible means the amount of *covered expenses* that *you*, either individually or combined as a covered family, must pay per *calendar year* before this Plan pays benefits for certain specified *covered expenses*. Any amount *you* pay exceeding the *maximum allowable fee* is not applied to the individual or family *deductibles*.

Dental injury means an injury to a *sound natural tooth* caused by a sudden and external force that could not be predicted in advance and could not be avoided. It does not include biting or chewing injuries, unless the biting or chewing injury is a result of an act of domestic violence or a medical condition (including both physical and mental health conditions)

Dependent means a covered *employee's*:

- Legally recognized spouse;
- Natural blood related child, step-child, legally adopted child or child placed with the *employee* for adoption, foster child, or child for which the *employee* has legal guardianship or a child of a spouse whose age is less than the limiting age.

  Limiting age and eligibility criteria:
  <u>*Dependent* children to age 26:</u>

  The limiting age for each *dependent* child is the end of the birth month he or she attains the age of 26 years, regardless if the child is:
  - Married;
  - A tax dependent;
  - A student;
  - Employed;
  - Residing or working outside of the network area:
  - Residing with or receives financial support from *you;* or
  - Eligible for other coverage through employment.

<u>*Dependent* children, age 26 and older, who are called to federal active duty:</u>

The limiting age is any age for each *dependent* child age 26 and older when they meet the requirements below. *Dependent* termination is the end of the month they no longer meet these requirements.

- The child is a full-time student; and
- The child was called to federal active duty in the National Guard or in a reserve component of the U.S. armed forces while the child was attending an institution of higher education on a full-time basis; and
- The child was under age 27 when called to federal active duty; and
- The child applies for full-time student status at an institution of higher education up to 12 months after completing active duty; and

- If the child is called to active duty more than once within a four-year period of time, the child's age at the time of their first call to active duty will be used when determining eligibility under this Plan.

- A covered *employee's* child whose age is less than the limiting age and is entitled to coverage under the provisions of this Plan because of a medical child support order;

- Grandchild, as long as the *employee's* covered *dependent*, who is the parent of the grandchild, is not yet age 18.

You must furnish satisfactory proof, upon request, to Humana that the above conditions continuously exist. If satisfactory proof is not submitted to Humana, the child's coverage will not continue beyond the last date of eligibility.

A covered *dependent* child who attains the limiting age while covered under this Plan will remain eligible for benefits if all of the following exist at the same time:

- Permanently mentally disabled or permanently physically handicapped;
- Incapable of self-sustaining employment;
- The child meets all of the qualifications of a *dependent* as determined by the United States Internal Revenue Service;
- Declared on and legally qualify as a *dependent* on the *employee's* federal personal income tax return filed for each year of coverage; and
- Unmarried.

You must furnish satisfactory proof to Humana that the above conditions continuously exist on and after the date the limiting age is reached. Humana may not request such proof more often than annually after two years from the date the first proof was furnished. If satisfactory proof is not submitted to Humana, the child's coverage will not continue beyond the last date of eligibility.

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 nonprescriptive oral agents for controlling blood sugar levels, prescriptive non-insulin agents for controlling blood sugar levels, glucagon emergency kits and alcohol swabs.

Distant site means the location of a *qualified provider* at the time a *telehealth* or *telemedicine* service is provided.

Durable medical equipment means equipment that meets all of the following criteria:

- It is prescribed by a *qualified provider*;
- It can withstand repeated use;
- It is primarily and customarily used for a medical purpose, rather than being primarily for comfort or convenience;
- It is generally not useful to *you* in the absence of *sickness* or *bodily injury*;
- It is appropriate for home use or use at other locations as necessary for daily living;
- It is related to and meets the basic functional needs of *your* physical disorder;
- It is not typically furnished by a *hospital* or *skilled nursing facility*; and
- It is provided in the most cost effective manner required by *your* condition, including, at this Plan's discretion, rental or purchase.

E

Eligibility date means the date the *employee* or *dependent* is eligible to participate in this plan.

Emergency care means services provided in an emergency facility for an *emergency medical condition*.

