



SUMMARY PLAN DESCRIPTION

For the

MEDICAL PLAN OPTION 2

Sponsored by

Knox County Government

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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 telephone number listed 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 that are at risk for an illness, to those who are at chronic or acute stages of illness. Health Resources offer a wide range of assistance including online educational tools, interventions, health assessments and personal discussions with registered nurses.

Below is a brief description of this Plan's Health Resources programs. All Health Resources programs are subject to change without notice. For additional information or questions regarding any of these programs, please call the toll-free customer service telephone number listed on *your* Humana ID card.

UTILIZATION MANAGEMENT

Utilization Management consists of *preauthorization*, claims review (*retrospective review*), coordination of care and referral processes that ensure Plan benefits are used properly. Utilization Management decisions are made using established criteria and care guidelines along with the medical information provided by the patient and the patient's *qualified practitioner*. The patient and his or her *qualified practitioner* determine the course of treatment. The assistance provided through these services does not constitute the practice of medicine. Payment of Plan benefits is not determined through these processes.

Preauthorization Requirements

Preauthorization is required by this Plan for certain *services*. If *you* do not obtain *preauthorization* for *services* being rendered, *your* benefits may be reduced or a penalty may apply. Refer to the "Preauthorization" section for more information.

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

Concurrent Review

Case managers assess the continuing *medical necessity* and appropriateness of additional days of *hospital confinement* and other health care *services*. To help with *concurrent review*, case managers receive a daily census of all inpatient *admissions* for their assigned facilities along with a notice of any *covered persons* admitted without a *preauthorization*, then, the nurses use priority review criteria and guidelines to prioritize these cases for clinical review.

Retrospective Review

If an *admission* or *service* occurs without *preauthorization*, Humana may complete a *retrospective review* after receiving the claim to determine if both the *admission* and length of stay were medically appropriate.

HEALTH RESOURCES (continued)

CASE MANAGEMENT

Humana's case management components work to support the *covered person* through the hospitalization or procedure, along with discharge assistance and follow up after discharge to reduce the risk of readmission. Humana performs the following case management services:

- **Acute Case Management:** Acute case managers review cases, perform *concurrent review*, and assist with discharge planning as needed during a *covered person's* hospitalization. Nurses are assigned by facility and may provide either telephonic or onsite case management services.
- **Transitional Case Management:** Transitional case managers will call a *covered person* with a high risk of readmission one to two business days after they leave the *hospital* to make sure they understand their discharge plan of care and that they follow the plan by:
 - Reinforcing the *qualified practitioner's* orders
 - Confirming follow-up appointments
 - Verifying that *prescriptions* were filled
 - Identifying early signs of complications
 - Confirming that discharge services were provided
- **Complex Case Management:** A *covered person* with complex or catastrophic case management needs is referred to a complex case manager for ongoing case management support by telephone after discharge or after their initial post-discharge follow-up conversation. In these situations, complex case managers work closely with the *covered person* and their family until they no longer need this level of support.

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, in the case of *you* being in the 2nd or 3rd trimester of pregnancy.

HUMANA HEALTH ALERTS

Humana pulls together detailed data for each *covered person*, such as medical and pharmacy claims history, lab results and biometrics and compiles it into a comprehensive clinical profile. This data is continually run through a rules engine, which applies clinical and business rules, and helps identify *covered persons* with potential health issues and route them to the most appropriate support. The rules engine automatically recognizes when a *covered person* is not getting the recommended care, referred to as a “gap in care.”

A health alert and a message, if appropriate, are generated to communicate the findings through physician and member messaging. Gaps in care fall in to the following categories:

- Preventive (e.g. cancer screening reminder or notification that a child’s immunization was missed)
- Disease-specific (e.g. annual exam reminder to diabetics)
- Care modification (e.g. addressing potentially harmful drug-to-drug or drug-to-disease interactions)

NEONATAL INTENSIVE CARE UNIT (NICU) MANAGEMENT

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

The Neonatal Case Management program includes:

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

To contact a NICU program representative, call 1-1-855-391-8655.

TRANSPLANT MANAGEMENT

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

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

MYHUMANA

Visit Humana's Website at www.humana.com and click on "Sign in or Register" to receive step-by-step instructions on how to set up *your* MyHumana page. After *you* have set up *your* page, log on anytime to find a *participating provider*, look up *your* Plan benefits or check the status of a claim along with estimated costs, if any. *You* can also find *prescription* drug information, information on specific health conditions, financial tools to help with budgeting for health care and more.

MyHumana Mobile app allows *you* quick access to important information anytime, anywhere. Whether *you* prefer downloading a mobile application, using *your* mobile device or receiving text messages, *you* have the ability to manage *your* healthcare needs virtually.

Use the MyHumana Mobile app and website to:

- View medical, dental, vision and pharmacy claims;
- View *your* HumanaVitality Dashboard, if applicable;
- Receive medication reminders;
- Research drug prices;
- Locate providers in *your* network;
- Refill *your* Humana Pharmacy *prescriptions*

HUMANAFIRST[®] NURSE ADVICE LINE

HumanaFirst is a nurse triage service available 24 hours a day, seven days a week. *You* can talk to a registered nurse about any immediate medical concerns, and obtain health planning and support assistance by calling the toll-free telephone number on back of *your* Humana ID card. When *you* call HumanaFirst, *you* can select one of two options:

Immediate Medical Concerns: A nurse triage service, available twenty-four (24) hours a day, seven (7) days a week to address *your* urgent medical concerns.

Health Planning and Support: Guidance by telephone for non-urgent health concerns and the option to self-refer to results-focused clinical support programs and services. This service is available Monday through Friday from 8:30 a.m. to 5:00 p.m. in the *covered person's* time zone (ET, CT, MT, PT).

MANAGED BEHAVIORAL HEALTH

Humana's Managed Behavioral Health (MBH) program addresses *behavioral health* issues needing long-term treatment, access to psychotropic medications, and outpatient, residential, or inpatient treatment for more chronic concerns.

You can access *behavioral health services* by calling Humana at the toll-free customer service telephone number listed on *your* Humana ID card or *you* may be referred to the MBH program by *your* employee assistance program (EAP) (if one is available to *you*), assessment, a referral from an EAP medical or other *behavioral health* provider, or by calling Humana directly. No matter how the *covered person* enters, the process starts with a thorough clinical assessment.

TELEPHONIC AND ONLINE HEALTH COACHING

Experienced health coaches provide support and motivation, access to resources, and routine check-ins via telephone or e-mail, to participants that want help with certain wellness and workplace problems. Health coaching focuses on ten of these most common problems including: weight management, physical activity, tobacco cessation, healthy eating, stress management, back care, preventive care, cholesterol management, blood pressure management and blood sugar management.

To enroll in the Telephonic Health Coaching and Online Program, log in to *MyHumana* at www.humana.com.

HUMANAVITALITY PROGRAM

From time to time Humana may enter into agreements with related or third party vendors who administer Rewards programs that may be available to *you*. Through these programs, *you* may earn rewards by:

- Completing certain activities such as wellness, educational, or informational programs; or
- Working toward certain goals such as lowering blood pressure or becoming smoke free.

The rewards may include non-health plan benefits such as merchandise, gift cards, debit cards, discounts or contributions to *your* health spending account.

The rewards may also include health plan benefits such as a reduction in *copayments*, *deductibles* or *coinsurance*, as permitted under applicable state and federal laws.

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

Humana's agreement with any vendor does not eliminate any of *your* obligations under this Plan or change any of the terms of this Plan. Humana's agreement with the vendors and the program may be terminated at any time.

Please call the telephone number listed on *your* identification card or in the marketing literature issued by the Rewards program administrator for a possible alternative activity if:

- It is unreasonably difficult for *you* to reach certain goals due to *your* medical condition; or
- *Your qualified practitioner* advises *you* not to take part in the activities presented to reach certain goals.

HEALTH RESOURCES (continued)

The Rewards program administrator or Humana 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 these programs or activities is voluntary and *you* may decide to participate anytime during the *year*. Refer to the marketing literature issued by the Rewards program administrator for their program's eligibility, rules and limitations.

HEALTH ASSESSMENT

The Health Assessment is the first step of the Vitality Program, this is a confidential, online health survey that provides *you* with an overall assessment of *your* health. Upon completion of the assessment, *you* will receive an individualized health score and an action plan on how *you* can improve *your* health. Responses may also result in a referral to another Health Resources program.

PREAUTHORIZATION

Humana will provide *preauthorization* as required by this Plan. *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 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.

The following *services* require *preauthorization*:

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

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

If *preauthorization* is not received, *services* will be reduced to 50% after any applicable *deductibles* or *copayments*.

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

Penalties do not apply to *emergency services*.

TRANSPLANTS

Humana must be notified prior to receiving transplant *services*.

If *preauthorization* is not received, *services* will not be covered.

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

Penalties do not apply to *emergency services*

PRECERTIFICATION (continued)

BARIATRIC SURGERY

Humana must be notified prior to receiving *bariatric surgery*.

If *preauthorization*: is not received, *services* will not be covered.

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

Penalties do not apply to *emergency services*.

INPATIENT BEHAVIORAL HEALTH

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

If *preauthorization*: is not received, *services* will be reduced to 50% after any applicable *deductibles* or *copayments*.

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

Penalties do not apply to *emergency services*.

