Humana®

Discrimination is Against the Law

Humana Inc. and its subsidiaries comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, gender identity, or religion. Humana Inc. and its subsidiaries do not exclude people or treat them differently because of race, color, national origin, age, disability, sex, sexual orientation, gender identity, or religion.

Humana Inc. and its subsidiaries provide:

- 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.

- Free language services to people whose primary language is not English when those services are necessary to provide meaningful access, such as translated documents or oral interpretation.

If you need these services, call the number on your ID card or if you use a TTY, call 711.

If you believe that Humana Inc. and its subsidiaries have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, sexual orientation, gender identity, or religion, you can file a grievance with:

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 the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**

Multi-Language Interpreter Services

English: 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).

Español (Spanish): 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).

繁體中文 (Chinese): 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）。

Tiếng Việt (Vietnamese): 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).

한국어 (Korean): 주의 : 한국어를 사용하시는 경우 , 언어 지원 서비스를 무료로 이용하실 수 있습니다 . ID 카드에 적혀 있는 번호로 전화해 주십시오 (TTY: 711).

Tagalog (Tagalog – Filipino): 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).

Русский (Russian): ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Наберите номер, указанный на вашей карточке-удостоверении (телетайп: 711).

Kreyòl Ayisyen (French Creole): 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).

Français (French): 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).

Polski (Polish): UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Proszę zadzwonić pod numer podany na karcie identyfikacyjnej (TTY: 711).

Português (Portuguese): ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para o número presente em seu cartão de identificação (TTY: 711).

Italiano (Italian): 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).

Deutsch (German): ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Wählen Sie die Nummer, die sich auf Ihrer Versicherungskarte befindet (TTY: 711).

日本語 (Japanese): 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)。

فارسی (Farsi):

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).

Diné Bizaad (Navajo): 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 nééh ho'dólzin bikáá'ígíí bee hólne' (TTY: 711).

العربية (Arabic):

ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم الهاتف الموجود على بطاقة الهوية الخاصة بك (رقم هاتف الصم والبكم: 711).

Humana.

SUMMARY PLAN DESCRIPTION

For the

EHDHP NPOS MEDICAL AND PRESCRIPTION DRUG PLAN

Sponsored by

Specialty Composites Group, LTD

Group Number: 737070
Package ID: SF500838

Effective: 12/01/2018

This Summary Plan Description (SPD): Welcome to *your employer*-sponsored health care plan (Plan) administered by Humana Health Plan, Inc. (Humana). *Your employer* has provided *you* with this *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 "Schedule of Benefits", "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 call Humana at the toll-free customer service telephone number on *your* Humana Identification (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.

Customer Service Telephone Number: Please refer to *your* Humana Identification (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

TABLE OF CONTENTS

Page Number

UNDERSTANDING YOUR COVERAGE

As *you* read this *Summary Plan Description (SPD)*, *you* will see some words are printed in italics. Italicized words may have different meanings in this *SPD* than in general. Refer to the "Glossary" sections for the meaning of the italicized words as they apply to *your* plan.

The *SPD* gives *you* information about *your* plan. It tells *you* what is covered and what is not covered. It also tells *you* what *you* must do and how much *you* must pay for services. *Your* plan covers many services, but it is important to remember it has limits. Be sure to read *your SPD* carefully before using *your* benefits.

Covered and non-covered expenses

This Plan will provide coverage for services, equipment and supplies that are *covered expenses*. All requirements of this Plan apply to *covered expenses*.

The date used on the bill Humana receives for *covered expenses* or the date confirmed in *your* medical records is the date that will be used when *your* claim is processed to determine the benefit period.

You must pay the health care provider any amount due that this Plan does not pay. Not all services and supplies are a *covered expense*, even when they are ordered by a *health care practitioner*.

Refer to the "Schedule of Benefits", the "Covered Expenses" and the "Limitations and Exclusions" sections and any amendment attached to the *SPD* to see when services or supplies are *covered expenses* or are non-covered expenses.

How this Plan works

You may have to pay a *deductible* before this Plan will pay for certain *covered expenses*. If a *deductible* applies, and it is met, this Plan will pay *covered expenses* at the *coinsurance* amount. Refer to the "Schedule of Benefits" to see when the *deductible* applies and the *coinsurance* amount this Plan pay. *You* will be responsible for the *coinsurance* amount this Plan does not pay.

If an *out-of-pocket limit* applies and it is met, this Plan will pay *covered expenses* at 100% the rest of the *year*, subject to the *maximum allowable fee*.

This Plan's payment for *covered expenses* is calculated by applying any *deductible* and *coinsurance* to what this Plan will allow. For a *covered expense*, this Plan will allow the total amount billed by the *qualified provider*, less any amounts such as:

- Those negotiated by contract, directly or indirectly, between this Plan and the *qualified provider*;
- Those in excess of the *maximum allowable fee*; or
- Adjustments related to this Plan's claims processing procedures.

The service and diagnostic information submitted on the *qualified provider's* bill will be used to determine which provision of the "Schedule of Benefits" applies.

Your choice of providers affects your benefits

This Plan will pay a higher percentage most of the time if *you* see a *network provider,* so the amount *you* pay will be lower. *You* must pay any *copayment*, *deductible* or *coinsurance* to the *network provider*. Be sure to check if *your qualified provider* is a *network provider* before seeing them.

This Plan may appoint certain *network providers* for certain kinds of services. If *you* do not see the appointed *network provider* for these services, this Plan may pay less.

This Plan will pay a lower percentage if *you* see a *non-network provider*, so the amount *you* pay will be higher. *Non-network providers* have not signed an agreement with this Plan for lower costs for services and they may bill *you* for any amount over the *maximum allowable fee*. *You* will have to pay this amount and any *copayment*, *deductible* and *coinsurance* to the *non-network provider*. Any amount *you* pay over the *maximum allowable fee* will not apply to *your deductible* or any *out-of-pocket limit*.

Some *non-network providers* work with *network hospitals*. This Plan will apply the *network provider copayment, deductible* and *coinsurance* to *covered expenses* received by non-network pathologists, anesthesiologists, radiologists and emergency room physicians working with *network hospitals*. However, *you* may still have to pay these *non-network providers* any amount over the *maximum allowable fee*. If possible, *you* may want to check if all health care providers working with *network hospitals* are *network providers.*

Refer to the "Schedule of Benefits" sections to see what *your network provider* and *non-network provider* benefits are.

How to find a network provider

You may find a list of *network providers* at www.humana.com. This list is subject to change. Please check this list before receiving services from a *qualified provider*. *You* may also call *Humana's* customer service department at the number listed on *your* ID card to determine if a *qualified provider* is a *network provider*, or this Plan can send the list to *you*. A *network provider* can only be confirmed by this Plan.

How to use your point of service (POS) plan

You may receive services from a *network provider* or a *non-network provider* without a referral. Refer to the "Schedule of Benefits" for any *preauthorization* requirements.

Seeking emergency care

If *you* need *emergency care*:

- Go to the nearest *network hospital* emergency room; or
- Find the nearest *hospital* emergency room if *your* condition does not allow *you* to go to a *network hospital*.

You, or someone on *your* behalf, must call Humana within 48 hours after *your admission* to a *non-network hospital* for *emergency care*. If *your* condition does not allow *you* to call Humana within 48 hours after *your admission*, contact Humana as soon as *your* condition allows. This Plan may transfer *you* to a *network hospital* in the *service area* when *your* condition is stable. *You* must receive services from a *network provider* for any follow-up care for the *network provider copayment, deductible* or *coinsurance* to apply.

Seeking urgent care

If *you* need *urgent care*, go to the nearest network *urgent care center* to receive the *network provider* benefit. *You* must receive services from a *network provider* for any follow-up care for the *network provider copayment, deductible* or *coinsurance* to apply.

This Plan's relationship with qualified providers

Qualified providers are not this Plan's agents, employees or partners. All providers are independent contractors. *Qualified providers* make their own clinical judgments or give their own treatment advice without coverage decisions made by this Plan.

This Plan will not change what is decided between *you* and *qualified providers* regarding *your* medical condition or treatment options. *Qualified providers* act on *your* behalf when they order services. *You* and *your qualified providers* make all decisions about *your* health care, no matter what this Plan covers. This Plan is not responsible for anything said or written by a *qualified provider* about *covered expenses* and/or what is not covered under this *SPD*. Call Humana's customer service department at the telephone number listed on *your* ID card if *you* have any questions.

This Plan's financial arrangements with network providers

This Plan have agreements with *network providers* that may have different payment arrangements:

- Many *network providers* are paid on a discounted fee-for-services basis. This means they have agreed to be paid a set amount for each *covered expense*;

- Some *qualified providers* may have capitation agreements. This means the *qualified provider* is paid a set dollar amount each month to care for each *covered person* no matter how many services a *covered person* may receive from the *qualified provider*, such as a primary care physician or a specialist;

- *Hospitals* may be paid on a Diagnosis Related Group (DRG) basis or a flat fee per day basis for *inpatient* services. *Outpatient* services are usually paid on a flat fee per service or procedure or a discount from their normal charges.

SCHEDULE OF BENEFITS

Reading this "Schedule of Benefits" section will help *you* understand:

- The level of benefits generally paid for *covered expenses*;
- The amounts of *copayments* or *coinsurance you* are required to pay;
- The services that require *you* to meet a *deductible*, if any, before benefits are paid; and
- *Preauthorization* requirements.

This "Schedule of Benefits" outlines the coverage and limitations provided under this Plan. A more detailed explanation of *your* coverage and its limitations and exclusions for these benefits is provided in the "Covered Expenses" and "Limitations and Exclusions" sections of this *SPD*. Please refer to any applicable riders for additional coverage and limitations.

The benefits outlined under the "Schedule of Benefits – Behavioral Health," "Schedule of Benefits – Transplant Services" and "Schedule of Benefits – Pharmacy Services" sections are not payable under any other Schedule of Benefits of the *policy*. However, all other terms and provisions of the *policy* apply, including the *preauthorization* requirements, annual *deductible(s)* and any *out-of-pocket limit(s)*, unless otherwise stated.

Network provider verification

This *SPD* contains multiple benefit levels. Refer to each Schedule of Benefits to see what benefit levels apply to *covered expenses*.

Refer to the Online Provider Finder on Humana's Website at www.humana.com for a list of *network providers*. *You* may also contact Humana's customer service department at the telephone number shown on *your* ID card. This list is subject to change.

Preauthorization requirements and penalty

Preauthorization by Humana is required for certain services and supplies. Visit Humana's Website at www.humana.com or call the customer service telephone number on *your* identification card to obtain a list of services and supplies that require *preauthorization*. 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.

You are responsible for informing *your health care practitioner* of the *preauthorization* requirements. *You* or *your health care practitioner* must contact Humana by telephone, or *electronic mail*, or in writing to request the appropriate authorization. *Your* identification card will show the *health care practitioner* the telephone number to call to request authorization. Benefits are not paid at all for services or supplies that are not *covered expenses*.

If any required *preauthorization* of services or supplies is not obtained, the benefit payable for any *covered expenses* incurred for the services, will be reduced to 50%, after any applicable *deductibles* or *copayments*. If the rendered services are not *covered expenses*, no benefits are payable. The out-of-pocket amounts incurred by *you* due to these benefit reductions may not be used to satisfy any *out-of-pocket limits*. This *preauthorization* penalty will apply if *you* received the services from either a *network provider* or a *non-network provider* when *preauthorization* is required and not obtained.

Annual deductible

An annual *deductible* is a specified dollar amount that *you* must pay for *covered expenses* per *year* before most benefits will be paid under this Plan. There are individual and family *network provider* and *non-network provider deductibles* addressed under both this *SPD*. The *deductible* amount(s) for each *covered person* and each covered family are as follows, and must be satisfied each *year*, either individually or combined as a covered family. Once the family *deductible* is met as specified in this *SPD*, any remaining *deductible* for a *covered person* in the family will be waived for that *year*.

Any expense incurred by *you* for *covered expenses* provided by a *network provider* under this *SPD* or by a *network provider* will be applied to the *network provider deductible* as stated in this *SPD*. Any expense incurred by *you* for *covered expenses* provided by a *non-network provider* will be applied to the *non-network provider deductible*.

Deductible	**Deductible amount**
Individual *network provider deductible*	$5,500
Family *network provider deductible*	$11,000
Individual *non-network provider deductible*	$16,500
Family *non- network provider deductible*	$33,000

Maximum out-of-pocket limit

The *out-of-pocket limit* is the maximum amount of any *copayments*, *deductibles* and *coinsurance* for *covered expenses*, which must be paid by *you*, either individually or combined as a covered family, per *year* before a benefit percentage for *covered expenses* will be increased. There are individual and family *network provider* and *non-network provider out-of-pocket limits*.

After the individual *network provider out-of-pocket limit* addressed under this *SPD* and has been satisfied in a *year*, the *network provider* benefit percentage for *covered expenses*, for that *covered person* will be payable at the rate of 100% for the rest of the *year,* subject to any maximum benefit and all other terms, provisions, limitations and exclusions of this Plan. After the family *network provider out-of-pocket limit* addressed under this *SPD* and has been satisfied in a *year*, the *network provider* benefit percentage for *covered expenses*, will be payable at the rate of 100% for the rest of the *year,* subject to any maximum benefit and all other terms, provisions, limitations and exclusions of this Plan.

After the individual *non-network provider out-of-pocket limit* has been satisfied in a *year*, the *non-network provider* benefit percentage for *covered expenses* for that *covered person* will be payable at the rate of 100% for the rest of the *year,* subject to any maximum benefit and all other terms, provisions, limitations and exclusions of this Plan. After the family *non-network provider out-of-pocket limit* has been satisfied in a *year*, the *non-network provider* benefit percentage for *covered expenses* will be payable at the rate of 100% for the rest of the *year*, subject to any maximum benefit and all other terms, provisions, limitations and exclusions of this Plan.

Any expense incurred by *you* for *covered expenses* provided by a *network provider* under this *SPD* or by a *network provider* will be applied to the *network provider out-of-pocket limit* as stated in this *SPD*. Any expense incurred by *you* for *covered expenses* provided by a *non-network provider* will be applied to the *non-network provider out-of-pocket limit*.

If any *copayment*, *deductible* or *coinsurance* amount applied to *your* claim is waived by *your* health care provider, *you* are required to inform *us*. Any amount, thus waived and not paid by *you*, would not apply to any *out-of-pocket limit*.

Out-of-pocket expenses for covered transplants provided by a *non-network provider* and *prescriptions* and *specialty drugs* obtained from a *non-network pharmacy* or non-network *specialty pharmacy*, and *specialty drugs* provided by or obtained from a *non-network provider* do not apply towards any *out-of-pocket limit*.