Emergency care does not mean services for the convenience of the *covered person* or the provider of treatment or services.

Emergency medical condition means a *bodily injury* or *sickness* manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of that individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment of bodily functions; or
- Serious dysfunction of any bodily organ or part.

Employee means *you*, as an *employee*, when *you* are permanently employed and paid a salary or earnings and are in an *active status* at *your employer's* place of business, or *you* as a former *employee*, who is now a *retiree* as determined by *your employer*, except with regards to eligibility.

Employer means the sponsor of this *group* plan or any subsidiary or affiliate. An *employer* must either employ at least one common-law employee or be a partnership with a bona fide partner who provides services on behalf of the partnership. A business owner and his or her spouse are not considered common-law employees for this purpose if the entity is considered to be wholly owned by one individual or one individual and his or her spouse.

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:

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

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

- 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;

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

- 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 state or 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).

Free-standing facility means any licensed public or private establishment other than a *hospital*, which has permanent facilities equipped and operated to provide laboratory and diagnostic laboratory, *outpatient* radiology, *advanced imaging*, chemotherapy, inhalation therapy, radiation therapy, lithotripsy, physical, cardiac, speech and occupational therapy, or renal dialysis services.

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

G

Gender dysphoria refers to discomfort or distress that is caused by a discrepancy between a person's gender identity and that person's sex assigned at birth (and the associated gender role and/or primary and secondary sex characteristics). For a person to be diagnosed with gender dysphoria, there must be a marked difference between the individual's expressed/experienced gender and the gender others would assign him or her and it must continue for at least six months. This condition may cause clinically significant distress or impairment in social, occupational or other important areas of functioning.

H

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

Health care treatment facility means a facility, institution or clinic, duly licensed by the appropriate state agency to provide medical services, *behavioral health* services, and is primarily established and operating within the scope of its license.

Home health care agency means a *home health care agency* or *hospital*, which meets all of the following requirements:

- It must primarily provide skilled nursing services and other therapeutic services under the supervision of physicians or registered *nurses*;
- It must be operated according to established processes and procedures by a group of medical professionals, including *health care practitioner qualified providers* and *nurses*;
- It must maintain clinical records on all patients; and
- It must be licensed by the jurisdiction where it is located, if licensure is required. It must be operated according to the laws of that jurisdiction, which pertains to agencies providing home health care.

Hospital means an institution that meets all of the following requirements:

- It must provide, for a fee, medical care and treatment of sick or injured patients on an inpatient basis;
- It must provide or operate, either on its premises or in facilities available to the *hospital* on a pre-arranged basis, medical, diagnostic and surgical facilities;
- Care and treatment must be given by and supervised by physicians. Nursing services must be provided on a 24-hour basis and must be given by or supervised by registered nurses;
- It must be licensed by the laws of the jurisdiction where it is located. It must be operated as a *hospital* as defined by those laws; and

- It must not be primarily a:
  - Convalescent, rest or nursing home; or
  - Facility providing custodial, educational or rehabilitative care.

The *hospital* must be accredited by one of the following:

- The Joint Commission on the Accreditation of Hospitals;
- The American Osteopathic Hospital Association; or
- The Commission on the Accreditation of Rehabilitative Facilities.

I

Immune effector cell therapy means immune cells or other blood products that are engineered outside of the body and infused into a patient. *Immune effector cell therapy* may include acquisition, integral chemotherapy components and engineered immune cell infusion.

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:

- Group therapeutic sessions greater than one hour a day, three days a week;
- *Behavioral health* therapeutic focus;
- Group sessions centered on cognitive behavioral constructs, social/occupational/educational skills development and family interaction;
- Additional emphasis on recovery strategies, monitoring of participation in 12-step programs and random drug screenings for the treatment of *chemical dependency*; and
- Physician *Qualified provider* availability for medical and medication management.

Intensive outpatient program does not include services that are for:

- *Custodial care*; or
- Day care.

L

Late applicant means an *employee* and/or an *employee's* eligible *dependent* who applies for medical coverage more than 31 days after the *eligibility date*.