INPATIENT BEHAVIORAL HEALTH RESIDENTIAL TREATMENT

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

If *preauthorization*: is not received, *services* will be reduced to 50% after any applicable *deductibles* or *copayments*.

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

Penalties do not apply to *emergency services*.

PREDETERMINATION OF BENEFITS

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

If treatment is to commence more 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*, *coinsurance* amounts and/or *copayments*.

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*, *coinsurance* amounts and/or *copayments*. Any amount *you* pay to the provider in excess of *your coinsurance* or *copayment* will not apply to *your out-of-pocket limit* or *deductible*.

Not all *qualified 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*. If *you* do not have access to the online directory, call Humana at the toll-free customer service telephone number listed on *your* Humana ID card prior to *services* being rendered or to request a directory.

COVERED AND NON-COVERED EXPENSES

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

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

If you incur non-covered expenses, whether from a *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.

CLAIMS PROCESSING EDITS

Payment of *covered expenses* for *services* rendered by a provider is subject to this Plan's claims processing edits. The amount determined to be payable under this Plan's 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 provider is less than if the *service* had been provided in a separate *service* session. For example:
 - Two or more *surgeries* occurring at the same *service* session that do not require two preparation times; or
 - Two or more radiologic imaging views performed on the same body part;
- Whether an assistant surgeon, physician assistant, registered nurse, certified operating room technician or any other health care professional 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 the *covered person*;
- Whether *services* can be billed as a complete set of *services* under one billing code.

UNDERSTANDING YOUR COVERAGE (continued)

This Plan develops claims processing edits 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 Technology (CPT);
- UB-04 Data Specifications Manual;
- 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 certification boards;
- Humana's medical coverage policies; and/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.

Non-participating providers may bill *covered persons* for any amount this Plan does not pay even if such amount exceeds these claims processing edits. Any amount that exceeds the claims processing edits paid by the *covered person* will not apply to *deductibles*, *out-of-pocket limits* or *PAR provider Plan maximum out-of-pocket limits*, if applicable. The *covered person* will also be responsible for any applicable *deductible*, *coinsurance* amount or *copayment*.

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 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, MEDICAL COINSURANCE AND OUT-OF-POCKET LIMITS		
BENEFIT FEATURES	PAR PROVIDER BENEFIT	NON-PAR PROVIDER BENEFIT
Single Medical <i>Deductible</i>	\$1,000 per covered person	\$3,000 per covered person
Family <i>Deductible</i>	\$2,000 per covered family	\$6,000 per covered family
Medical <i>Coinsurance</i>	The Plan pays 80%, you pay 20%.	The Plan pays 50%, you pay 50%.
Single Medical <i>Out-of-Pocket Limit</i>	\$3,500 per covered person	\$10,500 per covered person
Family <i>Out-of-Pocket Limit</i>	\$7,000 per covered family	\$21,000 per covered family
<i>Lifetime Maximum Benefit</i>	Unlimited	

MEDICAL SCHEDULE OF BENEFITS (continued)

OFFICE VISIT COPAYMENTS		
BENEFIT FEATURES	PAR PROVIDER BENEFIT	NON-PAR PROVIDER BENEFIT
<i>Qualified Practitioner Primary Care Physician (PCP) Office Visit Copayment</i>	\$35	Not applicable
<i>Qualified Practitioner Specialist Office Visit Copayment</i>	\$45	Not applicable
<i>Retail Clinic Copayment</i>	\$35	Not applicable
<p>Primary Care Physician (PCP) is defined as a family practice physician, pediatrician, doctor of internal medicine, general practitioner, nurse practitioner, physician assistant and registered nurse. A specialist would be all other <i>qualified practitioners</i>.</p> <p>One <i>copayment</i> will be taken per day per servicing provider, unless otherwise indicated in this Schedule.</p>		

MEDICAL SCHEDULE OF BENEFITS (continued)

ROUTINE/PREVENTIVE CHILD CARE SERVICES BIRTH TO AGE 18 (Services Received at a Clinic or Outpatient Hospital)		
MEDICAL SERVICES	PAR PROVIDER BENEFIT	NON-PAR PROVIDER BENEFIT
Routine/Preventive Child Care Examination	100%	Not covered
Routine/Preventive Child Care Vision Screening	100%	Not covered
Routine/Preventive Child Care Hearing Screening	100%	Not covered
Routine/Preventive Child Care Laboratory	100%	Not covered, except for <i>services</i> sent from a <i>PAR provider</i> to a Non-PAR provider will pay at the <i>PAR Provider Benefit</i> .
Routine/Preventive Child Care X-ray	100%	Not covered
Routine/Preventive Child Care Immunizations (e.g. HPV Vaccine, Meningitis Vaccine, Shingles Vaccine, etc.) Immunizations are covered based on the recommendations by the Department of Health and Human Services - Centers for Disease Control and Prevention.	100%	Not covered
Routine/Preventive Child Care Flu/Pneumonia Immunizations	100%	Not covered

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%	Not covered
Routine/Preventive Adult Care Vision Screening	100%	Not covered
Routine/Preventive Adult Care Hearing Screening	100%	Not covered
Routine/Preventive Adult Care Laboratory	100%	Not covered, except for <i>services</i> sent from a <i>PAR provider</i> to a Non-PAR provider will pay at the <i>PAR Provider Benefit</i> .
Routine/Preventive Adult Care X-ray	100%	Not covered
Routine/Preventive Adult Care Immunizations (e.g. Shingles Vaccine, Meningitis Vaccine, HPV Vaccine, etc.) Immunizations are covered based on the recommendations by the Department of Health and Human Services - Centers for Disease Control and Prevention.	100%	Not covered

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 Flu/Pneumonia Immunizations	100%	Not covered
Routine/Preventive Adult Care Mammograms	100%	Not covered
Routine/Preventive Adult Care Pap Smears	100%	Not covered
Age limits do not apply to shingles vaccine, routine mammograms and pap smears.		
Routine/Preventive Adult Care Colonoscopy, Proctosigmoidoscopy and Sigmoidoscopy Screenings (including related <i>services</i>) (performed at an outpatient facility, <i>ambulatory surgical center</i> or clinic location)	100%	Not covered
Routine/Preventive Adult Care Prostate Specific Antigen (PSA) Testing	100%	Not covered

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
Breast Feeding Counseling	100%	50% after <i>deductible</i>
Breast Feeding Support and Supplies	100%	50% after <i>deductible</i>
<p>Contraceptive Methods - devices (e.g. IUD or diaphragms), injections, implant insertion/removal, emergency contraceptives and condoms; Sterilization - tubal ligation and vasectomy (excludes birth control pills/patches and spermicide)</p> <p>For information on <i>prescription</i> drug coverage for birth control pills/patches, spermicide, emergency contraceptives and condoms, please see <i>your prescription</i> drug.</p>	<p>100%</p> <p>If <i>services</i> are not to prevent pregnancy, then they are payable the same as any other <i>sickness</i>.</p>	<p>50% after <i>deductible</i></p> <p>If <i>services</i> are not to prevent pregnancy, then they are payable the same as any other <i>sickness</i>.</p>

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

MEDICAL SCHEDULE OF BENEFITS (continued)

ROUTINE HEARING SERVICES		
MEDICAL SERVICES	PAR PROVIDER BENEFIT	NON-PAR PROVIDER BENEFIT
Routine Hearing Examination	Not covered	Not covered
Routine Hearing Testing	Not covered	Not covered
Hearing Aids and Fitting	80% after <i>deductible</i>	50% after <i>deductible</i>
Routine Hearing Aids and Fitting Limits	\$1,000 per ear, every 3 years for covered dependent children under age 18.	

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	100% after a \$35 <i>copayment</i>	50% after <i>deductible</i>
Diagnostic Office Examination at a Clinic, including Second Surgical Opinion - <i>Qualified Practitioner</i> Specialist	100% after a \$45 <i>copayment</i>	50% after <i>deductible</i>
Office Examination at <i>Retail Clinic</i> including Second Surgical Opinion	100% after a \$35 <i>copayment</i>	50% 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
<p>Office examination benefit applies only to the office examination. All other <i>services</i> will be paid based on the benefits listed below.</p> <p>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.</p>		
Diagnostic Laboratory at a Clinic	100%	50% after <i>deductible</i>
Diagnostic X-ray at a Clinic (other than <i>advanced imaging</i>)	100%	50% after <i>deductible</i>
Independent Laboratory	100%	<i>Services</i> sent from a <i>PAR provider</i> to a Non- <i>PAR provider</i> will pay at the <i>PAR Provider Benefit</i> .
<i>Advanced Imaging</i> at a Clinic	100%	50% after <i>deductible</i>
Allergy Testing at a Clinic	100%	50% after <i>deductible</i>
Allergy Serum/Vials at a Clinic	100%	50% after <i>deductible</i>
Allergy Injections at a Clinic	100%	50% 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)	100% after applicable office visit <i>copayment</i>	50% after <i>deductible</i>
Anesthesia at a Clinic	100%	50% after <i>deductible</i>
<i>Surgery</i> at a Clinic (including <i>Qualified Practitioner, Assistant Surgeon and Physician Assistant</i>)	100% after applicable office visit <i>copayment</i>	50% after <i>deductible</i>
Medical and Surgical Supplies	80% after <i>deductible</i>	50% after <i>deductible</i>
Eyeglasses or Contact Lenses after <i>Cataract Surgery</i> (initial pair only)	80% after <i>deductible</i>	50% after <i>deductible</i>
Diabetic Nutritional Counseling (<i>Diabetes Self-Management Training</i>) (all places of <i>service</i>)	100% after applicable office visit <i>copayment</i>	50% after <i>deductible</i>
<i>Diabetes Supplies</i>	Payable under the <i>prescription</i> drug benefits.	Payable under the <i>prescription</i> drug benefits.

