



SUMMARY PLAN DESCRIPTION

For the

MEDICAL AND PRESCRIPTION DRUG PLAN

Sponsored by

HUMANA INC.

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HUNH0116**

Effective: January 1, 2022

Important!

At Humana, it is important you are treated fairly.

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

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

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

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

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

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

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

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

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

NO SURPRISES ACT AMENDMENT

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

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

This amendment is effective for the Summary Plan Description issued or renewed on or after January 1, 2022.

No Surprises Act

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

Definitions

Air ambulance means a professionally operated helicopter or airplane, provided by a licensed ambulance service, equipped for the transportation of a sick or injured person to or from the nearest medical facility qualified to treat the person's *sickness* or *bodily injury*. Use of the *air ambulance* must be *medically necessary*. When transporting the sick or injured person from one medical facility to another, the *air ambulance* must be ordered by a *qualified practitioner*.

Ancillary services mean *covered expenses* that are:

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

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

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

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

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

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

Recognized amount means the reimbursement rate as determined by:

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

Emergency and non-emergency services

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

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

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

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

Continuity of care

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

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

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

External Review

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

IMPORTANT NOTICE REGARDING YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

On January 1, 2006, the *Medicare* Part D Prescription Drug Coverage went into effect for individuals entitled to *Medicare* Part A, or enrolled (or entitled to receive benefits) in *Medicare* Part B. All *Medicare* prescription drug plans provide at least a standard level of coverage set by *Medicare*. Some plans also offer additional coverage for a higher monthly premium.

How you are affected:

- *Employees* can enroll in a *Medicare* plan if eligible;
- *Employees* who have prescription drug coverage which is at least as good as *Medicare's* prescription drug coverage, can keep their coverage and not pay extra if they later decide to enroll in *Medicare* Part D coverage.
- People with *Medicare* were able to enroll in a *Medicare* prescription drug plan during the initial annual election period of November 15, 2005 through May 15, 2006. However, because there are coverage options *you* have through the Humana Inc. group plan as well as medical coverage *you* may elect through the Humana Inc. group Plan for January 1, 2021 that are on average, as good as *Medicare* prescription coverage, *you* may elect to join a *Medicare* prescription drug plan later than the initial enrollment period without being subject to a premium penalty. *You* will have the opportunity to enroll in a *Medicare* prescription drug plan each year during the annual election period. Contact your employer to understand the Medicare creditable plan options available to *you*.
- If *you* go 63 days or longer without prescription drug coverage which is at least as good as *Medicare's* prescription drug coverage, and *you* seek coverage under *Medicare* Part D Prescription Drug Plan, *your* monthly payment to *Medicare* will increase at least 1% per month for every month after the initial annual election period that *you* do not have prescription drug coverage.

You can also obtain more information about Medicare Prescription drug plans from these places:

- *You can obtain a copy of the Medicare booklet from Medicare;*
- *Visit www.medicare.gov for personalized help;*
- *Call your State Health Insurance Assistance Program;*
- *Call 1-800-MEDICARE (1-800-633-4227);*
- *TTY users should call 1-877-486-2048.*



INTRODUCTION

THE SUMMARY PLAN DESCRIPTION – YOUR HEALTH CARE PLAN GUIDE

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

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

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

DEFINED TERMS

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

PRIVACY

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

CONTACT INFORMATION

Customer Service Telephone Number:

Please refer to *your* Humana ID card for the applicable toll-free customer service telephone number.

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

Claims Submittal Address:

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

Claims Appeal Address:

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

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SECTION 1

HEALTH RESOURCES AND PREAUTHORIZATION

HEALTH RESOURCES

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

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

All Health Resources programs are subject to change without notice. For additional information or questions regarding any of these programs, please contact the customer service telephone number on the back of *your* ID card.

WELLNESS PROGRAMS

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

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

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

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

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

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

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

HEALTH RESOURCES (continued)

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

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

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

PREAUTHORIZATION

Humana will provide *preauthorization* as required by this Plan. Visit Humana's website at www.humana.com* or call the toll-free customer service telephone number listed on *your* Humana ID card to obtain a list of *services* that require *preauthorization*. The list of *services* that require *preauthorization* is subject to change. Coverage provided in the past for *services* that did not receive or require *preauthorization*, is not a guarantee of future coverage of the same *services*.

You are responsible for informing *your qualified practitioner* of this Plan's *preauthorization* requirements. *You* or *your qualified practitioner* must contact Humana at the toll-free customer service telephone number listed on *your* Humana ID card or in writing to request the appropriate authorization. If any required *preauthorization* of *services* is not obtained, *your* benefits may be reduced or a penalty may apply. *Preauthorization* and *preauthorization* penalties do not apply to *emergency care services*.

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

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

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

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

PREAUTHORIZATION PENALTY

If *preauthorization* is not received, benefits will be subject to any applicable *deductible* and then payable at 50 percent of the allowable charge. When the penalty is applied, the coinsurance reduction will not apply toward the maximum out-of-pocket expense limit.

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

PREDETERMINATION OF BENEFITS

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

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

SECTION 2

MEDICAL BENEFITS

UNDERSTANDING YOUR COVERAGE

PARTICIPATING AND NON-PARTICIPATING PROVIDERS

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

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

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

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

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

PAR PROVIDER DIRECTORY

Your employer will automatically provide, without charge, information to *you* about how *you* can access a directory of *PAR providers* appropriate to *your* service area. An online directory of *PAR providers* is available to *you* and accessible via Humana's website at www.humana.com. This directory is subject to change. Due to the possibility of *PAR providers* changing status, please check the online directory of *PAR providers* prior to obtaining *services*. The name of your Plan's *PAR* network that covers your area is National Point of Service Open Access Plus (NPOS+), as listed on *your* medical ID card.

If *you* are located in Minnesota, your directory of *PAR providers* is called PreferredOne. To view *PAR providers* for that network, please go to www.preferredone.com and click on "PreferredOne PPO Network" under Search by Plan Type. MyHumana and Humana's Find a Doctor or Provider Finder tools do not support the PreferredOne network. It is necessary for *you* to search the PreferredOne site for *participating providers* in the PreferredOne PPO network. If *you* need to receive care outside this area, the Humana PPO network of *participating providers* will be available to *you*. *You* can search the Provider Finder tool on **MyHumana or Humana.com** for Humana PPO providers. If *you* do not have access to the online directory, contact Humana at the customer service number on the back of *your* identification (ID) card prior to *services* being rendered or to request a directory.

UNDERSTANDING YOUR COVERAGE (continued)

If you are located in certain counties in Milwaukee, Wisconsin, your directory of *PAR* providers is called HPN. To view *PAR providers* for that network, please go to www.humana.com and click on “Find a doctor or pharmacy” and enter your home zip code. Then, select HPN-WI as your network. If you need to receive care outside the HPN service area, the Humana Choicecare network of participating providers will be available to you. If you choose a Humana Choicecare participating provider, your claim will be processed as an in-network claim and you will not be penalized for going outside of the HPN network. If *you* do not have access to the online directory, call Humana at the customer service number on the back of *your* identification (ID) card prior to *services* being rendered or to request a directory.

COVERED AND NON-COVERED EXPENSES

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

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

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

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

TRANSITION OF CARE

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

CONTINUITY OF CARE

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

HEALTH SAVINGS ACCOUNT

A Health Savings Account (HSA) is a personal savings account established with a Custodian or Trustee to be used primarily for reimbursement of “eligible medical expenses” incurred by *you* and *your* eligible tax dependents (as defined in IRS Code Section 152), as set forth in IRS Code Section 223. The HSA is administered by an HSA Custodian or Trustee, or its designee, and the terms of the HSA are set forth in the custodial or trust agreement. An HSA is not a health benefit plan.

Only individuals who satisfy the following IRS guidelines are eligible for an HSA:

- *You* are enrolled in a qualifying High Deductible Health Plan (HDHP), such as the HDHP offered by *your employer*;
- *You* have opened an HSA with a qualified HSA Custodian;
- *You* are not covered (as a *dependent* or otherwise) under any other non-HDHP health plan (this includes a non-HSA compatible health flexible spending account); and
- *You* have certified that *you* are otherwise eligible to participate in the HSA (i.e., *you* (i) cannot be claimed as a tax dependent; (ii) are not enrolled in *Medicare* coverage; (iii) have qualifying HDHP coverage; and (iv) have no disqualifying coverage from any other source).

MEDICAL SCHEDULE OF BENEFITS

IMPORTANT INFORMATION ABOUT PLAN BENEFITS

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

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

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

MEDICAL AND PRESCRIPTION DRUG DEDUCTIBLES, COINSURANCE AND OUT-OF-POCKET LIMITS		
BENEFIT FEATURES	PAR PROVIDER BENEFIT	NON-PAR PROVIDER BENEFIT
Both medical and <i>prescription</i> drug covered expenses apply towards the medical and <i>prescription</i> drug deductibles and medical and <i>prescription</i> drug out-of-pocket limits outlined below. Please see the "Prescription Drug Benefits" section of this SPD for a detailed description of your <i>prescription</i> drug coverage.		
Single Medical and <i>Prescription Drug Deductible</i>	\$3,000 per <i>covered person</i>	\$6,000 per <i>covered person</i>
Family Medical and <i>Prescription Drug Deductible</i>	\$6,000 per covered family	\$12,000 per covered family
Medical and <i>Prescription</i> Drug <i>Coinsurance</i>	The Plan pays 80%, <i>you</i> pay 20%.	The Plan pays 60%, <i>you</i> pay 40%.
Single Medical and <i>Prescription Drug Out-of-Pocket Limit</i>	\$4,500 per <i>covered person</i>	\$9,000 per <i>covered person</i>

MEDICAL SCHEDULE OF BENEFITS (continued)

MEDICAL AND PRESCRIPTION DRUG DEDUCTIBLES, COINSURANCE AND OUT-OF-POCKET LIMITS		
BENEFIT FEATURES	PAR PROVIDER BENEFIT	NON-PAR PROVIDER BENEFIT
Family Medical and <i>Prescription Drug Out-of- Pocket Limit*</i>	\$9,000 per covered family	\$18,000 per covered family
*Each <i>covered person</i> on a family plan will pay no more than \$8,700 for covered, <i>PAR provider services</i> . This amount includes both the <i>deductible</i> and <i>coinsurance</i> combined.		
<i>Lifetime Maximum Benefit</i>	Unlimited	Unlimited
The <i>lifetime maximum benefit</i> for <i>PAR</i> and <i>Non-PAR providers</i> is combined.		

MEDICAL SCHEDULE OF BENEFITS (continued)

ROUTINE/PREVENTIVE CHILD CARE SERVICES BIRTH TO AGE 18 <i>(Services Received at a Clinic or Outpatient Hospital)</i>		
MEDICAL SERVICES	PAR PROVIDER BENEFIT	NON-PAR PROVIDER BENEFIT
Routine/Preventive Child Care Examination	100%	60% after <i>deductible</i>
Routine/Preventive Child Care Vision Screening	100%	60% after <i>deductible</i>
Routine/Preventive Child Care Hearing Screening	100%	60% after <i>deductible</i>
Routine/Preventive Child Care Laboratory and X-ray	100%	60% after <i>deductible</i>
Cotinine testing	Not Covered	Not Covered
Routine/Preventive Child Care Immunizations (e.g. Covid Vaccine, HPV Vaccine, Meningitis Vaccine, etc.) Immunizations are covered based on the recommendations by the Department of Health and Human Services - Centers for Disease Control and Prevention (www.cdc.gov)	100%	60% after deductible
Routine/Preventive Child Care COVID Immunizations	100%	60% after deductible
Routine/Preventive Child Care Flu/Pneumonia Immunizations	100%	60% after deductible

MEDICAL SCHEDULE OF BENEFITS (continued)

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

MEDICAL SERVICES	PAR PROVIDER BENEFIT	NON-PAR PROVIDER BENEFIT
Routine/Preventive Adult Care Examination	100%	60% after <i>deductible</i>
Routine/Preventive Adult Care Vision Screening	100%	60% after <i>deductible</i>
Routine/Preventive Adult Care Hearing Screening	100%	60% after <i>deductible</i>
Routine/Preventive Adult Care Laboratory and X-ray	100%	60% after <i>deductible</i>
Cotinine testing	Not Covered	Not Covered
<p>Routine/Preventive Adult Care Immunizations (e.g. Covid Vaccine, Shingles Vaccine, Meningitis Vaccine, HPV Vaccine, etc.)</p> <p>Immunizations are covered based on the recommendations by the Department of Health and Human Services - Centers for Disease Control and Prevention (www.cdc.gov)</p> <p>Shingles Vaccine covered for age 50 and older</p>	100%	60% after <i>deductible</i>
Routine/Preventive Adult Care COVID Immunizations	100%	60% after <i>deductible</i>

MEDICAL SCHEDULE OF BENEFITS (continued)

<p style="text-align: center;">ROUTINE/PREVENTIVE ADULT CARE SERVICES AGE 18 AND OVER <i>(Services Received at a Clinic or Outpatient Hospital)</i></p>		
MEDICAL SERVICES	PAR PROVIDER BENEFIT	NON-PAR PROVIDER BENEFIT
Routine/Preventive Adult Care Flu/Pneumonia Immunizations	100%	60% after <i>deductible</i>
Routine/Preventive Adult Care Mammograms	100%	60% after <i>deductible</i>
Mammograms Mammograms covered 1 per <i>calendar year</i> , regardless of diagnosis.	100%	60% after <i>deductible</i>
Routine/Preventive Adult Care Pap Smears	100%	60% after <i>deductible</i>
Routine/Preventive Adult Care Colonoscopy, Proctosigmoidoscopy and Sigmoidoscopy Screenings (including related <i>services</i> , i.e. anesthesia) (performed at an outpatient facility, <i>ambulatory surgical center</i> or clinic location) Colonoscopy, Proctosigmoidoscopy and Sigmoidoscopy Screenings are payable under this Routine/Preventive Adult Care Benefit when billed by the <i>qualified practitioner</i> with a routine diagnosis.	100%	60% after <i>deductible</i>

MEDICAL SCHEDULE OF BENEFITS (continued)

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

MEDICAL SERVICES	PAR PROVIDER BENEFIT	NON-PAR PROVIDER BENEFIT
Routine/Preventive Adult Care Prostate Specific Antigen (PSA) Testing	100%	60% after <i>deductible</i>
Breast Feeding Counseling	100%	Same as <i>PAR Provider</i> Benefit
Breast Feeding Support and Supplies	100%	60% after <i>deductible</i>
Contraceptive Methods - devices (e.g. IUD or diaphragms), injections, implant insertion/removal, emergency contraceptives - tubal ligation and tubal sterilization	100%	60% after <i>deductible</i>
Male Sterilization	Payable the same as any other <i>sickness</i> .	60% after <i>deductible</i>
Male Contraceptives	Not Covered	Not Covered
<p>Note: If <i>services</i> are not to prevent pregnancy, then they will be payable the same as any other <i>sickness</i>.</p> <p>Note: Excludes birth control pills/patches and spermicide - refer to the Pharmacy Benefit for coverage for these and for <i>prescription</i> drug coverage for emergency contraceptives.</p>		

MEDICAL SCHEDULE OF BENEFITS (continued)

ROUTINE HEARING SERVICES		
MEDICAL SERVICES	PAR PROVIDER BENEFIT	NON-PAR PROVIDER BENEFIT
Hearing Aids and Fitting	80% after <i>deductible</i>	60% after <i>deductible</i>
Hearing Aids and Fitting Limits	1 hearing aid per ear, per every 36 months, with a \$1,400 per ear maximum. Available to children and adults Note: Can be replaced anytime during the <i>calendar year</i> in which the 36 months falls.	

