Humana

SUMMARY PLAN DESCRIPTION

For the

CONTRACEPTIVE BENEFITS PLAN

Humana

INTRODUCTION

YOUR SUMMARY PLAN DESCRIPTION

This Contraceptive Benefits Plan (Plan) is administered either by Humana Insurance Company or Humana Health Plan, Inc. ("Humana"). Humana has made available to *you* this *Summary Plan Description* (*SPD*), which outlines *your* contraceptive benefits, as well as *your* rights and responsibilities under this Plan.

This *SPD* is *your* guide to the benefits and provisions 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 "Contraceptive Medical Benefits", "Contraceptive Prescription Drug Benefits" and "Limitations and Exclusions" sections to better understand how *your* benefits work. If *you* are unable to find the information *you* need, please contact Humana at the toll-free customer service number on *your* Humana Identification (ID) card.

DEFINED TERMS

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

PRIVACY

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

CONTACT INFORMATION

Customer Service Telephone Number:

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

Medical Claims Submittal Address:
Humana Claims Office
P.O. Box 14601
Lexington, KY 40512-4601

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

Claims Appeal Address:
Humana Grievance and Appeals
P.O. Box 14546
Lexington, KY 40512-4546

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SECTION 1

ELIGIBILITY

ELIGIBILITY

ELIGIBILITY FOR COVERAGE UNDER THIS PLAN

If *you* are eligible for coverage under *your employer's* self-funded plan administered by Humana (as an *employee* or a *dependent*), *you* are eligible for coverage under this Plan. If *you* have questions regarding *your* eligibility under *your employer's* self-funded plan, please refer to *your employer's* summary plan description.

Eligibility for Contraceptive Medical Benefits

If *your employer* does not have medical health plan coverage with Humana, *you* and *your* covered *dependents* will NOT have contraceptive coverage under the "Contraceptive Medical Benefits" section. Please refer to Section 3, "Contraceptive Prescription Drug Benefits" for *your* contraceptive *prescription* drug benefits coverage.

Eligibility for Contraceptive Prescription Drug Benefits

If *your employer* does not have *prescription* drug coverage with Humana, *you* and *your* covered *dependents* will NOT have contraceptive coverage under the "Contraceptive Prescription Drug Benefits" section. Please refer to Section 2, "Contraceptive Medical Benefits" for *your* contraceptive medical benefits coverage.

TERMINATION OF COVERAGE

Coverage terminates on the earliest of the following:

1. The date this Plan terminates;

2. The date *your employer* terminates their self-funded plan with Humana;

3. The date *you* or *your dependent* fail to be eligible for *your employer's* self-funded plan, according to the eligibility requirements of *your employer*;

4. For any benefit, the date the benefit is removed from this Plan.

SECTION 2

CONTRACEPTIVE MEDICAL BENEFITS

CONTRACEPTIVE MEDICAL BENEFITS

SCHEDULE OF CONTRACEPTIVE MEDICAL BENEFITS

Additional benefit and *participating provider* information can be obtained by calling the toll-free customer service number on the back *your* Humana ID card.

SERVICES	BENEFIT
Contraceptive Methods, which include: devices (e.g. IUD or diaphragms), injections, implant insertion/removal, emergency contraceptives, condoms and sterilization (tubal ligation and vasectomy)	Covered at 100% when *services* are received from a *participating provider*. *Services* received from a *non-participating provider* are not covered.
To the extent required by the Affordable Care Act, age limits do not apply to contraceptive methods. Birth control pills and patches and spermicide are not covered under this "Contraceptive Medical Benefits" section. Please refer to the "Contraceptive Prescription Drug Benefits" section for these benefits.	

SECTION 3

CONTRACEPTIVE PRESCRIPTION DRUG BENEFITS

CONTRACEPTIVE PRESCRIPTION DRUG BENEFITS

SCHEDULE OF CONTRACEPTIVE PRESCRIPTION DRUG BENEFITS

Additional benefit and *participating pharmacy* information can be obtained by calling the toll-free customer service number on the back *your* Humana ID card.

SERVICES	BENEFIT
Contraceptives Obtained from a Retail *Participating Pharmacy*	Covered at 100% for a 30-day supply of a *prescription* or refill or a 90-day supply of a *prescription* or refill from a *pharmacy* that participates in a program which allows *you* to obtain a 90-day supply.
Contraceptives Obtained from a *Mail Order Pharmacy* that is a *Participating Pharmacy*	Covered at 100% for a 90-day supply of a *prescription* or refill.