Maximum out-of-pocket limit	**Maximum out-of-pocket limit amount**
Individual *network provider out-of-pocket limit*	$6,550
Family *network provider out-of-pocket limit*	$13,100
Individual *non-network provider out-of-pocket limit*	$19,650
Family *non-network provider out-of-pocket limit*	$39,300

Preventive services

Includes prostate screenings (PSA). Does not include drugs, medicines or medications and supplies on the Preventive Medication Coverage *drug list*. Refer to the Pharmacy Services sections in this *SPD*.

Network provider	100% benefit payable
Non-network provider	50% benefit payable after *non-network provider deductible*

Health care practitioner office services

Health care practitioner office visit

Level 1 network health care practitioner	70% benefit payable after *network provider deductible*
Level 2 network health care practitioner	70% benefit payable after *network provider deductible*
Non-network health care practitioner	50% benefit payable after *non-network provider deductible*

Diagnostic laboratory and radiology services when performed in the office and billed by the health care practitioner

Does not include *advanced imaging*. Refer to "Advanced imaging when performed in a health care practitioner's office" in this "Schedule of Benefits" section.

Level 1 network health care practitioner	70% benefit payable after *network provider deductible*
Level 2 network health care practitioner	70% benefit payable after *network provider deductible*
Non-network health care practitioner	50% benefit payable after *non-network provider deductible*

Advanced imaging when performed in a health care practitioner's office

Level 1 network health care practitioner	70% benefit payable after *network provider deductible*
Level 2 network health care practitioner	70% benefit payable after *network provider deductible*
Non-network health care practitioner	50% benefit payable after *non-network provider deductible*

Allergy serum when received in the health care practitioner's office

Level 1 network health care practitioner	70% benefit payable after *network provider deductible*
Level 2 network health care practitioner	70% benefit payable after *network provider deductible*
Non-network health care practitioner	50% benefit payable after *non-network provider deductible*

Allergy injections when received in a health care practitioner's office

Level 1 network health care practitioner	70% benefit payable after *network provider deductible*
Level 2 network health care practitioner	70% benefit payable after *network provider deductible*
Non-network health care practitioner	50% benefit payable after *non-network provider deductible*

Injections other than allergy when received in a health care practitioner's office

Level 1 network health care practitioner	70% benefit payable after *network provider deductible*
Level 2 network health care practitioner	70% benefit payable after *network provider deductible*
Non-network health care practitioner	50% benefit payable after *non-network provider deductible*

Surgery performed in the office and billed by the health care practitioner

Level 1 network health care practitioner	70% benefit payable after *network provider deductible*
Level 2 network health care practitioner	70% benefit payable after *network provider deductible*
Non-network health care practitioner	50% benefit payable after *non-network provider deductible*

Telehealth and telemedicine services

Level 1 network health care practitioner	70% benefit payable after *network provider deductible*
Level 2 network health care practitioner	70% benefit payable after *network provider deductible*
Non-network health care practitioner	50% benefit payable after *non-network provider deductible*

Health care practitioner services at a retail clinic

Health care practitioner office visit in a retail clinic

Level 1 network health care practitioner	70% benefit payable after *network provider deductible*
Non-network health care practitioner	50% benefit payable after *non-network provider deductible*

Diagnostic laboratory when performed by a health care practitioner in a retail clinic

Level 1 network health care practitioner	70% benefit payable after *network provider deductible*
Non-network health care practitioner	50% benefit payable after *non-network provider deductible*

Injections other than allergy when received by a health care practitioner in a retail clinic

Level 1 network health care practitioner	70% benefit payable after *network provider deductible*
Non-network health care practitioner	50% benefit payable after *non-network provider deductible*

Hospital services

Hospital inpatient services

Network hospital	70% benefit payable after *network provider deductible*
Non-network hospital	50% benefit payable after *non-network provider deductible*

Health care practitioner inpatient services when provided in a hospital

Level 1 network health care practitioner	70% benefit payable after *network provider deductible*
Level 2 network health care practitioner	70% benefit payable after *network provider deductible*
Non-network health care practitioner	50% benefit payable after *non-network provider deductible*

Hospital outpatient surgical services

Must be performed in a *hospital's outpatient* department.

Network hospital	70% benefit payable after *network provider deductible*
Non-network hospital	50% benefit payable after *non-network provider deductible*

Health care practitioner outpatient services when provided in a hospital

Includes *outpatient surgery*.

Level 1 network health care practitioner	70% benefit payable after *network provider deductible*
Level 2 network health care practitioner	70% benefit payable after *network provider deductible*
Non-network health care practitioner	50% benefit payable after *non-network provider deductible*

Hospital outpatient non-surgical services

Must be performed in a *hospital's outpatient* department. Does not include diagnostic radiology, diagnostic laboratory and *advanced imaging*. Refer to "Hospital outpatient diagnostic radiology and laboratory" and "Hospital outpatient advanced imaging" in this "Schedule of Benefits" section.

Network hospital	70% benefit payable after *network provider deductible*
Non-network hospital	50% benefit payable after *non-network provider deductible*

Hospital outpatient diagnostic radiology and laboratory

Network hospital	70% benefit payable after *network provider deductible*
Non-network hospital	50% benefit payable after *non-network provider deductible*

Hospital outpatient advanced imaging

Must be performed in a *hospital's outpatient* department.

Network hospital	70% benefit payable after *network provider deductible*
Non-network hospital	50% benefit payable after *non-network provider deductible*

Pregnancy and newborn benefit

Same as any other *sickness* based upon location of services and the type of provider.

Emergency services

Must be for *emergency care* as defined in the "Glossary" section.

Hospital emergency room services

Does not include *advanced imaging*. Refer to "Hospital emergency room advanced imaging" in this "Schedule of Benefits" section.

Network hospital	70% benefit payable after *network provider deductible*
Non-network hospital	70% benefit payable after *network provider deductible*

Hospital emergency room advanced imaging

Network hospital	70% benefit payable after *network provider deductible*
Non-network hospital	70% benefit payable after *network provider deductible*

Hospital emergency room health care practitioner services

Network health care practitioner	70% benefit payable after *network provider deductible*
Non-network health care practitioner	70% benefit payable after *network provider deductible*

Ambulance services

Network provider	70% benefit payable after *network provider deductible*
Non-network provider	70% benefit payable after *network provider deductible*

Ambulatory surgical center services

Ambulatory surgical center for outpatient surgery

Network provider	70% benefit payable after *network provider deductible*
Non-network provider	50% benefit payable after *non-network provider deductible*

Health care practitioner outpatient services when provided in an ambulatory surgical center

Includes *outpatient surgery*.

Level 1 network health care practitioner	70% benefit payable after *network provider deductible*
Level 2 network health care practitioner	70% benefit payable after *network provider deductible*
Non-network health care practitioner	50% benefit payable after *non-network provider deductible*

Durable medical equipment

Network provider	70% benefit payable after *network provider deductible*
Non-network provider	50% benefit payable after *non-network provider deductible*

Free-standing facility services

Free-standing facility non-surgical services

Does not include *advanced imaging*. Refer to "Free-standing facility outpatient advanced imaging" in this "Schedule of Benefits" section.

Network provider	70% benefit payable after *network provider deductible*
Non-network provider	50% benefit payable after *non-network provider deductible*

Health care practitioner non-surgical services when provided in a free-standing facility

Level 1 network health care practitioner	70% benefit payable after *network provider deductible*
Level 2 network health care practitioner	70% benefit payable after *network provider deductible*
Non-network health care practitioner	50% benefit payable after *non-network provider deductible*

Free-standing facility outpatient advanced imaging

Network provider	70% benefit payable after *network provider deductible*
Non-network provider	50% benefit payable after *non-network provider deductible*

Home health care services

Limited to a maximum of 100 visits per *year*.

Network provider	70% benefit payable after *network provider deductible*
Non-network provider	50% benefit payable after *non-network provider deductible*

Hospice services

Network provider	70% benefit payable after *network provider deductible*
Non-network provider	50% benefit payable after *non-network provider deductible*

Physical medicine and rehabilitative services

Physical therapy, occupational therapy, speech therapy, audiology and cognitive rehabilitation services are limited to a combined maximum 40 visits per *year*. After 10 visits are incurred, no coverage is available for services received from a *non-network provider* for the remainder of the *year.*

Network provider	70% benefit payable after *network provider deductible*
Non-network provider	50% benefit payable after *non-network provider deductible*

Respiratory or pulmonary rehabilitation services

Network provider	70% benefit payable after *network provider deductible*
Non-network provider	50% benefit payable after *non-network provider deductible*

Cardiac rehabilitation services

Network provider	70% benefit payable after *network provider deductible*
Non-network provider	50% benefit payable after *non-network provider deductible*

Other therapy

Includes radiation therapy and chemotherapy.

Network provider	70% benefit payable after *network provider deductible*
Non-network provider	50% benefit payable after *non-network provider deductible*

Habilitative services

Physical therapy, occupational therapy, speech therapy and audiology services are limited to a combined maximum 40 visits per *year*. After 10 visits are incurred, no coverage is available for services received from a *non-network provider* for the remainder of the *year*.

Network provider	70% benefit payable after *network provider deductible*
Non-network provider	50% benefit payable after *non-network provider deductible*

Spinal manipulations/adjustments

Limited to a maximum of 20 visits per year. After 10 visits are incurred, no coverage is available for services received from a *non-network provider* for the remainder of the *year*.

Network provider	70% benefit payable after *network provider deductible*
Non-network provider	50% benefit payable after *non-network provider deductible*

Skilled nursing facility services

Limited to a maximum of 60 days per *year*.

Network provider	70% benefit payable after *network provider deductible*
Non-network provider	50% benefit payable after *non-network provider deductible*

Health care practitioner services when provided in a skilled nursing facility

Network health care practitioner	70% benefit payable after *network provider deductible*
Non-network health care practitioner	50% benefit payable after *non-network provider deductible*

Specialty drugs in a medical place of service

Specialty drugs administered in a health care practitioner's office, free-standing facility and urgent care center

Network provider	70% benefit payable after *network provider deductible*
Non-network provider	50% benefit payable after *non-network provider deductible*

Specialty drugs administered in home health care

Network provider designated by Humana as a preferred provider of *specialty drugs*	100% benefit payable after *network provider deductible*
Network provider	70% benefit payable after *network provider deductible*
Non-network provider	50% benefit payable after *non-network provider deductible*

Specialty drugs administered in a hospital, skilled nursing facility, ambulance or emergency room

Same as any other *sickness* based upon location of services and the type of provider.

Urgent care services

Network provider	70% benefit payable after *network provider deductible*
Non-network provider	50% benefit payable after *non-network provider deductible*

Additional covered expenses

Same as any other *sickness* based upon location of services and the type of provider.

SCHEDULE OF BENEFITS - BEHAVIORAL HEALTH

Reading this "Schedule of Benefits – Behavioral Health" section will help *you* understand:

- The level of benefits generally paid for the *mental health services* and *chemical dependency* services under this Plan;
- The amounts of *copayments* and/or *coinsurance you* are required to pay; and
- The services that require *you* to meet a *deductible* before benefits are paid.

This "Schedule of Benefits – Behavioral Health" outlines the coverage and limitations provided under this Plan. A more detailed explanation of *your* coverage and its limitations and exclusions for these benefits is provided in the "Covered Expenses – Behavioral Health" and "Limitations and Exclusions" sections of this *SPD*. Please refer to this *SPD* and any applicable riders for additional coverage and/or limitations.

All services are subject to all the terms and provisions, limitations and exclusions of this Plan.

Acute inpatient services

Network hospital	70% benefit payable after *network provider deductible*
Non-network hospital	50% benefit payable after *non-network provider deductible*

Partial hospitalization services

Network provider	70% benefit payable after *network provider deductible*
Non-network provider	50% benefit payable after *non-network provider deductible*

Residential treatment facility services

Network provider	70% benefit payable after *network provider deductible*
Non-network provider	50% benefit payable after *non-network provider deductible*

Acute inpatient, partial hospitalization and residential treatment facility health care practitioner services

Network health care practitioner	70% benefit payable after *network provider deductible*
Non-network health care practitioner	50% benefit payable after *non-network provider deductible*

Emergency services

Must be for *emergency care* as defined in the "Glossary" section.

Hospital emergency room services

Does not include *advanced imaging*. Refer to "Hospital emergency room advanced imaging" in the "Schedule of Benefits – Behavioral Health" section.

Network hospital	70% benefit payable after *network provider deductible*
Non-network hospital	70% benefit payable after *network provider deductible*

Hospital emergency room advanced imaging

Network hospital	70% benefit payable after *network provider deductible*
Non-network hospital	70% benefit payable after *network provider deductible*

Hospital emergency room health care practitioner services

Network health care practitioner	70% benefit payable after *network provider deductible*
Non-network health care practitioner	70% benefit payable after *network provider deductible*

Urgent care services

Network provider	70% benefit payable after *network provider deductible*
Non-network provider	50% benefit payable after *non-network provider deductible*

Outpatient services

Health care practitioner office visit

Does not include *behavioral health* therapy in a *health care practitioner's* office. Refer to "Therapy" in the "Schedule of Benefits – Behavioral Health" section.

Network health care practitioner	70% benefit payable after *network provider deductible*
Non-network health care practitioner	50% benefit payable after *non-network provider deductible*

Injections when performed in a health care practitioner's office

Does not include *preventive services* and allergy injections. Refer to "Preventive services" and "Allergy injections when received in a health care practitioner's office" in the "Schedule of Benefits" section.

Network health care practitioner	70% benefit payable after *network provider deductible*
Non-network health care practitioner	50% benefit payable after *non-network provider deductible*

SCHEDULE OF BENEFITS - BEHAVIORAL HEALTH (continued)

Therapy

Includes *outpatient behavioral health* therapy, *behavioral health* therapy in a *health care practitioner's* office and an *intensive outpatient program*.

Network provider	70% benefit payable after *network provider deductible*
Non-network provider	50% benefit payable after *non-network provider deductible*

Outpatient hospital services

Does not include *outpatient behavioral health* therapy. Refer to "Therapy" in the "Schedule of Benefits – Behavioral Health" section.

Does not include *advanced imaging*. Refer to "Advanced imaging performed in a health care practitioner's office, hospital outpatient department or free-standing facility" in the "Schedule of Benefits – Behavioral Health" section.