MEDICAL SCHEDULE OF BENEFITS (continued)

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> .
<p>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.</p>		

REVERSAL OF STERILIZATION AND ABORTIONS

MEDICAL SERVICES	PAR PROVIDER BENEFIT	NON-PAR PROVIDER BENEFIT
Reversal of Sterilization	Not covered	Not covered
Life Threatening Abortions	80% after <i>deductible</i>	50% after <i>deductible</i>
Elective Abortions	Payable the same as any other <i>sickness</i> .	50% after <i>deductible</i>

MEDICAL SCHEDULE OF BENEFITS (continued)

MATERNITY (Normal, C-Section and Complications)		
MEDICAL SERVICES	PAR PROVIDER BENEFIT	NON-PAR PROVIDER BENEFIT
Inpatient <i>Hospital Room and Board and Ancillary Facility Services</i>	Payable the same as any other <i>sickness</i> .	Payable the same as any other <i>sickness</i> .
Birthing Center Room and Board and Ancillary <i>Services</i>	Payable the same as any other <i>sickness</i> .	Payable the same as any other <i>sickness</i> .
<i>Qualified Practitioner Services</i> (Office visit <i>copayment</i> will apply to the initial maternity visit only.)	Payable the same as any other <i>sickness</i> .	Payable the same as any other <i>sickness</i> .
<i>Dependent Daughter Maternity</i>	Payable the same as any other <i>sickness</i> .	Payable the same as any other <i>sickness</i> .
Newborn Inpatient <i>Qualified Practitioner Services</i>	80% after <i>deductible</i>	50% after <i>deductible</i>
Newborn Inpatient Facility <i>Services</i>	80% after <i>deductible</i> The newborn <i>deductible</i> will be waived for facility <i>services</i> .	50% after <i>deductible</i> The newborn <i>deductible</i> will be waived for facility <i>services</i> .

MEDICAL SCHEDULE OF BENEFITS (continued)

INPATIENT SERVICES		
MEDICAL SERVICES	PAR PROVIDER BENEFIT	NON-PAR PROVIDER BENEFIT
Inpatient <i>Hospital</i> Room and Board and Ancillary Facility Services	80% after <i>deductible</i>	50% after <i>deductible</i>
<i>Qualified Practitioner</i> Inpatient <i>Hospital</i> Visit	80% after <i>deductible</i>	50% after <i>deductible</i>
<i>Qualified Practitioner</i> Inpatient Surgery and Anesthesia	80% after <i>deductible</i>	50% after <i>deductible</i>
<i>Qualified Practitioner</i> Inpatient Pathology and Radiology	80% after <i>deductible</i>	50% after <i>deductible</i>
Private Duty Nursing (inpatient <i>hospital</i> only)	80% after <i>deductible</i>	50% 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>	50% after <i>deductible</i>
Skilled Nursing Facility Yearly Limits	100% days per <i>covered person</i>	
Skilled Nursing <i>Qualified Practitioner</i> Visit	80% after <i>deductible</i>	50% 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>	100% after a \$250 <i>copayment</i>	50% after <i>deductible</i>
<i>Ambulatory Surgical Center Ancillary Services</i>	100% after a \$250 <i>copayment</i>	50% after <i>deductible</i>
Outpatient <i>Hospital</i> Facility Surgical Services	100% after a \$250 <i>copayment</i>	50% after <i>deductible</i>
Outpatient <i>Hospital</i> Facility Non-Surgical Services (e.g. clinic facility services; observation)	100%	50% 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> Surgical and Non-Surgical Ancillary Services (e.g. supplies; medication; anesthesia)	100%	50% after <i>deductible</i>
Outpatient <i>Hospital</i> Facility Diagnostic Laboratory and X-ray (other than <i>advanced imaging</i>)	100%	50% after <i>deductible</i>
Outpatient <i>Hospital</i> Facility <i>Advanced Imaging</i>	80% after <i>deductible</i> and a \$125 <i>copayment</i>	50% after <i>deductible</i>
Outpatient <i>Hospital</i> and <i>Ambulatory Surgical Center</i> <i>Qualified Practitioner</i> Visit	100%	50% after <i>deductible</i>
Outpatient <i>Hospital</i> and <i>Ambulatory Surgical Center</i> <i>Surgery</i> (including surgeon; assistant surgeon; and physician assistant) and Anesthesia	100%	50% after <i>deductible</i>
Outpatient <i>Hospital</i> and <i>Ambulatory Surgical Center</i> Pathology and Radiology	100%	50% after <i>deductible</i>

MEDICAL SCHEDULE OF BENEFITS (continued)

EMERGENCY AND URGENT CARE SERVICES		
MEDICAL SERVICES	PAR PROVIDER BENEFIT	NON-PAR PROVIDER BENEFIT
<p>Emergency Room Facility and Ancillary Services (e.g. laboratory; x-ray; supplies) (true <i>emergency</i>)</p> <p>If you are admitted to the <i>hospital</i>, the <i>copayment</i> will be waived.</p>	80% after <i>deductible</i> and a \$200 <i>copayment</i>	Same as <i>PAR Provider Benefit</i>
<p>Emergency Room All Physician Services (including Emergency Room Physician, Radiologist, Pathologist, Anesthesiologist and ancillary services billed by an Emergency Room Physician) (true <i>emergency</i>)</p>	80% after <i>deductible</i>	Same as <i>PAR Provider Benefit</i>
<p>Emergency Room Facility and Ancillary Services (e.g. laboratory; x-ray; supplies) (non-emergency)</p> <p>If you are admitted to the <i>hospital</i>, the <i>copayment</i> will be waived.</p>	80% after <i>deductible</i> and a \$200 <i>copayment</i>	Same as <i>PAR Provider Benefit</i>
<p>Emergency Room All Physician Services (including Emergency Room Physician, Radiologist, Pathologist, Anesthesiologist and ancillary services billed by an Emergency Room Physician) (non-emergency)</p>	80% after <i>deductible</i>	Same as <i>PAR Provider Benefit</i>

MEDICAL SCHEDULE OF BENEFITS (continued)

EMERGENCY AND URGENT CARE SERVICES		
MEDICAL SERVICES	PAR PROVIDER BENEFIT	NON-PAR PROVIDER BENEFIT
<p>Urgent Care Center (facility, ancillary services and qualified practitioner services)</p> <p>Only one copayment will be taken per day.</p> <p>If you are admitted to the hospital, the copayment will be waived.</p>	100% after a \$35 copayment	Same as PAR Provider Benefit

HOSPICE SERVICES		
MEDICAL SERVICES	PAR PROVIDER BENEFIT	NON-PAR PROVIDER BENEFIT
Hospice Inpatient Room and Board and Ancillary Services	80% after deductible	50% after deductible
Hospice Outpatient (including hospice home visits)	80% after deductible	50% after deductible
Hospice Qualified Practitioner Visit	80% after deductible	50% after deductible

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>	50% after <i>deductible</i>
Home Health Care Yearly Limits	60 visits per <i>covered person</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 home health care 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 day.</p>		
Home Health Care Ancillary <i>Services</i> (excluding <i>durable medical equipment</i> , prosthetics and private duty nursing)	80% after <i>deductible</i>	50% after <i>deductible</i>

DURABLE MEDICAL EQUIPMENT (DME)		
MEDICAL SERVICES	PAR PROVIDER BENEFIT	NON-PAR PROVIDER BENEFIT
<i>Durable Medical Equipment (DME)</i>	80% after <i>deductible</i>	50% after <i>deductible</i>
Prosthesis	80% after <i>deductible</i>	50% after <i>deductible</i>

MEDICAL SCHEDULE OF BENEFITS (continued)

DURABLE MEDICAL EQUIPMENT (DME)		
MEDICAL SERVICES	PAR PROVIDER BENEFIT	NON-PAR PROVIDER BENEFIT
Wigs for cancer patients with hair loss resulting from chemotherapy and/or radiation therapy	80% after <i>deductible</i>	50% after <i>deductible</i>
Wig Limits	1 wig(s) per <i>covered person</i>	
Wig Dollar Limit	\$100 per <i>covered person</i>	
Artificial Aids (JOBST/Elastic Stocking)	80% after <i>deductible</i>	50% after <i>deductible</i>
Artificial Aids Yearly Limit	1 pair per <i>covered person</i>	
Artificial Aids Dollar Limit	\$100 per <i>covered person</i>	
Othotics	80% after <i>deductible</i>	50% after <i>deductible</i>

MEDICAL SCHEDULE OF BENEFITS (continued)

SPECIALTY DRUGS		
MEDICAL SERVICES	PAR PROVIDER BENEFIT	NON-PAR PROVIDER BENEFIT
<i>Specialty Drugs (Qualified Practitioner's Office Visit, Freestanding Facility and Urgent Care)</i>	100% after a \$100 copayment	50% after deductible
<i>Specialty Drugs administered for Home Health Care</i>	100% after a \$100 copayment	50% after deductible
<i>Specialty Drugs (Emergency Room, Ambulance, Inpatient Hospital, Outpatient Hospital and Skilled Nursing Facility)</i>	Payable the same as any other sickness.	Payable the same as any other sickness.