QUALIFIED PRACTITIONER SERVICES (Non-Routine/Non-Preventive Care Services)		
MEDICAL SERVICES	PAR PROVIDER BENEFIT	NON-PAR PROVIDER BENEFIT
Diagnostic Office Examination at a Clinic, including Second Surgical Opinion – <i>Qualified Practitioner</i> Primary Care Physician and <i>Qualified Practitioner</i> Specialist	80% after <i>deductible</i>	60% after <i>deductible</i>
<i>Virtual Visit</i>	80% after <i>deductible</i>	60% after <i>deductible</i>
If an office examination is billed from an outpatient location, the <i>services</i> will be payable the same as an office examination at a clinic.		
X-ray at clinic (other than <i>advanced imaging</i>)	80% after <i>deductible</i>	60% after <i>deductible</i>

MEDICAL SCHEDULE OF BENEFITS (continued)

QUALIFIED PRACTITIONER SERVICES (Non-Routine/Non-Preventive Care Services)		
MEDICAL SERVICES	PAR PROVIDER BENEFIT	NON-PAR PROVIDER BENEFIT
Diagnostic Laboratory including cotinine testing)	80% after <i>deductible</i>	60% after <i>deductible</i>
Independent Laboratory	Payable same as Diagnostic Laboratory and X-ray	Payable same as Diagnostic Laboratory and X-ray
<i>Advanced Imaging</i> at a Clinic	80% after <i>deductible</i>	60% after <i>deductible</i>
Allergy Testing at a Clinic	80% after <i>deductible</i>	60% after <i>deductible</i>
Allergy Serum/Vials at a Clinic	80% after <i>deductible</i>	60% after <i>deductible</i>
Allergy Injections at a Clinic	80% after <i>deductible</i>	60% after <i>deductible</i>

MEDICAL SCHEDULE OF BENEFITS (continued)

QUALIFIED PRACTITIONER SERVICES (Non-Routine/Non-Preventive Care Services)		
MEDICAL SERVICES	PAR PROVIDER BENEFIT	NON-PAR PROVIDER BENEFIT
Injections at a Clinic (other than routine immunizations, flu or pneumonia immunizations, contraceptive injections for birth control reasons and allergy injections)	80% after <i>deductible</i>	60% after <i>deductible</i>
Anesthesia at a Clinic	80% after <i>deductible</i>	60% after <i>deductible</i>
<i>Surgery</i> at a Clinic (including <i>Qualified Practitioner, Assistant Surgeon</i> and Physician Assistant)	80% after <i>deductible</i>	60% after <i>deductible</i>
Medical and Surgical Supplies	80% after <i>deductible</i>	60% after <i>deductible</i>
Eyeglasses or Contact Lenses after Cataract <i>Surgery</i> (initial pair only)	80% after <i>deductible</i>	60% after <i>deductible</i>
Nutritional Counseling (Diabetes & Obesity)	100%	60% after <i>deductible</i>

MEDICAL SCHEDULE OF BENEFITS (continued)

**QUALIFIED PRACTITIONER SERVICES
(Non-Routine/Non-Preventive Care Services)**

MEDICAL SERVICES	PAR PROVIDER BENEFIT	NON-PAR PROVIDER BENEFIT
Nutritional Counseling (Eating Disorders, Cancer, Celiac Disease, Rheumatoid Arthritis and Inflammatory Bowel Disease)	80% after <i>deductible</i>	60% after <i>deductible</i>
Nutritional Counseling is covered for Diabetes, Obesity, Cancer, Celiac Disease, Rheumatoid Arthritis, Inflammatory Bowel Disease and Eating Disorders diagnosis only.		
<i>Diabetes Supplies</i>	Payable under the <i>prescription</i> drug benefits or medical supplies.	Payable under the <i>prescription</i> drug benefits or medical supplies.

**DENTAL/ORAL SURGERIES COVERED UNDER THE
MEDICAL PLAN**

MEDICAL SERVICES	PAR PROVIDER BENEFIT	NON-PAR PROVIDER BENEFIT
Dental/Oral <i>Surgeries</i>	Payable the same as any other <i>sickness</i> .	Payable the same as any other <i>sickness</i> .
Please refer to the Medical Covered Expenses section, Dental/Oral Surgeries Covered Under the Medical Plan, for a list of oral surgeries covered under this benefit.		

MEDICAL SCHEDULE OF BENEFITS (continued)

REVERSAL OF STERILIZATION AND ABORTIONS

MEDICAL SERVICES	PAR PROVIDER BENEFIT	NON-PAR PROVIDER BENEFIT
Reversal of Sterilization	Not Covered	Not Covered
Life Threatening Abortions	Payable the same as any other <i>sickness</i> .	Payable the same as any other <i>sickness</i> .
Elective Abortions	Not Covered	Not Covered

**MATERNITY
(Normal, C-Section and Complications)**

MEDICAL SERVICES	PAR PROVIDER BENEFIT	NON-PAR PROVIDER BENEFIT
Inpatient <i>Hospital</i> Room and Board and Ancillary Facility <i>Services</i>	Payable same as any other <i>sickness</i> .	Payable same as any other <i>sickness</i> .
Birthing Center Room and Board and Ancillary <i>Services</i>	Payable same as any other <i>sickness</i> .	Payable same as any other <i>sickness</i> .
<i>Qualified Practitioner Services</i>	Payable same as any other <i>sickness</i> .	Payable same as any other <i>sickness</i> .
<i>Dependent</i> Daughter Maternity	Payable the same as any other <i>sickness</i> .	Payable the same as any other <i>sickness</i> .
Newborn Inpatient Facility <i>Services</i> and <i>Qualified Practitioner Services</i> .	80% after <i>deductible</i>	60% after <i>deductible</i>

MEDICAL SCHEDULE OF BENEFITS (continued)

AUTISM BENEFIT		
MEDICAL SERVICES	PAR PROVIDER BENEFIT	NON-PAR PROVIDER BENEFIT
<i>Services provided for Therapeutic, Respite and Rehabilitative care and Applied Behavioral Analysis (ABA) Therapy for dependent children</i>	80% after <i>deductible</i>	60% after <i>deductible</i>
<i>ABA Therapy must be provided by a licensed Autism Spectrum Disorder (ASD) provider or other health or allied professional licensed in the treatment of ASD to be a covered expense.</i>		

INPATIENT SERVICES		
MEDICAL SERVICES	PAR PROVIDER BENEFIT	NON-PAR PROVIDER BENEFIT
<i>Inpatient Hospital Room and Board and Ancillary Facility Services</i>	80% after <i>deductible</i>	60% after <i>deductible</i>
<i>Qualified Practitioner Inpatient Hospital Visit</i>	80% after <i>deductible</i>	60% after <i>deductible</i>
<i>Qualified Practitioner Inpatient Surgery and Anesthesia</i>	80% after <i>deductible</i>	60% after <i>deductible</i>
<i>Qualified Practitioner Inpatient Pathology and Radiology</i>	80% after <i>deductible</i>	60% after <i>deductible</i>

MEDICAL SCHEDULE OF BENEFITS (continued)

SKILLED NURSING SERVICES		
MEDICAL SERVICES	PAR PROVIDER BENEFIT	NON-PAR PROVIDER BENEFIT
Skilled Nursing Room and Board and Ancillary Facility Services	80% after <i>deductible</i>	60% after <i>deductible</i>
Skilled Nursing Facility Yearly Limits	60 day(s) per <i>covered person</i> per <i>calendar year</i>	
Skilled Nursing <i>Qualified Practitioner</i> Visit	80% after <i>deductible</i>	60% after <i>deductible</i>

OUTPATIENT AND AMBULATORY SURGICAL CENTER SERVICES		
MEDICAL SERVICES	PAR PROVIDER BENEFIT	NON-PAR PROVIDER BENEFIT
<i>Ambulatory Surgical Center Facility Services</i>	80% after <i>deductible</i>	60% after <i>deductible</i>
<i>Ambulatory Surgical Center Ancillary Services</i>	80% after <i>deductible</i>	60% after <i>deductible</i>
Outpatient <i>Hospital</i> Facility Surgical Services	80% after <i>deductible</i>	60% after <i>deductible</i>

MEDICAL SCHEDULE OF BENEFITS (continued)

OUTPATIENT AND AMBULATORY SURGICAL CENTER SERVICES		
MEDICAL SERVICES	PAR PROVIDER BENEFIT	NON-PAR PROVIDER BENEFIT
Outpatient <i>Hospital</i> Facility Non-Surgical Services (e.g. clinic facility services; observation)	80% after <i>deductible</i>	60% after <i>deductible</i>
Outpatient <i>Hospital</i> Surgical and Non-Surgical Ancillary Services (e.g. supplies; medication; anesthesia)	80% after <i>deductible</i>	60% after <i>deductible</i>
Outpatient <i>Hospital</i> Facility Diagnostic Laboratory (including cotinine testing) and X-ray (other than <i>advanced imaging</i>)	80% after <i>deductible</i>	60% after <i>deductible</i>
Outpatient <i>Hospital</i> Facility <i>Advanced Imaging</i>	80% after <i>deductible</i>	60% after <i>deductible</i>
Outpatient <i>Hospital</i> and Ambulatory Surgical Center Qualified Practitioner Visit	80% after <i>deductible</i>	60% after <i>deductible</i>
Outpatient <i>Hospital</i> and Ambulatory Surgical Center Surgery (including surgeon; assistant surgeon; and physician assistant) and Anesthesia	80% after <i>deductible</i>	60% after <i>deductible</i>
Outpatient <i>Hospital</i> and Ambulatory Surgical Center Pathology and Radiology	80% after <i>deductible</i>	60% after <i>deductible</i>

MEDICAL SCHEDULE OF BENEFITS (continued)

EMERGENCY CARE AND URGENT CARE SERVICES		
MEDICAL SERVICES	PAR PROVIDER BENEFIT	NON-PAR PROVIDER BENEFIT
Emergency Room Facility and Ancillary <i>Services (emergency care)</i>	80% after <i>deductible</i>	Same as <i>PAR Provider</i> Benefit
Emergency Room All Physician <i>Services</i> (including Emergency Room Physician Radiologist, Pathologist, Anesthesiologist and ancillary <i>services</i> billed by an Emergency Room Physician) (<i>emergency care</i>)	80% after <i>deductible</i>	Same as <i>PAR Provider</i> Benefit
Emergency Room Facility and Ancillary <i>Services</i> (non-emergency)	80% after <i>deductible</i>	60% after <i>deductible</i>

MEDICAL SCHEDULE OF BENEFITS (continued)

EMERGENCY CARE AND URGENT CARE SERVICES		
MEDICAL SERVICES	PAR PROVIDER BENEFIT	NON-PAR PROVIDER BENEFIT
Emergency Room All Physician <i>Services</i> (including Emergency Room Physician Radiologist, Pathologist, Anesthesiologist and ancillary <i>services</i> billed by an Emergency Room Physician) (non-emergency)	80% after <i>deductible</i>	60% after <i>deductible</i>
Urgent Care Center (facility, ancillary <i>services</i> and <i>qualified practitioner services</i>)	80% after <i>deductible</i>	60% after <i>deductible</i>
Flu immunizations administered at an Emergency Room, Urgent Care or <i>Retail Clinic</i>	100%	60% after <i>deductible</i>

HOSPICE SERVICES		
MEDICAL SERVICES	PAR PROVIDER BENEFIT	NON-PAR PROVIDER BENEFIT
Hospice Inpatient Room and Board and Ancillary <i>Services</i>	80% after <i>deductible</i>	60% after <i>deductible</i>
Hospice Outpatient (including hospice home visits)	80% after <i>deductible</i>	60% after <i>deductible</i>
Hospice <i>Qualified Practitioner</i> Visit	80% after <i>deductible</i>	60% after <i>deductible</i>

MEDICAL SCHEDULE OF BENEFITS (continued)

HOME HEALTH CARE SERVICES		
MEDICAL SERVICES	PAR PROVIDER BENEFIT	NON-PAR PROVIDER BENEFIT
Home Health Care <i>Services</i>	80% after <i>deductible</i>	60% after <i>deductible</i>
Home Health Care Yearly Limits	100 visit(s) per <i>covered person</i> per <i>calendar year</i>	
<p>Home therapy benefits will be reimbursed under the therapy benefit.</p> <p>If therapies are done in the home (such as physical or occupational therapy), these therapy <i>services</i> will apply to the therapy limits.</p> <p>If therapies and home health visits are done on the same day the <i>services</i> will track as one visit per service type (e.g. home health, physical therapy, speech therapy, etc.).</p>		
Home Health Care Ancillary <i>Services</i> (excluding <i>durable medical equipment</i> , prosthetics and private duty nursing)	80% after <i>deductible</i>	60% after <i>deductible</i>

MEDICAL SCHEDULE OF BENEFITS (continued)

DURABLE MEDICAL EQUIPMENT (DME)		
MEDICAL SERVICES	PAR PROVIDER BENEFIT	NON-PAR PROVIDER BENEFIT
<i>Durable Medical Equipment (DME)</i>	80% after <i>deductible</i>	60% after <i>deductible</i>
Prosthesis	80% after <i>deductible</i>	60% after <i>deductible</i>
Wigs for cancer patients with hair loss resulting from chemotherapy and/or radiation therapy. Available at any location including retail.	80% after <i>deductible</i>	Same as <i>PAR Provider Benefit</i>
Wig Limits	1 wig per <i>covered person</i> per <i>calendar year</i> \$250 maximum	

SPECIALTY DRUGS		
MEDICAL SERVICES	PAR PROVIDER BENEFIT	NON-PAR PROVIDER BENEFIT
<i>Specialty Drugs (Qualified Practitioner's Office Visit, Home Health Care, Home Infusion, Freestanding Facility and Urgent Care)</i>	80% after <i>deductible</i>	60% after <i>deductible</i>
<i>Specialty Drugs (Emergency Room, Ambulance, Inpatient Hospital, Outpatient Hospital and Skilled Nursing Facility)</i>	80% after <i>deductible</i>	60% after <i>deductible</i>

MEDICAL SCHEDULE OF BENEFITS (continued)

AMBULANCE SERVICES		
MEDICAL SERVICES	PAR PROVIDER BENEFIT	NON-PAR PROVIDER BENEFIT
<i>Ground Ambulance</i>	80% after <i>deductible</i>	Same as <i>PAR Provider</i> Benefit
<i>Air Ambulance</i>	80% after <i>deductible</i>	Same as <i>PAR Provider</i> Benefit
<i>Ambulance</i> (Ground or Air) Transportation is not covered unless required because of true <i>emergency</i> care, as defined in <i>covered person's SPD</i> .		

MEDICAL SCHEDULE OF BENEFITS (continued)

MORBID OBESITY SERVICES

The following *services* will be covered under the *morbid obesity* benefit: examinations/*qualified practitioner* visits; laboratory and x-ray *services*, other diagnostic testing; *bariatric surgery*; inpatient facility *services*; outpatient facility *services*; *durable medical equipment*; physical/occupational therapy (must follow therapy limits), home healthcare *services* and nutritional counseling.

MEDICAL SERVICES	PAR PROVIDER BENEFIT	NON-PAR PROVIDER BENEFIT
<i>Morbid Obesity</i>	80% after <i>deductible</i>	60% after <i>deductible</i>
Non-Surgical <i>Services</i> and Complications	Payable the same as any other <i>sickness</i> .	Payable the same as any other <i>sickness</i> .
Obesity Drugs	Not Covered	Not Covered

The following *services* will be covered under the *morbid obesity* benefit: examinations/*qualified practitioner* visits; laboratory and x-ray *services*, other diagnostic testing; *bariatric surgery*; inpatient facility *services*; outpatient facility *services*; *durable medical equipment*; physical/occupational therapy (must follow therapy limits), home healthcare *services* and nutritional counseling.

<i>Morbid Obesity Limits</i>	<p>\$10,000 per <i>covered person</i> per lifetime.</p> <p>The dollar limit applies to <i>services</i> associated with the <i>bariatric surgery</i>, which includes <i>qualified practitioner</i>, facility <i>services</i> and anesthesia.</p>
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Deductible, as well as the Member cost share up to the \$10,000 applies to the *Deductible* and Out-of-Pocket Maximum. Once the *Deductible* is met, benefit will reimburse at *coinsurance* up to the \$10,000 Lifetime Limit per member. *Par* and *non-par services* are combined for this limit. Any amounts over the \$10,000 Limit are the full responsibility of the member.

MEDICAL SCHEDULE OF BENEFITS (continued)

OBESITY SERVICES		
MEDICAL SERVICES	PAR PROVIDER BENEFIT	NON-PAR PROVIDER BENEFIT
Obesity Services excluding bariatric surgery	Payable the same as <i>morbid obesity services</i> , excluding surgery	Payable the same as <i>morbid obesity services</i> , excluding surgery

EXCESS SKIN REMOVAL		
MEDICAL SERVICES	PAR PROVIDER BENEFIT	NON-PAR PROVIDER BENEFIT
The following <i>services</i> will be covered under the excess skin removal benefit: surgery; inpatient facility <i>services</i> and outpatient facility <i>services</i> .		
Excess Skin Removal (including Panniculectomy)	50% after <i>deductible</i>	50% after <i>deductible</i>
Excess Skin Removal Limits	The dollar limit applies to the following excess skin removal benefits: surgery; inpatient facility <i>services</i> , Panniculectomy and outpatient facility <i>services</i> .	
Deductible, as well as the Member cost share up to the \$5,000 applies to the <i>Deductible</i> and Out-of-Pocket Maximum. Once the <i>Deductible</i> is met, benefit will reimburse at 50% up to the \$5,000 Lifetime Limit per member. <i>Par</i> and <i>non-par services</i> are combined for this limit. Any amounts over the \$5,000 Limit are the full responsibility of the member.		