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

M

Maintenance care means services and supplies furnished mainly to:

- Maintain, rather than improve, a level of physical or mental function; or
- Provide a protected environment free from exposure that can worsen the *covered person's* physical or mental condition.

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

- The fee charged by the provider for the *services*;
- The fee that has been negotiated with the provider whether directly or through one or more intermediaries or shared savings contracts for the *services*;
- 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;
- The fee based upon rates negotiated by this Plan or other payors with one or more *network providers* in a geographic area determined by this Plan for the same or similar *services*;
- 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
- 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.

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 health care *services* that a *health care practitioner* exercising prudent clinical judgment would provide to his or her patient for the purpose of preventing, evaluating, diagnosing or treating a *sickness* or *bodily injury* or its symptoms. Such health care *service* must be:

- In accordance with generally accepted standards of medical practice;
- Clinically appropriate in terms of type, frequency, extent, site and duration, and considered effective for the patient's *sickness* or *bodily injury*;
- Neither sourced from a location, nor provided primarily for the convenience of the patient, physician or other health care provider;
- Not more costly than an alternative source, service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the patient's *sickness* or *bodily injury*; and
- Performed in the least costly site or sourced from, or provided by the least costly *qualified provider*.

For the purpose of *medically necessary*, generally accepted standards of medical practice means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations, the views of physicians practicing in relevant clinical areas and any other relevant factors.

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 services mean those diagnoses and treatments related to the care of a *covered person* who exhibits mental, nervous or emotional conditions classified in the Diagnostic and Statistical Manual of Mental Disorders.

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

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

N

Network facility means a *hospital*, *hospital outpatient* department or *ambulatory surgical center* that has been designated as such or has signed an agreement with *us* as an independent contractor, or has been designated by *us* to provide services to all *covered persons*. *Network facility* designation by Humana may be limited to specified services.

Network provider means a *hospital*, *health care treatment facility*, *health care practitioner*, or other health services provider who is designated as such or has signed an agreement with Humana as an independent contractor, or who has been designated by Humana to provide services to all *covered persons*. *Network provider* designation by Humana may be limited to specified services.

Network Provider Plan Maximum Out-of-Pocket Limit means the maximum amount of any *network 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 *plan year* before a benefit percentage for *network provider covered expenses* will be increased. The *network provider out-of-pocket limit* apply toward the *network provider Plan maximum out-of-pocket limit*. Once the *network provider Plan maximum out-of-pocket limit* is met, any remaining *network provider* medical *out-of-pocket limit* will be waived for the remainder of the *year*. Any applicable *preauthorization* penalties do not apply to the *network provider Plan maximum out-of-pocket limit*.

Non-network provider means a *hospital*, *health care treatment facility*, *health care practitioner*, or other health services provider who has not been designated by Humana as a *network provider*.

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

O

Observation status means *hospital* outpatient *services* provided to *you* to help the *health care qualified provider* decide if *you* need to be admitted as an *inpatient*.

Originating site means the location of a *covered person* at the time a *telehealth* or *telemedicine* service is being furnished.

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 provider*.

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.

Outpatient means *you* are not *confined* as a registered bed patient.

Outpatient surgery means *surgery* performed in a *health care practitioner's* office, *ambulatory surgical center*, or the *outpatient* department of a *hospital*.

P

Palliative care means care given to a *covered person* to relieve, ease, or alleviate, but not to cure, a *bodily injury* or *sickness*.

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

- Has a comprehensive and intensive interdisciplinary psychiatric treatment for minimum of 5 hours a day, 5 days per week under the supervision of a psychiatrist for *mental health services* or a psychiatrist or addictionologist for *chemical dependency*, and patients are seen by a psychiatrist or addictionologist, as applicable, at least once a week;

- 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

- Has physicians and appropriately licensed *behavioral health* and *substance abuse* practitioners readily available for the emergent and urgent *service* 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.

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 drugs* medications are dispensed by a *pharmacist.*

Plan Administrator means Kenosha County.

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*.

Plan Sponsor means Kenosha County.