AMBULANCE SERVICES		
MEDICAL SERVICES	PAR PROVIDER BENEFIT	NON-PAR PROVIDER BENEFIT
<i>Ground Ambulance</i>	80% after deductible	Same as PAR Provider Benefit
<i>Air Ambulance</i>	80% after deductible	Same as PAR Provider Benefit

MEDICAL SCHEDULE OF BENEFITS (continued)

MORBID OBESITY SERVICES		
MEDICAL SERVICES	FACILITIES/QUALIFIED PRACTITIONERS DESIGNATED BY HUMANA AS APPROVED BARIATRIC SERVICES PROVIDERS (Payable at the <i>PAR Provider</i> Benefit Level)	FACILITIES/QUALIFIED PRACTITIONERS <u>NOT</u> DESIGNATED BY HUMANA AS APPROVED BARIATRIC SERVICES PROVIDERS (Payable at the <i>Non-PAR Provider</i> Benefit Level)
The following <i>services</i> will be covered under the <i>morbid obesity</i> benefit: examinations/ <i>qualified practitioner</i> visits;laboratory and x-ray and other diagnostic testing; <i>bariatric surgery</i> ; inpatient facility <i>services</i> ; outpatient facility <i>services</i> ; <i>durable medical equipment</i> ; nutritional counseling.		
<i>Morbid Obesity</i>	80% after <i>deductible</i>	Not covered

OBESITY SERVICES		
MEDICAL SERVICES	PAR PROVIDER BENEFIT	NON-PAR PROVIDER BENEFIT
Obesity Services Excluding Bariatric Surgeries	Payable the same as any other <i>sickness</i> .	Payable the same as any other <i>sickness</i> .
Obesity Services for Bariatric Surgeries	Payable the same as any other <i>sickness</i> .	Payable the same as any other <i>sickness</i> .

MEDICAL SCHEDULE OF BENEFITS (continued)

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.		

THERAPY SERVICES		
MEDICAL SERVICES	PAR PROVIDER BENEFIT	NON-PAR PROVIDER BENEFIT
Therapy <i>copayments</i> apply to therapy <i>services</i> , regardless of provider specialty (for example, if a Podiatrist is performing physical therapy, the physical therapy <i>copayment</i> will apply).		
Chiropractic Examinations	100% after a \$35 <i>copayment</i>	50% after <i>deductible</i>
Chiropractic Laboratory and X-ray	100% after a \$35 <i>copayment</i>	50% after <i>deductible</i>
Chiropractic Manipulations	100% after a \$35 <i>copayment</i>	50% after <i>deductible</i>
Chiropractic Therapy	100% after a \$35 <i>copayment</i>	50% after <i>deductible</i>
Chiropractic Limits	60 visits per <i>covered person</i> The visit limit applies to the following chiropractic benefits: office visit; therapies; manipulations.	
If <i>copayments</i> apply to multiple chiropractic <i>services</i> , one <i>copayment</i> will apply per day per servicing provider.		

MEDICAL SCHEDULE OF BENEFITS (continued)

THERAPY SERVICES		
MEDICAL SERVICES	PAR PROVIDER BENEFIT	NON-PAR PROVIDER BENEFIT
Physical therapy when provided by a chiropractor will deplete the chiropractic limits.		
Physical Therapy (Clinic and Outpatient)	100% after a \$35 <i>copayment</i>	50% after <i>deductible</i>
Occupational Therapy (Clinic and Outpatient)	100% after a \$35 <i>copayment</i>	50% after <i>deductible</i>
Speech Therapy (Clinic and Outpatient)	100% after a \$35 <i>copayment</i>	50% after <i>deductible</i>
Cognitive Therapy (Clinic and Outpatient)	100% after a \$35 <i>copayment</i>	50% after <i>deductible</i>
If <i>copayments</i> apply to multiple therapy <i>services</i> , one <i>copayment</i> will apply per day per servicing provider.		
Therapy Limits	60 visits per <i>covered person</i>	
Physical, occupational, speech, and cognitive therapies, chiropractic <i>services</i> and outpatient cardiac rehabilitation are combined and track toward the Therapy Limits.		
Acupuncture	Not covered	Not covered
Respiratory Therapy and Pulmonary Therapy (Clinic and Outpatient)	100% after a \$35 <i>copayment</i>	50% after <i>deductible</i>

MEDICAL SCHEDULE OF BENEFITS (continued)

THERAPY SERVICES		
MEDICAL SERVICES	PAR PROVIDER BENEFIT	NON-PAR PROVIDER BENEFIT
Vision Therapy (eye exercises to strengthen the muscles of the eye) (Clinic and Outpatient)	Not covered	Not covered
Chemotherapy (Clinic and Outpatient)	Payable the same as any other <i>sickness</i> .	50% after <i>deductible</i>
Radiation Therapy (Clinic and Outpatient)	Payable the same as any other <i>sickness</i> .	50% after <i>deductible</i>
Cardiac Rehabilitation (Phase II) Phase I is covered under the inpatient facility benefits. Phase III, an unsupervised exercise program, is not covered.	100% after a \$35 <i>copayment</i>	50% after <i>deductible</i>
Physical, occupational, speech, and cognitive therapies, chiropractic <i>services</i> and outpatient cardiac rehabilitation are combined and track toward the Therapy Limits.		

MEDICAL SCHEDULE OF BENEFITS (continued)

TRANSPLANT SERVICES		
[Variable: Preauthorization is required, if preauthorization is not received, organ transplant services will not be covered.]		
MEDICAL SERVICES	HUMANA NATIONAL TRANSPLANT NETWORK (NTN) FACILITY (Payable at the <i>PAR Provider</i> Benefit Level)	NON-HUMANA NATIONAL TRANSPLANT NETWORK (NTN) FACILITY (Payable at the <i>PAR Provider</i> Benefit Level)
Organ Transplant Medical Services	100%	80% after <i>deductible</i>
Organ Transplant Medical Services Limits	None	None
Non-Medical Services - Lodging and Transportation	100%	100%
Non-Medical Services - Lodging and Transportation Combined Limits	\$10,000 per covered transplant	\$10,000 per covered transplant
<i>Covered expenses for organ transplants will aggregate toward the Plan out-of-pocket limits.</i>		

MEDICAL SCHEDULE OF BENEFITS (continued)

BEHAVIORAL HEALTH INPATIENT SERVICES		
MEDICAL SERVICES	PAR PROVIDER BENEFIT	NON-PAR PROVIDER BENEFIT
Inpatient <i>Behavioral Health Room and Board and Ancillary Services</i>	Payable the same as medical inpatient <i>hospital services</i> .	50% after <i>deductible</i>
Inpatient <i>Behavioral Health Professional Services</i>	Payable the same as medical inpatient <i>qualified practitioner services</i> .	Payable the same as medical inpatient <i>qualified practitioner services</i> .
<i>Behavioral Health Residential Treatment Facility Services</i>	Payable the same as medical inpatient <i>hospital and qualified practitioner services</i> .	Payable the same as medical inpatient <i>hospital and qualified practitioner services</i> .

BEHAVIORAL HEALTH PARTIAL HOSPITALIZATION SERVICES		
MEDICAL SERVICES	PAR PROVIDER BENEFIT	NON-PAR PROVIDER BENEFIT
<i>Behavioral Health Partial Hospitalization Services</i>	Payable the same as medical outpatient non-surgical <i>hospital services</i> .	Payable the same as medical outpatient non-surgical <i>hospital services</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 and Office Visit Services (Clinic, Outpatient and Intensive Outpatient)</i>	Payable the same as a <i>qualified practitioner</i> primary care physician office visit	Payable the same as a <i>qualified practitioner</i> primary care physician office visit
<i>Behavioral health services not listed above, such as laboratory and x-ray, are payable the same as the qualified practitioner or facility, based on place of service.</i>		
<i>Applied Behavioral Analysis (ABA) Therapy</i> ABA Therapy	Not Covered	Not Covered

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* or the *Plan maximum out-of-pocket limit*, whichever comes first. After *you* have met the *out-of-pocket limit*, if any, this Plan will pay *covered expenses* at 100% for the rest of the *calendar year*, subject to the *maximum allowable fee(s)*, any *maximum benefits* and all other terms, provisions, limitations and exclusions of this Plan. Any applicable *deductible*, *coinsurance* 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*. *Copayments* do not apply toward 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 each *covered person* each *calendar year*. Once a *covered person* meets their single *deductible*, this Plan will begin to pay benefits for that *covered person*.

Family Deductible

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

PAR and Non-PAR Deductible Accumulation

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

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, either individually or combined as a covered family, per *calendar year* before a benefit percentage will be increased. The single and family *out-of-pocket limits* are stated on the Medical Schedule of Benefits.

Single Out-of-Pocket Limits

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

Family Out-of-Pocket Limit

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

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 *PAR out-of-pocket limit* will not reduce the *Non-PAR out-of-pocket limit* however the *Non-PAR out-of-pocket limit* will reduce the *PAR out-of-pocket limit*.