MEDICAL SCHEDULE OF BENEFITS (continued)

TRANSGENDER SERVICES		
MEDICAL SERVICES	PAR PROVIDER BENEFIT	NON-PAR PROVIDER BENEFIT
Gender Reassignment <i>Services</i> (Surgery & Facility)	Payable same as any other <i>sickness</i> .	Payable same as any other <i>sickness</i> .
Office visits	Payable same as any other <i>sickness</i> .	Payable same as any other <i>sickness</i> .
Laboratory <i>services</i>	Payable same as any other <i>sickness</i> .	Payable same as any other <i>sickness</i> .
Behavioral Health	Payable same as any other <i>sickness</i> .	Payable same as any other <i>sickness</i> .
Pharmacy (including hormone replacement therapies)	Payable same as any other <i>sickness</i> .	Payable same as any other <i>sickness</i> .
Routine, chronic or urgent non-transition <i>services</i>	Payable same as any other <i>sickness</i> .	Payable same as any other <i>sickness</i> .

MEDICAL SCHEDULE OF BENEFITS (continued)

TEMPOROMANDIBULAR JOINT DYSFUNCTION (TMJ)		
MEDICAL SERVICES	PAR PROVIDER BENEFIT	NON-PAR PROVIDER BENEFIT
Temporomandibular Joint Dysfunction (TMJ) (Other than Splint/Appliances)	80% after <i>deductible</i>	60% after <i>deductible</i>
Temporomandibular Joint Dysfunction (TMJ) Splint/Appliances	80% after <i>deductible</i>	60% after <i>deductible</i>

DENTAL INJURY SERVICES		
MEDICAL SERVICES	PAR PROVIDER BENEFIT	NON-PAR PROVIDER BENEFIT
<i>Dental Injuries</i>	Payable the same as any other <i>sickness</i> .	Payable the same as any other <i>sickness</i> .
Please see the Medical Covered Expenses section, Dental Injury, for benefit details.		

MEDICAL SCHEDULE OF BENEFITS (continued)

INFERTILITY SERVICES		
MEDICAL SERVICES	PAR PROVIDER BENEFIT	NON-PAR PROVIDER BENEFIT
Infertility Counseling and Treatment	80% after <i>deductible</i>	60% after <i>deductible</i>
Infertility Counseling, Treatment and Artificial Means of Achieving Pregnancy Lifetime Limits, includes infertility medications	\$10,000 per <i>covered person</i> per lifetime	
Artificial Means of Achieving Pregnancy	80% after <i>deductible</i>	60% after <i>deductible</i>
Cryopreservation (including the thawing of eggs and sperm)	80% after <i>deductible</i>	60% after <i>deductible</i>
Artificial means of achieving pregnancy or ovulation includes but is not limited to, artificial insemination, in vitro fertilization, spermatogenesis, gamete intra fallopian transfer (GIFT), zygote intra fallopian transfer (ZIFT), tubal ovum transfer, embryo freezing or transfer and sperm banking.		
Sexual Dysfunction/Impotence (When not related to a <i>Mental Health Disorder</i>)	Payable same as any other <i>sickness</i> .	Payable same as any other <i>sickness</i> .

MEDICAL SCHEDULE OF BENEFITS (continued)

INFERTILITY SERVICES		
MEDICAL SERVICES	PAR PROVIDER BENEFIT	NON-PAR PROVIDER BENEFIT
<p><i>Deductible</i>, as well as the Member cost share up to the \$10,000 applies to the <i>Deductible</i> and Out-of-Pocket Maximum. Once the <i>Deductible</i> is met, benefit will reimburse at <i>coinsurance</i> up to the \$10,000 Lifetime Limit per member. <i>Par</i> and <i>non-par services</i> are combined for this limit. Any amounts over the \$10,000 Limit are the full responsibility of the member.</p>		
NOTE: Infertility Medical Coverage Policy		The infertility requirements of 12 months of no conception or donor insemination with no success (6 months or 6 cycles for women age 35+) does not apply. This will allow all families, couples and singles to access plan-covered fertility treatment.

CHIROPRACTIC SERVICES		
MEDICAL SERVICES	PAR PROVIDER BENEFIT	NON-PAR PROVIDER BENEFIT
Chiropractic Examinations	80% after <i>deductible</i>	60% after <i>deductible</i>
Chiropractic Laboratory and X-ray	80% after <i>deductible</i>	60% after <i>deductible</i>
Chiropractic Manipulations	80% after <i>deductible</i>	60% after <i>deductible</i>
Chiropractic Therapy	80% after <i>deductible</i>	60% after <i>deductible</i>
Chiropractic Limits	<p>30 visit(s) per <i>covered person</i></p> <p>The visit limit applies to the following chiropractic benefits: therapies; and manipulations</p>	

MEDICAL SCHEDULE OF BENEFITS (continued)

THERAPY SERVICES		
MEDICAL SERVICES	PAR PROVIDER BENEFIT	NON-PAR PROVIDER BENEFIT
Physical Therapy (Clinic and Outpatient)	80% after <i>deductible</i>	60% after <i>deductible</i>
Occupational Therapy (Clinic and Outpatient)	80% after <i>deductible</i>	60% after <i>deductible</i>
Speech Therapy (Clinic and Outpatient)	80% after <i>deductible</i>	60% after <i>deductible</i>
Cognitive Therapy (Clinic and Outpatient)	80% after <i>deductible</i>	60% after <i>deductible</i>
Audiology Therapy (Clinic and Outpatient)	80% after <i>deductible</i>	60% after <i>deductible</i>
Therapy Limits	60 visit(s) per <i>covered person per calendar year</i>	
Physical, occupational, speech, audiology and cognitive therapies are combined and track toward the Therapy Limits. Chiropractic <i>services</i> track toward the Chiropractic Limits.		
Physical therapy when provided by a chiropractor will deplete the chiropractic limits.		

MEDICAL SCHEDULE OF BENEFITS (continued)

THERAPY SERVICES		
MEDICAL SERVICES	PAR PROVIDER BENEFIT	NON-PAR PROVIDER BENEFIT
Acupuncture	80% after <i>deductible</i>	Same as <i>PAR Provider</i> Benefit
Acupuncture Limits	<p>Up to 12 visits per <i>calendar year</i> to a licensed provider for <i>medically necessary</i> acupuncture treatment to manage the following conditions:</p> <ul style="list-style-type: none"> • Nausea and vomiting associated with chemotherapy • Nausea and vomiting associated with pregnancy • Post-operative nausea and vomiting • Hot flashes related to peri/menopause and cancer treatment • Infertility (will accumulate to infertility benefit maximum) • Treatment of pain: <ul style="list-style-type: none"> - Post-op dental pain - Migraine and tension headache - Low back pain - Neck pain - Joint pain - Pain related to TMJ disorders <p>Any acupuncture <i>services</i> for treatment of infertility will accumulate to the \$10,000 infertility maximum.</p>	
Respiratory Therapy and Pulmonary Therapy (Clinic and Outpatient)	80% after <i>deductible</i>	60% after <i>deductible</i>
Vision Therapy (eye exercises to strengthen the muscles of the eye, based on <i>medical necessity</i>) (Clinic and Outpatient)	80% after <i>deductible</i>	60% after <i>deductible</i>
Treatment must be <i>medically necessary</i> . <i>Services</i> are subject to <i>medical necessity</i> review as determined by <i>Plan Manager</i> .		

MEDICAL SCHEDULE OF BENEFITS (continued)

THERAPY SERVICES		
MEDICAL SERVICES	PAR PROVIDER BENEFIT	NON-PAR PROVIDER BENEFIT
Chemotherapy (Clinic and Outpatient)	80% after <i>deductible</i>	60% after <i>deductible</i>
Radiation Therapy (Clinic and Outpatient)	80% after <i>deductible</i>	60% after <i>deductible</i>
<p>Cardiac Rehabilitation (Phase II)</p> <p>Phase I is covered under the inpatient facility benefits.</p> <p>Phase III, an unsupervised exercise program, is not covered.</p>	80% after <i>deductible</i>	60% after <i>deductible</i>
<i>Infusion therapy</i>	80% after <i>deductible</i>	60% after <i>deductible</i>
<p><i>You may be required to utilize an infusion provider who is also a designated pharmacy for the infusion services to be a covered expense.</i></p>		

MEDICAL SCHEDULE OF BENEFITS (continued)

TRANSPLANT SERVICES AND IMMUNE EFFECTOR CELL THERAPY		
MEDICAL SERVICES	HUMANA NATIONAL TRANSPLANT NETWORK (NTN) FACILITY (Payable at the <i>PAR</i> Provider Benefit Level)	NON-HUMANA NATIONAL TRANSPLANT NETWORK (NTN) FACILITY (Payable at the <i>Non-PAR</i> Provider Benefit Level)
Organ Transplant Services and <i>Immune Effector Cell Therapy</i>	Payable the same as any other <i>sickness</i> .	Payable the same as any other <i>sickness</i> .
Non-Medical Services - Lodging and Transportation	80% after <i>deductible</i>	Not Covered
Organ Transplant Services and <i>Immune Effector Cell Therapy</i> s Limits	Unlimited	Unlimited
Non-Medical Services - Lodging and Transportation Combined Limits	\$10,000 per covered transplant	Not applicable – lodging and transportation are not covered for a Non-Humana National Transplant Network provider
<p><i>Covered expenses</i> for organ transplants performed at a Humana National Transplant Network facility will aggregate toward the Plan <i>out-of-pocket limits</i>. <i>Covered expenses</i> for organ transplants performed at a facility other than a Humana National Transplant Network facility do not aggregate toward the Plan <i>out-of-pocket limits</i>.</p>		

MEDICAL SCHEDULE OF BENEFITS (continued)

BEHAVIORAL HEALTH INPATIENT SERVICES		
MEDICAL SERVICES	PAR PROVIDER BENEFIT	NON-PAR PROVIDER BENEFIT
Inpatient <i>Behavioral Health</i> Room and Board and Ancillary Services	Payable same as medical inpatient <i>hospital</i> .	Payable same as medical inpatient <i>hospital</i> .
Inpatient <i>Behavioral Health</i> Professional Services	Payable same as medical inpatient <i>Qualified Practitioner</i> .	Payable same as medical inpatient <i>Qualified Practitioner</i> .
<i>Behavioral Health Residential Treatment Facility Services</i>	Payable the same as medical inpatient <i>hospital</i> and <i>qualified practitioner services</i> .	Payable the same as medical inpatient <i>hospital</i> and <i>qualified practitioner services</i> .
Inpatient Nutritional Counseling for eating disorders	<i>Qualified Practitioner</i> and hospital payable the same as medical inpatient	Payable same as medical outpatient non-surgical <i>hospital</i> .
<i>Behavioral Health Partial Hospitalization Services</i>	Payable same as medical outpatient non-surgical <i>hospital</i> .	Payable same as medical outpatient non-surgical <i>hospital</i> .

MEDICAL SCHEDULE OF BENEFITS (continued)

BEHAVIORAL HEALTH CLINIC, OUTPATIENT AND INTENSIVE OUTPATIENT SERVICES		
MEDICAL SERVICES	PAR PROVIDER BENEFIT	NON-PAR PROVIDER BENEFIT
<i>Behavioral Health Therapy Services (Clinic, Outpatient, Intensive Outpatient and Virtual Visit)</i>	Payable the same as <i>Qualified Practitioner</i> primary care physician.	Payable the same as <i>Qualified Practitioner</i> primary care physician.
Nutritional Counseling for eating disorders	Payable the same as Medical <i>Qualified Practitioner</i> primary care physician.	Payable the same as Medical <i>Qualified Practitioner</i> primary care physician.
<p><i>Behavioral health services</i> not listed above, such as laboratory and x-ray, are payable the same as the <i>qualified practitioner</i> or facility, based on place of <i>service</i>.</p> <p><i>Prescription</i> drug expenses for the treatment of <i>behavioral health services</i> are covered under the Prescription Drug Benefit.</p>		

BEHAVIORAL HEALTH SKILLED NURSING SERVICES		
MEDICAL SERVICES	PAR PROVIDER BENEFIT	NON-PAR PROVIDER BENEFIT
Skilled Nursing Room & Board and Ancillary Facility Services	80% after <i>deductible</i>	60% after <i>deductible</i>
Skilled Nursing <i>Qualified Practitioner</i> visit	80% after <i>deductible</i>	60% after <i>deductible</i>

MEDICAL SCHEDULE OF BENEFITS (continued)

BEHAVIORAL HEALTH EMERGENCY AND URGENT CARE SERVICES		
MEDICAL SERVICES	PAR PROVIDER BENEFIT	NON-PAR PROVIDER BENEFIT
Emergency Room MRI, MRA, PET, CAT, SPECT scans	Payable the same as any other <i>sickness</i> .	Payable the same as any other <i>sickness</i> .
Urgent Care Facility, Ancillary and <i>Qualified Practitioner</i> services	80% after <i>deductible</i>	60% after <i>deductible</i>

BEHAVIORAL HEALTH HOME HEALTH SERVICES		
MEDICAL SERVICES	PAR PROVIDER BENEFIT	NON-PAR PROVIDER BENEFIT
Home Health Care	80% after <i>deductible</i>	60% after <i>deductible</i>
Home Health Care Ancillary Services (excluding DME, Prosthetics and Private duty Nursing)	Payable the same as any other <i>sickness</i> .	Payable the same as any other <i>sickness</i> .

MEDICAL SCHEDULE OF BENEFITS (continued)

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

MEDICAL SCHEDULE OF BENEFITS (continued)

BEHAVIORAL HEALTH THERAPY SERVICES

MEDICAL SERVICES	PAR PROVIDER BENEFIT	NON-PAR PROVIDER BENEFIT
Physical therapy	80% after <i>deductible</i>	60% after <i>deductible</i>
Occupational therapy (clinical and outpatient)	80% after <i>deductible</i>	60% after <i>deductible</i>
Speech therapy (clinical and outpatient)	80% after <i>deductible</i>	60% after <i>deductible</i>
Audiology therapy (clinical and outpatient)	80% after <i>deductible</i> .	60% after <i>deductible</i>
Cognitive therapy (clinical and outpatient)	80% after <i>deductible</i>	60% after <i>deductible</i>

OTHER COVERED EXPENSES

MEDICAL SERVICES	PAR PROVIDER BENEFIT	NON-PAR PROVIDER BENEFIT
Other Covered Expenses	Payable the same as any other <i>sickness</i> .	Payable the same as any other <i>sickness</i> .

MEDICAL COVERED EXPENSES

HOW BENEFITS PAY

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

DEDUCTIBLE

A *deductible* is a specified dollar amount that must be satisfied, either individually or combined as a covered family, per *calendar year* before this Plan pays benefits for certain specified *services*. Only charges which qualify as a *covered expense* may be used to satisfy the *deductible*. The single and family *deductible* amounts are stated on the Medical Schedule of Benefits. *Preauthorization* penalties do not apply toward the *deductibles*.

Single Deductible

The single *deductible* applies to individual coverage only each *calendar year*. Once a *covered person* meets their single *deductible*, this Plan will begin to pay benefits for that *covered person* at the *coinsurance* level.

Family Deductible

The family *deductible* is the total *deductible* applied to all *covered persons* in one family in a *calendar year*. No single *deductible* applies. Once *you* and/or *your* covered *dependents* meet the family *deductible*, any remaining *deductible* for a *covered person* in the family will be waived for that year and this Plan will begin to pay benefits for all *covered persons* in the family.

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

PAR and Non-PAR Deductible Accumulation

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

COINSURANCE

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

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

OUT-OF-POCKET LIMIT

An *out-of-pocket limit* is a specified dollar amount that must be satisfied, per *calendar year*. The single and family *out-of-pocket limits* are stated on the Medical Schedule of Benefits.

Single Out-of-Pocket Limits

There is a single *out-of-pocket* limit applies if you have single coverage under this Plan. Once a *covered person* satisfies the single *out-of-pocket limits*, this Plan will pay 100% of *covered expenses* for the remainder of the *calendar year* for that *covered person*, unless specifically indicated, subject to any *calendar year* maximums. The single *out-of-pocket* include the *deductible*, *coinsurance* and *copayment* amounts paid by an individual on a single plan apply to the single *out-of-pocket* limit.