Network hospital	70% benefit payable after *network provider deductible*
Non-network hospital	50% benefit payable after *non-network provider deductible*

Advanced imaging performed in a health care practitioner's office, hospital outpatient department or free-standing facility

Network provider	70% benefit payable after *network provider deductible*
Non-network provider	50% benefit payable after *non-network provider deductible*

Home health care services

Network provider	70% benefit payable after *network provider deductible*
Non-network provider	50% benefit payable after *non-network provider deductible*

SCHEDULE OF BENEFITS – TRANSPLANT SERVICES

Reading this "Schedule of Benefits – Transplant Services" section will help *you* understand:

- The level of benefits generally paid for the transplant services covered under this Plan;
- The amounts of *copayments* or *coinsurance you* are required to pay; and
- The services that require *you* to meet a *deductible* before benefits are paid.

This "Schedule of Benefits – Transplant Services" outlines the coverage and limitations provided under this Plan. A more detailed explanation of *your* coverage and its limitations and exclusions for these benefits is provided in the "Covered Expenses – Transplant Services" and "Limitations and Exclusions" sections of this *SPD*. Please refer to this *SPD* and any applicable riders for additional coverage and limitations.

All services are subject to all of the terms, provisions, limitations and exclusions of this Plan.

Hospital services

Hospital benefits as shown under "Hospital services" in the "Schedule of Benefits" section of this Plan will be payable as follows:

Network hospital designated by Humana as an approved transplant facility	Same as any other *sickness* based on location of services and type of provider
Non-network hospital	Same as any other sickness based on location of services and type of provider.

Health care practitioner services

Health care practitioner benefits as shown under "Health care practitioner office services" in the "Schedule of Benefits" section of the *SPD* will be payable as follows:

Network health care practitioner designated by Humana as an approved transplant *health care practitioner*	Same as any other *sickness* based on location of services and type of coverage of provider
Non-network health care practitioner	Same as any other *sickness* based on location of services and type of provider.

SCHEDULE OF BENEFITS - TRANSPLANT SERVICES (continued)

Direct, non-medical costs

Limited to a combined maximum of $10,000 per covered transplant.

- Transportation

Network hospital designated by Humana as an approved transplant facility	100% benefit payable after *network provider deductible*

- Temporary lodging

Network hospital designated by *us* as an approved transplant facility	100% benefit payable after *network provider deductible*

COVERED EXPENSES

This "Covered Expenses" section describes the services that will be considered *covered expenses* under this Plan. Benefits will be paid for such covered medical services for a *bodily injury* or *sickness*, or for specified *preventive services*, on a *maximum allowable fee* basis and as shown on the "Schedules of Benefits", subject to any applicable:

- *Deductible*;
- *Copayment*;
- *Coinsurance* percentage; and
- Maximum benefit.

Refer to the "Limitations and Exclusions" section listed in this *SPD*. All terms and provisions of this Plan, including the *preauthorization* requirements specified in this *SPD*, are applicable to *covered expenses*.

Preventive services

Covered expenses 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 customer service telephone number on *your* identification card.

Preventive services office visit

Covered expenses include charges incurred for an office visit made to a *health care practitioner* for examinations and physicals to detect or prevent *sickness* as recommended by the U.S. Preventive Services Task Force.

Preventive screenings and immunizations

Covered expenses include charges incurred by *you* for the following *preventive services* as recommended by the United States Preventive Services Task Force:

- Laboratory, radiology or endoscopic services to detect or prevent *sickness*.
- A baseline mammogram for a female *covered person* between the ages of 35 and 40 and an annual mammogram for a female *covered person* 40 years of age or older.

- Routine pap smear.
- A prostate specific antigen (PSA) test for a male *covered person* 40 years of age or older.
- Routine immunizations for *covered persons* under the age of 18. TB tine tests and allergy desensitization injections are not considered routine immunizations.
- Immunizations against influenza and pneumonia.

Health care practitioner office services

This Plan will pay the following benefits for *covered expenses* incurred by *you* for *health care practitioner* office visit services. *You* must incur the *health care practitioner's* services as the result of a *sickness* or *bodily injury*.

Health care practitioner office visit

Covered expenses include:

- Office visits for the diagnosis and treatment of a *sickness* or *bodily injury*.
- Office visits for prenatal care.
- Office visits for *diabetes self-management training.*
- Diagnostic laboratory and radiology.
- Allergy testing.
- Allergy serum.
- Allergy injections.
- Injections other than allergy.
- *Surgery*, including anesthesia.
- Second surgical opinions.

Telehealth and telemedicine services

This Plan will pay benefits for *covered expenses* incurred by *you* for *telehealth* and *telemedicine* services for the diagnosis and treatment of a *sickness* or *bodily injury*. *Telehealth* or *telemedicine* services must be:

- Services that would otherwise be a *covered expense* if provided during a face-to-face consultation between a *covered person* and a *health care practitioner*;
- Provided to a *covered person* at the *originating site*; and
- Provided by a *health care practitioner* at the *distant site*.

Telehealth and *telemedicine* services must comply with:

- 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.

Health care practitioner services at a retail clinic

This Plan will pay benefits for *covered expenses* incurred by *you* for *health care practitioner* services at a *retail clinic* for a *sickness* or *bodily injury*.

Hospital services

This Plan will pay benefits for *covered expenses* incurred by *you* while *hospital confined* or for *outpatient* services. A *hospital confinement* must be ordered by a *health care practitioner*.

For *emergency care* benefits provided in a *hospital*, refer to the "Emergency services" provision of this section.

Hospital inpatient services

Covered expenses include:

- Daily semi-private, ward, intensive care or coronary care *room and board* charges for each day of *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*.

- Services and supplies, other than *room and board*, provided by a *hospital* while *confined*.

Health care practitioner inpatient services when provided in a hospital

Services that are payable as a *hospital* charge are not payable as a *health care practitioner* charge. If *you* receive services from a *non-network provider*, *you* may be responsible for any charges in excess of the *maximum allowable fee* and charges in excess of any percentages listed in this provision.

Covered expenses include:

- Medical services furnished by an attending *health care practitioner* to *you* while *you* are *hospital confined*.

- *Surgery* performed on an *inpatient* basis. If several *surgeries* are performed during one operation, this Plan will allow the *maximum allowable fee* for the most complex procedure. Subsequent procedures received from a *network provider* will be paid according to the provider contract. For a *non-network provider*, each additional procedure this Plan will allow:

  - 50% of *maximum allowable fee* for the secondary procedure; and
  - 25% of *maximum allowable fee* for the third and subsequent procedures.

  If two surgeons work together as primary surgeons performing distinct parts of a single reportable procedure, each surgeon will be paid according to the provider contract if they are a *network provider*. For a *non-network provider*, this Plan will allow each surgeon 62.5% of the *maximum allowable fee* for the procedure.

- Services of a surgical assistant or assistant surgeon. The surgical assistant or assistant surgeon will be paid according to the provider contract if they are a *network provider*. For a *non-network provider*, this Plan will allow the surgical assistant or assistant surgeon 16% of the *maximum allowable fee* for the *surgery*.

- Services of a physician assistant (P.A.), registered nurse (R.N.) or a certified operating room technician. The P.A., R.N. or certified operating room technician will be paid according to the provider contract if they are a *network provider*. For a *non-network provider*, this Plan will allow the P.A., R.N. or certified operating room technician 10% of the *maximum allowable fee* for the *surgery*.

- Anesthesia administered by a *health care practitioner* or certified registered anesthetist attendant to a *surgery*.

- Consultation charges requested by the attending *health care practitioner* during a *hospital confinement*. The benefit is limited to one consultation by any one *health care practitioner* per specialty during a *hospital confinement*.

- Services of a pathologist.

- Services of a radiologist.

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

For the purpose of this "Health care practitioner inpatient services when provided in a hospital" provision, provider contract means a written contract with a *network provider* that specifies reimbursement for a *covered expense*.

Hospital outpatient services

Covered expenses include *outpatient* services and supplies, as outlined in the following provisions, provided in a *hospital's outpatient* department.

Covered expenses provided in a *hospital's outpatient* department will not exceed the average semi-private room rate when *you* are in *observation status*.

Hospital outpatient surgical services

Covered expenses include services provided in a *hospital's outpatient* department in connection with *outpatient surgery*.

Health care practitioner outpatient services when provided in a hospital

Services that are payable as a *hospital* charge are not payable as a *health care practitioner* charge. If *you* receive services from a *non-network provider*, *you* may be responsible for any charges in excess of the *maximum allowable fee* and charges in excess of any percentages listed in this provision.

Covered expenses include:

- *Surgery* performed on an *outpatient* basis. If several *surgeries* are performed during one operation, this Plan will allow the *maximum allowable fee* for the most complex procedure. Subsequent procedures received from a *network provider* will be paid according to the provider contract. For a *non-network provider*, each additional procedure this Plan will allow:

  - 50% of *maximum allowable fee* for the secondary procedure; and
  - 25% of *maximum allowable fee* for the third and subsequent procedures.

  If two surgeons work together as primary surgeons performing distinct parts of a single reportable procedure, each surgeon will be paid according to the provider contract if they are a *network provider*. For a *non-network provider*, this Plan will allow each surgeon 62.5% of the *maximum allowable fee* for the procedure.

- Services of a surgical assistant or assistant surgeon. The surgical assistant or assistant surgeon will be paid according to the provider contract if they are a *network provider*. For a *non-network provider*, this Plan will allow the surgical assistant or assistant surgeon 16% of the *maximum allowable fee* for the *surgery*.

- Services of a physician assistant (P.A.), registered nurse (R.N.) or a certified operating room technician. The P.A., R.N. or certified operating room technician will be paid according to the provider contract if they are a *network provider*. For a *non-network provider*, this Plan will allow the P.A., R.N. or certified operating room technician 10% of the *maximum allowable fee* for the *surgery*.

- Anesthesia administered by a *health care practitioner* or certified registered anesthetist attendant for a *surgery*.

- Services of a pathologist.

- Services of a radiologist.

For the purpose of this "Health care practitioner outpatient services when provided in a hospital" provision, provider contract means a written contract with a *network provider* that specifies reimbursement for a *covered expense*.

Hospital outpatient non-surgical services

Covered expenses include services provided in a *hospital's outpatient* department in connection with non-surgical services.

Hospital outpatient advanced imaging

This Plan will pay benefits for *covered expenses* incurred by *you* for *outpatient advanced imaging* in a *hospital's outpatient* department.

Pregnancy and newborn benefit

This Plan will pay benefits for *covered expenses* incurred by a *covered person* for a pregnancy.

Covered expenses include:

- A minimum stay of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated cesarean section. If an earlier discharge is consistent with the most current protocols and guidelines of the American College of Obstetricians and Gynecologists or the American Academy of Pediatrics and is consented to by the mother and the attending *health care practitioner*, a post-discharge office visit to the *health care practitioner* or a home health care visit within the first 48 hours after discharge is also covered, subject to the terms of this plan.

- For a newborn, *hospital confinement* during the first 48 hours or 96 hours following birth, as applicable and listed above for:

  - *Hospital* charges for *routine nursery care*;
  - The *health care practitioner's* charges for circumcision of the newborn child; and
  - The *health care practitioner's* charges for routine examination of the newborn before release from the *hospital*.

- If the covered newborn must remain in the *hospital* past the mother's *confinement*, services and supplies received for:

  - A *bodily injury* or *sickness*;
  - Care and treatment for premature birth; and
  - Medically diagnosed birth defects and abnormalities.

Covered expenses also include *cosmetic surgery* specifically and solely for:

- Reconstruction due to *bodily injury*, infection or other disease of the involved part; or
- *Congenital anomaly* of a covered *dependent* child that resulted in a *functional impairment*.

The newborn will not be required to satisfy a separate *deductible* and/or *copayment* for *hospital* facility charges for the *confinement* period immediately following birth. A *deductible* and/or *copayment*, if applicable, will be required for any subsequent *hospital admission*.

Emergency services

This Plan will pay benefits for *covered expenses* incurred by *you* for *emergency care,* including the treatment and stabilization of an emergency medical condition.

Emergency care provided by a *non-network hospital* or a *non-network health care practitioner* will be covered at the *network provider* benefit, as specified in the Emergency Care benefit on the "Schedule of Benefits", subject to the *maximum allowable fee*. *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*. *You* may be required to pay any amount not paid by this Plan.

Covered expenses also include *health care practitioner* services for *emergency care*, including the treatment and stabilization of an emergency medical condition, provided in a *hospital* emergency facility. These services are subject to the terms, conditions, limitations, and exclusions of this Plan.

Benefits under this "Emergency services" provision are not available if the services provided do not meet the definition of *emergency care*.

Ambulance services

This Plan will pay benefits for *covered expenses* incurred by *you* for licensed *ambulance* services to, from or between medical facilities for *emergency care*.

Ambulance services for *emergency care* provided by a *non-network provider* will be covered at the *network provider* benefit, as specified in the Ambulance benefit on the "Schedule of Benefits", subject to the *maximum allowable fee*. *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*. *You* may be required to pay any amount not paid by this Plan.

Ambulatory surgical center services

This Plan will pay benefits for *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*.

Health care practitioner outpatient services when provided in an ambulatory surgical center

Services that are payable as an *ambulatory surgical center* charge are not payable as a *health care practitioner* charge. If *you* receive services from a *non-network provider*, *you* may be responsible for any charges in excess of the *maximum allowable fee* and charges in excess of any percentages listed in this provision.

Covered expenses include:

- *Surgery* performed on an *outpatient* basis. If several *surgeries* are performed during one operation, this Plan will allow the *maximum allowable fee* for the most complex procedure. Subsequent procedures received from a *network provider* will be paid according to the provider contract. For a *non-network provider*, each additional procedure this Plan will allow:

  - 50% of *maximum allowable fee* for the secondary procedure; and
  - 25% of *maximum allowable fee* for the third and subsequent procedures.

  If two surgeons work together as primary surgeons performing distinct parts of a single reportable procedure, each surgeon will be paid according to the provider contract if they are a *network provider*. For a *non-network provider*, this Plan will allow each surgeon 62.5% of the *maximum allowable fee* for the procedure.

- Services of a surgical assistant or assistant surgeon. The surgical assistant or assistant surgeon will be paid according to the provider contract if they are a *network provider*. For a *non-network provider*, this Plan will allow the surgical assistant or assistant surgeon 16% of the *maximum allowable fee* for the *surgery*.

- Services of a physician assistant (P.A.), registered nurse (R.N.) or a certified operating room technician. The P.A., R.N. or certified operating room technician will be paid according to the provider contract if they are a *network provider*. For a *non-network provider*, this Plan will allow the P.A., R.N. or certified operating room technician 10% of the *maximum allowable fee* for the *surgery*.

- Anesthesia administered by a *health care practitioner* or certified registered anesthetist attendant to a *surgery*.

- Services of a pathologist.

- Services of a radiologist.