Penalties and *Non-PAR copayments* 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* recommended by the U.S. Department of Health and Human Services (HHS) for *your plan year* as follows:

1. Services with an A or B rating in the current recommendations of the U. S. Preventive Services Task Force (USPSTF). The recommendations by the USPSTF for breast cancer screenings, mammography and preventions issued prior to November 2009 will be considered current.
2. Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC).
3. Preventive care for infants, children and adolescents provided in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA).
4. Preventive care for women provided in the comprehensive guidelines supported by HRSA.

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

MEDICAL COVERED EXPENSES (continued)

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

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

ROUTINE HEARING SERVICES

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

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

QUALIFIED PRACTITIONER SERVICES

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

Second Surgical Opinion

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

Multiple Surgical Procedures

If multiple or bilateral surgical procedures are performed at one operative session, the amount payable for these procedures will be limited to the *maximum allowable fee* for the primary surgical procedure. When a *participating provider* is utilized, subsequent procedures will be paid in accordance with the *provider contract*. When a *non-participating provider* is utilized, the amount payable will be: a) 50% of the *maximum allowable fee* for the secondary procedure; and b) 25% of the *maximum allowable fee* for the third and subsequent procedures.

No benefits will be payable for incidental procedures.

Surgical Assistant/Assistant Surgeon

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

Physician Assistant

Physician assistants will be paid at 10% of the *covered expense* for *surgery*.

DENTAL/ORAL SURGERIES COVERED UNDER THE MEDICAL PLAN

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

1. Excision of partially or completely unerupted impacted teeth;
2. Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth when such conditions require pathological examination;

MEDICAL COVERED EXPENSES (continued)

3. Surgical procedures required to correct accidental injuries of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
4. Reduction of fractures and dislocations of the jaw;
5. External incision and drainage of cellulitis;
6. Incision of accessory sinuses, salivary glands or ducts;
7. Frenectomy (the cutting of the tissue in the midline of the tongue);
8. Dental osteotomies.

REVERSAL OF STERILIZATION AND ABORTIONS

Reversal of sterilization and abortions *services* are payable as shown on the Schedule of Benefits.

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

MATERNITY

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

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

Newborns

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

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

MEDICAL COVERED EXPENSES (continued)

Birthing Centers

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

INPATIENT HOSPITAL

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

SKILLED NURSING FACILITY

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

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

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

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

1. Permanent and full-time bed care facilities for resident patients;
2. A physician's *services* available at all times;
3. 24-hour-a-day skilled nursing *services* under the full-time supervision of a physician or registered nurse (R.N.);
4. A daily record for each patient;
5. Continuous skilled nursing care for sick or injured persons during their convalescence from *sickness* or *bodily injury*; and
6. A utilization review plan.

MEDICAL COVERED EXPENSES (continued)

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

OUTPATIENT AND AMBULATORY SURGICAL CENTER

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

EMERGENCY AND URGENT CARE SERVICES

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

HOSPICE SERVICES

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

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

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

1. Room and board and other *services* and supplies;
2. Part-time nursing care by, or supervised by, a registered nurse for up to 8 hours per day;
3. Counseling *services* by a *qualified practitioner* for the hospice patient and the immediate family;
4. Medical social *services* provided to *you* or *your* immediate family under the direction of a *qualified practitioner*, which include the following:
 - a. Assessment of social, emotional and medical needs, and the home and family situation;
 - b. Identification of the community resources available; and
 - c. Assistance in obtaining those resources;
5. Nutritional counseling;
6. Physical or occupational therapy;
7. Part-time home health aide service for up to 8 hours in any one day;
8. Medical supplies, drugs and medicines prescribed by a *qualified practitioner*.

Hospice care benefits do NOT include:

1. Private duty nursing *services* when *confined* in a hospice facility;
2. A *confinement* not required for pain control or other acute chronic symptom management;

MEDICAL COVERED EXPENSES (continued)

3. Funeral arrangements;
4. Financial or legal counseling, including estate planning or drafting of a will;
5. Homemaker or caretaker *services*, including a sitter or companion *services*;
6. Housecleaning and household maintenance;
7. *Services* of a social worker other than a licensed clinical social worker;
8. *Services* by volunteers or persons who do not regularly charge for their *services*; or
9. *Services* by a licensed pastoral counselor to a member of his or her congregation when *services* are in the course of the duties to which he or she is called as a pastor or minister.

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

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

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

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

HOME HEALTH CARE

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

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

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

MEDICAL COVERED EXPENSES (continued)

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

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

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

The home health care plan consists of:

1. Care by or under the supervision of a registered nurse (R.N.);
2. Physical, speech, occupational, cognitive and respiratory therapy and home health aide *services*; and
3. Medical supplies, laboratory *services* and nutritional counseling, if such *services* and supplies would have been covered if *you* were *hospital confined*.

Home health care benefits do not include:

1. Charges for mileage or travel time to and from the *covered person's* home;
2. Wage or shift differentials for home health care providers;
3. Charges for supervision of home health care providers;
4. Private duty nursing;
5. *Durable medical equipment* and prosthetics.

DURABLE MEDICAL EQUIPMENT (DME)

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

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

1. The manufacturer's warranty is expired; and

MEDICAL COVERED EXPENSES (continued)

2. Repair or maintenance is not a result of misuse or abuse; and
3. Maintenance is not more frequent than every 6 months; and
4. The repair cost is less than the replacement cost.

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

1. The manufacturer's warranty is expired; and
2. The replacement cost is less than the repair cost; and
3. The replacement is not due to lost or stolen equipment or misuse or abuse of the equipment; or
4. 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 minimal basic function. Replacement is a *covered expense* if due to pathological changes or growth. Repair of the basic prosthetic device, including replacing a part or putting together what is broken, is a *covered expense*.

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.

AMBULANCE

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

MORBID OBESITY

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

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

1. The patient is age 18 or older; and
2. The patient meets the definition of *morbid obesity* as defined in the Definitions section; and

MEDICAL COVERED EXPENSES (continued)

3. The patient has been previously unsuccessful with medical treatment for obesity; and
4. The Patient has had a recent (within 12 months prior to planned surgical intervention) psychological evaluation in which member is evaluated to rule out psychiatric disorders (e.g., schizophrenia, major depression, chemical dependency) that interfere with adherence to a new lifestyle and cleared for surgery. This is necessary in order to exclude members who are unable to provide informed consent or who are unable to comply with the pre and post-operative regimen; and

You MAY be eligible under this Plan for repeat *bariatric surgery* if:

1. Coverage for *bariatric surgery* is available under this Plan; AND
2. The patient utilizes a Humana preferred facility for the repeat *bariatric surgery*; AND
3. You have *medically necessary* complications because of a covered *bariatric surgery* (e.g. anastomotic strictures); OR
4. You have inadequate weight loss or weight re-gain after a covered primary *bariatric surgery* that is evidenced by documentation of compliance with postoperative nutritional counseling, exercise recommendations and physician follow-up visits.

OBESITY

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

DENTAL INJURY

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

Services for teeth injured as a result of chewing are not covered.

Services must begin within 180 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.

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 Schedule of Benefits.

TRANSPLANT SERVICES

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

Preauthorization

Preauthorization is required. If *preauthorization* is not received, transplant *services* will not be covered.

Covered Organ Transplant

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

1. Heart;
2. Lung(s);
3. Liver;
4. Kidney;
5. Bone Marrow*;
6. Intestine;
7. Pancreas;
8. Auto islet cell;
9. Multivisceral;
10. Any combination of the above listed organs;
11. Any organ not listed above required by federal law.

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

MEDICAL COVERED EXPENSES (continued)

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

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

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

Exclusions

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

1. It is *experimental, investigational or for research purposes* as defined in the Definitions section;
2. Humana is not contacted for authorization prior to referral for evaluation of the transplant;
3. Humana does not approve coverage for the transplant, based on its established criteria;
4. Expenses are eligible to be paid under any private or public research fund, government program, except Medicaid, or another funding program, whether or not such funding was applied for or received;
5. The expense relates to the transplantation of any non-human organ or tissue, unless otherwise stated in this Plan;
6. The expense relates to the donation or acquisition of an organ for a recipient who is not covered by this Plan;
7. A denied transplant is performed; this includes the pre-transplant evaluation, pre-transplant *services*, the transplant procedure, post-discharge *services*, immunosuppressive drugs and complications of such transplant;
8. The *covered person* for whom a transplant is requested has not met pre-transplant criteria as established by Humana.

Covered Services

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

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

MEDICAL COVERED EXPENSES (continued)

2. Organ acquisition and donor costs. Except for bone marrow transplants, donor costs are not payable under this Plan if they are payable in whole or in part by any other group plan, insurance company, organization or person other than the donor's family or estate. Coverage for bone marrow transplants procedures will include costs associated with the donor-patient to the same extent and limitations associated with the *covered person*;
3. Direct, non-medical costs for the *covered person* 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;
4. Direct, non-medical costs for one support person of the *covered person* (two persons if the patient is under age 18 years) 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.

BEHAVIORAL HEALTH SERVICES

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

1. Charges made by a *qualified practitioner*;
2. Charges made by a *hospital*;
3. Charges made by a *qualified treatment facility*;
4. Charges for x-ray and laboratory expenses.