Plan year means a period of time beginning on the Plan anniversary date of any year and ending on the day before the same date of the succeeding year.

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.

Preauthorization means approval by the Plan, or its designee, of a service prior to it being provided. Certain services require medical review by the Plan in order to determine eligibility for coverage.

Preauthorization is granted when such a review determines that a given *service* is a *covered expense* according to the terms and provisions of this Plan.

Predetermination of benefits means a review by Humana of a *qualified provider'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 *prescription* must be written by a *qualified provider* and provided to a *pharmacist* for *your* benefit and used for the treatment of a *sickness* or *bodily injury* which is covered under this plan. The drug, medicine or medication must be obtainable only by *prescription*. The *prescription* may be given to a *pharmacist* verbally, electronically or in writing by a *health care practitioner*. The *prescription* must include at least:

- *Your* name;
- The type and quantity of the drug, medicine or medication prescribed, and the directions for its use;
- The date the *prescription* was prescribed; and
- The name and address of the prescribing *qualified provider*.

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.

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 *network provider* that includes a provider payment arrangement.

Q

Qualified payment amount means the lesser of:

- Billed charges; or
- The median of the contracted rates negotiated by Humana with three or more *network providers* in the same geographic area for the same or similar services.

If sufficient information is not available for Humana to calculate the median of the contracted rates, the rate established by Humana through use of any database that does not have any conflict of interest and has sufficient information reflecting allowed amounts paid to a *qualified provider* for relevant services furnished in the applicable geographic region.

The *qualified payment amount* applies to *covered expenses* when *you* receive the following services from a *non-network provider*:

- *Emergency care* and *air ambulance* services;
- *Ancillary services* while *you* are at a *network facility*;
- Services that are not considered *ancillary services* while *you* are at a *network facility*, and *you* did not consent to the *non-network provider* to obtain such services; or
- *Post-stabilization services* when *you* do not consent to the *non-network provider* to obtain such services; and

- *Post-stabilization services* when:
    - The attending *qualified provider* determines *you* are not able to travel by non-medical transportation to obtain services from a *network provider*; and
    - *You* do not consent to the *non-network provider* to obtain such services.

Qualified provider means a person, facility, supplier or any other health care provider:

- That is licensed by the appropriate state agency to:
    - Diagnose, prevent or treat a *bodily injury* or *sickness*; or
    - Provide preventive *services*.

A *qualified provider* must provide *services* within the scope of their license and their primary purpose must be to provide health care *services*.

R

Residential treatment facility means an institution which:

- Is licensed as a 24-hour residential facility for *behavioral health treatment* and *substance abuse* treatment, although not licensed as a *hospital*;
- Provides a multidisciplinary treatment plan in a controlled environment, under the supervision of a physician who is able to provide treatment on a daily basis;
- Provides supervision and treatment by a Ph.D. psychologist, licensed therapist, psychiatric nursing staff or registered nurse;
- Provides programs such as social, psychological, family counseling and rehabilitative training, age appropriate for the special needs of the age group of patients, with focus on reintegration back into the community; and
- Provides structured activities throughout the day and evening.

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

Retiree means *you* as a former *employee*, who meets the requirements for retirement as determined by *your employer*.

Retail Clinic means a *qualified treatment facility*, located in a retail store, that is often staffed by *nurse providers* and physician assistants who provide minor medical services on a "walk-in" basis (no appointment required).

Room and board means all charges made by a *hospital* or other *health care treatment facility* on its own behalf for room and meals and all general services and activities needed for the care of registered bed patients.

S

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

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

Skilled nursing facility means a licensed institution (other than a *hospital*, as defined) which meets all of the following requirements:

- It must provide permanent and full-time bed care facilities for resident patients;
- It must maintain, on the premises and under arrangements, all facilities necessary for medical care and treatment;
- It must provide such services under the supervision of physicians at all times;
- It must provide 24-hours-a-day nursing services by or under the supervision of a registered nurse; and
- It must maintain a daily record for each patient.

A *skilled nursing facility* is not, except by incident, a rest home, a home for the care of the aged.