If *you* have elected to cover *your dependents* under this Plan, there are different family *out-of-pocket* limits that apply.

Family Out-of-Pocket Limit

There are both single and family *out-of-pocket* limits for those on with family coverage under this plan.

Each individual covered on a family plan has a single *out-of-pocket* limit of \$8,700. Once an individual has paid \$8,700 for covered, in-network services, this plan will pay 100% of *covered expenses* for that individual for the remainder of the *calendar year*. This amount includes any *deductible* and *coinsurance* amounts paid by that individual. Any *out-of-pocket* amounts paid by an individual on a family plan apply to the family *out-of-pocket* limit.

There is a higher *out-of-pocket* limit amount that applies to the family. Once the family *out-of-pocket limit* is met by a combination of *you* and/or *your covered dependents*, this Plan will pay 100% of *covered expenses* for the remainder of the *calendar year* for the family, unless specifically indicated, subject to any *calendar year* maximums. The family *out-of-pocket limits* include the *deductible*, *coinsurance* and *copayments* amount paid by all family members combined.

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

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

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

ROUTINE/PREVENTIVE SERVICES

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

- Services with an A or B rating in the current recommendations of the U. S. Preventive Services Task Force (USPSTF).
- Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC).
- Preventive care for infants, children and adolescents provided in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA).
- Preventive care for women provided in the comprehensive guidelines supported by HRSA.

For the recommended preventive *services* that apply to *your plan year*, refer to the www.healthcare.gov website or call the toll-free customer service telephone number listed on *your* Humana ID card.

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

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

QUALIFIED PRACTITIONER SERVICES

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

Not all healthcare practitioners, including but not limited to pathologist, anesthesiologist, radiologist and emergency room physicians, that contract with participating hospitals to provide services at participating hospitals are participating healthcare practitioners. If services are provided to you by such non-participating healthcare practitioners at a participating hospital, the Plan will pay for those services at the participating level. The Plan will also pay for the services of non-participating *assistant surgeons* if these services are received at a participating hospital. These payments will be subject to *maximum allowable fee*. Nonparticipating healthcare practitioners may require payment from you for any amount not paid by the Plan. If possible, you may want to verify whether services are available from participating healthcare practitioners.

Second Surgical Opinion

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

Multiple Surgical Procedures

If multiple or bilateral surgical procedures are performed during the same day, the *surgeries* will be paid according to the *provider contract* for a *participating provider*. When a *non-participating provider* is utilized, the *surgery* with the highest *maximum allowable fee* monetary amount will be allowed at 100% of the *maximum allowable fee*. For each additional *surgery* for a *non-participating provider* the amount allowed will be: a) 50% of the *maximum allowable fee* for the *surgery* with the second highest *maximum allowable fee* monetary amount; and b) 25% of the *maximum allowable fee* for all the other surgeries.

Assistant Surgeon

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

Physician Assistant

The physician assistant will be paid according to the *provider contract* if they are a *network provider*. This Plan will allow the physician assistant 10% of the *maximum allowable fee* for the *surgery* that would apply if the physician assistant were the primary surgeon.

DENTAL/ORAL SURGERIES COVERED UNDER THE MEDICAL PLAN

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

- Excision of partially or completely unerupted impacted teeth;
- Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth in conjunction with a pathological examination;
- Surgical procedures required to correct accidental injuries of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
- Reduction of fractures and dislocations of the jaw;
- External incision and drainage of cellulitis;
- Incision of accessory sinuses, salivary glands or ducts;
- Frenectomy (the cutting of the tissue in the midline of the tongue);
- Dental osteotomies; and
- Coverage for Anesthesia and Hospital/Facility charges for dental procedures for children through age 8.

REVERSAL OF STERILIZATION AND ABORTIONS

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

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

MATERNITY

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

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

Newborns

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

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

Birthing Centers

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

INPATIENT HOSPITAL

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

SKILLED NURSING FACILITY

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

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

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

OUTPATIENT AND AMBULATORY SURGICAL CENTER

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

EMERGENCY CARE AND URGENT CARE SERVICES

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

HOSPICE SERVICES

Hospice *services* are payable as shown on the Medical Schedule of Benefits, and must be furnished in a hospice facility or in *your* home. A *qualified practitioner* must certify *you* are terminally ill with a life expectancy of eighteen (18) months or less.

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

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

- Room and board and other *services* and supplies;
- Part-time nursing care by, or supervised by, a registered nurse for up to 8 hours per day;

MEDICAL COVERED EXPENSES (continued)

- Counseling *services* by a *qualified practitioner* for the hospice patient and the immediate family;
- Medical social *services* provided to *you* or *your* immediate family under the direction of a *qualified practitioner*, which include the following:
 - Assessment of social, emotional and medical needs, and the home and family situation;
 - Identification of the community resources available.
- Psychological and dietary counseling;
- Physical therapy;
- Part-time home health aide service for up to 8 hours in any one day;
- Medical supplies, drugs and medicines prescribed by a *qualified practitioner* for *palliative care*.

Hospice care benefits do NOT include:

- A *confinement* not required for pain control or other acute chronic symptom management;
- Bereavement counseling services for family members that are not covered under this Plan.
- Funeral arrangements;
- Financial or legal counseling, including estate planning or drafting of a will;
- Homemaker or caretaker *services*, including a sitter or companion *services*;
- Housecleaning and household maintenance;
- *Services* of a social worker other than a licensed clinical social worker;
- *Services* by volunteers or persons who do not regularly charge for their *services*; or
- *Services* by a licensed pastoral counselor to a member of his or her congregation when *services* are in the course of the duties to which he or she is called as a pastor or minister.

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

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

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

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

HOME HEALTH CARE

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

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

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

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

- Hospitalization or *confinement* in a skilled nursing facility would otherwise be required if home care were not provided;
- Necessary care and treatment are not available from a *family member* or other persons residing with *you*; and
- The home health care *services* will be provided or coordinated by a state-licensed or *Medicare*-certified home health agency or certified rehabilitation agency.

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

The home health care plan consists of:

- Care provided by a *nurse*;
- Physical, speech, occupational therapy
- Medical social work and nutrition services; and

MEDICAL COVERED EXPENSES (continued)

- Medical appliances, equipment and laboratory services.

Home health care benefits do not include:

- Charges for mileage or travel time to and from the *covered person's* home;
- Wage or shift differentials for home health care providers;
- Charges for supervision of home health care providers; and
- Private duty nursing;

DURABLE MEDICAL EQUIPMENT (DME)

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

Repair or maintenance of purchased *DME* is a *covered expense* if:

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

Replacement of purchased *DME* is a *covered expense* if:

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

Duplicate *DME* is not covered.

Prosthetics

Initial prosthetic devices or supplies, including but not limited to, limbs and eyes are payable as shown on the Medical Schedule of Benefits. Coverage will be provided for prosthetic devices necessary to restore the previous level of function lost as a result of a *bodily injury* or *sickness* or improve function caused by a *congenital anomaly*. *Covered expense* for prosthetic devices includes repair or replacement, if not covered by the manufacturer and if due to a change in the *covered person's* physical condition causing the device to become non-functional; normal wear and tear or misuse or loss.

SPECIALTY DRUG MEDICAL BENEFIT

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

AMBULANCE

Local professional ground or air *ambulance* service to the nearest *hospital* equipped to provide the necessary treatment is covered as shown on the Medical Schedule of Benefits. *Ambulance* service must not be provided primarily for the convenience of the patient or the *qualified practitioner*. ***Ambulance services not classified as an emergency as defined in definition section will not be a covered expense.***

MORBID OBESITY

When in need of *bariatric services* and to obtain a list of covered *bariatric surgeries*, please contact customer service at the phone number listed on the back of *your* medical id card:

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

For eligibility criteria and a list of covered *bariatric surgeries*, including how to access the Humana Medical Coverage Policy for Bariatric Surgery, please call the toll-free customer service telephone number listed on the back of *your* Humana ID card. Criteria and covered *bariatric services* are governed by this policy and are subject to change without notice.

Benefits are payable only if the *bariatric services* are approved by Humana and the maximum benefit is not exhausted.

OBESITY

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

EXCESS SKIN REMOVAL

Humana members may be eligible under the Plan for Excess Skin Removal and Panniculectomy following the Humana Standard Coverage Policy (policy details can be found on Humana.com), EXCEPT for the following:

- Medical complications related to excess tissue and skin folds such as candidiasis, intertrigo or tissue necrosis (changes in tissue caused by cell death); and
- Have failed a trial of at least three months of conservative management (oral and/or topical medication) as evidenced by documentation in medical records.

Documentation of panniculus at grade two or above, using the following scale:

- Grade 1 – panniculus covers hairline and mons pubis but not the genitals
- Grade 2 – panniculus covers genitals and upper thigh crease
- Grade 3 – panniculus covers upper thigh
- Grade 4 – panniculus covers mid-thigh
- Grade 5 – panniculus covers knees and below; AND

Maintenance of a stable body weight (normal BMI) for at least six months if the panniculectomy is performed following significant weight loss (unless excluded by contract)

TRANSGENDER COVERAGE

Humana members may be eligible under the Plan for Transgender *services* following the Humana Standard Coverage Policy (policy details can be found on Humana.com).

For eligibility criteria and a list of covered Transgender *services*, including how to access the Humana Medical Coverage Policy for Gender Reassignment Surgery, please call the toll-free customer service telephone number listed on the back of *your* Humana ID card.

TEMPOROMANDIBULAR JOINT DYSFUNCTION (TMJ)

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

DENTAL INJURY

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

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

MEDICAL COVERED EXPENSES (continued)

Services must begin within 90 days after the date of the *dental injury*. *Services* must be completed within 12 months after the date of the *dental injury*.

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

INFERTILITY

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

Artificial Means of Achieving Pregnancy

Services performed to achieve pregnancy or ovulation by artificial means include but are not limited to, artificial insemination, in vitro fertilization, spermatogenesis, gamete intra fallopian transfer (GIFT), zygote intra fallopian transfer (ZIFT), tubal ovum transfer, embryo freezing or transfer or sperm banking.

THERAPY SERVICES

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

Chiropractic Care

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

TRANSPLANT SERVICES AND IMMUNE EFFECTOR CELL THERAPY

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

Covered Organ Transplant

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

- Heart;
- Lung(s);
- Liver;

MEDICAL COVERED EXPENSES (continued)

- Kidney;
- *Bone Marrow*;
- Intestine;
- Pancreas;
- Auto islet cell;
- Any combination of the above listed organs;
- Any organ not listed above required by federal law.

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

Prior written approval from Humana is required for a transplant or *immune effector cell therapy*. *You or your qualified practitioner* must notify Humana in advance of *your* need for an initial evaluation in order for Humana to determine if the transplant or *immune effector cell therapy* will be covered. Humana must be given a reasonable opportunity to review the clinical results of the evaluation before rendering a determination.

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

Exclusions

No benefit is payable for, or in connection with, a transplant or *immune effector cell therapy* if:

- It is *experimental, investigational or for research purposes* as defined in the Definitions section;
- Humana is not contacted for authorization prior to referral for evaluation of the transplant or *immune effector cell therapy*;
- Humana does not approve coverage for the transplant or *immune effector cell therapy*, based on its established criteria;
- Expenses are eligible to be paid under any private or public research fund, government program, except Medicaid, or another funding program, whether or not such funding was applied for or received;
- The expense relates to the transplantation of any non-human organ or tissue, unless otherwise stated in this Plan;
- The expense relates to storage of cord blood and stem cells, unless it is an integral part of a transplant approved by Humana;

MEDICAL COVERED EXPENSES (continued)

- The expense relates to a transplant or *immune effector cell therapy* performed outside of the United States and any care resulting from that transplant or *immune effector cell therapy*. This exclusion applies even if the *employee* and *dependents* live outside the United States and the employee is actively employed with the *employer*;
- The expense relates to the donation or acquisition of an organ for a recipient who is not covered by this Plan;
- A denied transplant or *immune effector cell therapy* is performed; this includes the pre-transplant evaluation, pre-transplant *services*, the transplant procedure, post-discharge *services*, immunosuppressive drugs and complications of such transplant and;
- The *covered person* for whom a transplant or *immune effector cell therapy* is requested has not met pre-transplant criteria as established by Humana.

Covered Services

For approved transplants or *immune effector cell therapy*, and all related complications, this Plan will cover only the following expenses:

- *Hospital* and *qualified practitioner services*, payable as shown on the Medical Schedule of Benefits. If *services* are rendered at a Humana National Transplant Network (NTN) facility, *covered expenses* are paid in accordance to the NTN contracted rates; Organ acquisition and donor costs. Except for bone marrow transplants, donor costs are not payable under this Plan if they are payable in whole or in part by any other group plan, insurance company, organization or person other than the donor's family or estate. Coverage for bone marrow transplants procedures will include costs associated with the donor-patient to the same extent and limitations associated with the *covered person*;
- Direct, non-medical costs for the *covered person* when the transplant is performed at a Humana National Transplant Network facility, will be paid as shown on the Medical Schedule of Benefits, for: (a) transportation to and from the *hospital* where the transplant is performed; and (b) temporary lodging at a prearranged location when requested by the *hospital* and approved by Humana. These direct, non-medical costs are only available if the *covered person* lives more than 100 miles from the transplant facility;
- Direct, non-medical costs for one support person of the *covered person* (two persons if the patient is under age 18 years), when the transplant is performed at a Humana National Transplant Network facility, will be paid as shown on the Medical Schedule of Benefits, for: (a) transportation to and from the approved facility where the transplant is performed; and (b) temporary lodging at a prearranged location during the *covered person's confinement* in the *hospital*. These direct, non-medical costs are only available if the *covered person's* support person(s) live more than 100 miles from the transplant facility.

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

BEHAVIORAL HEALTH SERVICES

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

- Charges made by a *Qualified practitioner*;
- Free-standing facility;
- Urgent care center;
- A home;
- Hospital;
- Skilled nursing facility;
- Ambulance; and
- Emergency Room.

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

Inpatient Services

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

Outpatient Services

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

VIRTUAL VISIT SERVICES

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

VIRTUAL VISIT SERVICES

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

Once you provide your personal email address during enrollment and register with the *network provider* designated by Humana as a preferred provider for a *virtual visit*, you will receive a care kit for your household. The care kit includes medical equipment to use during a *virtual visit*. The *network provider* may recommend additional services and may assist in scheduling in-person appointments with other *network providers* during the *virtual visit*.

MEDICAL COVERED EXPENSES (continued)

Limitations

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

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

OTHER COVERED EXPENSES

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

- Blood and blood plasma are payable as long as it is NOT replaced by donation, and administration of blood and blood products including blood extracts or derivatives;
- Casts, trusses, crutches, and splints Unless specifically stated otherwise, fabric supports, replacement *orthotics* and braces, oral splints and appliances, dental splints and appliances, and dental braces are not a *covered expense*;
- Reconstructive *surgery* due to *bodily injury*, infection or other disease of the involved part or congenital disease or anomaly of a covered *dependent* child which resulted in a *functional impairment*;
- Reconstructive *services* following a covered mastectomy, including but not limited to:
 - Reconstruction of the breast on which the mastectomy was performed;
 - *Surgery* and reconstruction of the other breast to achieve symmetrical appearance;
 - Prosthesis; and
 - Treatment of physical complications of all stages of the mastectomy, including lymphedemas.
- Routine costs associated with clinical trials, when approved by this Plan. For additional details, go to www.humana.com or call the toll-free customer service telephone number listed on *your* Humana ID card;
- Cranial banding, when approved by this Plan. For additional details, go to www.humana.com, or call the toll-free customer service telephone number listed on *your* Humana ID card.