Inpatient Services

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

Outpatient Services

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

Limitations

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

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

OTHER COVERED EXPENSES

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

1. Blood and blood plasma are payable as long as it is NOT replaced by donation, and administration of blood and blood products including blood extracts or derivatives;
2. Casts, trusses, crutches, *orthotics*, splints and braces. *Orthotics* must be custom made or custom fitted, made of rigid or semi-rigid material. Oral or dental splints and appliances must be custom made and for the treatment of documented obstructive sleep apnea. Unless specifically stated otherwise, fabric supports, replacement *orthotics* and braces, oral splints and appliances, dental splints and appliances, and dental braces are not a *covered expense*;
3. Reconstructive *surgery* due to *bodily injury*, infection or other disease of the involved part or congenital disease or anomaly of a covered *dependent* child which resulted in a *functional impairment*;
4. Reconstructive *services* following a covered mastectomy, including but not limited to:
 - a. Reconstruction of the breast on which the mastectomy was performed;
 - b. Reconstruction of the other breast to achieve symmetry;
 - c. Prosthesis; and
 - d. Treatment of physical complications of all stages of the mastectomy, including lymphedemas;
5. Routine costs associated with clinical trials, when approved by this Plan. For additional details, go to www.humana.com or call the toll-free customer service telephone number listed on *your* Humana ID card.
6. 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

This Plan does not provide benefits for:

1. *Services*:
 - a. Not furnished by a *qualified practitioner* or *qualified treatment facility*;
 - b. Not authorized or prescribed by a *qualified practitioner*;
 - c. Not specifically covered by this Plan whether or not prescribed by a *qualified practitioner*;
 - d. Which are not provided;
 - e. For which no charge is made, or for which *you* would not be required to pay if *you* were not covered under this Plan unless charges are received from and reimbursable to the United States Government or any of its agencies as required by law;
 - f. Furnished by or payable under any plan or law through any government or any political subdivision (this does not include *Medicare* or *Medicaid*);
 - g. Furnished for a military service connected *sickness* or *bodily injury* by or under an agreement with a department or agency of the United States Government, including the Department of Veterans Affairs;
 - h. Performed in association with a *service* that is not covered under this Plan.
2. Immunizations required for foreign travel;
3. Radial keratotomy, refractive keratoplasty or any other *surgery* to correct myopia, hyperopia or stigmatic error;
4. *Services* related to gender change;
5. *Cosmetic surgery* and *cosmetic services* or devices, unless for reconstructive *surgery*:
 - a. Resulting from a *bodily injury*, infection or other disease of the involved part, when *functional impairment* is present; or
 - b. Resulting from a congenital disease or anomaly of a covered *dependent* child which resulted in a *functional impairment*.

Expense incurred for reconstructive *surgery* performed due to the presence of a psychological condition is not covered, unless the condition(s) described above are also met;
6. Hair prosthesis, hair transplants or hair implants;
7. Dental *services* or appliances for the treatment of the teeth, gums, jaws or alveolar processes, including but not limited to, implants and related procedures, routine dental extractions and orthodontic procedures, unless specifically provided under this Plan;
8. *Services* which are:
 - a. Rendered in connection with a *mental health* disorder not classified in the International Classification of Diseases of the U.S. Department of Health and Human Services;
 - b. Extended beyond the period necessary for evaluation and diagnosis of learning and behavioral disabilities or for mental retardation.
9. Marriage counseling;
11. *Court-ordered mental health* or *substance abuse services*;
12. Education or training, unless otherwise specified in this Plan;

LIMITATIONS AND EXCLUSIONS (continued)

13. 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;
14. Expenses for *services* that are primarily and customarily used for environmental control or enhancement (whether or not prescribed by a *qualified practitioner*) and certain medical devices including, but not limited to:
 - a. Common household items including air conditioners, air purifiers, water purifiers, vacuum cleaners, waterbeds, hypoallergenic mattresses or pillows or exercise equipment;
 - b. Motorized transportation equipment (e.g. scooters), escalators, elevators, ramps or modifications or additions to living/working quarters or transportation vehicles;
 - c. Personal hygiene equipment including bath/shower chairs and transfer equipment or supplies;
 - d. Personal comfort items including cervical pillows, gravity lumbar reduction chairs, swimming pools, whirlpools, spas or saunas;
 - e. Medical equipment including blood pressure monitoring devices, PUVA lights and stethoscopes;
 - f. Communication system, telephone, television or computer systems and related equipment or similar items or equipment;
 - g. Communication devices, except after surgical removal of the larynx or a diagnosis of permanent lack of function of the larynx.
15. Any medical treatment, procedure, drug, biological product or device which is *experimental, investigational or for research purposes*, unless otherwise specified in this Plan;
16. *Services* that are not *medically necessary*, except routine/preventive *services*;
17. Charges in excess of the *maximum allowable fee* for the *service*;
18. *Services* provided by a person who ordinarily resides in *your* home or who is a *family member*;
19. 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;
20. *Expenses incurred* for which *you* are entitled to receive benefits under *your* previous dental or medical plan;
21. Any expense due to the *covered person's*:
 - a. Engaging in an illegal occupation; or
 - b. Commission of or an attempt to commit a criminal act.
22. Any loss caused by or contributed to:
 - a. War or any act of war, whether declared or not;
 - b. Insurrection; or
 - c. Any act of armed conflict, or any conflict involving armed forces of any authority.
23. Any *expense incurred* for *services* received outside of the United States, except for *emergency care services*, unless otherwise determined by this Plan;
24. 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)

25. Vitamins, dietary supplements and dietary formulas, except enteral formulas, nutritional supplements or low protein modified food products for the treatment of an inherited metabolic disease, e.g. phenylketonuria (PKU);
26. *Prescription drugs and self-administered injectable drugs*, unless administered to you:
 - a. While inpatient in a *hospital, qualified treatment facility* or skilled nursing facility; or
 - b. By the following, when deemed appropriate by this Plan: a *qualified practitioner*, during an office visit, while outpatient, or at a home health care agency as part of a covered home health care plan approved by this Plan.
27. Any drug prescribed, except:
 - a. FDA approved drugs utilized for FDA approved indications; or
 - b. FDA approved drugs utilized for *off-label drug indications* recognized in at least one compendia reference or peer-reviewed medical literature deemed acceptable to this Plan.
28. *Off-evidence drug indications*;
29. 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;
30. 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*);
31. Growth hormones (medications, drugs or hormones to stimulate growth);
32. Therapy and testing for treatment of allergies including, but not limited to, *services* related to clinical ecology, environmental allergy and allergic immune system dysregulation and sublingual antigen(s), extracts, neutralization test and/or treatment UNLESS such therapy or testing is approved by:
 - a. The American Academy of Allergy and Immunology, or
 - b. The Department of Health and Human Services or any of its offices or agencies.
33. Professional pathology or radiology charges, including but not limited to, blood counts, multi-channel testing, and other clinical chemistry tests, when:
 - a. The *services* do not require a professional interpretation, or
 - b. The *qualified practitioner* did not provide a specific professional interpretation of the test results of the *covered person*.
34. *Services* that are billed incorrectly or billed separately, but are an integral part of another billed *service*;
35. 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;
36. *Alternative medicine*;
37. *Services* rendered in a premenstrual syndrome clinic or holistic medicine clinic;

LIMITATIONS AND EXCLUSIONS (continued)

38. *Services* of a midwife, unless provided by a Certified Nurse Midwife;
39. The following types of care of the feet:
 - a. Shock wave therapy of the feet.
 - b. The treatment of weak, strained, flat, unstable or unbalanced feet.
 - c. Hygienic care and the treatment of superficial lesions of the feet, such as corns, calluses or hyperkeratosis.
 - d. The treatment of tarsalgia, metatarsalgia, or bunion, except surgically.
 - e. The cutting of toenails, except the removal of the nail matrix.
 - f. The provision of heel wedges, lifts or shoe inserts.
 - g. The provision of arch supports or orthopedic shoes. Arch supports and orthopedic shoes are covered if *medically necessary* because of diabetes or hammertoe.
40. *Custodial care* and *maintenance care*;
41. 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;
42. *Hospital inpatient services* when *you* are in observation status;
43. *Services* rendered by a standby physician, surgical assistant, assistant surgeon, physician assistant, registered nurse or certified operating room technician unless *medically necessary*;
44. *Ambulance services* for routine transportation to, from or between medical facilities and/or a *qualified practitioner's* office;
45. *Preadmission testing/procedural testing* duplicated during a *hospital confinement*;
46. Lodging accommodations or transportation, unless specifically provided under this Plan;
47. Communications or travel time;
48. No benefits will be provided for the following, unless otherwise determined by this Plan:
 - a. Immunotherapy for recurrent abortion;
 - b. Chemonucleolysis;
 - c. Biliary lithotripsy;
 - d. Home uterine activity monitoring;
 - e. Sleep therapy;
 - f. Light treatments for Seasonal Affective Disorder (S.A.D.);
 - g. Immunotherapy for food allergy;
 - h. Prolotherapy;
 - i. i. Hyperhidrosis *surgery*;
 - j. Lactation therapy; or
 - k. Sensory integration therapy.