Sound natural tooth means a tooth that:

- Is organic and formed by the natural development of the body (not manufactured, capped, crowned or bonded);
- Has not been extensively restored;
- Has not become extensively decayed or involved in periodontal disease; and
- Is not more susceptible to injury than a whole natural tooth (for example a tooth that has not been previously broken, chipped, filled, cracked or fractured).

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

- Be injected, infused or require close monitoring by a *health care provider* or clinically trained individual;
- Require nursing services or special programs to support patient compliance;
- Require disease-specific treatment programs;
- Have limited distribution requirements; or
- Have special handling, storage or shipping requirements

Stem cell means the transplant of human blood precursor cells. 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, from a matched related or unrelated donor, or cord blood. The *stem cell* transplant includes the harvesting, integral chemotherapy components and the *stem cell* infusion. A *stem cell* transplant is commonly referred to as a bone marrow transplant.

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

- Be injected, infused or require close monitoring by a *qualified provider* or clinically trained individual;
- Require nursing services or special programs to support patient compliance;
- Require disease-specific treatment programs;
- 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.

Summary Plan Description (SPD) means this document which outlines the benefits, provisions and limitations of this Plan.

Surgery means procedures categorized as Surgery in either the:

- Current Procedural Terminology (CPT) manuals published by the American Medical Association; or
- Healthcare Common Procedure Coding System (HCPCS) Level II manual published by the Centers for Medicare & Medicaid Services (CMS).

The term *surgery* includes, but is not limited to:

- Excision or incision of the skin or mucosal tissues;
- Insertion for exploratory purposes into a natural body opening;
- Insertion of instruments into any body opening, natural or otherwise, done for diagnostic or other therapeutic purposes;
- Treatment of fractures;
- Procedures to repair, remove or replace any body part or foreign object in or on the body; and
- Endoscopic procedures.

Surgical assistant means a *health care provider* who assists at *surgery* and is not a Doctor of Medicine (MD), Doctor of Osteopathic Medicine (DO) or Doctor of Podiatric Medicine (DPM), or where state law does not require that specific *health care providers* be treated and reimbursed the same as an MD, DO or DPM.

T

Telehealth means services, other than *telemedicine*, provided via telephonic or electronic communications. *Telehealth* services must comply with the following, as applicable

- Federal and state licensure requirements;
- Accreditation standards; and
- Guidelines of the American Telemedicine Association or other qualified medical professional societies to ensure quality of care.

Telemedicine means audio and video real-time interactive communication between a *covered person* at an *originating site* and a *qualified provider* at a *distant site*. *Telemedicine* services must comply with the following, as applicable:

- Federal and state licensure requirements;
- Accreditation standards; and
- Guidelines of the American Telemedicine Association or other qualified medical professional societies to ensure quality of care.

Timely applicant means an *employee* and/or an *employee's* eligible *dependent* who applies for medical coverage within 31 days of the *eligibility date*.

Total disability *or* ***totally disabled*** means *your* continuing inability, as a result of a *bodily injury* or *sickness*, to perform the material and substantial duties of any job for which *you* are or become qualified by reason of education, training or experience.

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

U

Urgent care means health care services provided on an *outpatient* basis for an unforeseen condition that usually requires attention without delay but does not pose a threat to life, limb or permanent health of the *covered person.*

Urgent care center means any licensed public or private non-*hospital free-standing facility* which has permanent facilities equipped to provide *urgent care services.*

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

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

- 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.

- Generally, whether a claim is a claim involving urgent care will be determined by the *Plan Manager*. However, any claim that a physician with knowledge of a *claimant's* medical condition determines is a "claim involving urgent care" will be treated as a "claim involving urgent care."

Urgent care services means those health care services that are appropriately provided for an unforeseen condition of a kind that usually requires attention without delay but that does not pose a threat to life, limb or permanent health of the *covered person*.

V

Virtual visit means *telehealth* or *telemedicine* services.