ADDITIONAL CONTRACEPTIVE PRESCRIPTION DRUG INFORMATION

This Plan requires the use of *generic medications* when they are available. If *you* choose to purchase a *brand name medication*, when an equivalent *generic medication* is available, *you* will responsible for the full cost of the *brand name medication*, regardless of who is requesting the *brand name medication*. If *your qualified practitioner* indicates on the *prescription* "dispense as written," the drug will be dispensed as such however, *you* will be required to pay the full cost of the *brand name medication*. A *brand name medication* will be paid the same as a *generic medication* if an equivalent *generic medication* is not available.

Participating Pharmacy

When a *participating pharmacy* is used and *you* do not present *your* I.D. card at the time of purchase, *you* must pay the *pharmacy* the full retail price and submit the *pharmacy* receipt to Humana at the address listed below.

Mail *pharmacy* receipts to:

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

Non-participating Pharmacy

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

RETAIL AND MAIL ORDER PRESCRIPTIONS

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

This Plan includes a retail *prescription* drug benefit for contraceptives. *You* will receive an ID card which includes *your* name, group number and *your* effective date. Present *your* ID card at a *participating pharmacy* when purchasing a *prescription*.

This Plan also includes a *mail order pharmacy* benefit, allowing participants an easy and convenient way to obtain contraceptive *prescription* drugs. Additional *mail order pharmacy* information can be obtained by calling the toll-free customer service phone number on the back of *your* ID card.

Prescriptions dispensed at a retail *pharmacy* or *mail order pharmacy* will only be filled with the quantity prescribed by *your qualified practitioner* and are limited to the day supply per *prescription* or refill as shown on the Schedule of Contraceptive Prescription Drug Benefits. *You* are responsible for payment of the cost of any quantity of medication dispensed in excess of the day supply.

PRESCRIPTION DRUG COVERAGE

Because this Plan may make updates to which contraceptive *prescription* drugs are approved or not approved for coverage, *you* must call the toll-free customer service phone number on the back of *your* ID card to verify whether a *prescription* drug is covered or not covered under this Plan.

Covered *prescription* drugs, medicine or medications must:

1. Be prescribed by a *qualified practitioner*; and

2. Be dispensed by a *pharmacist*.

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

SECTION 4

LIMITATIONS AND EXCLUSIONS

LIMITATIONS AND EXCLUSIONS

No benefits are payable under any provision of this Plan for:

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

2. Any medical or *prescription service*, drug, medicine, medication or supply that is: a) not a contraceptive; b) not for contraceptive purposes; or c) not approved for coverage under this Plan. If *you* are unsure whether or not a particular medical or *prescription service*, drug, medicine, medication or supply is covered under this Plan, please call the toll-free customer service phone number on the back of *your* ID card;

3. Contraceptive *services* under the "Contraceptive Medical Benefits" section if *your employer* does not have medical health plan coverage with Humana or contraceptive *services* under the "Contraceptive Prescription Drug Benefits" section if *your employer* does not have *prescription* drug coverage with Humana (see the "Eligibility" section of this *SPD*);

4. Medical *services* received from a *non-participating provider* or *prescriptions* filled at a *non-participating pharmacy*;

5. *Brand name medications* when an equivalent *generic medication* is available;

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

7. *Services* for a reversal of sterilization;

8. Medical or surgical abortions; abortifacients;

9. Minerals, herbs and vitamins;

10. Any medical treatment, procedure, biological product or device which is *experimental, investigational or for research purposes*, unless otherwise determined by this Plan;

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

12. Therapeutic devices or appliances, including, but not limited to: hypodermic needles and syringes; mechanical pumps for delivery of medications; drug delivery implants; test reagents; and other non-medical substances not required by the Health Resources and Services Administration's preventive services guidelines for women;

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

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

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

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

17. Repackaged drugs;

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

19. 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*;

20. More than one *prescription* or refill for the same drug or therapeutic equivalent medication prescribed by one or more *qualified practitioners* and dispensed by one or more *pharmacies* until *you* have used, or should have used, at least 75% of the previous *prescription* or refill. If the drug or therapeutic equivalent medication is purchased through a *mail order pharmacy*, until *you* have used, or should have used, at least 66% of the previous *prescription* or refill. If the drug or therapeutic equivalent medication is purchased through a retail *pharmacy* that participates in the program which allows *you* to receive a 90 day supply of a *prescription* or refill at a retail *pharmacy*, until *you* have used, or should have used, at least 66% of the previous *prescription* or refill (based on the dosage schedule prescribed by the *qualified practitioner*);