LIMITATIONS AND EXCLUSIONS (continued)

49. Any *covered expenses* to the extent of any amount received from others for the *bodily injuries* or losses which necessitate such benefits. Without limitation, "amounts received from others" specifically includes, but is not limited to, liability insurance, workers' compensation, uninsured motorists, underinsured motorists, "no-fault" and automobile med-pay payments or recovery from any identifiable fund regardless of whether the *beneficiary* was made whole;
50. Routine physical examinations and related *services* for occupation, employment, school, sports, camp, travel, purchase of insurance or premarital tests or examinations, unless specifically provided under this Plan;
51. Surrogate parenting;
52. Any *bodily injury* or *sickness* arising from or sustained in the course of any occupation or employment for compensation, profit or gain for which:
 - a. Benefits are provided or payable under any Workers' Compensation or Occupational Disease Act or Law, or
 - b. Coverage was available under any Workers' Compensation or Occupational Disease Act or Law regardless of whether such coverage was actually purchased.
53. Routine vision examinations;
54. Routine vision refraction;
55. The purchase, fitting or repair of eyeglass frames and lenses or contact lenses, unless specifically provided under this Plan;
56. Vision therapy;
57. Routine hearing examinations;
58. Routine hearing testing;
59. *Services* for a reversal of sterilization;
60. Contraceptive pills and patches and spermicide (see the Prescription Drug Benefit for coverage);
62. Private duty nursing, except in an inpatient *hospital*;
63. Wigs, except for cancer patients with hair loss resulting from chemotherapy and/or radiation therapy;
64. Surgical procedures for the removal of excess skin and/or fat in conjunction with or resulting from weight loss or weight loss *surgery*;

LIMITATIONS AND EXCLUSIONS (continued)

65. No benefits will be provided for, or on account of, the following items:
- a. Expenses for a *bariatric surgery* that are *experimental, investigational or for research purposes*;
 - b. Expenses for *bariatric surgery* performed outside of the United States;
 - c. Any care resulting from a non-covered *bariatric surgery*.
66. *Services* 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;
67. Infertility counseling and treatment *services*;
68. Artificial means to achieve pregnancy or ovulation, including, but 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;
69. *Services* related to the treatment and/or diagnosis of sexual dysfunction/impotence;
70. Acupuncture;
71. Halfway-house *services*;
72. *Applied behavioral analysis (ABA) therapy*.

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

COORDINATION OF BENEFITS

BENEFITS SUBJECT TO THIS PROVISION

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

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

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

EFFECT ON BENEFITS

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

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

ORDER OF BENEFIT DETERMINATION

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

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

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

COORDINATION OF BENEFITS (continued)

4. 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.

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

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

COORDINATION OF BENEFITS WITH MEDICARE

ACTIVE EMPLOYEE COORDINATION

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

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

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

MEDICARE Part D means Medicare offers prescription drug coverage to everyone with Medicare. If you decide not to join a Medicare Prescription Drug Plan (Part D) when you're first eligible, and you don't have other creditable prescription drug coverage, or you don't get Extra Help, you'll likely pay a late enrollment penalty

RETIREMENT/DISABILITY COORDINATION

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

OPTIONS

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

COORDINATION OF BENEFITS (continued)

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

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

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

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

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

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

CALCULATION AND PAYMENT OF BENEFITS

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

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

RIGHT OF RECOVERY

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

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

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

CLAIM PROCEDURES

SUBMITTING A CLAIM

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

- A claim must be filed with Humana in writing and delivered to Humana by mail, postage prepaid. However, a submission to obtain *preauthorization* may also be filed with Humana by telephone;
- Claims must be submitted to Humana at the address indicated in the documents describing this Plan or *claimant's* 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 12 months after the the claim was incurred for *Non-PAR provider* claims, except if *you* were legally incapacitated. Claims should be submitted by a *PAR provider* in accordance with the timely filing period outlined in that *provider's contract* with Humana (typically 180 days for physicians and 90 days for facilities and ancillary providers, however, a provider's contractual timely filing period may vary), 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:
 - a. The name of the *covered person* who incurred the *covered expense*;
 - b. The name and address of the health care provider;
 - c. The diagnosis of the condition;
 - d. The procedure or nature of the treatment;
 - e. The date of and place where the procedure or treatment has been or will be provided;
 - f. The amount billed and the amount of the *covered expense* not paid through coverage other than Plan coverage, as appropriate;
 - g. Evidence that substantiates the nature, amount, and timeliness of each *covered expense* in a format that is acceptable according to industry standards and in compliance with applicable law.

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

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

CLAIM PROCEDURES (continued)

Mail medical claims and correspondence to:

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

MISCELLANEOUS MEDICAL CHARGES

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

PROCEDURAL DEFECTS

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

ASSIGNMENTS AND REPRESENTATIVES

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

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

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

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

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

CLAIMS DECISIONS

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

Pre-Service Claims

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

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

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

Urgent Care Claims

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

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

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

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

CLAIM PROCEDURES (continued)

Concurrent Care Decisions

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

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

Post-Service Claims

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

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

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

TIMES FOR DECISIONS

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

PAYMENT OF CLAIMS

Many health care providers will request an assignment of benefits as a matter of convenience to both provider and patient. Also as a matter of convenience, Humana will, in its sole discretion, assume that an assignment of benefits has been made to certain *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.

CLAIM PROCEDURES (continued)

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

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

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

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

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

NOTICES – GENERAL INFORMATION

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

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

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

INITIAL DENIAL NOTICES

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

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

CLAIM PROCEDURES (continued)

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 *adverse benefit determination* on review.

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

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

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

APPEALS OF ADVERSE BENEFIT DETERMINATIONS

A *claimant* must *appeal* an *adverse benefit determination* within 180 days after receiving written notice of the denial (or partial denial). With the exception of *urgent care claims* and *concurrent care decisions*, this Plan uses a two level *appeals* process for all *adverse benefit determinations*. Humana will make the determination on the first level of *appeal*. If the *claimant* is dissatisfied with the decision on this first level of *appeal*, or if Humana fails to make a decision within the time frame indicated below, the *claimant* may *appeal* again to the *Plan Administrator*. *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.

CLAIM PROCEDURES (continued)

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.

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.

CLAIM PROCEDURES (continued)

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

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

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

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

FULL AND FAIR REVIEW

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

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

RIGHT TO REQUIRE MEDICAL EXAMINATIONS

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

EXHAUSTION

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

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

LEGAL ACTIONS AND LIMITATIONS

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

STANDARD EXTERNAL REVIEW

Request for an External Review

A *claimant* may file a request for an *external review* with 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:

CLAIM PROCEDURES (continued)

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

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

1. If the request is complete but not eligible for *external review*. The notice must include the reason(s) for its ineligibility and contact information for the Department of Health and Human Services Health Insurance Assistance Team (HIAT), including this number: 1-888-393-2789.
2. If the request is not complete. The notice must describe the information or materials needed to make it complete, and Humana must allow the *claimant* to perfect the *external review* request within whichever of the following two options is later:
 - a. The initial 4-month filing period; or
 - b. The 48-hour period following receipt of the notification.

Referral to an Independent Review Organization (IRO)

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

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

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

CLAIM PROCEDURES (continued)

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

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

6. The assigned *IRO* must provide written notice of the *final external review decision* within 45 days after receiving the *external review* request to the *claimant* and Humana. The decision notice must contain the following:
 - a. A general description of the reason an *external review* was requested, including information sufficient to identify the claim including:
 - (1) The date(s) of service;
 - (2) The health care provider;
 - (3) The claim amount (if applicable); and
 - (4) The reason for the previous denial.
 - b. The date the *IRO* received assignment to conduct the *external review* and the date of the *IRO* decision;
 - c. References to the evidence or documentation considered in reaching the decision, including the specific coverage provisions and evidence-based standards;
 - d. A discussion of the principal reason(s) for its decision, including the rationale and any evidence-based standards relied on in making the decision;
 - e. A statement that the determination is binding except to the extent that other remedies may be available under state or federal law to either the *Plan Administrator* or the *claimant*;
 - f. A statement that judicial review may be available to the *claimant*; and
 - g. Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under PPACA (*section 2793 of PHSa, as amended*).

CLAIM PROCEDURES (continued)

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

Reversal of this Plan's Decision

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

EXPEDITED EXTERNAL REVIEW

Request for an Expedited External Review

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

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

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

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

Notice of Final External Review Decision

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

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

For more information on *your* internal claims and *appeals* and *external review* rights, *you* can contact the Department of Health and Human Services Health Insurance Assistance Team (HIAT) at 1-888-393-2789.

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

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

Tennessee Department of Commerce and Insurance
500 James Robertson Pkwy
Davy Crockett Tower, 4th floor
Nashville, TN 37243-0574
(615) 741-2218
(800) 342-4029
(615) 532-7389 (Fax)
www.tn.gov/commerce/insurance

SECTION 3

**ELIGIBILITY AND
EFFECTIVE DATE OF
COVERAGE**

ELIGIBILITY AND EFFECTIVE DATE OF COVERAGE

OPEN ENROLLMENT

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

EMPLOYEE ELIGIBILITY

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

1. *You* are a grandfathered member; or
2. *You* are an *employee* who meets the eligibility requirements of the *employer*; and
3. *You* are performing on a regular, full-time basis all customary occupational duties for 30 hours per week, at the *employer's* business locations or when required to travel for the *employer's* business purposes. An *employee* shall be deemed at work on each day of a regular paid vacation or a regular non-working holiday; and
4. *You* satisfy an eligibility period of 30 calendar days of full-time employment.