Y

You and your means any *covered person*

SECTION 7

PRESCRIPTION DRUG BENEFIT

PRESCRIPTION DRUG BENEFIT

All defined terms used in this "Prescription Drug Benefit" section have the same meaning given to them in the "Definitions" section of this *Summary Plan Description*, unless otherwise specifically defined below.

DEFINITIONS

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

Brand name medication means a drug, medicine or medication that is manufactured and distributed by only one pharmaceutical manufacturer, or any drug product that has been designated as brand name by an industry-recognized source used by Serve You Rx.

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 applicable *copayment* and/or percentage amount that *you* must pay per *prescription* drug or refill.

Default rate means the rate or amount equal to the *Medicare* reimbursement rate for the *prescription* 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 Serve You Rx.

Generic medication means a drug, medicine or medication that is manufactured, distributed, and available from a pharmaceutical manufacturer and identified by the chemical name, or any drug product that has been designated as generic by an industry-recognized source used by Serve You Rx.

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

Mail order pharmacy means a *pharmacy* that provides covered *mail order pharmacy* services, as defined by Serve You Rx, 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 Serve You Rx or has NOT been designated by Serve You Rx to provide covered *pharmacy* services, covered *specialty pharmacy* services or covered *mail order pharmacy* services, as defined by Serve You Rx, to *covered persons*, including covered *prescriptions* or refills delivered to *your* home.

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:

- Affects less than 200,000 persons in the United States; or
- 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 Serve You Rx or has been designated by Serve You Rx to provide covered *pharmacy services*, covered *specialty pharmacy* services or covered *mail order pharmacy* services, as defined by Serve You Rx, 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 provider* 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 provider*. The *prescription* must include at least:

- *Your* name;
- The type and quantity of the drug, medicine or medication prescribed, and the directions for its use;
- The date the *prescription* was prescribed; and
- The name and address of the prescribing *qualified provider*.

Prior authorization means the required prior approval from Serve You Rx for the coverage of *prescription* drugs, medicines and medications, *specialty drugs* including the dosage, quantity and duration, as *medically necessary* for the *covered person'*. Certain *prescription* drugs, medicines or medications may require *prior authorization*. Visit Serve You Rx Website at www.serveyourx.com or call the toll-free customer service telephone number listed on *your* Humana ID 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 pharmacy means a *pharmacy* that provides covered *specialty pharmacy* services, as defined by Serve You Rx, to *covered persons*.

Tier 1 drugs means a category of *prescription* drugs, medicines or medications within the *drug list* that are designated by Serve You Rx as *Tier 1 drugs*.

Tier 2 drugs means a category of *prescription* drugs, medicines or medications within the *drug list* that are designated by Serve You Rx as *Tier 2 drugs*.

Tier 3 drugs means a category of *prescription* drugs, medicines or medications within the *drug list* that are designated by Serve You Rx as *Tier 3 drugs*.

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

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:

- Be injected, infused or require close monitoring by a *qualified providers* or clinically trained individual;
- Require nursing services or special programs to support patient compliance;
- Require disease-specific treatment programs;
- Have limited distribution requirements; Require fulfillment through Serve You Direct Rx Specialty pharmacy; or
- Have special handling, storage or shipping requirements.

SCHEDULE OF PRESCRIPTION DRUG BENEFITS

Additional drug information can be obtained by accessing Serve You Rx website at www.serveyourx.com or calling the toll-free customer service number on the back *your* ID card.

RETAIL PHARMACY AND SPECIALTY PHARMACY	
***Prescription* drugs are subject to the *network provider* medical *deductible* and *out-of-pocket limit* provisions as outlined on the Medical Schedule of Benefits. Once the combined medical and *prescription* drug combined *deductibles* are met, *prescription* drugs will be subject to the *copayments* as outlined below.** ***Prescription* drug *copayments* will apply toward the combined medical and *prescription* drug *out-of-pocket limits*.**	
Tier 1 Drugs	$12 *copayment* per *prescription* or refill per 30 day supply
Tier 2 Drugs	$35 *copayment* per *prescription* or refill per 30 day supply
Tier 3 Drugs	$60 *copayment* per *prescription* or refill per 30 day supply
Covered Vaccines	No *cost share*
Drugs, Medicines or Medications on the Women's Healthcare Drug List (with a *prescription* from a *qualified provider*)	No *cost share*
Health Care Reform Preventive Medications	No *cost share*
Oral Chemo Medications	Applicable *cost share* with $100 maximum