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

22. *Off-evidence drug indications*;

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

24. Education or training including, but not limited to, educational or vocational videos, tapes, books and similar materials unless otherwise determined by this Plan;

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

26. *Expenses incurred* for which *you* are entitled to receive benefits under *your* previous medical or *prescription* drug plan;

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

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

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

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

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

32. Lodging accommodations or transportation;

33. Communications or travel time;

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

35. The following are specifically excluded under the contraceptive medical benefits:
    a. Contraceptive pills, patches and spermicide;
    b. *Prescription* drugs, unless administered to *you* while inpatient in a *hospital*, *qualified treatment facility* or skilled nursing facility; or by the following, when deemed appropriate by this Plan: a *qualified practitioner*, during an office visit, while outpatient, or at a home health care agency as part of a covered home health care plan approved by this Plan.

36. The following are specifically excluded under the contraceptive *prescription* drug benefits:
    a. Charges for the administration or injection of any drug;
    b. Any drug, medicine or medication that is consumed or injected at the place where the *prescription* is given, or dispensed by the *qualified practitioner*;
    c. *Prescriptions* that are to be taken by or administered to the *covered person*, in whole or in part, while he or she is a patient in a facility where drugs are ordinarily provided by the facility on an inpatient basis. Inpatient facilities include, but are not limited to a *hospital*, skilled nursing facility or hospice facility.

SECTION 5

CLAIM PROCEDURES

CLAIM PROCEDURES

SUBMITTING A CLAIM

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

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

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

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

- Claims submissions must be timely. Claims must be filed as soon as reasonably possible after they are incurred, and in no event later than 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:
  a. The name of the *covered person* who incurred the *covered expense*;
  b. The name and address of the health care provider;
  c. The procedure or nature of the item and/or *service*;
  d. The date of and place where the procedure, item, or treatment has been or will be provided;
  e. The amount billed and the amount of the *covered expense* not paid through coverage other than Plan coverage, as appropriate;
  f. 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.

Mail medical claims and correspondence to:

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

Mail *prescription* drug claims and correspondence to:

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

PROCEDURAL DEFECTS

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

ASSIGNMENTS AND REPRESENTATIVES

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

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

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

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

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

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

CLAIMS DECISIONS

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

Pre-Service Claims

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

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

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

Urgent Care Claims

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

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

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

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

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

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

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

Concurrent Care Decisions

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

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

Post-Service Claims

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

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

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

TIMES FOR DECISIONS

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

PAYMENT OF CLAIMS

Many health care providers will request an assignment of benefits as a matter of convenience to both provider and patient. Also as a matter of convenience, Humana will, in its sole discretion, assume that an assignment of benefits has been made to certain Network Providers. In those instances, Humana will make direct payment to the *hospital*, clinic or physician's office, unless Humana is advised in writing that *you* have already paid the bill. If *you* have paid the bill, please indicate on the original statement, "paid by *employee*," and send it directly to Humana. *You* will receive a written explanation of 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:

1. The date of *service*;

2. The health care provider;

3. The claim amount, if applicable;

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

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

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

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

INITIAL DENIAL NOTICES

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

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

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

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

The notice will also disclose any internal Plan rule, protocol or similar criterion that was relied on to deny the claim. A copy of the rule, protocol or similar criterion relied upon will be provided to a *claimant* free of charge upon request. *Claimants* may also, upon request, be given reasonable access to, and copies of, all documents, records, and other information to their claim for benefits.

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 *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:

1. Relied on in making the determination;

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

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

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

FULL AND FAIR REVIEW

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

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

RIGHT TO REQUIRE MEDICAL EXAMINATIONS

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

EXHAUSTION

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

A *claimant* may seek immediate *external review* of an *adverse benefit determination* if Humana fails to strictly adhere to the requirements for internal claims and *appeals* processes set forth by the federal regulations, unless the violation was: a) Minor; b) Non-prejudicial; c) Attributable to good cause or matters beyond this 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 this 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 this Plan met this standard, the *claimant* has the right to resubmit and pursue the internal *appeal* of the claim.