For the purpose of this "Health care practitioner outpatient services when provided in an ambulatory surgical center" provision, provider contract means a written contract with a *network provider* that specifies reimbursement for a *covered expense*.

Durable medical equipment

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

At this 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 cost of the purchase is considered to be 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 this 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;
- Repair or maintenance is not a result of misuse or abuse;
- Maintenance is not more frequent than every six 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;
- 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.

Free-standing facility services

Free-standing non-surgical services

This Plan will pay benefits for *covered expenses* for services provided in a *free-standing facility*.

Health care practitioner non-surgical services when provided in a free-standing facility

This Plan will pay benefits for *outpatient* non-surgical services provided by a *health care practitioner* in a *free-standing facility*.

Free-standing facility outpatient advanced imaging

This Plan will pay benefits for *covered expenses* incurred by *you* for *outpatient advanced imaging* in a *free-standing facility*.

Home health care services

This Plan will pay benefits for *covered expenses* incurred by *you* in connection with a *home health care plan*. 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.

Home health care *covered expenses* include:

- Care provided by a *nurse*;
- Physical, occupational, respiratory or speech therapy;
- Medical social work and nutrition services; and
- Medical appliances, 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 this Plan.

Hospice services

This Plan will pay benefits for *covered expenses* incurred by *you* for a *hospice care program*. 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 this Plan.

Hospice care benefits are payable as shown on the "Schedule of Benefits" 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 prescribed by a *health care practitioner* 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 this Plan.

Physical medicine and rehabilitative services

This Plan will pay benefits for *covered expenses* incurred by *you* for the following physical medicine and/or rehabilitative services for a documented *functional impairment*, pain, or developmental delay or defect as ordered by a *health care practitioner* and performed by a *health care practitioner*:

- Physical therapy services;
- Occupational therapy services;
- Speech therapy or speech pathology services;
- Audiology services;
- Cognitive rehabilitation services;
- Respiratory or pulmonary rehabilitation services; and
- Cardiac rehabilitation services.

The "Schedule of Benefits" shows the maximum number of visits for physical medicine and/or rehabilitative services, if any.

Habilitative services

This Plan will pay benefits for *covered expenses* incurred by *you* for the following *habilitative services* ordered and performed by a *health care practitioner* for a *covered person* with a *congenital anomaly*, developmental delay or defect:

- Physical therapy services;
- Occupational therapy services;
- Speech therapy or speech pathology services; and
- Audiology services.

The "Schedule of Benefits" shows the maximum number of visits for *habilitative services*, if any.

Spinal manipulations/adjustments

This Plan will pay benefits for *covered expenses* incurred by *you* for spinal manipulations/adjustments performed by a *health care practitioner*.

The "Schedule of Benefits" shows the maximum number of visits for spinal manipulations/adjustments, if any.

Skilled nursing facility services

This Plan will pay benefits for *covered expenses* incurred by *you* for charges made by a *skilled nursing facility* for *room and board* and for services and supplies. *Your confinement* to a *skilled nursing facility* must be based upon a written recommendation of a *health care practitioner*.

The "Schedule of Benefits" shows the maximum length of time for which this Plan will pay benefits for charges made by a *skilled nursing facility*, if any.

Health care practitioner services when provided in a skilled nursing facility

Services that are payable as a *skilled nursing facility* charge are not payable as a *health care practitioner* charge.

Covered expenses include:

- Medical services furnished by an attending *health care practitioner* to *you* while *you* are *confined* in a *skilled nursing facility*;
- Consultation charges requested by the attending *health care practitioner* during a *confinement* in a *skilled nursing facility*;
- Services of a pathologist; and
- Services of a radiologist.

Specialty drugs in a medical place of service

This Plan will pay benefits for *covered expenses* incurred by *you* for *specialty drugs* that are administered in the following medical places of service:

- *Health care practitioner's* office;
- *Free-standing facility*;
- *Urgent care center*;
- Home health care;
- *Hospital*;
- *Skilled nursing facility*;
- Ambulance; and
- Emergency room.

Benefits for *specialty drugs* may be subject to *preauthorization* requirements, if any. Please refer to the "Schedule of Benefits" in this *SPD* for *preauthorization* requirements and contact this Plan prior to receiving *specialty drugs*.

Benefits for *specialty drugs* do not include the charge for the actual administration of the *specialty drug*. Payment for the administration of *specialty drugs* is addressed in the "Schedule of Benefits" section of this *SPD*.

Urgent care services

This Plan will pay benefits for *covered expenses* incurred by *you* for charges made by an *urgent care center* for *urgent care* services. *Covered expense* also includes *health care practitioner* services for *urgent care* provided at and billed by an *urgent care center*.

Additional covered expenses

This Plan will pay benefits for *covered expenses* incurred by *you*, based upon the location of the services and the type of provider for:

- Blood and blood plasma, which is not replaced by donation; administration of the blood and blood products including blood extracts or derivatives.

- Oxygen and rental of equipment for its administration.

- Prosthetic devices and supplies, including but not limited to limbs and eyes. Coverage will be provided for prosthetic devices to:

  - Restore the previous level of function lost as a result of a *bodily injury* or *sickness*; or
  - Improve function caused by a *congenital anomaly*.

  Covered expense for prosthetic devices includes repair or replacement, if not covered by the manufacturer, and if due to:

  - A change in the *covered person's* physical condition causing the device to become non-functional; or
  - Normal wear and tear.

- Cochlear implants, when approved by this Plan, for a *covered person*:

  Replacement or upgrade of a cochlear implant and its external components may be a *covered expense* if:

  - The existing device malfunctions and cannot be repaired;
  - Replacement is due to a change in the *covered person's* condition that makes the present device non-functional; or
  - The replacement or upgrade is not for cosmetic purposes.

- Orthotics used to support, align, prevent, or correct deformities.

  Covered expense does not include:

  - Replacement orthotics;
  - Dental braces; or
  - Oral or dental splints and appliances, unless custom made for the treatment of documented obstructive sleep apnea.

- The following special supplies, dispensed up to a 30-day supply, when prescribed by *your* attending *health care practitioner*:

  - Surgical dressings;
  - Catheters;
  - Colostomy bags, rings and belts; and
  - Flotation pads.

- The initial pair of eyeglasses or contacts needed due to cataract *surgery* or an *accident* if the eyeglasses or contacts were not needed prior to the *accident*.

- Dental treatment only if:

  - The charges are incurred for treatment of a *dental injury* to a *sound natural tooth*;
  - The treatment begins within 90 days after the date of the *dental injury*; and
  - The treatment is completed within 12 months after the date of the *dental injury*.

  However, benefits will be paid only for the least expensive service that will, in this Plan's opinion, produce a professionally adequate result.

- Certain oral surgical operations as follows:

  - Excision of partially or completely impacted teeth;
  - Surgical preparation of soft tissues and excision of bone or bone tissue performed with or without extraction or excision of erupted, partially erupted or completely un-erupted teeth;
  - Excisions of tumors and cysts of the jaws, cheeks, lips, tongue, roof, and floor of the mouth and related biopsy of bone, tooth, or related tissues when such conditions require pathological examinations;
  - Surgical procedures related to repositioning of teeth, tooth transplantation or re-implantation;
  - Services required to correct accidental injuries of the jaws, cheeks, lips, tongue, and roof and floor of the mouth;
  - Reduction of fractures and dislocation of the jaw;
  - External incision and drainage of cellulitis and abscess;
  - Incision and closure of accessory sinuses, salivary glands or ducts;
  - Frenectomy (the cutting of the tissue in the midline of the tongue); and
  - Orthognathic *surgery* for a *congenital anomaly*, *bodily injury* or *sickness* causing a *functional impairment*.

- Orthodontic treatment for a *congenital anomaly* related to or developed as a result of cleft palate, with or without cleft lip.

- For a *covered person*, who is receiving benefits in connection with a mastectomy, service for:

  - Reconstructive *surgery* of the breast on which the mastectomy has been performed;
  - *Surgery* and reconstruction on the non-diseased breast to achieve symmetrical appearance; and
  - Prostheses and treatment of physical complications for all stages of mastectomy, including lymphedemas.

- Reconstructive *surgery* resulting from:

  - A *bodily injury*, infection or other disease of the involved part, when a *functional impairment* is present; or
  - A *congenital anomaly* of a covered *dependent* child that resulted in a *functional impairment*.

  Expenses for reconstructive *surgery* due to a psychological condition are not considered a *covered expense*, unless the condition(s) described above are also met.

- Enteral formulas, nutritional supplements and low protein modified foods for use at home by a *covered person* that are prescribed or ordered by a *health care practitioner* and are for the treatment of an inherited metabolic disease, e.g. phenylketonuria (PKU).

- Nutritional counseling for the treatment of obesity, which includes *morbid obesity*, limited to 4 visits per *year*.

- Routine costs for a *covered person* participating in an approved Phase I, II, III or IV clinical trial.

  Routine costs include health care services that are otherwise a *covered expense* if the *covered person* were not participating in a clinical trial.

  Routine costs do not include services or items that are:

  - *Experimental*, *investigational* or *for research purposes*;
  - Provided only for data collection and analysis that is not directly related to the clinical management of the *covered person*; or
  - Inconsistent with widely accepted and established standards of care for a diagnosis.

  The *covered person* must be eligible to participate in a clinical trial according to the trial protocol and:

  - Referred by a *health care practitioner*; or
  - Provide medical and scientific information supporting their participation in the clinical trial is appropriate.

For the routine costs to be considered a *covered expense*, the approved clinical trial must be a Phase I, II, III or IV clinical trial for the treatment of cancer or a life threatening condition and is:

- Federally funded or approved by the appropriate federal agency;
- The study or investigation is conducted under an investigational new drug application reviewed by the Federal Food and Drug Administration; or
- The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

COVERED EXPENSES - BEHAVIORAL HEALTH

This "Covered Expenses – Behavioral Health" section describes the services that will be considered *covered expenses* for *mental health services* and *chemical dependency* services under this Plan. Benefits for *mental health services* and *chemical dependency* services will be paid on a *maximum allowable fee* basis and as shown in the "Schedule of Benefits – Behavioral Health". Refer to the "Schedule of Benefits" for any service not specifically listed in the "Schedule of Benefits – Behavioral Health". Benefits are subject to any applicable:

- The *deductible*;
- Any *copayment*;
- Any *coinsurance* percentage; and
- Any maximum benefit.

Refer to the "Limitations and Exclusions" section listed in this *SPD*. All terms and provisions of this Plan, including *preauthorization* requirements specified in this *SPD*, are applicable to *covered expenses*.

Acute inpatient services

This Plan will pay benefits for *covered expenses* incurred by *you* due to an *admission* or *confinement* for *acute inpatient services* for *mental health services* and *chemical dependency* services provided in a *hospital* or *health care treatment facility*.

Partial hospitalization services

This Plan will pay benefits for *covered expenses* incurred by *you* for *partial hospitalization* for *mental health services* and *chemical dependency* services in a *hospital* or *health care treatment facility*.

Residential treatment facility

This Plan will pay benefits for *covered expenses* incurred by *you* due to an *admission* or *confinement* for *mental health services* and *chemical dependency* services provided in a *residential treatment facility*.

Acute inpatient, partial hospitalization and residential treatment facility health care practitioner services

This Plan will pay benefits for *covered expenses* incurred by *you* for *mental health services* and *chemical dependency* services provided by a *health care practitioner* in a *hospital*, or *health care treatment facility* or *residential treatment facility*.

Emergency services

This Plan will pay benefits for *covered expenses* incurred by *you* for *emergency care,* including the treatment and stabilization of an emergency condition for *mental health services* and *chemical dependency* services.

Emergency care provided by a *non-network hospital* or a *non-network health care practitioner* will be covered at the *network provider* benefit as specified in the "Emergency care benefit" on the "Schedule of Benefits – Behavioral Health", subject to the *maximum allowable fee*. *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*. *You* may be required to pay any amount not paid by this Plan.

Covered expenses also include *health care practitioner* services for *emergency care*, including the treatment and stabilization of an emergency condition, provided in a *hospital* emergency facility. These services are subject to the terms, conditions, limitations, and exclusions of this Plan.

Benefits under this "Emergency services" provision are not available if the services provided do not meet the definition of *emergency care*.

Urgent care services

This Plan will pay benefits for *covered expenses* incurred by *you* in an *urgent care center* for *mental health services* and *chemical dependency* services. *Covered expense* also includes *health care practitioner* services for *urgent care* provided at and billed by an *urgent care center*.

Outpatient services

This Plan will pay benefits for *covered expense* incurred by *you* for *mental health services* and *chemical dependency* services, including services in a *health care practitioner* office, *outpatient behavioral health* therapy, *outpatient* services provided as part of an *intensive outpatient program*, and other *outpatient* services, while not *confined* in a *hospital*, *residential treatment facility* or *health care treatment facility*.

Home health care services

This Plan will pay benefits for *covered expenses* incurred by *you*, in connection with a *home health care plan*, for *mental health services* and *chemical dependency* services. 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*.

Home health care *covered expenses* include services provided by a *health care practitioner* who is a *behavioral health* professional, such as a counselor, psychologist or psychiatrist.

COVERED EXPENSES - TRANSPLANT SERVICES

This "Covered Expenses – Transplant Services" section describes the services that will be considered *covered expenses* for transplant services under this Plan. Benefits for transplant services will be paid on a *maximum allowable fee* basis and as shown in the "Schedule of Benefits – Transplant Services," subject to any applicable:

- *Deductible*;
- *Copayment*;
- *Coinsurance* percentage; and
- Maximum benefit.

Refer to the "Limitations and Exclusions" section listed in this *SPD* for transplant services not covered by this Plan. All terms and provisions of this Plan apply.

Transplant covered expenses

This Plan will pay benefits for *covered expenses* incurred by *you* for a transplant that is preauthorized and approved by Humana. This Plan must be notified of the initial transplant evaluation and given a reasonable opportunity to review the clinical results to determine if the transplant will be covered. *You* or *your health care practitioner* must contact Humana's Transplant Management Department by calling the Customer Service number on *your* ID card when in need of a transplant. This Plan will advise *your health care practitioner* once coverage of the requested transplant is approved by this Plan. Benefits are payable only if the transplant is approved by this Plan.

Covered expenses for a transplant include 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;
- *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 transplantations performed simultaneously are considered one transplant surgery.

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.

COVERED EXPENSES - TRANSPLANT SERVICES (continued)

The following are *covered expenses* for an approved transplant and all related complications:

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

- Acquisition for transplants and associated donor costs, including pre-transplant services, the acquisition procedure, and any complications resulting from the acquisition. Donor costs for post-discharge services and treatment of complications for or in connection with acquisition for an approved transplant will not exceed the transplant treatment period of 365 days from the date of *hospital* discharge following acquisition.