90-DAYS AT RETAIL PHARMACY AND SPECIALTY PHARMACY	
Some retail *pharmacies* and *specialty pharmacies* participate in a program which allows *you* to receive a 90 day supply of a *prescription* or refill. *Your* cost is outlined below. Self-administered *specialty drugs* may be limited to a 30 day supply from a retail or *specialty pharmacy,* as determined by this Plan. ***Prescription* drugs are subject to the *network provider* medical *deductible* and *out-of-pocket limit* provisions as outlined on the Medical Schedule of Benefits. Once the combined medical and *prescription* drug combined *deductibles* are met, *prescription* drugs will be subject to the *copayments* as outlined below.** ***Prescription* drug *copayments* will apply toward the combined medical and *prescription* drug *out-of-pocket limits*.**	
Tier 1 Drugs	$24 *copayment* per *prescription* or refill per 90 day supply
Tier 2 Drugs	$70 *copayment* per *prescription* or refill per 90 day supply
Tier 3 Drugs	$120 *copayment* per *prescription* or refill per 90 day supply
Health Care Reform Preventive Medications	No *cost share*
Drugs, Medicines or Medications on the Women's Healthcare Drug List (with a *prescription* from a *qualified provider*)	No *cost share*
Oral Chemo Medications	Applicable *cost share* with $200 maximum

MAIL ORDER PHARMACY	
***Prescription* drugs are subject to the *network provider* medical *deductible* and *out-of-pocket limit* provisions as outlined on the Medical Schedule of Benefits. *Prescription* drug *copayments* will apply toward the combined medical and *prescription* drug *out-of-pocket limit*.** ***Prescription* drug *copayments* will apply toward the combined medical and *prescription* drug *out-of-pocket limit*.**	
Tier 1 Drugs	$24 *copayment* per *prescription* or refill per 90 day supply
Tier 2 Drugs	$70 *copayment* per *prescription* or refill per 90 day supply
Tier 3 Drugs	$120 *copayment* per *prescription* or refill per 90 day supply
Drugs, Medicines or Medications on the Women's Healthcare Drug List (with a *prescription* from a *qualified provider*)	Health Care Reform Preventive Medications
Health Care Reform Preventive Medications	No *cost share*
Oral Chemo Medications	Applicable *cost share* with $200 maximum
Self-administered *specialty drugs* are limited to a 30 day supply from Serve you Direct Rx specialty pharmacy or a limited distribution provider, as determined by this Plan.	

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 provider's* office through Humana Specialty Pharmacy	Payable under the medical plan, subject to any applicable *network provider* medical *deductible*, *coinsurance*, and *out-of-pocket limit* provisions as follows: 100% after *participating pharmacy deductible*

ADDITIONAL PRESCRIPTION DRUG BENEFIT INFORMATION

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 price of the *prescription* or refill at the time it is dispensed and submit the *pharmacy* receipt to Serve You Rx at the address listed below. *You* will be reimbursed at 100% of billed charges after the charge has been reduced by any applicable *cost share*.

Non-participating Pharmacy

When a *non-participating pharmacy* is used, *you* must pay the *pharmacy* the full price of the *prescription* or refill at the time it is dispensed and submit the *pharmacy* receipt to Serve You Rx at the address listed below. *You* will be reimbursed at the *default rate*, after the charge has been reduced by the applicable *cost share*. *You* are responsible for 100% of the difference between the *default rate* and the *non-participating pharmacy's* charge. The charge received from a *non-participating pharmacy* for a *prescription* or refill may be higher than the *default rate*.