LIMITATIONS AND EXCLUSIONS (continued)

This Plan does not provide benefits for:

- *Services:*
 - Not furnished by a *qualified practitioner* or *qualified treatment facility*;
 - Not authorized or prescribed by a *qualified practitioner*;
 - Not specifically covered by this Plan whether or not prescribed by a *qualified practitioner*;
 - Which are not provided;
 - 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;
 - Furnished by or payable under any plan or law through any government or any political subdivision (this does not include *Medicare* or *Medicaid*);
 - 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;
 - Performed in association with a *service* that is not covered under this Plan;
 - Immunizations required for foreign travel;
 - Radial keratotomy, refractive keratoplasty or any other *surgery* to correct myopia, hyperopia or stigmatic error;
 - Cosmetic *surgery* and cosmetic *services* or devices, unless for reconstructive *surgery*:
 - Resulting from a *bodily injury*, infection or other disease of the involved part, when *functional impairment* is present; or
 - Resulting from a congenital disease or anomaly of a covered *dependent* child which resulted in a *functional impairment*.
- Expense incurred* for reconstructive *surgery* performed due to the presence of a psychological condition is not covered, unless the condition(s) described above are also met;
- Hair prosthesis, hair transplants or hair implants;
 - Dental *services* or appliances for the treatment of the teeth, gums, jaws or alveolar processes, including but not limited to, implants and related procedures, routine dental extractions and orthodontic procedures, unless specifically provided under this Plan;
 - *Services* which are:
 - Rendered in connection with a *mental health* disorder not classified in the International Classification of Diseases of the U.S. Department of Health and Human Services;
 - Extended beyond the period necessary for evaluation and diagnosis of learning and behavioral disabilities or for mental retardation.
 - Marriage counseling;
 - Education or training, unless otherwise specified in this Plan;
 - Educational or vocational therapy, testing, services or schools, including therapeutic boarding schools and other therapeutic environments. Educational or vocational videos, tapes, books and similar materials are also excluded;

LIMITATIONS AND EXCLUSIONS (continued)

- Expenses for *services* that are primarily and customarily used for environmental control or enhancement (whether or not prescribed by a *qualified practitioner*) and certain medical devices including, but not limited to:
 - Common household items including air conditioners, air purifiers, water purifiers, vacuum cleaners, waterbeds, hypoallergenic mattresses or pillows or exercise equipment;
 - Motorized transportation equipment (e.g. scooters), escalators, elevators, ramps or modifications or additions to living/working quarters or transportation vehicles;
 - Personal hygiene equipment including bath/shower chairs and transfer equipment or supplies;
 - Personal comfort items including cervical pillows, gravity lumbar reduction chairs, swimming pools, whirlpools, spas or saunas;
 - Medical equipment including blood pressure monitoring devices unless prescribed by a *qualified practitioner* for *preventive services* and ambulatory blood pressure monitoring is not available to confirm diagnosis of hypertension, PUVA lights and stethoscopes;
 - Communication system, telephone, television or computer systems and related equipment or similar items or equipment;
 - Communication devices, except after surgical removal of the larynx or a diagnosis of permanent lack of function of the larynx.
- Any medical treatment, procedure, drug, biological product or device which is *experimental, investigational or for research purposes*, unless otherwise specified in this Plan;
- *Services* that are not *medically necessary*, except routine/preventive *services*;
- Charges in excess of the *maximum allowable fee* for the *service*;
- *Services* provided by a person who ordinarily resides in *your* home or who is a *family member*;
- 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;
- *Expenses incurred* for which *you* are entitled to receive benefits under *your* previous dental or medical plan;
- *Services* relating to a *sickness* or *bodily injury* as a result of:
 - Engaging in an illegal profession or occupation; or
 - Commission of or an attempt to commit a criminal act.
- Any loss caused by or contributed to:
 - War or any act of war, whether declared or not;
 - Insurrection; or
 - Any act of armed conflict, or any conflict involving armed forces of any authority.
- Treatment of nicotine habit or addiction, including, but not limited to hypnosis, smoking cessation products, classes or tapes, unless otherwise determined by this Plan;

LIMITATIONS AND EXCLUSIONS (continued)

- Vitamins, except for *preventive services* with a *prescription* from a *qualified practitioner*, dietary supplements and dietary formulas, except enteral formulas, nutritional supplements or low protein modified food products for the treatment of an inherited metabolic disease, e.g. phenylketonuria (PKU);
- *Prescription* drugs and *self-administered injectable drugs*, unless administered to you:
 - While inpatient in a *hospital*, *qualified treatment facility*, *residential treatment facility* or skilled nursing facility;
 - 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.
- Any drug prescribed, except:
 - FDA approved drugs utilized for FDA approved indications; or
 - FDA approved drugs utilized for *off-label drug indications* recognized in at least one compendia reference or peer-reviewed medical literature deemed acceptable to this Plan.
- *Off-evidence drug indications*;
- Over-the-counter, non-prescription medications, unless for drugs, medicines or medications on the Women's Healthcare Drug List with a *prescription* from a *qualified practitioner*. See the Prescription Drug Benefit;
- Over-the-counter medical items or supplies that can be provided or prescribed by a *qualified practitioner* but are also available without a written order or *prescription* , except for *preventive services* (with a *prescription* from a *qualified practitioner*);
- Growth hormones, except as otherwise specified in the pharmacy services sections of this *SPD*;
- Therapy and testing for treatment of allergies including, but not limited to, *services* related to clinical ecology, environmental allergy and allergic immune system dysregulation and sublingual antigen(s), extracts, neutralization test and/or treatment UNLESS such therapy or testing is approved by:
 - The American Academy of Allergy and Immunology, or
 - The Department of Health and Human Services or any of its offices or agencies.
- Professional pathology or radiology charges, including but not limited to, blood counts, multi-channel testing, and other clinical chemistry tests, when:
- The *services* do not require a professional interpretation, or
The *qualified practitioner* did not provide a specific professional interpretation of the test results of the *covered person*.
- *Services* that are billed incorrectly or billed separately, but are an integral part of another billed *service*, as determined by this Plan;
- Expenses for health clubs or health spas, aerobic and strength conditioning, work-hardening programs or weight loss or similar programs, and all related material and product for these programs;

LIMITATIONS AND EXCLUSIONS (continued)

- *Alternative medicine;*
- *Services rendered in a premenstrual syndrome clinic or holistic medicine clinic;*
- *Services of a midwife, unless provided by a Certified Nurse Midwife;*
- The following types of care of the feet:
 - Shock wave therapy of the feet.
 - The treatment of weak, strained, flat, unstable or unbalanced feet.
 - Hygienic care, and the treatment of superficial lesions of the feet, such as corns, calluses or hyperkeratosis.
 - The treatment of tarsalgia, metatarsalgia, or bunion, except surgically.
 - The cutting of toenails, except the removal of the nail matrix.
 - The provision of heel wedges, lifts or shoe inserts.
 - The provision of arch supports or orthopedic shoes. Arch supports and orthopedic shoes are covered if *medically necessary* because of diabetes or hammertoe.
- *Custodial care and maintenance care;*
- Weekend non-emergency *hospital admissions*, specifically *admissions* to a *hospital* on a Friday or Saturday at the convenience of the *covered person* or his or her *qualified practitioner* when there is no cause for an *emergency admission* and the *covered person* receives no *surgery* or therapeutic treatment until the following Monday;
- *Hospital inpatient services* when *you* are in observation status;
- *Services* rendered by a standby physician, surgical assistant, *assistant surgeon*, physician assistant, registered nurse or certified operating room technician unless *medically necessary*;
- *Ambulance services* for routine transportation to, from or between medical facilities and/or a *qualified practitioner's* office;
- *Preadmission testing/procedural testing* duplicated during a *hospital confinement*;
- Lodging accommodations or transportation, unless specifically provided under this Plan;
- Communications or travel time;
- No benefits will be provided for the following, unless otherwise determined by this Plan:
 - Immunotherapy for recurrent abortion;
 - Chemonucleolysis;
 - Biliary lithotripsy;
 - Home uterine activity monitoring;
 - Sleep therapy;
 - Light treatments for Seasonal Affective Disorder (S.A.D.);
 - Immunotherapy for food allergy;
 - Prolotherapy;
 - Sensory integration therapy.

LIMITATIONS AND EXCLUSIONS (continued)

- 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, worker's compensation, uninsured motorists, underinsured motorists, "no-fault" and automobile med-pay payments or recovery from any identifiable fund regardless of whether the *beneficiary* was made whole;
- Surrogate parenting
- Any *bodily injury* or *sickness* arising from or sustained in the course of any occupation or employment for compensation, profit or gain for which:
 - Benefits are provided or payable under any Workers' Compensation or Occupational Disease Act or Law, or
 - Coverage was available under any Workers' Compensation or Occupational Disease Act or Law regardless of whether such coverage was actually purchased.
- Routine physical examinations and related *services* for occupation, employment, school, sports, camp, travel, purchase of insurance or premarital tests or examinations, unless specifically provided under this Plan;
- Routine vision examinations, *services* to correct eye refractive disorders
- All *services* over the *lifetime maximum benefit* of \$10,000 per person for the treatment of *morbid obesity*. .
- *Services* in excess of the *lifetime maximum benefit* of \$5,000 per person for excess skin removal;
- *Services* in excess of the *lifetime maximum benefit* of \$10,000 per person for you and your covered dependent spouse for the treatment of infertility.
- The purchase, fitting or repair of eyeglass frames and lenses or contact lenses, unless specifically provided under this Plan;
- Routine hearing examinations;
- Routine hearing testing;
- Implantable hearing devices, except for cochlear implants and auditory brain stem implants as determined by this Plan;
- Elective medical or surgical abortion, unless:
 - The pregnancy would endanger the life of the mother; or
 - The pregnancy is a result of rape or incest; or
 - The fetus has been diagnosed with a lethal or otherwise significant abnormality.
- *Services* for a reversal of sterilization;
- Contraceptive pills and patches and spermicide (see the Prescription Drug Benefit for coverage);
- Private duty nursing;

LIMITATIONS AND EXCLUSIONS (continued)

- Wigs, except for cancer patients with hair loss resulting from chemotherapy and/or radiation therapy;
- No benefits will be provided for, or on account of, the following items:
 - Expenses for a *bariatric surgery* that are *experimental, investigational or for research purposes*;
 - *Bariatric services* for which *you* have not met criteria as established by this Plan;
 - Expenses for *bariatric surgery* performed outside of the United States;
 - Any care resulting from a non-covered *bariatric surgery*.
- Obesity *services* other than the covered *services* listed on the Medical Schedule of Benefits. There is no coverage for *bariatric surgery* under this benefit;
- *Morbid obesity services* other than the covered *services* listed on the Medical Schedule of Benefits;
- Halfway-house *services*;
- *Services* related to the treatment and/or diagnosis of sexual dysfunction/impotence when related to a *mental health* disorder;
- Acupuncture, other than the covered *services* listed on the Medical Schedule of Benefits.

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

COORDINATION OF BENEFITS

BENEFITS SUBJECT TO THIS PROVISION

Benefits described in this Plan are coordinated with benefits provided by other plans under which *you* are also covered. This is to prevent duplication of coverage and a resulting increase in the cost of medical or dental coverage. *Prescription* drug coverage under the *prescription* drug benefit, if applicable, is not subject to these coordination provisions.

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

- Employer, trustee, union, employee benefit, or other association; or
- Governmental programs, programs mandated by state statute, or sponsored or provided by an educational institution.

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

EFFECT ON BENEFITS

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

When this Plan is the secondary plan, the sum of the benefit payable by this Plan when added to the primary plan's benefits will not exceed this Plan's normal liability.

ORDER OF BENEFIT DETERMINATION

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

- The plan has no coordination of benefits provision;
- The plan covers the person as an *employee*;
- For a child who is covered under both parents' plans, the plan covering the parent whose birthday (month and day) occurs first in the *calendar year* pays before the plan covering the other parent. If the birthdates of both parents are the same, the plan which has covered the person for the longer period of time will be determined the primary plan;

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

COORDINATION OF BENEFITS (continued)

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

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

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

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

GENERAL COORDINATION OF BENEFITS WITH MEDICARE

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

RIGHT OF RECOVERY

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

- Any person(s) to, for or with respect to whom, such payments were made; or
- Any other insurance companies, or organizations which according to these provisions, owe benefits due for the same allowable expense under any other plan.

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

SUBMITTING A CLAIM

- This section describes what a *covered person* (or his or her authorized representative) must do to file a claim for Plan benefits.
- A claim must be filed with Humana in writing and delivered to Humana by mail, postage prepaid. However, a submission to obtain preauthorization may also be filed with Humana by telephone;
- Claims must be submitted to Humana at the address indicated in the documents describing this Plan or *claimant's* Humana ID card. Claims will not be deemed submitted for purposes of these procedures unless and until received at the correct address;
- Also, claims submissions must be in a format acceptable to Humana and compliant with any applicable legal requirements. Claims that are not submitted in accordance with the requirements of applicable federal law respecting privacy of *protected health information* and/or electronic claims standards will not be accepted by this Plan;
- Claims submissions must be timely. Claims must be filed as soon as reasonably possible after they are incurred, and in no event later than 15 months after the date of loss, except if *you* were legally incapacitated. Plan benefits are only available for claims that are incurred by a *covered person* during the period that he or she is covered under this Plan;
- Claims submissions must be complete. They must contain, at a minimum:
 - The name of the *covered person* who incurred the *covered expense*;
 - The name and address of the health care provider;
 - The diagnosis of the condition;
 - The procedure or nature of the treatment;
 - The date of and place where the procedure or treatment has been or will be provided;
 - The amount billed and the amount of the *covered expense* not paid through coverage other than Plan coverage, as appropriate;
 - Evidence that substantiates the nature, amount, and timeliness of each *covered expense* in a format that is acceptable according to industry standards and in compliance with applicable law.

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

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

Mail medical claims and correspondence to:

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

MISCELLANEOUS MEDICAL CHARGES

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

OTHER PROGRAMS AND PROCEDURES

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

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

CLAIMS PROCESSING EDITS

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

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

CLAIM PROCEDURES (continued)

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

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

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

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

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

PROCEDURAL DEFECTS

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

ASSIGNMENTS AND REPRESENTATIVES

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

CLAIM PROCEDURES (continued)

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

In addition, a *covered person* may designate an authorized representative to act on his or her behalf in pursuing a benefit claim or *appeal*. The designation must be made by the *covered person* on Humana's Appointment of Representative (AOR) Form or on a form approved in advance by Humana. An assignment of benefits does not constitute designation of an authorized representative.

- Humana's AOR Form must be submitted to Humana at the time or prior to the date an authorized representative commences a course of action on behalf of a *claimant*. At the same time, the authorized representative should also provide notice of commencement of the action on behalf of the *claimant* to the *claimant*, which Humana may verify with the *claimant* prior to recognizing the authorized representative status.
- 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.

CLAIM PROCEDURES (continued)

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

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

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

Concurrent Care Decisions

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

A request by a *claimant* to extend a course of treatment beyond the period of time or number of treatments that is a claim involving urgent care services 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 *participating providers*. In those instances, Humana will make direct payment to the *hospital*, clinic or physician's office, unless Humana is advised in writing that *you* have already paid the bill. If *you* have paid the bill, please indicate on the original statement, "paid by *employee*," and send it directly to Humana. *You* will receive a written explanation of an *adverse benefit determination*. Humana reserves the right to request any information required to determine benefits or process a claim. *You* or the provider of *services* will be contacted if additional information is needed to process *your* claim.

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

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

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

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

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

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

NOTICES – GENERAL INFORMATION

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

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

CLAIM PROCEDURES (continued)

- The reason(s) for the *adverse benefit determination* or *final internal adverse benefit determination* to include the denial code (e.g. CARC) and its corresponding meaning as well as a description of this Plan's standard (if any) that was used in denying the claim. For a *final internal adverse benefit determination*, this description must include a discussion of the decision;
- A description of available *internal appeals* and *external review* processes, including information on how to initiate an *appeal*; and
- Disclosure of the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman to assist individuals with internal claims and *appeals*, and *external review* processes.

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

INITIAL DENIAL NOTICES

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

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

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

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

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

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

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

APPEALS OF ADVERSE 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:

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

CLAIM PROCEDURES (continued)

Time Periods for Decisions on Appeal -- Second Level

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

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

APPEAL DENIAL NOTICES

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

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

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

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

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

- Relied on in making the determination;
- Submitted, considered or generated in the course of making the benefit determination;
- That demonstrates compliance with the administrative processes and safeguards required with respect to such determinations;
- That constitutes a statement of policy or guidance with respect to this Plan concerning the denied treatment, without regard to whether the statement was relied on.

FULL AND FAIR REVIEW

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

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

RIGHT TO REQUIRE MEDICAL EXAMINATIONS

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

EXHAUSTION

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

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

LEGAL ACTIONS AND LIMITATIONS

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

STANDARD EXTERNAL REVIEW

Request for an External Review

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

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

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

Preliminary Review

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

- If the *claimant* is, or was, covered under this Plan at the time the health care item or *service* was requested or provided;
- If the *adverse benefit determination* or *final internal adverse benefit determination* relates to the *claimant's* failure to meet this Plan's eligibility requirements;
- If the *claimant* has exhausted this Plan's *internal appeals* process, when required; and
- If the *claimant* has provided all the information and forms required to process an *external review*.