LEGAL ACTIONS AND LIMITATIONS

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

STANDARD EXTERNAL REVIEW

Request for an External Review

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

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

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

Preliminary Review

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

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

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

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

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

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

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

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

Referral to an Independent Review Organization (IRO)

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

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

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

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

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

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

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

f. Any applicable clinical review criteria developed and used by this Plan, unless inconsistent with the terms of this Plan or with applicable law; and

g. The opinion of the *IRO's* clinical reviewer(s) after considering the information described above to the extent the information or documents are available and the reviewer(s) consider them appropriate.

6. The assigned *IRO* must provide written notice of the *final external review decision* within 45 days after receiving the *external review* request to the *claimant* and Humana. The decision notice must contain the following:

   a. A general description of the reason an *external review* was requested, including information sufficient to identify the claim including:
      (1) The date(s) of *service*;
      (2) The health care provider;
      (3) The claim amount (if applicable); and
      (5) The treatment
      (4) The reason for the previous denial.

   b. The date the *IRO* received assignment to conduct the *external review* and the date of the *IRO* decision;

   c. References to the evidence or documentation considered in reaching the decision, including the specific coverage provisions and evidence-based standards;

   d. A discussion of the principal reason(s) for its decision, including the rationale and any evidence-based standards relied on in making the decision;

   e. A statement that the determination is binding except to the extent that other remedies may be available under state or federal law to either Humana or the *claimant*;

   f. A statement that judicial review may be available to the *claimant*; and

   g. Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under PPACA (section 2793 of PHSA, as amended).

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

Reversal of this Plan's Decision

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

EXPEDITED EXTERNAL REVIEW

Request for an Expedited External Review

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

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

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

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

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

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

Preliminary Review

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

Referral to an Independent Review Organization (IRO)

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

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

Notice of Final External Review Decision

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

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

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

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

A state office of consumer assistance or ombudsman may be available to assist *you* with internal claims and *appeals* and *external review* processes. To verify whether or not *your* state has an assistance program, visit www.dol.gov/ebsa/healthreform, and click on "Internal Claims and Appeals and External Review", then "Guidance", then "Consumer Assistance Programs".

SECTION 6

GENERAL PROVISIONS AND REIMBURSEMENT/ SUBROGATION

GENERAL PROVISIONS

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

PLAN FUNDING

This Plan is funded by Humana, not *employer* contributions or contributions from *you.*

DISCRETIONARY AUTHORITY OF PLAN ADMINISTRATOR

The *Plan Administrator* and its delegate (if any) have discretionary authority to interpret and administer this Plan and make any required factual determinations.

CONFLICT BETWEEN SPD AND PLAN DOCUMENT

In the event of a conflict between this *SPD* and the Plan Document, the Plan Document shall control.

RESCISSION

This Plan will rescind coverage only due to fraud or an intentional misrepresentation of a material fact. Rescission is a cancellation or discontinuance of coverage that has a retroactive effect. A cancellation or discontinuance is not a rescission if the cancellation or discontinuance of coverage has only a prospective effect, or the cancellation or discontinuance of coverage is effective retroactively, to the extent it is attributable to a failure to timely pay premium or costs of coverage.

CONTESTABILITY

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

RIGHT TO REQUEST OVERPAYMENTS

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

1. Made in error; or

2. 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:

1. The Workers' Compensation benefits are in dispute or are made by means of settlement or compromise;

2. No final determination is made that *bodily injury* or *sickness* was sustained in the course of, or resulted from, *your* employment;

3. The amount of Workers' Compensation due to medical or health care is not agreed upon or defined by *you* or the Workers' Compensation carrier;

4. 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

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

REIMBURSEMENT/SUBROGATION

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

1. 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.

2. 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*.

3. 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*.

4. 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.

SECTION 7

NOTICES

IMPORTANT NOTICES FOR EMPLOYEES AND SPOUSES AGE 65 AND OVER

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

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

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

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

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

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

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

PRIVACY OF PROTECTED HEALTH INFORMATION

This Plan is required by law to maintain the privacy of *your protected health information* (as defined by HIPAA) 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, individuals who perform Plan-related functions, 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. 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 the *Plan Administrator*, 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* which shall only be made with due regard for confidentiality.

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

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.

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.

CONTINUATION OF COVERAGE (COBRA AND USERAA)

THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1986 (COBRA)

COBRA coverage under the Plan will be available as long as *you* have coverage under *your employer's* health benefit plan. Please see *your employer* for more information regarding continuation of benefits under *your employer's* health benefit plan.

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 this 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 YOUR PLAN AND BENEFITS

1. 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.

2. 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.