Mail *pharmacy* receipts to:

Serve You Rx
Attention: Member Reimbursement
10201 West Innovation Drive, Suite 600
Milwaukee, WI 53226
Fax: (800) 480-4840

PRIOR AUTHORIZATION

Some *prescription* drugs may be subject to *prior authorization*. To verify if a *prescription* drug requires *prior authorization*, call the toll-free customer service Serve You RX telephone number listed on *your* Humana ID card. The following drugs require *prior authorization*:

- Anabolic steroids;
- Growth hormones;
- Progesterone crystals/powders;
- Anti-obesity drugs; and
- Anorexients.

DISPENSING LIMITS

Some *prescription* drugs may be subject to *dispensing limits*. To verify if a *prescription* drug has *dispensing limits*, call the toll-free Serve You RX customer service telephone number listed on *your* Humana ID card. The following drugs have *dispensing limits*:

- Migraine medications;
- Sleeping Aids; and
- Impotence agents.

RETAIL PHARMACY AND SPECIALTY PHARMACY

Your Plan provisions include a retail *prescription* drug benefit.

Present *your* Humana 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".

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 provider* 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 Serve You Rx at the toll-free customer service telephone number on *your* Humana ID card or by visiting Serve You Rx website at www.serveyourx.com.

OFFICE-ADMINISTERED SPECIALTY DRUGS

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

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:

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

PRESCRIPTION DRUG COVERAGE

Because Serve You Rx *drug list* is continually updated with *prescription* drugs approved or not approved for coverage, *you* must contact Serve You Rx by calling the toll-free customer service Serve You Rx telephone number listed on *your* Humana ID card or by visiting Serve You Rx website at www.serveyourx.com to verify whether a *prescription* drug is covered or not covered under the *prescription* drug benefits.

Covered *prescription* drugs, medicine or medications must:

- Be prescribed by a *qualified provider* for the treatment of a *sickness* or *bodily injury*; and
- Be dispensed by a *pharmacist*.

Prescription drug *covered expenses* aggregate toward any applicable medical and *prescription* drug *Participating pharmacy deductibles* and *out-of-pocket limits* outlined in the "Medical Schedule of Benefits" section. *Prescription* drug expenses do not apply toward any applicable medical and *prescription* drug *Non-Participating pharmacy deductibles* or *out-of-pocket limits* outlined in the Medical Schedule of Benefits section.

Serve You Rx 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:

- Any drug, medicine, medication or supply not approved for coverage under this Plan. Contact Serve You Rx by calling the toll-free customer service telephone number listed on *your* Humana ID card or by visiting Serve You Rx website at www.serveyourx.com to verify whether a *prescription* drug is covered or not covered under this Plan. *Your* Humana ID card can be used as a discount card for *prescription* drugs not covered under this Plan;
- *Legend drugs* which are not deemed *medically necessary* by a *qualified provider*;
- Charges for the administration or injection of any drug;
- 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*;
- Any drug, medicine or medication that is consumed or injected at the place where the *prescription* is given, or dispensed by the *qualified provider*;

- *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:
  - *Hospital*;
  - Skilled nursing facility; or
  - Hospice facility;

- Any drug prescribed, except:
  - FDA approved drugs utilized for FDA approved indications; or
  - 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;

- *Off-evidence drug indications*;

- *Prescription* refills:
  - In excess of the number specified by the *qualified provider*; or
  - Dispensed more than one year from the date of the original order;

- Any drug for which a charge is customarily not made;

- 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;

- 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);

- Drug delivery implants;

- 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 Plan;

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

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

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

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

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

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

- Repackaged drugs;

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

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

- 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*;

- Any amount exceeding the *default rate*;

- 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*;

- Any drug for which *prior authorization* is required and not obtained;

Based on the dosage schedule prescribed by the *qualified provider*, more than one *prescription* or refill for the same drug or therapeutic equivalent medication prescribed by one or more *qualified providers* 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. If the drug or therapeutic equivalent medication is purchased through a retail *pharmacy* or *specialty pharmacy* that participates in the program which allows *you* to receive a 90 day supply of a *prescription* or refill at a retail *pharmacy* or *specialty pharmacy*, until *you* have used, or should have used, at least 66% of the previous *prescription* or refill.

Administered by:

Humana

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