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

- If the request is complete but not eligible for *external review*. The notice must include the reason(s) for its ineligibility and contact information for the Department of Labor (DOL) Employee Benefits Security Administration (EBSA), including this toll-free number: 1-866-444-EBSA (3272) and this email address: www.askebsa.dol.gov.
 - If the request is not complete. The notice must describe the information or materials needed to make it complete, and Humana must allow the *claimant* to perfect the *external review* request within whichever of the following two options is later:
 - The initial 4-month filing period; or
 - The 48-hour period following receipt of the notification.

Referral to an Independent Review Organization (IRO)

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

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

- The assigned *IRO* will use legal experts where appropriate to make coverage determinations.
- The assigned *IRO* will timely provide the *claimant* with written notification of the request's eligibility and acceptance of the request for *external review*. This written notice must inform the *claimant* that he/she may submit, in writing, additional information that the *IRO* must consider when conducting the *external review* to the *IRO* within 10 business days following the date the notice is received by the *claimant*. The *IRO* may accept and consider additional information submitted after 10 business days.
- Humana must provide the *IRO* the documents and any information considered in making the *adverse benefit determination* or *final internal adverse benefit determination* within 5 business days after assigning the *IRO*. Failure to timely provide this information must not delay the conduct of the *external review* - the assigned *IRO* may terminate the *external review* and make a decision to reverse the *adverse benefit determination* or *final internal adverse benefit determination* if this Plan fails to timely provide this information. The *IRO* must notify the *claimant* and Humana within 1 business day of making the decision.
- If the *IRO* receives any information from the *claimant*, the *IRO* must forward it to Humana within 1 business day. After receiving this information, Humana may reconsider its *adverse benefit determination* or *final internal adverse benefit determination*. If Humana reverses or changes its original determination, Humana must notify the *claimant* and the *IRO*, in writing, within 1 business day. The assigned *IRO* will then terminate the *external review*.

CLAIM PROCEDURES (continued)

- The *IRO* will review all information and documents timely received. In reaching a decision, the *IRO* will not be bound by any decisions or conclusions reached during Humana's internal claims and *appeals* process. The *IRO*, to the extent the information or documents are available and the *IRO* considers them appropriate, will consider the following when reaching a determination:
 - The *claimant's* medical records;
 - The attending health care professional's recommendation;
 - Reports from the appropriate health care professional(s) and other documents submitted by Humana, *claimant*, or *claimant's* treating provider;
 - The terms of the *claimant's* plan to ensure the *IRO's* decision is not contrary, unless the terms are inconsistent with applicable law;
 - Appropriate practice guidelines, including applicable evidence-based standards that may include practice guidelines developed by the federal government, national or professional medical societies, boards, and associations;
 - Any applicable clinical review criteria developed and used by this Plan, unless inconsistent with the terms of this Plan or with applicable law; and
 - The opinion of the *IRO's* clinical reviewer(s) after considering the information described above to the extent the information or documents are available and the reviewer(s) consider them appropriate.
- The assigned *IRO* must provide written notice of the *final external review decision* within 45 days after receiving the *external review* request to the *claimant* and Humana. The decision notice must contain the following:
 - A general description of the reason an *external review* was requested, including information sufficient to identify the claim including:
 - (1) The date(s) of service;
 - (2) The health care provider;
 - (3) The claim amount (if applicable);
 - (4) The reason for the previous denial.
- The date the *IRO* received assignment to conduct the *external review* and the date of the *IRO* decision;
- References to the evidence or documentation considered in reaching the decision, including the specific coverage provisions and evidence-based standards;
- A discussion of the principal reason(s) for its decision, including the rationale and any evidence-based standards relied on in making the decision;
- A statement that the determination is binding except to the extent that other remedies may be available under state or federal law to either Humana or the *claimant*;
- A statement that judicial review may be available to the *claimant*; and
- Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under PPACA (*section 2793 of PHSA, as amended*).
- After a *final external review decision*, the *IRO* must maintain records of all claims and notices associated with the *external review* process for 6 years. An *IRO* must make such records available for examination by the *claimant*, Humana, or state/federal oversight agency upon request, except where such disclosure would violate state or federal privacy laws.

Reversal of this Plan's Decision

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

EXPEDITED EXTERNAL REVIEW

Request for an Expedited External Review

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

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

- An *adverse benefit determination* involving a medical condition of the *claimant* for which the time frame for completion of an expedited *internal appeal* under the interim final regulations would seriously jeopardize the life or health of the *claimant*, or would jeopardize the *claimant's* ability to regain maximum function and the *claimant* has filed a request for an expedited *external review*; or
- A *final internal adverse benefit determination* involving a medical condition where:
 - The time frame for completion of a standard *external review* would seriously jeopardize the life or health of the *claimant*, or would jeopardize the *claimant's* ability to regain maximum function; or
 - The *final internal adverse benefit determination* concerns an *admission*, availability of care, continued stay, or health care item or *service* for which the *claimant* received *emergency services*, but has not been 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.

CLAIM PROCEDURES (continued)

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.

SECTION 3

ELIGIBILITY AND EFFECTIVE DATE OF COVERAGE

ELIGIBILITY AND EFFECTIVE DATE OF COVERAGE

OPEN ENROLLMENT

Health insurance is really important and is a very valuable benefit offered by your *employer*, Humana. One time each year you will have a choice of enrolling in any Humana Inc. employee plans available in your location. You will be notified in advance when the open enrollment period is to begin and how long it will last. Even if you weren't covered under a Humana Plan previously, you are eligible to enroll during the open enrollment period.

If you decline coverage during the open enrollment period, you will not be allowed to enroll until the next open enrollment period, except when a special enrollment event occurs. You will find an explanation of special enrollment events toward the end of this section

EMPLOYEE ELIGIBILITY

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

- You are an *employee* who meets the eligibility requirements of the *employer*; and
- You are a *full-time* or *part-time employee* scheduled to work at least 20 hours per week or you are a *Flex* associate with a variable work schedule who has worked on average at least 30 hours per week over the last 12 months; and
- You are in *active status*.

Your *eligibility date* is your first day of employment with the *employer* or the day your employment status changes and you become eligible for benefits.

EMPLOYEE EFFECTIVE DATE OF COVERAGE

You must enroll in a manner acceptable to Humana.

- If your completed enrollment is received by Humana before your *eligibility date* or within 31 days after your *eligibility date*, your coverage is effective on your *eligibility date*;
- If your completed enrollment is received by Humana more than 31 days after your *eligibility date*, you are a *late applicant*. You will not be eligible for coverage under this Plan until the next annual Open Enrollment Period, unless a qualifying event occurs.

EMPLOYEE DELAYED EFFECTIVE DATE

If the *employee* is not in *active status* on the effective date of coverage, coverage will be effective the day the *employee* returns to *active status*. The *employer* must notify Humana in writing of the *employee's* return to *active status*.

DEPENDENT ELIGIBILITY

Each *dependent* is eligible for coverage on:

- The date the *employee* is eligible for coverage, if he or she has *dependents* who may be covered on that date; or
- The date of the *employee's* marriage for any *dependent* acquired on that date; or

ELIGIBILITY AND EFFECTIVE DATE OF COVERAGE (continued)

- The date of birth of the *employee's* natural-born child; or
- The date a child is placed for adoption under the *employee's* legal guardianship, or the date which the *employee* incurs a legal obligation for total or partial support in anticipation of adoption; or
- The date a covered *employee's* child is determined to be eligible as an alternate recipient under the terms of a medical child support order or;
- The date specified by a guardianship court order.

If you and your spouse or unmarried *employee* or extended family member are eligible *employees*, you may separately elect coverage under the medical plan. Since the Plan does not coordinate benefits within itself, you cannot have duplicate coverage as both an *employee* and a *dependent*. If you and your spouse or unmarried *employee* or extended family member have *dependents* you wish to cover, they may only be covered under one plan.

If a *dependent* child becomes an eligible *employee*, he or she cannot be covered both as your *dependent* and as an eligible *employee*.

DEPENDENT EFFECTIVE DATE OF COVERAGE

If the *employee* wishes to add a newborn *dependent* to the Plan, enrollment must be completed and submitted to the *Plan Manager*.

The newborn *dependent* will be covered on the date he or she is eligible.

If the *employee* wishes to add a *dependent* (other than a newborn) to the Plan enrollment must be completed and submitted to the *Plan Manager*.

The *dependent's* effective date of coverage is determined as follows:

- If completed enrollment is received by the *Plan Manager* before the *dependent's* *eligibility date* or within 31 days after the *dependent's* *eligibility date*, that *dependent* is covered on the date he or she is eligible.
- If completed enrollment is received by the *Plan Manager* more than 31 days after the *dependent's* *eligibility date*, the *dependent* is a *late applicant*. The *dependent* will not be eligible for coverage under this Plan until the next annual open enrollment period, unless a special enrollment event occurs.

No *dependent's* effective date will be prior to the covered *employee's* effective date of coverage.

If you and your spouse or unmarried *employee* or extended family member are eligible *employees*, you may separately elect coverage under the medical plan. Since the Plan does not coordinate benefits within itself, you cannot have duplicate coverage as both an *employee* and a *dependent*. If you and your spouse or unmarried *employee* or extended family member have *dependents* you wish to cover, they may only be covered under one plan.

If a *dependent* child becomes an eligible *employee* of the *employer*, he or she cannot be covered both as your *dependent* and as an eligible *employee*.

MEDICAL CHILD SUPPORT ORDERS

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

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

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

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

SPECIAL PROVISIONS FOR NOT BEING IN ACTIVE STATUS

If you will not be considered in active status for an extended period of time, your coverage may remain in force if required contributions are paid. Please contact your Human Resources representative for details.

REINSTATEMENT OF COVERAGE FOLLOWING INACTIVE STATUS

If your coverage under this Plan was terminated after a period of layoff, total disability, approved medical leave of absence, or during part-time status, and you are now returning to work, please contact your Human Resources representative for detail regarding your eligibility.

If *your* coverage under the Plan was terminated due to a period of service in the uniformed services covered under the Uniformed Services Employment and Reemployment Rights Act of 1994, *your* coverage is effective immediately on the day *you* return to work.

FAMILY AND MEDICAL LEAVE ACT (FMLA)

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

SPECIAL ENROLLMENT

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

- Loss of eligibility for prior coverage due to any of the following:
 - Death of your spouse/domestic partner or *dependent*;
 - Birth or adoption of your child;
 - A child is placed with you for future adoption;
 - *You* become the legal guardian of a child;
 - *You* become married, divorced, or experience a legal separation or annulment;
 - *You* or *your* spouse/domestic partner take an unpaid leave of absence;
 - Termination or start of employment by your spouse/domestic partner;
 - You or your spouse/domestic partner change from a part-time to full-time or a full-time to part-time employment status;
 - *You* obtain a family law court order, such as divorce decree or qualified medical support order;
 - *You*, *your* spouse/domestic partner or *your* dependent become enrolled under Medicare; also permitted are changes if *you*, *your* spouse/domestic partner or *your* dependent becomes eligible or loses eligibility for coverage under Medicaid;
 - *You*, *your* spouse/domestic partner or *your* dependent enroll in a medical plan offered through the Health Insurance Marketplace; and
 - *Your* spouse/domestic partner's open enrollment.

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

- Employer contributions toward the other coverage have been terminated. Employer contributions include contributions by any current or former employer (of the individual or another person) that was contributing to coverage for the individual.
- COBRA coverage under the other plan has since been exhausted.

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

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

- Marriage;
- Birth;

ELIGIBILITY AND EFFECTIVE DATE OF COVERAGE (continued)

- Adoption or placement for adoption of a child;
- Court ordered guardianship of a child;
- A child is determined to be eligible as an alternate recipient under the terms of a medical child support order;
- A spouse or extended family member's open enrollment;
- An extended family member is determined to be eligible under the Plan;
- Loss of eligibility due to termination of Medicaid or State Children's Health Insurance Program (SCHIP) coverage; or
- Eligibility for premium assistance subsidy under Medicaid or SCHIP.

You may elect coverage under this Plan and will be considered a *timely applicant* provided completed enrollment is received within 31 days from the qualifying event or 60 days from such event as identified in #8 and #9 above. *You* must provide proof, upon request that the qualifying event has occurred due to one of the reasons listed before coverage under this Plan will be effective. For a spouse or extended family member open enrollment, the qualifying event date is the spouse or extended family member's plan effective date. Coverage under this Plan will be effective the date immediately following the date of the qualifying event, unless otherwise specified in this section.

If *you* apply more than 31 days after a qualifying event or sixty (60) days from such event as identified in #8 and #9 above, *you* are considered a *late applicant*. *You* will not be eligible for coverage under this Plan until the next annual Open Enrollment Period.

Please see *your employer* for more details.

TERMINATION OF COVERAGE

Coverage terminates on the earliest of the following:

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

The provisions above will not apply if *you* are covered by an employment, severance, change in control or separation agreement that specifies *your* coverage will continue. In this case, *you* will remain eligible for coverage according to the terms of your agreement.

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

SECTION 4

GENERAL PROVISIONS AND REIMBURSEMENT/ SUBROGATION

GENERAL PROVISIONS

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

PLAN ADMINISTRATION

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

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

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

RESCISSION

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

CONTESTABILITY

This Plan has the right to contest the validity of *your* coverage under the Plan (or any other Plan that Humana administers) at any time.

RIGHT TO REQUEST OVERPAYMENTS

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

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

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

WORKERS' COMPENSATION NOT AFFECTED

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

WORKERS' COMPENSATION

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

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

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

MEDICAID

This Plan will take into account the fact that an *employee* or *dependent* is eligible for medical assistance or Medicaid under state law with respect to enrollment, determining eligibility for benefits, or paying claims.

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

CONSTRUCTION OF PLAN TERMS

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

REIMBURSEMENT/SUBROGATION

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

- This Plan shall be repaid the full amount of the *covered expenses* it pays from any amount received from others for the *bodily injuries* or losses which necessitated such *covered expenses*. Without limitation, "amounts received from others" specifically includes, but is not limited to, liability insurance, worker's compensation, uninsured motorists, underinsured motorists, "no-fault" and automobile med-pay payments or recovery from any identifiable fund regardless of whether the *beneficiary* was made whole.
- This Plan's right to repayment is, and shall be, prior and superior to the right of any other person or entity, including the *beneficiary*.
- The right to recover amounts from others for the injuries or losses which necessitate *covered expenses* is jointly owned by this Plan and the *beneficiary*. This Plan is subrogated to the *beneficiary's* rights to that extent. Regardless of who pursues those rights, the funds recovered shall be used to reimburse this Plan as prescribed above; this Plan has no obligation to pursue the rights for an amount greater than the amount that it has paid, or may pay in the future. The rights to which this Plan is subrogated are, and shall be, prior and superior to the rights of any other person or entity, including the *beneficiary*.
- The *beneficiary* will cooperate with this Plan in any effort to recover from others for the *bodily injuries* and losses which necessitate *covered expense* payments by this Plan. The *beneficiary* will notify this Plan immediately of any claim asserted and any settlement entered into, and will do nothing at any time to prejudice the rights and interests of this Plan. Neither this Plan nor the *beneficiary* shall be entitled to costs or attorney fees from the other for the prosecution of the claim.

RIGHT TO COLLECT NEEDED INFORMATION

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

- Authorizing the release of medical information including the names of all providers from whom *you* received medical attention;
- Obtaining medical information and/or records from any provider as requested by Humana;
- Providing information regarding the circumstances of *your sickness* or *bodily injury*;
- Providing information about other insurance coverage and benefits, including information related to any *bodily injury* or *sickness* for which another party may be liable to pay compensation or benefits; and
- Providing information Humana requests to administer this Plan.

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

DUTY TO COOPERATE IN GOOD FAITH

You are obliged to cooperate with Humana in order to protect this Plan's recovery rights. Cooperation includes promptly notifying Humana that *you* may have a claim, providing Humana relevant information, and signing and delivering such documents as Humana reasonably 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 5

NOTICES

IMPORTANT NOTICES FOR EMPLOYEES AND SPOUSES AGE 65 AND OVER

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

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

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

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

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

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

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

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

PRIVACY OF PROTECTED HEALTH INFORMATION

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

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

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

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

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

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

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

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

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

PRIVACY OF PROTECTED HEALTH INFORMATION (continued)

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

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

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

CONTINUATION OF MEDICAL BENEFITS

THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1986 (COBRA)

CONTINUATION OF BENEFITS

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

ELIGIBILITY

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

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

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

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

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

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

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

CONTINUATION OF MEDICAL BENEFITS (continued)

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

EXTENDED FAMILY MEMBER

An extended family member, including domestic partner, covered by the *employer's* Plan may have the right to elect continuation coverage if group coverage is lost due to one of the qualifying events listed under the Spouse" or "Dependent Child" sections above. For more information, please see your Plan Administrator.