- Direct, non-medical costs for:

  - The *covered person* receiving the transplant, if he or she lives more than 100 miles from the transplant facility; and
  - One designated caregiver or support person (two, if the *covered person* receiving the transplant is under 18 years of age), if they live more than 100 miles from the transplant facility.

  Direct, non-medical costs include:

  - Transportation to and from the *hospital* where the transplant is performed; and
  - Temporary lodging at a prearranged location when requested by the *hospital* and approved by this Plan.

  All direct, non-medical costs for the *covered person* receiving the transplant and the designated caregiver(s) or support person(s) are payable as specified in the "Schedule of Benefits – Transplant Services" section in this *SPD*.

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

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. This exclusion does not apply to an *employee* that is sole proprietor, partner, or corporate officer if the sole proprietor, partner or corporate officer is not eligible to receive Workers' Compensation benefits.
- 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*.
- Any service *you* would not be legally required to pay for in the absence of this insurance.
- *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, assistant surgeon, physician assistant, registered nurse or certified operating room technician unless *medically necessary*.
- Any service which is not rendered by the billing provider.
- Any service not substantiated in the medical records of the billing provider.
- 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 this 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 this 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 by a *covered person's family member*.

- *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*.

- Immunizations required for foreign travel for a *covered person* of any age.

- 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*.

- Hearing aids, the fitting of hearing aids or advice on their care; implantable hearing devices, except for cochlear implants as otherwise stated in this *SPD*.

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

- *Hospital inpatient* services when *you* are in *observation status*.

- *Infertility services*; or reversal of elective sterilization.

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

  - The expense relates to storage of cord blood and stem cells, unless it is an integral part of a transplant approved by this Plan.

  - This Plan does not approve coverage for the transplant, based on Humana's 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 Plan.

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

  - The expense relates to donor costs that are payable in whole or in part by any other group plan, insurance company, organization, or person other than the donor's family or estate.

  - The expense relates to a transplant performed outside of the United States and any care resulting from that transplant.

- No benefits will be provided for:

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

LIMITATIONS AND EXCLUSIONS (continued)

- *Cosmetic surgery* and cosmetic services or devices.

- Hair prosthesis, hair transplants or implants and wigs.

- 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 hyperkeratoses;
  - 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, or caused by:

  - War or any act of war, whether declared or not;
  - Insurrection; or
  - Any conflict involving armed forces of any authority.

- *Sickness* or *bodily injury* caused by the *covered person's*:

  - Engagement in an illegal 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, and strength conditioning, work-hardening programs, and weight loss or surgical programs, and any materials or products related to these programs.

LIMITATIONS AND EXCLUSIONS (continued)

- 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:

    - 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;

    - PUVA lights; and

    - Stethoscopes;

  - Communication system, telephone, television or computer systems and related equipment or similar items or equipment;

  - 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 unless 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.

LIMITATIONS AND EXCLUSIONS (continued)

- 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.

- *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*.

LIMITATIONS AND EXCLUSIONS (continued)

- 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 or camp physical examinations or for 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 this Plan.

- *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.

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 this provision, 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 has no coordination of benefits provision;

- 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 active *employee* or *dependent* of such *employee*. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule will be ignored.

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

COORDINATION OF BENEFITS WITH MEDICARE

When an employer employs 20 or more persons, the benefits of this Plan will be payable first for a *covered person* who is under age 65 and eligible for *Medicare*. The benefits of *Medicare* will be payable second.

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

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

OPTIONS

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

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

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

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

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

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

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

CALCULATION AND PAYMENT OF BENEFITS

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

For *covered persons* in Category 2, *Medicare* benefits are payable before any benefits are payable by this Plan. The benefits of this Plan will then be reduced by the full amount of all *Medicare* benefits the *covered person* is entitled to receive.

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 6 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 Humana.

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

Mail medical claims and correspondence to:

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

MISCELLANEOUS MEDICAL CHARGES

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

PROCEDURAL DEFECTS

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

ASSIGNMENTS AND REPRESENTATIVES

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

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

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

- Any document designating an authorized representative must be submitted to Humana in advance, or at the time an authorized representative commences a course of action on behalf of a *claimant*. At the same time, the authorized representative should also provide notice of commencement of the action on behalf of the *claimant* to the *claimant*, which Humana may verify with the *claimant* prior to recognizing the authorized representative status.
- In any event, a health care provider with knowledge of a *claimant's* medical condition acting in connection with an *urgent care claim* will be recognized by this Plan as the *claimant's* authorized representative.

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

CLAIMS DECISIONS

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

Pre-Service Claims

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

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

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

Urgent Care Claims

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

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

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

- The *claimant* will have a reasonable amount of time, taking into account his or her circumstances, to provide the necessary information but not less than 48 hours.
- Humana will notify the *claimant* of this Plan's *urgent care claim* determination as soon as possible, but in no event more than 48 hours after the earlier of:

    - 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, including a statement of the *claimant's* right to bring a civil action under ERISA Section 502(a) following an *adverse benefit determination* on review.

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

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

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

APPEALS OF ADVERSE BENEFIT DETERMINATIONS

A *claimant* must *appeal* an *adverse benefit determination* within 180 days after receiving written notice of the denial (or partial denial). 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 allow.

EXHAUSTION

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

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

LEGAL ACTIONS AND LIMITATIONS

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

STANDARD EXTERNAL REVIEW

Request for an External Review

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

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

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

Preliminary Review

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

- 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, 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 Labor (DOL) Employee Benefits Security Administration (EBSA), including this toll-free number: 1-866-444-EBSA (3272) and this email address: www.askebsa.dol.gov.

- 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 phone 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 U.S. Department of Labor's Employee Benefits Security Administration (EBSA) at 1-866-444-EBSA or at www.askebsa.dol.gov.

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

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

Texas Consumer Health Assistance Program
Texas Department of Insurance
Mail Code 111-1A
333 Guadalupe
P.O. Box 149091
Austin, TX 78714
(800) 252-3439
www.texashealthoptions.com (website)
ConsumerProtection@tdi.texas.gov (email)

ELIGIBILITY AND EFFECTIVE DATES

Eligibility date

Employee eligibility date

The *employee* is eligible for coverage on the date:

- The *employee* meets the eligibility requirements of the *employer*;
- The *employee* satisfies a *waiting period* of 30 calendar days of employment; and
- The *employee* is in an *active status*.

Dependent eligibility date

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;
- The date of the *employee's* marriage for any *dependents* (spouse or child) acquired on that date;
- The date of birth of the *employee's* natural-born child;
- The date of placement of the child for the purpose of adoption by the *employee*; or
- The date specified in a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN) for a child, or a valid court or administrative order for a spouse, which requires the *employee* to provide coverage for a child or spouse as specified in such orders.

The *employee* may cover his or her *dependents* only if the *employee* is also covered.

Enrollment

Employees and *dependents* eligible for coverage under this Plan may enroll for coverage as specified in the enrollment provisions outlined below.

Employee enrollment

The *employee* must enroll, within 31 days of the *employee's eligibility date* or within the time period specified in the "Special enrollment" provision.

The *employee* is a *late applicant* if enrollment is requested more than 31 days after the *employee's eligibility date* or later than the time period specified in the "Special enrollment" provision. A *late applicant* must wait to enroll for coverage during the *open enrollment period*, unless the *late applicant* becomes eligible for special enrollment as specified in the "Special enrollment" provision.

Health status will not be used to determine premium rates. This Plan will not use *health status-related factors* to decline coverage to an eligible *employee* and this Plan will administer this provision in a non-discriminatory manner.

Dependent enrollment

If electing *dependent* coverage, the *employee* must enroll eligible *dependents*, as agreed to by this Plan, within 31 days of the *dependent's eligibility date* or within the time period specified in the "Special enrollment" provision.

The *dependent* is a *late applicant* if enrollment is requested more than 31 days after the *dependent's eligibility date* or later than the time period specified in the "Special enrollment" provision. A *late applicant* must wait to enroll for coverage during the *open enrollment period*, unless the *late applicant* becomes eligible for special enrollment as specified in the "Special enrollment" provision.

Health status will not be used to determine premium rates. This Plan will not use *health status-related factors* to decline coverage to an eligible *dependent* and this Plan will administer this provision in a non-discriminatory manner.

Newborn and adopted dependent enrollment

A newborn *dependent* will be covered from the date of birth to 31 days of age. An adopted *dependent* will be covered from the date of adoption or placement of the child with the *employee* for the purpose of adoption, whichever occurs first, for 31 days.

If additional premium is not required to add additional *dependents* and if *dependent* child coverage is in force as of the newborn's date of birth in the case of newborn *dependents* or the earlier of the date of adoption or placement of the child with the *employee* for purposes of adoption in case of adopted *dependents*, coverage will continue beyond the initial 31 days. *You* must notify Humana Plan to make sure this Plan has accurate records to administer benefits.

If premium is required to add *dependents you* must enroll the *dependent* child and pay the additional premium within 31 days:

- Of the newborn's date of birth; or
- Of the date of adoption or placement of the child with the *employee* for the purpose of adoption to add the child to *your* plan, whichever occurs first.

If enrollment is requested more than 31 days after the date of birth, date of adoption or placement with the *employee* for the purpose of adoption, and additional premium is required, the *dependent* is a *late applicant*. A *late applicant* must wait to enroll for coverage during the *open enrollment period*, unless the *late applicant* becomes eligible for special enrollment as specified in the "Special enrollment" provision.

Special enrollment

Special enrollment is available if the following apply:

- *You* have a change in family status due to:

  - Marriage;
  - Divorce;
  - A Qualified Medical Child Support Order (QMCSO);
  - A National Medical Support Notice (NMSN);
  - The birth of a natural born child; or
  - The adoption of a child or placement of a child with the *employee* for the purpose of adoption; and
  - You enroll within 31 days after the *special enrollment date*; or

- You are an *employee* or *dependent* eligible for coverage under this Plan, and:

  - You previously declined enrollment stating you were covered under another group health plan or other *health insurance coverage*; and
  - Loss of eligibility of such other coverage occurs, regardless of whether you are eligible for, or elect COBRA; and
  - You enroll within 31 days after the *special enrollment date*.

  Loss of eligibility of other coverage includes, but is not limited to:

  - Termination of employment or eligibility;
  - Reduction in number of hours of employment;
  - Divorce, legal separation or death of a spouse;
  - Loss of dependent eligibility, such as attainment of the limiting age;
  - Termination of your employer's contribution for the coverage;
  - Loss of individual HMO coverage because you no longer reside, live or work in the service area;
  - Loss of group HMO coverage because you no longer reside, live or work in the service area, and no other benefit package is available;
  - The plan no longer offers benefits to a class of similarly situated individuals; or

- You had COBRA continuation coverage under another plan at the time of eligibility, and:

  - Such coverage has since been exhausted; and
  - You stated at the time of the initial enrollment that coverage under COBRA was your reason for declining enrollment; and
  - You enroll within 31 days after the *special enrollment date*; or

- You were covered under an alternate plan provided by the *employer* that terminates, and:

  - You are replacing coverage with this Plan; and
  - You enroll within 31 days after the *special enrollment date*; or

- You are an *employee* or *dependent* eligible for coverage under this Plan, and:

  - Your *Medicaid* coverage or your Children's Health Insurance Program (CHIP) coverage terminated as a result of loss of eligibility; and
  - You enroll within 60 days after the *special enrollment date*; or

- You are an *employee* or *dependent* eligible for coverage under this Plan, and:

  - You become eligible for a premium assistance subsidy under *Medicaid* or CHIP; and
  - You enroll within 60 days after the *special enrollment date*.

The *employee* or *dependent* is a *late applicant* if enrollment is requested later than the time period specified above. A *late applicant* must wait to enroll for coverage during the *open enrollment period*.

Dependent special enrollment

The *dependent* special enrollment is the time period specified in the "Special enrollment" provision.

If *dependent* coverage is available under this Plan an *employee* who is a *covered person* can enroll eligible *dependents* during the special enrollment. An *employee*, who is otherwise eligible for coverage and had waived coverage under this Plan when eligible, can enroll himself/herself and eligible *dependents* during the special enrollment.

The *employee* or *dependent* is a *late applicant* if enrollment is requested later than the time period specified above. A *late applicant* must wait to enroll for coverage during the *open enrollment period*.

Open enrollment

Eligible *employees* or *dependents*, who do not enroll for coverage under this Plan following their *eligibility date* or *special enrollment date*, have an opportunity to enroll for coverage during the *open enrollment period*. The *open enrollment period* is also the opportunity for *late applicants* to enroll for coverage.

Eligible *employees* or *dependents*, including *late applicants*, must request enrollment during the *open enrollment period.* If enrollment is requested after the *open enrollment period*, the *employee* or *dependent* must wait to enroll for coverage during the next *open enrollment period*, unless they become eligible for special enrollment as specified in the "Special enrollment" provision.

Effective date

The provisions below specify the *effective date* of coverage for *employees* or *dependents*, if enrollment is requested within 31 days of their *eligibility date* or within the time period specified in the "Special enrollment" provision. If enrollment is requested during an *open enrollment period*, the *effective date* of coverage is specified in the "Open enrollment effective date" provision.

Employee effective date

The *employee's effective date* provision is the first of the month following completion of the *waiting period*, if enrollment is requested within 31 days of the *employee's eligibility date*. The *special enrollment date* is the *effective date* of coverage for an *employee* who requests enrollment within the time period specified in the "Special enrollment" provision. The *employee effective dates* specified in this provision apply to an *employee* who is not a *late applicant*.

Dependent effective date

The *dependent's effective date* is the date the *dependent* is eligible for coverage if enrollment is requested within 31 days of the *dependent's eligibility date*. The *special enrollment date* is the *effective date* of coverage for the *dependent* who requests enrollment within the time period specified in the "Special enrollment" provision. The *dependent effective dates* specified in this provision apply to a *dependent* who is not a *late applicant*.

In no event will the *dependent's effective date* of coverage be prior to the *employee's effective date* of coverage.

Newborn and adopted dependent effective date

The *effective date* of coverage for a newborn *dependent* is the date of birth if the newborn is not a *late applicant*.

The *effective date* of coverage for an adopted *dependent* is the date of adoption or the date of placement with the *employee* for the purpose of adoption, whichever occurs first, if the *dependent* child is not a *late applicant*.

Premium is due for any period of *dependent* coverage whether or not the *dependent* is subsequently enrolled, unless specifically not allowed by applicable law. Additional premium may not be required when *dependent* coverage is already in force.