3. 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

1. Continue health care coverage for *yourself*, spouse or *dependents* if there is a loss of coverage under *your employer's* health benefits plan (and as a result, this Plan) as a result of a qualifying event. Review *your employer's* summary plan description and plan documents governing *your* COBRA continuation coverage rights.

2. Reduction or elimination of exclusionary periods of coverage for pre-existing conditions under the Plan, if *you* have creditable coverage from another Plan. *You* should be provided a certificate of creditable coverage, free of charge, from *your* group Plan or insurance issuer when:

   - *You* lose coverage under this Plan;
   - *You* become entitled to elect COBRA continuation coverage;
   - *Your* COBRA continuation coverage ceases, if *you* request it before losing coverage, or if *you* request it up to 24 months after losing coverage.

   Without evidence of creditable coverage, *you* may be subject to a pre-existing condition exclusion for 12 months (18 months for late applicants) after *your* enrollment date.

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 YOUR 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.

PLAN DESCRIPTION INFORMATION

1. Proper Name of Plan: Contraceptive Benefits Plan

2. *Plan Sponsor*, *Plan Administrator*, Named Fiduciary and Claim Fiduciary:

   Humana Insurance Company or Humana Health Plan, Inc.
   500 W. Main Street
   Louisville, Kentucky 40202
   Telephone: 502-580-1000

3. *Plan Sponsor* EIN: Humana Insurance Company: 39-1263473
   Humana Health Plan, Inc.: 61-1013183

4. The Plan number assigned for government reporting purposes is 510.

5. *Employer* Name and Address: Please see *your employer's* summary plan description.

6. Type of plan: Group Health Plan (providing contraceptive benefits only).

7. Administration of plan: Sponsor Administration

8. This Plan provides contraceptive benefits for *employees* and their enrolled *dependents* participating in their *employer's* self-funded plan administered by Humana.

9. Plan benefits described in this booklet are effective at the same time as the *employer*-sponsored health benefit plan and/or *prescription* drug plan administered by Humana.

10. The *Plan year* is the same as *your employer*-sponsored health benefit plan and/or *prescription* drug plan administered by Humana.

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

    Legal Counsel
    Humana
    500 W. Main Street
    Louisville KY 40202

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

13. 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.

14. 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.

15. This Plan does not constitute a contract between the Humana and any *covered person* and will not be considered as an inducement or condition of the employment of any *employee*.

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

SECTION 8

DEFINITIONS

DEFINITIONS

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

A

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

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

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

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

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

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

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

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

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

B

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*.

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

C

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

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.

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

Covered person means the *employee* or any of the *employee's* covered *dependents* enrolled for benefits under their *employer's* self-funded plan administered by Humana, making them eligible for the contraceptive benefits provided under this Plan.

D

Dependent means a covered *employee's* dependent spouse and/or child(ren) as defined in *your employer's* summary plan description.

E

Employee means *you*, as an employee, when *you* are permanently employed and paid a salary or earnings at *your employer's* place of business, or, if *your employer* extends their self-funded health plan coverage to retirees, *you* as a former *employee*, who is now a *retiree* as determined by *your employer*, except with regards to eligibility.

Employer means *your* employer who has a self-funded plan administered by Humana, making *you* eligible for this Plan.

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

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

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

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

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

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

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

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

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

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

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

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

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

F

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

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

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

G

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

H

Hospital means an institution which:

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

2. Has a physician and surgeon in regular attendance;

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

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

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

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

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

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

I

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

M

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

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.

N

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

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

O

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

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

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

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

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

P

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

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

Pharmacist means a person who is licensed to prepare, compound and dispense medication and who is practicing within the scope of his or her license.

Pharmacy means a licensed establishment where *prescription* medications are dispensed by a *pharmacist*.

Plan Administrator means Humana Insurance Company or Humana Health Plan, Inc.

Plan Sponsor means Humana Insurance Company or Humana Health Plan, Inc.

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

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

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

1. *Your* name;

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

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

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

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

Protected health information means individually identifiable health information about a *covered person* (as defined under HIPAA), 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*.

Q

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

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

R

Retiree means *you* as a former *employee*, who meets the requirements for retirement as determined by *your employer*, if *your employer* extends their self-funded health plan coverage to retirees.

S

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

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

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

U

Urgent care claim means a claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations:

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

2. In the opinion of a 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 that is the subject of the claim; or

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

Y

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

Administered by:

Humana

Humana Insurance Company or Humana Health Plan, Inc.
500 West Main Street
Louisville, Kentucky 40202

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