LOSS OF COVERAGE

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

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

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

NOTICES AND ELECTION

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

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

CONTINUATION OF MEDICAL BENEFITS (continued)

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

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

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

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

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

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

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

MAXIMUM COVERAGE PERIOD

Coverage may continue up to:

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

CONTINUATION OF MEDICAL BENEFITS (continued)

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

DISABILITY

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

SECOND QUALIFYING EVENT

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

TERMINATION BEFORE THE END OF MAXIMUM COVERAGE PERIOD

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

- The *employer* no longer provides group health coverage to any of its *employees*;
- The premium for continuation is not paid timely;
- The individual on continuation becomes covered under another group health plan (as an *employee* or otherwise);

CONTINUATION OF MEDICAL BENEFITS (continued)

- If there is a final determination under Title II or XVI of the Social Security Act that an individual is no longer disabled; however, continuation coverage will not end until the month that begins more than 30 days after the determination;
- The occurrence of any event (e.g. submission of a fraudulent claim) permitting termination of coverage for cause under this Plan.

TYPE OF COVERAGE; PREMIUM PAYMENT

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

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

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

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

OTHER INFORMATION

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

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

PLAN CONTACT INFORMATION

Humana Inc.
500 West Main Street
Louisville, KY 40202
1-888-431-4748

Humana Health Plan, Inc.
Billing/Enrollment Department
101 E. Main Street
Louisville, KY 40201

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

CONTINUATION OF BENEFITS

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

ELIGIBILITY

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

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

PREMIUM PAYMENT

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

DURATION OF COVERAGE

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

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

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

OTHER INFORMATION

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

STATEMENT OF ERISA RIGHTS

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

RECEIVE INFORMATION ABOUT THEIR PLAN AND BENEFITS

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

CONTINUE GROUP HEALTH PLAN COVERAGE

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

PRUDENT ACTIONS OF PLAN FIDUCIARIES

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

ENFORCE THEIR RIGHTS

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

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

ASSISTANCE WITH QUESTIONS

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

ADDITIONAL NOTICES

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

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

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

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

THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996

The Newborns' and Mothers' Health Protection Act of 1996 provides that group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any *hospital* length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). An attending provider is defined as an individual who is licensed under applicable state law to provide maternal or pediatric care and who is directly responsible for providing such care to a mother or newborn child. The definition of attending provider does not include a plan, *hospital*, managed care organization or other issuer. In any case, plans may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

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

PLAN DESCRIPTION INFORMATION

- Proper Name of Plan: Humana Inc. Plan
 - *Plan Sponsor:*
Humana Inc.
500 W. Main Street
Louisville KY 40202
Telephone: 502-580-1000
 - *Employer:*
Humana Inc.
500 W. Main Street
Louisville KY 40202
Telephone: 502-580-1000
- Common Name of *Employer*: Humana
- *Plan Administrator*, Named Fiduciary and Claim Fiduciary:
Humana Inc.
500 W. Main Street
Louisville KY 40202
Telephone: 502-580-1000
 - *Employer* Identification Number: 610647538
The Plan number assigned for government reporting purposes is 510.
 - This Plan provides medical and *prescription* drug benefits for participating *employees* and their enrolled *dependents*.
 - Plan benefits described in this booklet are effective January 1, 2022.
 - The *Plan year* is January through December of each year.
 - The fiscal year is January through December of each year.
 - Service of legal process may be served upon the *Plan Administrator* as shown above or the following agent for service of legal process:

Legal Counsel
Humana Inc.
500 W. Main Street
Louisville KY 40202

PLAN DESCRIPTION INFORMATION (continued)

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

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

- This is a self-insured and self-administered health benefit plan. This Plan is not subject to any medical requirements required by state law. The cost of this Plan is paid with contributions shared by the *employer* and *employee*. Benefits under this Plan are provided from the general assets of the *employer* and are used to fund payment of covered claims under this Plan plus administrative expenses. Please see *your employer* for the method of calculating contributions and the funding mechanism used for the accumulation of assets through which benefits are provided under this Plan.
- Each *employee* of the *employer* who participates in this Plan receives a *Summary Plan Description*, which is this booklet. This booklet will be provided to *employees* by the *employer*. It contains information regarding eligibility requirements, termination provisions, a description of the benefits provided and other Plan information.
- This Plan's benefits and/or contributions may be modified or amended from time to time, or may be terminated at any time by the *Plan Sponsor*. Significant changes to this Plan, including termination, will be communicated to participants as required by applicable law.
- Upon termination of this Plan, the rights of the participants to benefits are limited to claims incurred and payable by this Plan up to the date of termination. Plan assets, if any, will be allocated and disposed of for the exclusive benefit of the participating *employees* and their *dependents* covered by this Plan, except that any taxes and administration expenses may be made from this Plan's assets.
- This Plan does not constitute a contract between the *employer* and any *covered person* and will not be considered as an inducement or condition of the employment of any *employee*. Nothing in this Plan will give any *employee* the right to be retained in the service of the *employer*, or for the *employer* to discharge any *employee* at any time. .
- This Plan is not in lieu of and does not affect any requirement for coverage by workers' compensation insurance.

SECTION 6

DEFINITIONS

DEFINITIONS

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

A

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

Active status means the *employee* is performing on a regular, *full-time* or *part-time* basis all customary occupational duties at the *employer's* business locations or when required to travel for the *employer's* business purposes. Each day of a regular paid vacation and any regular non-working holiday will be deemed *active status* if *you* were in an *active status* on *your* last regular working day prior to the vacation or holiday. An *employee* is deemed to be in *active status* if an absence from work is due to a *sickness* or *bodily injury*, provided the individual otherwise meets the definition of *employee*.

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

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

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

- A determination based on a *covered person's* eligibility to participate in this Plan;
- A determination that a benefit is not a covered benefit;
- The imposition of a source-of-injury exclusion, network exclusion, or other limitation on otherwise covered benefits; or
- A determination resulting from the application of any utilization review, such as the failure to cover an item or *service* because it is determined to be experimental/investigational or not *medically necessary*.

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

- The cancellation or discontinuance of coverage has only a prospective effect; or
- The cancellation or discontinuance of coverage is effective retroactively, to the extent it is attributable to a failure to timely pay premium or costs of coverage.

DEFINITIONS (continued)

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

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

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

- It must be staffed by physicians and a medical staff which includes registered nurses;
- It must have permanent facilities and equipment for the primary purpose of performing *surgery*;
- It must provide continuous physicians' *services* on an outpatient basis;
- It must admit and discharge patients from the facility within a 24-hour period;
- It must be licensed in accordance with the laws of the jurisdiction where it is located. It must be operated as an *ambulatory surgical center* as defined by those laws;
- It must not be used for the primary purpose of terminating pregnancies, or as an office or clinic for the private practice of any physician or dentist.

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

Applied behavior analysis (ABA) therapy means an intensive behavioral treatment program that attempts to improve the cognitive and social functioning of children, primarily young children, with autism.

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

B

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

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

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

DEFINITIONS (continued)

Biosimilar/Biosimilars means a type of biological product that is licensed and approved by FDA because it is highly similar to an already FDA-approved biological product, known as the biological reference product (reference product), and has been shown to have no clinically meaningful difference from the reference product.

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

Bone marrow means the transplant of human blood precursor cells. Such cells may be derived from bone marrow, circulating blood, or a combination of bone marrow and circulating blood obtained from the patient in an autologous transplant, from a matched related or unrelated donor, or cord blood. The term *bone marrow* includes the harvesting, the transplantation and the integral chemotherapy components.

C

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

Chemical dependency means the abuse of, or psychological or physical dependence on, or addiction to alcohol or a controlled substance. (also called Substance Abuse)

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

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

Complications of pregnancy means:

- Conditions whose diagnoses are distinct from pregnancy but adversely affected by pregnancy or caused by pregnancy. Such conditions include: acute nephritis, nephrosis, cardiac decompensation, hyperemesis gravidarum, puerperal infection, toxemia, eclampsia and missed abortion;
- A nonelective cesarean section surgical procedure;
- Terminated ectopic pregnancy; or
- Spontaneous termination of pregnancy which occurs during a period of gestation in which a viable birth is not possible.

Complications of pregnancy do not mean:

- False labor;
- Occasional spotting;
- Prescribed rest during the period of pregnancy;
- Conditions associated with the management of a difficult pregnancy but which do not constitute distinct *complications of pregnancy*; or
- An elective cesarean section.

DEFINITIONS (continued)

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

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

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

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

Covered expense means:

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

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

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

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

DEFINITIONS (continued)

Custodial care means services given to *you* if:

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

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

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

D

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

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

Dependent means a covered *employee's*:

- Legally recognized spouse;
- Extended family member, including domestic partner (same sex or opposite sex). Each extended family member must be eighteen (18) years or older and have lived with the employee for at least six (6) months. Other requirements are listed below:

To qualify as a domestic partner, *you* must:

- Have a serious, committed relationship with the *employee*;
- Be financially interdependent;
- Not be related to the *employee* in any way that would prohibit legal marriage by state law;
- Not be legally married to anyone else;
- Not be a domestic partner of anyone else; and
- Not have a relationship with the *employee* that violates state or local laws.

DEFINITIONS (continued)

Eligible *employees* may have 1 domestic partner or 1 adult extended family member.

To qualify as extended family member, you must:

- Not be eligible for Medicare;
 - Not be of previous generation (no parents, grandparents, aunts, uncles); and
 - Meet the definition of a dependent as defined by the Internal Revenue Code during the period of coverage.
- Unmarried natural blood related child, step-child, legally adopted child or child for which the *employee*, extended family member or domestic partner has legal guardianship whose age is less than the limiting age.

The limiting age for each *dependent* child is the end of the month in which he or she attains the age of 26 years. *Your* child is covered to the limiting age regardless if the child is:

- Married;
 - A tax dependent;
 - A student;
 - Employed;
 - Residing with or receives financial support from *you*
 - Residing or working outside of the network area: or
 - Eligible for other coverage through employment.
- A covered *employee's* child whose age is less than the limiting age and is entitled to coverage under the provisions of this Plan because of a medical child support order;
 - Grandchild, as long as the *employee's* covered *dependent*, who is the parent of the grandchild, qualifies as a tax dependent as determined by the United States Internal Revenue Service or the grandchild qualifies as an IRS tax *dependent* of the *employee*.

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

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

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

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

DEFINITIONS (continued)

Designated pharmacy means a participating pharmacy that has entered into an agreement with Humana, or with an organization contracting on this plan's behalf, to provide specific prescription drugs and related clinical services, including, but not limited to, *specialty drugs*. *Designated pharmacies* may include a specific retail pharmacy, mail order pharmacy, outpatient pharmacy, specialty pharmacy, home infusion pharmacy, home health care agency provider, hospital-affiliated pharmacy or hemophilia treatment center contracted pharmacy.

Note: Not every participating pharmacy is also considered a *designated pharmacy*.

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

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

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

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

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

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

E

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

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

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

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

Employee means *you*, as an *employee*, when *you* are permanently employed and paid a salary or earnings and are in an *active status* at *your employer's* place of business.

Employer means the sponsor of this Group Plan or any subsidiary(s).

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

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

- Cannot be lawfully marketed without the final approval of the United States Food and Drug Administration (FDA) and which lacks such final FDA approval for the use or proposed use, unless:
Found to be accepted for that use in the most recently published edition of the United States Pharmacopeia-Drug Information for Healthcare Professional (USP-DI) or in the most recently published edition of the American Hospital Formulary Service (AHFS) Drug Information; (b) identified as safe, widely used and generally accepted as effective for that use as reported in nationally recognized peer reviewed medical literature published in the English language as of the date of service; or (c) is mandated by state law;
- Is a device required to receive Premarket Approval (PMA) or 510K approval by the FDA but has not received a PMA or 510K approval;
- Is not identified as safe, widely used and generally accepted as effective for the proposed use as reported in nationally recognized peer reviewed medical literature published in the English language as of the date of service;

DEFINITIONS (continued)

- Is the subject of a National Cancer Institute (NCI) Phase I, II or III trial or a treatment protocol comparable to a NCI Phase I, II or III trial, or any trial not recognized by NCI regardless of phase or
 - Is identified as not covered by the Centers for Medicare and Medicaid Services (CMS) Medicare Coverage Issues Manual, a CMS Operational Policy Letter or a CMS National Coverage Decision, except as required by state or federal law.

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

F

Family member means any person related to you by blood, marriage or adoption, or any person covered under this Plan. This definition of *family member* refers only to providers of care. *Services* provided by a *family member* as defined herein are excluded under this Plan. For any eligibility questions, refer to the Eligibility and Effective Date of Coverage section of this Summary Plan Description.

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).

Flex means an *employee* with a variable work schedule who has worked at least 30 hours a week or more over the last 12 months.

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

Full-time means an *employee* regularly scheduled to work at least 30 hours a week.

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

H

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

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

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

- It must provide, for a fee, medical care and treatment of sick or injured patients on an inpatient basis;
- It must provide or operate, either on its premises or in facilities available to the *hospital* on a pre-arranged basis, medical, diagnostic and surgical facilities;
- Care and treatment must be given by and supervised by physicians. Nursing services must be provided on a 24-hour basis and must be given by or supervised by registered nurses;
- It must be licensed by the laws of the jurisdiction where it is located. It must be operated as a *hospital* as defined by those laws; and
- It must not be primarily a:
 - Convalescent, rest or nursing home; or
 - Facility providing custodial, educational or rehabilitative care.

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

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

I

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

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

DEFINITIONS (continued)

Infusion therapy means a service or activity that provides:

- Nursing, durable medical equipment and drug services that are delivered and administered through an I.V.;
- Total parenteral nutrition (TPN), enteral nutrition therapy, antibiotic therapy, pain care and chemotherapy;
- May include injections (intra-muscular, subcutaneous, continuous subcutaneous), and
- Also covers specialty and prescription drugs when they are administered as part of infusion therapy in a doctor's visit, home infusion visit, or at an outpatient facility.

Intensive outpatient means *outpatient* services providing:

- Group therapeutic session greater than 1 hour a day, 3 days a week;
- Either mental health services or chemical dependency therapeutic focus;
- Group sessions centered on cognitive behavioral constructs, social/occupational/educational development and family interaction;
- Additional emphasis on recover strategies, monitoring of participating in 12-step programs and random drug screenings for the treatment of *chemical dependency*; and
- *Qualified practitioner* availability for medical and medication management.

Intensive outpatient program does not include services for:

- Custodial care; or
- Day Care.

L

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

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

M

Maintenance care means services and supplies furnished mainly to:

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

Maximum allowable fee for a *covered expense*, other than *emergency care services* provided by *Non-PAR providers* in a *hospital's* emergency department, is the lesser of:

DEFINITIONS (continued)

- The fee charged by the provider for the *services*;
- The fee that has been negotiated with the provider whether directly or through one or more intermediaries or shared savings contracts for the *services*;
- The fee established by this Plan by comparing rates from one or more regional or national databases or schedules for the same or similar *services* from a geographical area determined by this Plan;
- The fee based upon rates negotiated by this Plan or other payors with one or more *participating providers* in a geographic area determined by this Plan for the same or similar *services*;
- The fee based upon the provider's cost for providing the same or similar *services* as reported by such provider in its most recent publicly available *Medicare* cost report submitted to the Centers for Medicare and Medicaid Services (CMS) annually; or
- The fee based on a percentage determined by this Plan of the fee *Medicare* allows for the same or similar *services* provided in the same geographic area.

Unless this Plan utilizes a higher paying shared savings network or pays the *Non-PAR provider* full billed rate, *maximum allowable fee* for a *covered expense* for *emergency care* services provided by *Non-PAR providers* in a *hospital's* emergency department is an amount equal to the greatest of:

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

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

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

DEFINITIONS (continued)

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

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

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

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

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

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

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

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

N

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

DEFINITIONS (continued)

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

O

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

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.

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

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

Out-of-pocket limit means the amount of any *copayments*, *deductibles* and *coinsurance* for *covered expenses*, which *you* must pay, either individually or combined as a covered family, per *calendar year* before a benefit percentage will be increased. Any amount *you* pay exceeding the *maximum allowable fee* is not applied to the *out-of-pocket limits*.