OPEN ENROLLMENT

Eligible *employees* or *dependents*, who do not enroll for coverage under this Plan following their *eligibility date* or *special enrollment date*, have an opportunity to enroll for coverage during the *open enrollment period*. The *open enrollment period* is also the opportunity for *late applicants* to enroll for coverage.

Eligible *employees* or *dependents*, including *late applicants*, must request enrollment during the *open enrollment period.* If enrollment is requested after the *open enrollment period*, the *employee* or *dependent* must wait to enroll for coverage during the next *open enrollment period*, unless they become eligible for special enrollment as specified in the "Special Enrollment" provision.

EFFECTIVE DATE

The provisions below specify the *effective date* of coverage for *employees* or *dependents* if enrollment is requested within 31 days of their *eligibility date* or within the time period specified in the "Special Enrollment" provision. If enrollment is requested during an *open enrollment period*, the *effective date* of coverage is specified in the "Open Enrollment Effective Date" provision.

Employee Effective Date

The *employee's effective date* of coverage is the first of the month following completion of the *waiting period*, if enrollment is requested within 31 days of the *employee's eligibility date*. The *special enrollment date* is the *effective date* of coverage for an *employee* that requests enrollment within the time period specified in the "Special Enrollment" provision. The *employee effective dates* specified in this provision apply to an *employee* who is not a *late applicant*.

Dependent Effective Date

The *dependent's effective date* is the date the *dependent* is eligible for coverage if enrollment is requested within 31 days of the *dependent's eligibility date*. The *special enrollment date* is the *effective date* of coverage for the *dependent* who requests enrollment within the time period specified in the "Special Enrollment" provision. The *dependent effective dates* specified in this provision apply to a *dependent* who is not a *late applicant*.

In no event will the *dependent's effective date* of coverage be prior to the *employee's effective date* of coverage.

Newborn and Adopted Dependent Effective Date

The *effective date* of coverage for a newborn *dependent* is the date of birth if the newborn is not a *late applicant*.

The *effective date* of coverage for an adopted *dependent* is the date of adoption or the date of placement with the *employee* for the purpose of adoption, whichever occurs first, if the *dependent* child is not a *late applicant*.

Premium is due for any period of *dependent* coverage whether or not the *dependent* is subsequently enrolled, unless specifically not allowed by applicable law. Additional premium may not be required when *dependent* coverage is already in force.

Open Enrollment Effective Date

The *effective date* of coverage for an *employee* or *dependent*, including a *late applicant*, who requests enrollment during an *open enrollment period*, is the first day of the Plan *year*.

MEDICAL CHILD SUPPORT ORDERS

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

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

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

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

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

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

FAMILY AND MEDICAL LEAVE ACT (FMLA)

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

REPLACEMENT OF COVERAGE

Applicability

This "Replacement of Coverage" section applies when an *employer's* previous group health plan not offered by this Plan or this Plan's affiliates (Prior Plan) is terminated and replaced by coverage under this Plan and:

- *You* are eligible to become insured for medical coverage on the effective date of this Plan; and
- *You* were covered under the *employer's* Prior Plan on the day before the effective date of this Plan.

Benefits available for *covered expense* under this Plan will be reduced by any benefits payable by the Prior Plan during an extension period.

Deductible credit

Medical expense incurred while *you* were covered under the Prior Plan may be used to satisfy *your network provider deductible* amount under this Plan if the expense incurred:

- Was applied to the network deductible amount under the Prior Plan; and
- Will partially or fully satisfy the *network provider deductible* amount under this Plan for the *year* in which *your* coverage becomes effective.

Waiting period credit

If the *employee* had not completed the initial *waiting period* under the *employer's* Prior Plan on the day that it ended, any period of time that the *employee* satisfied will be applied to the appropriate *waiting period* under this Plan, if any. The *employee* will then be eligible for coverage under this Plan when the balance of the *waiting period* has been satisfied.

Out-of-pocket limit

Any amount applied to the Prior Plan's network *out-of-pocket limit* or stop-loss limit will be credited toward the satisfaction of any *network provider out-of-pocket limit* of this Plan if the amount applied under the Prior Plan will partially or fully satisfy the *network provider out-of-pocket limit* under this Plan for the *year* in which *your* coverage becomes effective.

TERMINATION PROVISIONS

Termination of insurance

The date of termination, as described in this "Termination Provisions" section, is the end of that month in which the date specified has occurred.

You must notify *your employer* as soon as possible if *you* or *your dependent* no longer meets the eligibility requirements of this Plan. Notice must be provided to this Plan within 31 days of the change.

When Humana receives notification of a change in eligibility status in advance of the effective date of the change, coverage will terminate on the end of that month in which the date specified has occurred.

Otherwise, coverage terminates on the earliest of the following:

- The date this Plan terminates;
- The end of the period for which required contribution was not paid;
- The date the *employee* terminated employment with the *employer*;
- The date the *employee* is no longer qualified as an *employee*;
- The date *you* fail to be in an eligible class of persons;
- The date *you* entered full-time military, naval or air service;
- The date the *employee* retired;
- The date of an *employee* request for termination of coverage for the *employee* or *dependents*;
- For a *dependent*, the date the *employee's* coverage terminates;
- For a *dependent*, the date the *employee* ceases to be in a class of *employees* eligible for *dependent* coverage;
- The date *your dependent* no longer qualifies as a *dependent*;
- For any benefit, the date the benefit is deleted from this Plan; or
- The date fraud or an intentional misrepresentation of a material fact has been committed by *you*.

Termination for cause

This Plan will terminate *your* coverage for cause under the following circumstances:

- If *you* allow an unauthorized person to use *your* identification card or if *you* use the identification card of another *covered person*. Under these circumstances, the person who receives the services provided by use of the identification card will be responsible for paying this Plan the *maximum allowable fee* for those services.

- If *you* perpetrate fraud or intentional misrepresentation on claims, identification cards or other identification in order to obtain services or a higher level of benefits. This includes, but is not limited to, the fabrication or alteration of a claim, identification card or other identification.

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. 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

The *Plan Manager* 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 the *Plan Manager* shall be final and uncontestable.

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, workers' compensation, uninsured motorists, underinsured motorists, "no-fault" and automobile med-pay payments or recovery from any identifiable fund regardless of whether the *beneficiary* was made whole.
- 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 request 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.

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 Humana who has contracted with a *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* 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 Humana who has contracted with a *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*.

On August 6, 2002, The Trade Act of 2002 (TAA), was signed in to 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. This 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

If continuation coverage is elected, the coverage must be identical to the coverage provided under the *employer's* Plan to similarly situated non-COBRA beneficiaries. This means that if the coverage for similarly situated non-COBRA beneficiaries is modified, coverage for the individual on continuation will be modified.

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 *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 *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 *COBRA Service Provider* or Humana.

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

PLAN CONTACT INFORMATION

Humana Health Plan, Inc.
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.

STATEMENT OF ERISA RIGHTS

As a participant in the Specialty Composites Group, LTD Level Funded Plan, *you* are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

RECEIVE INFORMATION ABOUT THEIR PLAN AND BENEFITS

- Examine, without charge, at the *Plan Administrator's* office and at other specified locations, such as work sites and union halls, all documents governing this Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by this Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request from the *Plan Administrator*, copies of documents governing the operation of this Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated *Summary Plan Description*. The administrator may make a reasonable charge for copies.
- Receive a summary of this Plan's annual financial report. The *Plan Administrator* is required by law to furnish each participant with a copy of this summary annual report.

CONTINUE GROUP HEALTH PLAN COVERAGE

- Continue health care coverage for *yourself*, spouse or *dependents* if there is a loss of coverage under this Plan as a result of a qualifying event. *You* or *your dependents* may have to pay for such coverage. Review this *Summary Plan Description* and this Plan's documents on the rules governing *your* COBRA continuation coverage rights.

PRUDENT ACTIONS OF PLAN FIDUCIARIES

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of employee benefit plans. The people who operate *your* Plan, called "fiduciaries" of this Plan, have a duty to do so prudently and in the interest of *you* and other Plan participants and beneficiaries. No one, including *your employer*, *your* union, or any other person, may fire *you* or otherwise discriminate against *you* in any way to prevent *you* from obtaining a welfare benefit or exercising *your* rights under ERISA.

ENFORCE THEIR RIGHTS

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

Under ERISA, there are steps *you* can take to enforce the above rights. For instance, if *you* request a copy of Plan documents or the latest annual report from this Plan and do not receive them within 30 days, *you* may file suit in a Federal court. In such a case, the court may require the *Plan Administrator* to provide the materials and pay *you* up to $110 a day until *you* receive the materials, unless the materials were not sent because of reasons beyond the control of the *Plan Administrator*. If *you* have a claim for benefits which is denied or ignored, in whole or in part, *you* may file suit in a state or Federal court. In addition, if *you* disagree with this Plan's decision, or lack thereof, concerning the qualified status of a domestic relations order or a medical child support order, *you* may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if *you* are discriminated against for asserting *your* rights, *you* may seek assistance from the U.S. Department of Labor, or *you* may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If *you* are successful, the court may order the person *you* have sued to pay these costs and fees. If *you* lose, the court may order *you* to pay these costs and fees, if for example, it finds *your* claim is frivolous.

ASSISTANCE WITH QUESTIONS

If *you* have any questions about *your* Plan, *you* should contact the *Plan Administrator*. If *you* have any questions about this statement or about *your* rights under ERISA, or if *you* need assistance in obtaining documents from the *Plan Administrator*, *you* should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in *your* telephone directory (or 1-866-444-3272), or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. *You* may also obtain certain publications about *your* rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration or visiting the U.S. Department of Labor web-site at http://www.dol.gov/ebsa.

ADDITIONAL NOTICES

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: Specialty Composites Group, LTD Level Funded Plan

- *Plan Sponsor*, *Plan Administrator* and Named Fiduciary:

  Specialty Composites Group, LTD
  481 Texas Central Parkway
  Waco, TX 76712
  Telephone: 254-870-3932

- *Employer*:

  Specialty Composites Group, LTD
  481 Texas Central Parkway
  Waco, TX 76712
  Telephone: 254-870-4067

- *Employer* Identification Number: 742982402

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

- Plan benefits described in this booklet are effective December 01, 2018.

- The Plan *year* is December 01 through November 30 of each year.

- The fiscal year is January 01 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:

  Greg Yates
  Specialty Composites Group, LTD
  457 Nathan Dean Blvd Suite 105 #95
  Dallas, GA 30132

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

  Humana Health Plan, Inc.
  500 West Main Street
  Louisville, KY 40202
  Telephone: Refer to *your* Humana ID card

- This is a self-insured and self-administered health benefit plan. The cost of this Plan is paid with contributions shared by the *employer* and *employee*. 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.

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

GLOSSARY

Terms printed in italic type in this *SPD* have the meaning indicated below. Defined terms are printed in italic type wherever found in this *SPD*.

A

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

Active status means the *employee* is performing all of his or her customary duties, whether performed at the *employer's* business establishment, some other location which is usual for the *employee's* particular duties or another location, when required to travel on the job:

- On a regular *full-time* basis or for the number of hours per week determined by the *employer*;
- For 48 weeks a year; and
- Is maintaining a bona fide *employer-employee* relationship on a regular basis with the *employer* sponsoring this Plan.

Each day of a regular vacation and any regular non-working holiday are deemed *active status*, if the *employee* was in *active status* on his or her last regular working day prior to the vacation or holiday. An *employee* is deemed to be in *active status* if an absence from work is due to a *sickness* or *bodily injury*, provided the individual otherwise meets the definition of *employee*.

Acute inpatient services mean care given in a *hospital* or *health care treatment facility*, which:

- Maintains permanent full-time facilities for *room and board* of resident patients;
- Provides emergency, diagnostic and therapeutic services with a capability to provide life-saving medical and psychiatric interventions;
- Has physician services, appropriately licensed behavioral health practitioners and skilled nursing services available 24-hours a day;
- Provides direct daily involvement of the physician; and
- Is licensed and legally operated in the jurisdiction where located.

Acute inpatient services are utilized when there is an immediate risk to engage in actions, which would result in death or harm to self or others or there is a deteriorating condition in which an alternative treatment setting is not appropriate.

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 are no longer registered as a bed patient.

Advanced imaging, for the purpose of this definition, includes 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 pre-existing condition exclusion, 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). 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.

Alternative medicine, for the purposes of this definition, includes, 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, shiatsue, yoga and chelation therapy.

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

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

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.

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*.

Bone marrow 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 term *bone marrow* includes the harvesting, the transplantation and the integral chemotherapy components.

C

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.

COBRA Service Provider means a provider of COBRA administrative services retained by Humana or the *employer* to provide specific COBRA administrative services.

Coinsurance means the amount expressed as a percentage of the *covered expense* that *you* must pay. The percentage of the *covered expense* this Plan pays is shown in the "Schedule of Benefits" sections.

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.

Confinement or ***confined*** means *you* are admitted as a registered bed patient as the result of a *health care practitioner's* recommendation. It does not mean *you* are 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 *you* must pay to a provider for *covered expenses*, regardless of any amounts that may be paid by this Plan, as shown in the "Schedule of Benefits" sections.

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

Covered expense means:

- *Medically necessary* services to treat a *sickness* or *bodily injury*, such as:
  - Procedures;
  - *Surgeries*;
  - Consultations;

- Advice;
- Diagnosis;
- Referrals;
- Treatment;
- Supplies;
- Drugs;
- Devices; or
- Technologies;

- *Preventive services*; or
- *Prescription* drugs, including *specialty drugs*, dispensed by a *pharmacy*.

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

- Ordered by a *health care practitioner*;
- 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 this Plan; and
- Incurred when *you* are insured for that benefit under this Plan on the date that the service is rendered.

Covered person means the *employee* or the *employee's dependents*, who are 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, 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 *health care practitioner*;
- The *health care practitioner* 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 *year* before this Plan pays benefits for certain specified *covered expenses*.

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 or *domestic partner*;
- Natural born child, step-child, legally adopted child, or child placed for adoption, whose age is less than the limiting age;
- Child whose age is less than the limiting age and for whom the *employee* has received a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN) to provide coverage, if the *employee* is eligible for family coverage until:
  - Such QMCSO or NMSN is no longer in effect; or
  - The child is enrolled for comparable health coverage, which is effective no later than the termination of the child's coverage under this Plan.
- *Domestic partner's* natural born child, step-child, legally adopted child, or child placed for adoption whose age is less than the limiting age;

  The *domestic partner's* child cannot qualify as a *dependent* prior to the *employee's domestic partner* becoming a qualified *dependent*.