P

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

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

- Has a comprehensive and intensive interdisciplinary psychiatric treatment for minimum of 5 hours a day, 5 days per week under the supervision of a psychiatrist for *mental health services* or a psychiatrist or addictionologist for *chemical dependency*, and patients are seen by a psychiatrist or addictionologist, as applicable, at least once a week;
- Provides for social, psychological and rehabilitative training programs with a focus on reintegration back into the community and admits children and adolescents who must have a treatment program designed to meet the special needs of that age range; and

DEFINITIONS (continued)

- Has physicians and appropriately licensed *behavioral health* practitioners readily available for the emergent and urgent care *service* needs of the patients.

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

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

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

Part-time means an *employee* regularly scheduled to work 20-29 hours a week.

Participating (PAR) provider means a *hospital*, *qualified treatment facility*, *qualified practitioner* or 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*. *Participating (PAR) provider* designation by Humana may be limited to specified *services*.

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

Pharmacy means a licensed establishment where *prescription* drugs, medicines or medications are dispensed by a *pharmacist*.

Plan Administrator means Humana Inc.

Plan Manager means Humana Health Plan, Inc. (HHP). The *Plan Manager* provides services to the *Plan Administrator*, as defined under the Plan Management Agreement. The *Plan Manager* is not the *Plan Administrator* or the *Plan Sponsor*.

Plan Sponsor means Humana 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*.

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

Preauthorization means approval of a *service* prior to it being provided. Certain *services* require medical review in order to determine eligibility for coverage.

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

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

DEFINITIONS (continued)

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

- Your name;
 - The type and quantity of the drug, medicine or medication prescribed, and the directions for its use;
 - The date the *prescription* was prescribed; and
- The name and address of the prescribing *qualified 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*, including: (a) patient records, which includes but is not limited to all health records, physician and provider notes and bills and claims with respect to a *covered person*; (b) patient information, which includes patient records and all written and oral information received about a *covered person*; and (c) any other individually identifiable health information about *covered persons*.

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

Q

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

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

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

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

R

Residential treatment facility means an institution which:

- Is licensed as a 24-hour residential facility for *behavioral health* treatment, although not licensed as a *hospital*;
- Provides a multidisciplinary treatment plan in a controlled environment under the supervision of a physician who is able to provide treatment on a daily basis;

DEFINITIONS (continued)

- Provides supervision and treatment by a Ph.D. psychologist, licensed therapist, psychiatric nursing staff or registered nurse;
- Provides programs such as social, psychological, family counseling and rehabilitative training, age appropriate for the special needs of the age group of patients, with focus on reintegration back into the community; and
- Provides structured activities throughout the day and evening, for a minimum of 6 hours a day.

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

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

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

S

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

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

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

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

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

Sound natural tooth means a tooth that:

- Is organic and formed by the natural development of the body (not manufactured, capped, crowned or bonded);
- Has not been extensively restored;

DEFINITIONS (continued)

- Has not become extensively decayed or involved in periodontal disease; and
- Is not more susceptible to injury than a whole natural tooth. (for example a tooth that has not been previously broken, chipped, filled, cracked or fractured)

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

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

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

Surgery means procedures categorized as Surgery in either the:

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

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

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

T

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

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

DEFINITIONS (continued)

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

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

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

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

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

U

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

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

- Could seriously jeopardize the life or health of the *claimant* or the ability of the *claimant* to regain maximum function; or
- In the opinion of the physician with knowledge of the *claimant's* medical condition, would subject the *claimant* to severe pain that cannot be adequately managed without the care or treatment recommended.

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

V

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

Y

You and your means any *covered person*.

SECTION 7

PRESCRIPTION DRUG BENEFIT

PRESCRIPTION DRUG BENEFIT

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

DEFINITIONS

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

Biosimilar/Biosimilars means a type of biological product that is licensed and approved by FDA because it is highly similar to an already FDA-approved biological product, known as the biological reference product (reference product), and has been shown to have no clinically meaningful difference from the reference product.

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.

Copayment (*prescription drug*) means the amount to be paid by *you* toward the cost of each separate *prescription* or refill of a covered *prescription* drug when dispensed by a *pharmacy*, after any applicable medical and *prescription drug deductible*.

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

Default rate means the rate or amount equal to the *Medicare* reimbursement rate for the *prescription* or refill.

Designated pharmacy means a participating pharmacy that has entered into an agreement with Humana, or with an organization contracting on this plan's behalf, to provide specific prescription drugs and related clinical services, including, but not limited to, *specialty drugs*. Designated pharmacies may include a specific retail pharmacy, *mail order pharmacy*, outpatient pharmacy, *specialty pharmacy*, home infusion pharmacy, home health care agency provider, hospital-affiliated pharmacy or hemophilia treatment center contracted pharmacy.

Note: Not every *participating pharmacy* is also considered a *designated pharmacy*.

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

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

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.

PRESCRIPTION DRUG BENEFIT (continued)

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

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

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

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

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

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

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

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:

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

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

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

PREScription DRUG BENEFIT (continued)

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

Pharmacy means a licensed establishment where *prescription drugs, medicine or medication fill* are dispensed by a *pharmacist*.

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

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

Prior authorization means the required prior approval from Humana for the coverage of *prescription* drugs, medicines and medications, including *specialty drugs*. Certain *prescription* drugs, medicines or medications may require *prior authorization*. Visit Humana's Website at www.humana.com or call Humana at the toll-free customer service telephone number listed on *your* Humana ID card to obtain a list of *prescription* drugs, medicines and medications that require *prior authorization*.

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

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

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

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

PRESCRIPTION DRUG BENEFIT (continued)

Step therapy means a requirement for *you* to first try certain drugs, medicines or medications or *specialty drugs* to treat *your* medical condition before this Plan will cover another *prescription* drug, medicine, medication or *specialty drug* for that condition.

SCHEDULE OF PRESCRIPTION DRUG BENEFITS

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

Exclusive Specialty Pharmacy: Following the initial fill and one refill of a covered *specialty drug* prescribed by one or more *qualified practitioners* and dispensed by one or more retail or *specialty pharmacies*, the third and subsequent fills of any one *specialty drug*, will not be covered if not obtained through Humana Specialty Pharmacy or a *designated pharmacy*.

You are required to pay the applicable expense per prescription or refill as follows:

RETAIL PHARMACY AND SPECIALTY PHARMACY	
<i>Level 1 Drugs</i>	\$10 <i>copayment</i> after medical and <i>prescription</i> drug <i>deductible</i> per <i>prescription</i> or refill per 30 day supply
<i>Level 2 Drugs</i>	\$40 <i>copayment</i> after medical and <i>prescription</i> drug <i>deductible</i> per <i>prescription</i> or refill per 30 day supply
<i>Level 3 Drugs</i>	\$70 <i>copayment</i> after medical and <i>prescription</i> drug <i>deductible</i> per <i>prescription</i> or refill per 30 day supply
<i>Level 4 Drugs</i>	25% <i>copayment</i> after medical and <i>prescription</i> drug <i>deductible</i> per <i>prescription</i> or refill per 30 day supply
Covered Immunizations	No <i>cost share</i>

PRESCRIPTION DRUG BENEFIT (continued)

RETAIL PHARMACY AND SPECIALTY PHARMACY	
Drugs, Medicines or Medications on the \$0 Preventive Medication Coverage Drug List with a <i>prescription</i> from a <i>qualified practitioner</i>	No <i>cost share</i>
Prescription Bowel Prep Supplies	No <i>cost share</i>
Humana Preventive Rx List* when purchasing through Humana Pharmacy and PrescribeIT Rx: Generic Preferred Brand	No <i>cost share</i> No <i>cost share</i>
Humana Preventive Rx List* when purchasing through any other retail pharmacy	<i>Copayment</i> varies by drug level after applicable <i>PAR provider medical</i> and <i>prescription drug deductible</i> .

*The Humana Preventive Rx List features certain single-source brand and generic diabetic supplies and medications, heart medications, and blood thinners.

Some retail *pharmacies* and *specialty pharmacies* participate in a program which allows *you* to receive a 90 day supply of a *prescription* or refill. *Your* cost is outlined above under Retail Pharmacy and Specialty Pharmacy. *Self-administered injectable drugs* and *specialty drugs* may be limited to a 30 day supply from a retail *pharmacy* or *specialty pharmacy*, as determined by this Plan.

PRESCRIPTION DRUG BENEFIT (continued)

MAIL ORDER PHARMACY	
Up to a 90 day supply of a <i>prescription</i> or refill received from a <i>mail order pharmacy</i> <i>Self-administered injectable drugs and specialty drugs</i> received from a <i>mail order pharmacy</i> may be limited to a 30 day supply, as determined by this Plan.	Two (2) times the applicable <i>copayments</i> outlined under Retail Pharmacy after medical and <i>prescription drug deductible</i> per <i>prescription</i> or refill
Drugs, Medicines or Medications on the \$0 Preventive Medication Coverage Drug List with a <i>prescription</i> from a <i>qualified practitioner</i>	No <i>cost share</i>
Prescription Bowel Prep Supplies	No <i>cost share</i>
Humana Preventive Rx List* when purchasing through Humana Pharmacy and PrescribeIT Rx: Generic Preferred Brand	No <i>cost share</i> No <i>cost share</i>

*The Humana Preventive Rx List features certain single-source brand and generic diabetic supplies and medications, heart medications, and blood thinners.

The mail order benefits of your prescription drug program are provided by a mail order prescription provider selected by the *Plan Manager*. This mail service program provides participants with an easy and convenient way to obtain *mail order pharmacy* medications. To learn more about the mail order benefit, go to www.humana.com, log in to MyHumana, click on Mail Order Rx to access information about the prescription-by-mail program.

PRESCRIPTION DRUG BENEFIT (continued)

SPECIALTY DRUGS	
Up to a 30 day supply of a <i>prescription</i> or refill for office-administered <i>specialty drugs</i> , through Humana Specialty Pharmacy or a <i>designated pharmacy</i> . <i>Specialty drugs</i> administered in a <i>qualified practitioner's</i> office do not include <i>self-administered injectable drugs</i> .	Subject to the applicable Plan <i>cost share</i> .

Participating Pharmacy

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

Non-participating Pharmacy

When a *non-participating pharmacy* is used, *you* must pay the *pharmacy* the full price of the drug and submit the *pharmacy* receipt to Humana at the address listed below. In addition to *your cost share*, *you* will be responsible for 30% of the *default rate*. *You* are also responsible for 100% of the difference between the *default rate* and the *non-participating pharmacy's* charge. The charge received from a *non-participating pharmacy* for a *prescription* or refill may be higher than the *default rate*.

Mail *pharmacy* receipts to:

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

PRIOR AUTHORIZATION/STEP THERAPY

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

DISPENSING LIMITS

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

RETAIL PHARMACY AND SPECIALTY PHARMACY

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

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

MAIL ORDER PHARMACY

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

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

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

PRESCRIPTION DRUG COST SHARING

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

You are responsible for:

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

HOW TO USE YOUR PRESCRIPTION DRUG BENEFIT

You will receive a Humana medical identification (ID) card that will show your *pharmacy* benefits. It will show your name, group number and the effective date of your coverage.

Present your ID card at a Humana *participating pharmacy* or a *non-participating pharmacy* when purchasing a *prescription*.

PRESCRIPTION DRUG COVERAGE

Because Humana's *drug list* is continually updated with *prescription* drugs approved or not approved for coverage, *you* must contact Humana by calling the toll-free customer service telephone number on the back of *your* Humana ID card or by visiting Humana's website at www.humana.com to verify whether a *prescription* drug is covered or not covered under this prescription drug benefit

Covered *prescription* drugs, medicine or medications must:

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

Prescription drug covered *expenses* aggregate toward any applicable medical *PAR deductibles* and *out-of-pocket limits* outlined in the Medical Schedule of Benefits section. Any *expenses incurred* under provisions of this Prescription Drug Benefit section do not apply toward *your* medical *Non-PAR deductibles* or *out-of-pockets limits*.

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

PRESCRIPTION DRUG LIMITATIONS

Expense incurred will not be payable for the following:

- Any drug, medicine, medication or supply not approved for coverage under this Plan by calling the toll-free customer service telephone number listed on the back of *your* Humana ID card or by visiting Humana's website at www.humana.com to verify whether a *prescription* drug is covered or not covered under this Plan. *Your* Humana ID card can be used as a discount card for *prescription* drugs not covered under this Plan;
- *Legend drugs* which are not deemed *medically necessary* by a *qualified practitioner*;
- Charges for the administration or injection of any drug;
- Any drug, medicine or medication labeled "Caution-limited by federal law to investigational use," or any drug, medicine or medication that is *experimental, investigational or for research purposes*, even though a charge is made to *you*;
- Any drug, medicine or medication that is consumed or injected at the place where the *prescription* is given, or dispensed by the *qualified practitioner*;
- *Prescriptions* that are to be taken by or administered to the *covered person*, in whole or in part, while he or she is a patient in a facility where drugs are ordinarily provided by the facility on an inpatient basis. Inpatient facilities include, but are not limited to:
 - *Hospital*;
 - Skilled nursing facility; or
 - Hospice facility.

PRESCRIPTION DRUG BENEFIT (continued)

- Any drug prescribed, except:
 - FDA approved drugs utilized for FDA approved indications; or
 - FDA approved drugs utilized for *off-label drug indications* recognized in at least one compendia reference or peer-reviewed medical literature deemed acceptable to this Plan.
- *Prescription* refills:
 - In excess of the number specified by the *qualified practitioner*; or
 - Dispensed more than one year from the date of the original order; or
 - The third and subsequent fills of any one *specialty drug* if not obtained through Humana Specialty Pharmacy or a *designated pharmacy*.
- *Off-evidence drug indications*;
- Any drug for which a charge is customarily not made;
- Therapeutic devices or appliances, including, but not limited to: hypodermic needles and syringes (except needles and syringes for use with insulin and covered *self-administered injectable drugs*, whose coverage is approved by *us*); support garments; test reagents; mechanical pumps for delivery of medications; and other non-medical substances;
- Dietary supplements (except enteral formulas and nutritional supplements for the treatment of phenylketonuria (PKU) or other inherited metabolic disease); nutritional products; fluoride supplements; minerals; herbs; and vitamins (except pre-natal vitamins, including greater than one milligram of folic acid, and pediatric multi-vitamins with fluoride);
- Drug delivery implants;
- Injectable drugs, including but not limited to: immunizing agents; biological sera; blood; blood plasma; or *self-administered injectable drugs* or *specialty drugs* not covered under this Plan;
- Any drug prescribed for a *sickness* or *bodily injury* not covered under this Plan;
- Any portion of a *prescription* or refill that exceeds the day supply as shown on the Schedule of Prescription Drug Benefits;
- Any drug, medicine or medication received by the *covered person*:
 - Before becoming covered under this Plan; or
 - After the date the *covered person's* coverage under this Plan has ended.
- Any costs related to the mailing, sending, or delivery of *prescription* drugs;
- Any intentional misuse of this benefit including *prescriptions* purchased for consumption by someone other than the *covered person*;
- Any *prescription* or refill for drugs, medicines, or medications that are lost, stolen, spilled, spoiled, or damaged;
- Repackaged drugs;

PRESCRIPTION DRUG BENEFIT (continued)

- Any drug or medicine that is:
 - Lawfully obtainable without a *prescription* (over the counter drugs), except insulin; or
 - Available in *prescription* strength without a *prescription* or;
 - Other non-medical substances.
- Any drug or biological that has received designation as an *orphan drug*, unless approved by this Plan;
- Any amount *you* paid for a *prescription* that has been filled, regardless of whether the *prescription* is revoked or changed due to adverse reaction or change in dosage or *prescription*;
- Any portion of a *prescription* or refill that exceeds the drug specific *dispensing limit*, e.g., is dispensed to a *covered person* whose age is outside the drug specific age limits, is refilled early or exceeds the duration-specific *dispensing limit*;
- Any drug for which *prior authorization* or *step therapy* is required and not obtained;
- Any amount exceeding the *default rate*;
- Based on the dosage schedule prescribed by the *qualified practitioner*, more than one *prescription* or refill for the same drug or therapeutic equivalent medication prescribed by one or more *qualified practitioners* and dispensed by one or more *pharmacies* until *you* have used, or should have used, at least 75% of the previous *prescription* or refill. If the drug or therapeutic equivalent medication is purchased through a retail *pharmacy* or *specialty pharmacy* that participates in the program which allows *you* to receive a 90 day supply of a *prescription* or refill at a retail *pharmacy* or *specialty pharmacy*, until *you* have used, or should have used, at least 66% of the previous *prescription* or refill.

Administered by:



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