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

The limiting age means the end of the birth month the *dependent* child attains age 26. Each *dependent* child is covered to the limiting age, regardless if the child is:

- Married;
- A tax dependent;
- A student;
- Employed;
- Residing or working outside of the network area;
- Residing with or receiving financial support from *you*; or
- Eligible for other coverage through employment.

A covered *dependent* child who attains the limiting age while covered under this Plan remains eligible if the covered *dependent* child is:

- Permanently mentally or physically handicapped;
- Incapable of self-sustaining employment; and
- Unmarried.

In order for the covered *dependent* child to remain eligible as specified above, this Plan must receive notification within 31 days prior to the covered *dependent* child attaining the limiting age.

You must furnish satisfactory proof to this Plan, upon request, that the conditions, as defined in the bulleted items above, continuously exist on and after the date the limiting age is reached. After two years from the date the first proof was furnished, this Plan may not request such proof more often than annually. If satisfactory proof is not submitted to this Plan, 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 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 agents for controlling blood sugar levels; prescriptive non-insulin injectable agents for controlling blood sugar levels; glucagon emergency kits; and alcohol swabs.

Distant site means the location of a *health care practitioner* at the time a *telehealth* or *telemedicine* service is provided.

Domestic partner means an individual of the same or opposite gender, who resides with the covered *employee* in a long-term relationship of indefinite duration; and, there is an exclusive, mutual commitment in which the partners agree to be jointly responsible for each other's common welfare and share financial obligations. This Plan will allow coverage for only one *domestic partner* of the covered *employee* at any one time. The *employee* and *domestic partner* must each be at a minimum 18 years of age, competent to contract, and not related by blood to a degree of closeness, which would prohibit legal marriage in the state in which the *employee* and *domestic partner* both legally reside.

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

- It is prescribed by a *health care practitioner*;
- 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 s*killed 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

Effective date means the date *your* coverage begins under this Plan.

Electronic* or *electronically means relating to technology having electrical, digital, magnetic, wireless, optical, electromagnetic, or similar capabilities.

Electronic mail means a computerized system that allows a user of a network computer system and/or computer system to send and receive messages and documents among other users on the network and/or with a computer system.

Electronic signature means an electronic sound, symbol, or process attached to, or logically associated with, a record and executed or adopted by a person with the intent to sign the record.

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

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

Emergency care means services provided in a *hospital* emergency facility for 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.

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

Employee means a person, who is in *active status* for the *employer* on a *full-time* basis. The *employee* must be paid a salary or wage by the *employer* that meets the minimum wage requirements of *your* state or federal minimum wage law for work done at the *employer's* usual place of business or some other location, which is usual for the *employee's* particular duties.

Employee also includes a sole proprietor, partner or corporate officer, where:

- The *employer* is a sole proprietorship, partnership or corporation; and

- The sole proprietor, partner or corporate officer is actively performing activities relating to the business, gains their livelihood from the sole proprietorship, partnership or corporation and is in an *active status* at the *employer's* usual place of business or some other location, which is usual for the sole proprietor's, partner's or corporate officer's particular duties.

Employer means the sponsor of this *group* Plan or any subsidiary or affiliate.

Endodontic services mean the following dental procedures, related tests or treatment and follow-up care:

- Root canal therapy and root canal fillings;
- Periradicular *surgery*;
- Apicoectomy;
- Partial pulpotomy; or
- Vital pulpotomy.

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 lacks such final FDA approval for the use or proposed use, unless (a) found to be accepted for that use in the most recently published edition of the United States Pharmacopeia-Drug Information for Healthcare Professional (USP-DI) or in the most recently published edition of the American Hospital Formulary Service (AHFS) Drug Information; or (b) identified as safe, widely used and generally accepted as effective for that use as reported in nationally recognized peer reviewed medical literature published in the English language as of the date of service;

- 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; or

- 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.

- ***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 *domestic partner*. It also means *your* or *your* spouse's or *domestic partner's* child, brother, sister, or parent.

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. An appropriately licensed birthing center is also considered a *free-standing facility*.

Full-time, for an *employee*, means a work week of 32 hours.

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

G

Group means the persons for whom this Plan coverage has been arranged to be provided.

H

Habilitative services mean health care services and devices that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

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 or *behavioral health* services and is primarily established and operating within the scope of its license.

Health insurance coverage means medical coverage under any hospital or medical service policy or certificate, hospital or medical service plan contract or health maintenance organization (HMO) contract offered by a health insurance issuer. "Health insurance issuer" means an insurance company, insurance service, or insurance organization (including an HMO) that is required to be licensed to engage in the business of insurance in a state and that is subject to the state law that regulates insurance.

Health status-related factor means any of the following:

- Health status or medical history;
- Medical condition, either physical or mental;
- Claims experience;
- Receipt of health care;
- Genetic information;
- Disability; or
- Evidence of insurability, including conditions arising out of acts of domestic violence.

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 professional medical people, including physicians 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.

Home health care plan means a plan of care and treatment for *you* to be provided in *your* home. To qualify, the *home health care plan* must be established and approved by a *health care practitioner*. The services to be provided by the plan must require the skills of a *nurse*, or another *health care practitioner* and must not be for *custodial care*.

Hospice care program means a coordinated, interdisciplinary program provided by a hospice that is designed to meet the special physical, psychological, spiritual and social needs of a terminally ill *covered person* and his or her immediate covered family members, by providing *palliative care* and supportive medical, nursing and other services through at-home or *inpatient* care. A hospice must be licensed by the laws of the jurisdiction where it is located and must be run as a hospice as defined by those laws. It must provide a program of treatment for at least two unrelated individuals, who have been medically diagnosed as having no reasonable prospect for cure for their *sickness* and, as estimated by their physicians, are expected to live 18 months or less as a result of that *sickness*.

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;
- It must <u>not</u> 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

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

Infertility services mean any diagnostic evaluation, treatment, supply, medication, or service provided to achieve pregnancy or to achieve or maintain ovulation. This includes, but is not limited to:

- Artificial insemination;
- In vitro fertilization;
- Gamete Intrafallopian Transfer (GIFT);
- Zygote Intrafallopian Transfer (ZIFT);

- Tubal ovum transfer;
- Embryo freezing or transfer;
- Sperm storage or banking;
- Ovum storage or banking;
- Embryo or zygote banking;
- Diagnostic and/or therapeutic laparoscopy;
- Hysterosalpingography;
- Ultrasonography;
- Endometrial biopsy; and
- Any other assisted reproductive techniques or cloning methods.

Inpatient means *you* are *confined* as a registered bed patient.

Intensive outpatient program 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 availability for medical and medication management.

Intensive outpatient program does not include services that are for:

- *Custodial care*; or
- Day care.

J

K

L

Late applicant means an *employee* or *dependent*, who requests enrollment for coverage under this Plan more than 31 days after his or her *eligibility date*, later than the time period specified in the "Special enrollment" provision, or after the *open enrollment period*.

Level 1 network health care practitioner means a *network health care practitioner* practicing in a *health care treatment facility* or *retail clinic:*

- With a specialty of pediatric or internal medicine; or
- Who is a general practitioner, nurse practitioner, physician assistant or registered nurse.

Level 2 network health care practitioner means a *network health care practitioner*, practicing in a *health care treatment facility*, who has received training in a specific medical field other than those listed in the *level 1 network health care practitioner* definition.

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*, other than *emergency care* services provided by *non-network providers* in a *hospital's* emergency department, 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 allowable fee for a *covered expense* for *emergency care* services provided by *non-network providers* in a *hospital's* emergency department is an amount equal to the greatest of:

- The fee negotiated with *network providers*;
- The fee calculated using the same method to determine payments for *non-network provider* services; or
- The fee paid by *Medicare* for the same services.

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

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

Medically necessary 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 nationally recognized 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*;
- Not primarily for the convenience of the patient, physician or other health care provider;
- Not more costly than an alternative 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.

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 means 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 means a body mass index (BMI) as determined by a *health care practitioner* 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 hypertension, type II diabetes, life-threatening cardiopulmonary conditions, or joint disease that is treatable, if not for the obesity.

N

Network health care practitioner means a *health care practitioner*, who has been designated as such or has signed an agreement with this Plan as an independent contractor, or who has been designated by this Plan to provide services to all *covered persons*. *Network health care practitioner* designation by this Plan may be limited to specified services.

Network hospital means a *hospital* which has been designated as such or has signed an agreement with this Plan as an independent contractor, or has been designated by this Plan to provide services to all *covered persons*. *Network hospital* designation by this Plan 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 this Plan as an independent contractor, or who has been designated by this Plan to provide services to all *covered persons*. *Network provider* designation by this Plan may be limited to specified services.

Non-network health care practitioner means a *health care practitioner* who has not been designated by this Plan as a *network health care practitioner*.

Non-network hospital means a *hospital* which has not been designated by this Plan as a *network hospital*.

Non-network provider means a *hospital*, *health care treatment facility*, *health care practitioner*, or other health services provider who has not been designated by this Plan 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 practitioner* decide if *you* need to be admitted as an *inpatient*.

Open enrollment period means no less than a 31 day period of time, occurring annually for the *group,* during which the *employees* have an opportunity to enroll themselves and their eligible *dependents* for coverage under this Plan.

Oral surgery means procedures to correct diseases, injuries and defects of the jaw and mouth structures. These procedures include, but are not limited to, the following:

- Surgical removal of full bony impactions;
- Mandibular or maxillary implant;
- Maxillary or mandibular frenectomy;
- Alveolectomy and alveoplasty;
- Orthognathic *surgery*;
- *Surgery* for treatment of temporomandibular joint syndrome/dysfunction; and
- Periodontal surgical procedures, including gingivectomies.

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

Out-of-pocket limit means the amount of *covered expenses* which must be paid by *you*, either individually or combined as a covered family, per *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 services provided by a *hospital* or *health care treatment facility* in which patients do not reside for a full 24-hour period:

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

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

- That has physicians and appropriately licensed behavioral health practitioners readily available for the emergent and urgent 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 *partial hospitalization* services.

Partial hospitalization does not include services that are for:

- *Custodial care*; or
- Day care.

Periodontics means the branch of dentistry concerned with the study, prevention, and treatment of diseases of the tissues and bones supporting the teeth. *Periodontics* includes the following dental procedures, related tests or treatment and follow-up care:

- Periodontal maintenance;
- Scaling and root planing;
- Gingivectomy;
- Gingivoplasty; or
- Osseous surgical procedures.

Plan Administrator means Specialty Composites Group, LTD.

Plan Manager means Humana Health Plan, Inc. 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 Specialty Composites Group, LTD.

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

Pre-service claim means a 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.

Pre-surgical/procedural testing means:

- Laboratory tests or radiological examinations done on an *outpatient* basis in a *hospital* or other facility accepted by the *hospital* before *hospital confinement* or *outpatient surgery* or procedure;
- The tests must be accepted by the *hospital* or *health care practitioner* in place of like tests made during *confinement*; and
- The tests must be for the same *bodily injury* or *sickness* causing *you* to be *hospital confined* or to have the *outpatient surgery* or procedure.

Preauthorization means approval by this Plan, or this Plan's designee, of a service prior to it being provided. Certain services require medical review by this 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.

Preventive services means services in the following recommendations appropriate for *you* during *your* plan *year*:

- 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 or call the customer service telephone number on *your* identification card.

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

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

Q

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

- That is licensed by the appropriate state agency to:

    - Diagnose or treat a *sickness* or *bodily injury*; or
    - Provide *preventive services*;

- That provides services within the scope of their license; and
- Whose primary purpose is to provide health care services.

R

Rehabilitation facility means any licensed public or private establishment which has permanent facilities that are equipped and operated primarily to render physical and occupational therapies, diagnostic services and other therapeutic services.

Rescission, ***rescind*** or ***rescinded*** means a cancellation or discontinuance of coverage that has a retroactive effect.

Residential treatment facility means an institution that:

- Is licensed as a 24-hour residential facility for *behavioral health* 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, for a minimum of 6 hours a day.

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

Retail clinic means a *health care treatment facility*, located in a retail store, that is often staffed by nurse practitioners 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.

Routine nursery care means the charges made by a *hospital* or licensed birthing center for the use of the nursery. It includes normal services and supplies given to well newborn children following birth. *Health care practitioner* visits are not considered *routine nursery care*. Treatment of a *bodily injury*, *sickness*, birth abnormality, congenital defect following birth and care resulting from prematurity is not considered *routine nursery care*.

S

Self-administered injectable drugs means an FDA approved medication which a person may administer to himself or herself by means of intramuscular, intravenous, or subcutaneous injection, excluding insulin, and prescribed for use by *you*.

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, or engaged in the care and treatment of *chemical dependency*.

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).

Special enrollment date means the date of:

- Change in family status after the *eligibility date*;
- Loss of other coverage under another group health plan or other *health insurance coverage*;
- COBRA exhaustion;
- Loss of coverage under *your employer's* alternate plan;
- Termination of your *Medicaid* coverage or your Children's Health Insurance Program (CHIP) coverage as a result of loss of eligibility; or
- Eligibility for a premium assistance subsidy under *Medicaid* or CHIP.

To be eligible for special enrollment, *you* must meet the requirements specified in the "Special enrollment" provision within the "Eligibility and Effective Dates" section of this *SPD*.

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

Surgery means services categorized as Surgery in the Current Procedural Terminology (CPT) Manuals published by the American Medical Association. The term *surgery* includes, but is not limited to: excision or incision of the skin or mucosal tissues or 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; and treatment of fractures.

T

Telehealth means an audio and video real-time interactive communication between a patient and a *health care practitioner* at a *distant site*.

Telemedicine means services, other than *telehealth* provided via telephonic or electronic communications.

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 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*.

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

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.

V

W

Waiting period means the period of time, elected by *your employer*, that must pass before an *employee* is eligible for coverage under this Plan.

X

Y

Year means the period of time which begins on any January 1st and ends on the following December 31st. When *you* first become covered by this Plan, the first *year* begins for *you* on the *effective date* of *your* coverage and ends on the following December 31st.

You or ***your*** means any *covered person*.

Z

PRESCRIPTION DRUG BENEFIT

Reading this "Prescription drug benefit" section will help *you* understand:

- The level of benefits *we* generally pay for the *prescription* drugs, medicines or medications, including *specialty drugs*, covered under this Plan;
- The *copayment* and/or *coinsurance* amount *you* are required to pay; and
- The required *deductible* amount to be met, if any, before benefits are paid; and
- *Prior authorization* requirements.

This "Prescription drug benefit" outlines the coverage and limitations provided under this Plan. A more detailed explanation of *your* coverage and its limitations and exclusions for these benefits is provided in the "Covered Expenses – Pharmacy Services," "Limitations and Exclusions" and "Limitations and Exclusions – Pharmacy Services" sections of this *SPD*.

Covered expenses for *prescription* drugs and *specialty drugs* obtained from a *network pharmacy* under provisions of this benefit apply toward *your out-of-pocket limit*.

For the purposes of coordination of benefits, *prescription* drug coverage under this benefit will be considered a separate plan and will therefore only be coordinated with other *prescription* drug coverage.

All terms used in this "Prescription drug benefit" have the meaning given to them in the "Glossary" section, unless otherwise specifically defined in the "Glossary – Pharmacy Services" section of this *SPD*. All services are subject to all of the terms, provisions, limitations and exclusions of this Plan, unless otherwise stated.

Prior authorization requirements

Prior authorization and/or *step therapy* is required for certain *prescription* drugs, medicines or medications, including *specialty drugs*. Visit Humanas Website at www.humana.com or call the customer service telephone number on *your* identification card to obtain the *drug list* that identifies the drugs, medicines or medications, including *specialty drugs* that require *prior authorization* and/or *step therapy*. The *drug list* is subject to change. Coverage provided in the past is not a guarantee of future coverage.

Your health care practitioner must contact Humanas Clinical Pharmacy Review to request and receive *our* approval for *prescription* drugs, medicines or medications, including *specialty drugs* that require *prior authorization* and/or *step therapy*. Benefits are payable only if approved by this Plan.

PRESCRIPTION DRUG BENEFIT (continued)

Preventive medication coverage

Drugs, medicines or medications and supplies on the Preventive Medication Coverage *drug list* are covered in full when obtained from a *network pharmacy* with a *prescription* from a *health care practitioner.*

Prescription drug cost sharing

You are responsible for any and all *cost share*, when applicable, as specified below. If the dispensing *pharmacy's* charge is less than *your copayment* or *coinsurance* for *prescription* drugs, *you* will be responsible for the dispensing *pharmacy* charge amount. The amount paid by *us* to the dispensing *pharmacy* may not reflect the ultimate cost to *us* for the drug. *Your copayment* or *coinsurance* is made on a per *prescription* fill or refill basis and will not be adjusted if *we* receive any retrospective volume discounts or *prescription* drug rebates.

Retail pharmacy	**Coverage for up to a 30-day supply**
Network pharmacy	70% benefit payable per *prescription* fill or refill after *network provider deductible*
Non-network pharmacy	50% benefit payable per prescription fill or refill after non-network provider deductible

90-day Retail pharmacy

Some retail *pharmacies* participate in this Plans program, which allows *you* to receive a 90-day supply of a *prescription* fill or refill. After the *deductible* is met, *your* cost is based on the applicable benefit amount specified above. *Specialty drugs* are limited to a 30-day supply from a *specialty pharmacy* or a retail *pharmacy*, unless otherwise determined by this Plan.

Mail order pharmacy	**90-day supply**

Specialty drugs are not included. Refer to the "Specialty pharmacy / Retail pharmacy" provision below for *specialty drug* benefits.

Network pharmacy	70% benefit payable per *prescription* fill or refill after *network provider deductible*
Non-network pharmacy	50% benefit payable per *prescription* fill or refill after *non-network provider deductible*

COVERED EXPENSES – PHARMACY SERVICES

This "Covered Expenses – Pharmacy Services" section describes *covered expenses* under this Plan for *prescription* drugs, including *specialty drugs*, dispensed by a *pharmacy*. Benefits are subject to applicable *cost share* shown on the "Schedule of Benefits – Pharmacy Services" section of this *SPD*.

Refer to the "Limitations and Exclusions", "Limitations and Exclusions – Pharmacy Services", "Glossary" and "Glossary – Pharmacy Services" sections in this *SPD*. All terms and provisions of this Plan apply, including *prior authorization* requirements specified in the "Schedule of Benefits – Pharmacy Services" of this *SPD*.

Coverage description

This Plan will cover *prescription* drugs that are received by *you* under this "Covered Expenses – Pharmacy Services" section. Benefits may be subject to *dispensing limits*, *prior authorization* and *step therapy* requirements, if any.

Covered *prescription* drugs are:

- Drugs, medicines or medications and *specialty drugs* that under federal or state law may be dispensed only by *prescription* from a *health care practitioner*.
- Drugs, medicines or medications and *specialty drugs* included on this Plan's *drug list*.
- Insulin and *diabetes supplies*.
- *Self-administered injectable drugs* approved by this Plan.
- Hypodermic needles, syringes or other methods of delivery when prescribed by a *health care practitioner* for use with insulin or *self-administered injectable drugs*. (Hypodermic needles, syringes or other methods of delivery used in conjunction with covered drugs may be available at no cost to *you*).
- Enteral formulas and nutritional supplements for the treatment of phenylketonuria (PKU) or other inherited metabolic disease, or as otherwise determined by this Plan.
- Spacers and/or peak flow meters for the treatment of asthma.
- Drugs, medicines or medications on the Preventive Medication Coverage *drug list* with a *prescription* from a *health care practitioner*.

Notwithstanding any other provisions of this Plan, this Plan may decline coverage or, if applicable, exclude from the *drug list* any and all *prescriptions* until the conclusion of a review period not to exceed six months following FDA approval for the use and release of the *prescriptions* into the market.

About our drug list

Prescription drugs, medicines or medications, including *specialty drugs* and *self-administered injectable drugs* prescribed by *health care practitioners* and covered by this Plan are specified on Humana's printable *drug list*. The *drug list* identifies categories of drugs, medicines or medications by levels. It also indicates *dispensing limits*, *specialty drug* designation and any applicable *prior authorization* or *step therapy* requirements. This information is reviewed on a regular basis by a Pharmacy and Therapeutics committee made up of physicians and *pharmacists*. Placement on the *drug list* does not guarantee *your health care practitioner* will prescribe that *prescription* drug, medicine or medication for a particular medical condition. *You* can obtain a copy of this Plan's *drug list* by visiting Humana's Website at www.humana.com or calling the customer service telephone number on *your* identification card.

Access to non-formulary contraceptives

A *covered person* may gain access to non-formulary contraceptive drugs with no cost-sharing when a *health care practitioner* recommends and determines that a particular method of contraception or FDA-approved contraceptive item is *medically necessary*.

LIMITATIONS AND EXCLUSIONS – PHARMACY SERVICES

The "Limitations and Exclusions – Pharmacy Services" section describes the limitations and exclusions under this Plan that apply to *prescription* drugs, including *specialty drugs*, dispensed by a *pharmacy*. Please refer to the "Limitations and Exclusions" section of this *SPD* for additional limitations.

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

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

- *Legend drugs,* which are not deemed *medically necessary* by this Plan.
- *Prescription* drugs not included on the *drug list*.
- Any amount exceeding the *default rate*.
- More than two fills for the same *specialty drug* obtained from a *pharmacy* which is not designated by this Plan as a preferred provider of *specialty drugs*.
- *Specialty drugs* for which coverage is not approved by this Plan.
- Drugs and/or ingredients not approved by the FDA, including bulk compounding ingredients.
- Any drug prescribed for intended use other than for:
    - Indications approved by the FDA; or
    - Off-label indications recognized through peer-reviewed medical literature.
- Any drug prescribed for a *sickness* or *bodily injury* not covered under this Plan.
- Any drug, medicine or medication that is either:
    - Labeled "Caution - limited by federal law to investigational use"; or
    - *Experimental, investigational* or *for research purposes,* even though a charge is made to *you*.
- Allergen extracts.

LIMITATIONS AND EXCLUSIONS – PHARMACY SERVICES (continued)

- Therapeutic devices or appliances, including, but not limited to:

  - Hypodermic needles and syringes (except when prescribed by a *health care practitioner* for use with insulin and *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. Refer to the "Covered Expenses" section of the *SPD* for coverage of low protein modified foods.

- Nutritional products.

- Minerals.

- Growth hormones for idiopathic short stature or any other condition, unless there is a laboratory confirmed diagnosis of growth hormone deficiency, or as otherwise determined by this Plan.

- Herbs and vitamins, except prenatal (including greater than one milligram of folic acid), pediatric multi-vitamins with fluoride and vitamins on the Preventive Medication Coverage *drug list* when obtained from a *network pharmacy* with a *prescription* from a *health care practitioner*.

- Anorectic or any drug used for the purpose of weight control.

- Any drug used for cosmetic purposes, including, but not limited to:

  - Dermatological or hair growth stimulants; or
  - Pigmenting or de-pigmenting agents.

- Any drug or medicine that is lawfully obtainable without a *prescription* (over-the-counter drugs), except:

  - Insulin; and

  - Drugs, medicines or medications and supplies on the Preventive Medication Coverage *drug list* when obtained from a *network pharmacy* with a *prescription* from a *health care practitioner*.

LIMITATIONS AND EXCLUSIONS – PHARMACY SERVICES (continued)

- Any drug or medicine that is available in prescription strength without a *prescription*.

- Compounded drugs in any dosage form, except when prescribed for pediatric use for children up to 19 years of age, or as otherwise determined by this Plan.

- Abortifacients (drugs used to induce abortions).

- *Infertility services* including medications.

- Any drug prescribed for impotence and/or sexual dysfunction.

- Any drug, medicine or medication that is consumed or injected at the place where the *prescription* is given, or dispensed by the *health care practitioner*.

- The administration of covered medication(s).

- *Prescriptions* that are to be taken by or administered to *you*, in whole or in part, while *you* are a patient in a facility where drugs are ordinarily provided on an *inpatient* basis by the facility. *Inpatient* facilities include, but are not limited to:

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

- Injectable drugs, including, but not limited to:

  - Immunizing agents, unless for *preventive services* determined by this Plan to be dispensed by or administered in a *pharmacy*;
  - Biological sera;
  - Blood;
  - Blood plasma; or
  - *Self-administered injectable drugs* or *specialty drugs* for which *prior authorization* or *step therapy* is not obtained from this Plan.

- *Prescription* fills or refills:

  - In excess of the number specified by the *health care practitioner*; or
  - Dispensed more than one year from the date of the original order.

- Any portion of a *prescription* fill or refill that exceeds a 90-day supply when received from a *mail order pharmacy* or a retail *pharmacy* that participates in Humana's program, which allows *you* to receive a 90-day supply of a *prescription* fill or refill.

LIMITATIONS AND EXCLUSIONS – PHARMACY SERVICES (continued)

- Any portion of a *prescription* fill or refill that exceeds a 30-day supply when received from a retail *pharmacy* that does not participate in Humana's program, which allows *you* to receive a 90-day supply of a *prescription* fill or refill.

- Any portion of a *specialty drug prescription* fill or refill that exceeds a 30-day supply, unless otherwise determined by this Plan.

- Any portion of a *prescription* fill or refill that:

  - Exceeds this Plan drug-specific *dispensing limit*;
  - Is dispensed to a *covered person*, whose age is outside the drug-specific age limits defined by this Plan;
  - Is refilled early, as defined by this Plan; or
  - Exceeds the duration-specific *dispensing limit*.

- Any drug for which this Plan requires *prior authorization* or *step therapy* and it is not obtained.

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

- Any drug, medicine or medication received by *you*:

  - Before becoming covered; or
  - After the date *your* coverage 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 *you*.

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

- Drug delivery implants and other implant systems or devices.

- 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*.

GLOSSARY – PHARMACY SERVICES

All terms used in the "Schedule of Benefits – Pharmacy Services", "Covered Expenses – Pharmacy Services" and "Limitations and Exclusions – Pharmacy Services" sections have the same meaning given to them in the "Glossary" section of this *SPD*, unless otherwise specifically defined below:

A

B

Brand-name drug 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 this Plan.

C

Copayment means the specified dollar amount to be paid by *you* toward the cost of each separate *prescription* fill or refill dispensed by a *pharmacy*.

Cost share means any *deductible* and *coinsurance* that *you* must pay per *prescription* fill or refill.

D

Default rate means the fee based on rates negotiated by this Plan or other payers with one or more *network providers* in a geographic area determined by this Plan for the same or similar *prescription* fill or refill.

Dispensing limit means the monthly drug dosage limit and/or the number of months the drug usage is commonly prescribed to treat a particular condition, as determined by this Plan.

Drug list means a list of covered *prescription* drugs, medicines or medications and supplies specified by this Plan. The *drug list* identifies categories of drugs, medicines or medications and supplies by applicable levels, if any, and indicates applicable *dispensing limits*, *specialty drug* designation and/or any *prior authorization* or *step therapy* requirements. Visit Humana's Website at www.humana.com or call the customer service telephone number on *your* ID card to obtain the *drug list*. The *drug list is* subject to change without notice.

E

F

GLOSSARY – PHARMACY SERVICES (continued)

G

Generic drug 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 this Plan.

H

I

J

K

L

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".

M

Mail order pharmacy means a *pharmacy* that provides covered *mail order pharmacy* services, as defined by this Plan, and delivers covered *prescription* drug, medicine or medication fills or refills through the mail to *covered persons*.

GLOSSARY – PHARMACY SERVICES (continued)

N

Network pharmacy means a *pharmacy* that has signed a direct agreement with this Plan or has been designated by this Plan to provide:

- Covered *pharmacy* services;
- Covered *specialty pharmacy* services; or
- Covered *mail order pharmacy* services, as defined by this Plan, to *covered persons*, including covered *prescription* fills or refills delivered to *your* home or health care provider.

Non-network pharmacy means a *pharmacy* that has not signed a direct agreement with this Plan or has not been designated by this Plan to provide:

- Covered *pharmacy* services;
- Covered *specialty pharmacy* services; or
- Covered *mail order pharmacy* services, as defined by this Plan, to *covered persons*, including covered *prescription* fills or refills delivered to *your* home or health care provider.

O

P

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, medicines or 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 written by a *health care practitioner* 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, or for drugs, medicines or medications on the Preventive Medication Coverage *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 Preventive Medication Coverage *drug list*. The *prescription* may be given to the *pharmacist* verbally, *electronically* or in writing by the *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 *health care practitioner*.

Prior authorization means the required prior approval from Humana for the coverage of certain *prescription* drugs, medicines or medications, including *specialty drugs*. The required prior approval from Humana for coverage includes the dosage, quantity and duration, as *medically necessary* for the *covered person*.

Q

R

S

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 *health care practitioner* 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.

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

Step therapy means a type of *prior authorization*. This Plan may require *you* to follow certain steps prior to coverage of some medications, including *specialty drugs*. This Plan may also require *you* to try similar drugs, medicines or medications, including *specialty drugs* that have been determined to be safe, effective and more cost-effective for most people with *your* condition. Alternatives may include over-the-counter drugs, *generic drugs* and *brand-name drugs*.

T

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V

W

X

Y

Z

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