Your eligibility date is the first working day of the month following *your* date of hire.

EMPLOYEE EFFECTIVE DATE OF COVERAGE

You must enroll in a manner acceptable to Humana.

1. 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;
2. 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.

DEPENDENT ELIGIBILITY

Each *dependent* is eligible for coverage on:

1. The date the *employee* is eligible for coverage, if he or she has *dependents* who may be covered on that date; or
2. The date of the *employee's* marriage for any *dependent* acquired on that date; or
3. The date of birth of the *employee's* natural-born child; or
4. 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
5. 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.

Late enrollment will result in denial of *dependent* coverage until the next annual Open Enrollment Period.

ELIGIBILITY AND EFFECTIVE DATE OF COVERAGE (continued)

No person may be simultaneously covered as both an *employee* and a *dependent*. If both parents are eligible for coverage, only one may enroll for *dependent* coverage.

DEPENDENT EFFECTIVE DATE OF COVERAGE

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

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

1. If the completed enrollment is received by Humana before the *dependent's* eligibility date or within 31 days after the *dependent's* eligibility date, that *dependent* is covered on the date he or she is eligible.
2. If the completed enrollment is received by Humana more than 31 days after the *dependent's* eligibility date, the *dependent* is a *late applicant*. The *dependent* will not be eligible for coverage under this Plan until the next annual Open Enrollment Period.

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

MEDICAL CHILD SUPPORT ORDERS

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

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

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

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

SPECIAL PROVISIONS

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

REINSTATEMENT OF COVERAGE

If *your* coverage under this Plan was terminated after a period of layoff, *total disability*, approved medical leave of absence, approved non-medical leave of absence, approved military leave of absence (other than USERRA) or during part-time status, and *you* are now returning to work, *your* coverage is effective as determined by *your employer*.

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

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

FAMILY AND MEDICAL LEAVE ACT (FMLA)

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

Retiree Medical Coverage

Eligibility:

You may be entitled to continue coverage under this Active Medical Plan if *you* retire from Knox County. If *you* are entitled to and elect to continue coverage, *you* may be entitled to continue coverage for *your* eligible dependents.

Retiree Coverage:

Effective for retirements on or after January 1, 2014, to be eligible for coverage under this Active Medical Plan as a *retiree*, *you* must generally meet the continuous covered service requirement or fall within one of the exceptions described below. *You* will be responsible for paying the monthly premium.

You will meet the continuous covered service requirement if *you* are a *retiree* who was continuously employed by Knox County for five (5) or more years since the date of *your* last employment or re-employment and *you* maintained continuous coverage under the Active Medical Plan for five (5) or more years ending on *your* date of retirement.

So long as *you* maintain coverage under the Active Medical Plan both before and after an approved leave of absence (FMLA, military leave, etc.), *your* period of leave is not treated as interrupting continuous covered service.

ELIGIBILITY AND EFFECTIVE DATE OF COVERAGE (continued)

If *you* leave County employment, elect COBRA coverage and maintain it continuously, and return to County employment prior to the end of COBRA coverage, the period of COBRA coverage shall be counted as part of *your* continuous covered service.

You will be treated as having met the continuous covered service requirement if *you* were employed on the date of retirement for a single period of continuous County employment for five (5) or more years since the date of *your* last employment or re-employment and *you* maintained continuous coverage under the Active Medical Plan for less than five (5) years ending on the date of retirement, so long as *you* were (1) covered by the Active Medical Plan on the date of *your* retirement; and (2) covered by the Active Medical Plan as a result of a timely election during open enrollment or due to a status change involving the loss of other creditable coverage as a *dependent* under *your* spouse's health plan; and (3) covered in the aggregate by that other health plan and this Active Medical Plan continuously for at least five (5) years ending on *your* date of retirement.

Continuous covered service is not required if *you* become eligible for disability benefits under Knox County's Disability Plan, UOPP, or Closed Defined Benefit Plan so long as *you* maintained continuous coverage under this Active Medical Plan during the last five (5) years of *your* employment prior to *your* disability, or *your* entire period of County employment, if less than five (5) years. If *you* retire and elect coverage under this Active Medical Plan, subsequently return to benefit-eligible County employment and maintain continuous coverage under the Active Medical Plan during that period of re-employment, *you* will be eligible to elect to resume coverage under this Active Medical Plan upon *your* subsequent retirement, without regard to the length of that period of re-employment.

Dependent Coverage:

Generally, if *you* are eligible for, elect and maintain continuous coverage under this Active Medical Plan commencing on *your* retirement, *your* eligible *dependents* may also be covered so long as each *dependent* was continuously covered as a *dependent* under the Active Medical Plan for five (5) or more years ending on the date of *your* retirement. *You* will be responsible for paying the monthly premium for *your dependent's* coverage.

If *you* are treated as having met the continuous covered service requirement as a result of *your* timely election during open enrollment or due to a status change involving the loss of other creditable coverage as a *dependent* under *your* spouse's health plan, *your dependents* may also be covered so long as each was covered as a *dependent* under the Active Medical Plan on *your* date of retirement. If *you* are covered under this Active Medical Plan as a *retiree*, *your dependent* who became a *dependent* less than five (5) years before *your* date of retirement due to marriage, birth, adoption or other similar family status change will also be eligible for coverage under this Active Medical Plan if that *dependent* was timely covered by the Active Medical Plan following that family status change and was continuously covered until *your* date of retirement.

If *you* die while employed by the County, *your dependent* is eligible for coverage under this Active Medical Plan if *you* maintained continuous coverage for that *dependent* under the Active Medical Plan during the last five (5) years of *your* employment prior to *your* death, or *your* entire period of County employment, if less than five (5) years.

ELIGIBILITY AND EFFECTIVE DATE OF COVERAGE (continued)

Termination of Coverage:

Your coverage under this Active Medical Plan as a *retiree* will automatically terminate at the end of the month prior to *your* attainment of age 65. As an exception, if *you* retired prior to April 1, 1995 *you* are considered a “grandfathered” *retiree* and *you* may continue coverage under this Plan regardless of *your* age. In any event, once *you* leave the Active Medical Plan coverage, *you* may not re-enter the Plan.

If a covered *dependent* leaves Plan coverage, the *dependent* may not re-enter the Plan. If *you* voluntarily dis-enroll or are no longer eligible for coverage as a *retiree*, *your* eligible dependents under the age of 65 may continue coverage under the Plan until the earliest of the following: (1) *dependent(s)* enrolls in Medicare and voluntarily dis-enrolls from this Plan; (2) a *dependent* child loses *dependent* status; or (3) *you* terminate the *dependent's* coverage.

Medicare Coordination:

To avoid higher out of pocket expenses, *you* must enroll yourself and any of *your dependents* in Medicare parts A & B as soon as *you* or *your dependents* become eligible following your retirement. When *you* are retired and enrolled in Medicare parts A & B, Medicare is the primary payer of *your* medical claims and this Plan is secondary. Moreover, if *you* are retired and Medicare eligible, even if *you* do not enroll in Medicare, this Plan will pay as secondary payer, regardless of whether *you* actually enroll in Medicare parts A & B. When *you* are retired and one of *your dependents* is enrolled in Medicare parts A & B, Medicare is the primary payer of that *dependent's* medical claims and this Plan is secondary. If *you* are retired and *your dependent* is Medicare eligible, even if *your dependent* is not enrolled in Medicare, this Plan will pay as secondary payer, regardless of the Medicare-eligible dependent's actual enrollment in Medicare parts A & B.

As one-time exceptions:

For *retirees*: (i) if *you* are retired as of October 1, 2014 and (ii) *you* are Medicare-eligible as of October 1, 2014, and (iii) *you* have not previously enrolled in Medicare parts A & B, and (iv) *you* do not have either a Medicare open enrollment or a Medicare special enrollment period at any time between October 1, 2014 and March 31, 2015, then this Plan will pay *your* claims as primary payer through June 30, 2015, but will pay as secondary payer on and after July 1, 2015, regardless of whether *you* actually enroll in Medicare parts A & B.

For eligible *dependents*: (i) if *you* are retired as of October 1, 2014 and (ii) *your* eligible *dependent* is Medicare-eligible as of October 1, 2014, and (iii) that *dependent* has not previously enrolled in Medicare parts A & B, and (iv) that *dependent* does not have either a Medicare open enrollment or a Medicare special enrollment period at any time between October 1, 2014 and March 31, 2015, then this Plan will pay that *dependent's* claims as primary payer through June 30, 2015, but will pay as secondary payer on and after July 1, 2015, regardless of whether that *dependent* actually enrolls in Medicare parts A & B.

In addition, for Medicare purposes, this Active Medical Plan is not considered creditable coverage for either *you* or *your* covered *dependents* once *you* retire. If *you* do not enroll in Medicare parts A & B as soon as *you* are eligible (and within the eight (8) month Medicare Special Enrollment Period following *your* retirement), *you* may be assessed by Medicare a lifetime monthly premium penalty for late enrollment when *you* enroll in Medicare. This is also true for Medicare Part D. If *your dependent* does not enroll in Medicare parts A & B as soon as that *dependent* becomes eligible (and within the eight (8) month Medicare Special Enrollment Period following *your* retirement), *your dependent* may be assessed by Medicare a life-time monthly premium penalty for late enrollment when that dependent enrolls in Medicare. This is also true for Medicare Part D.

ELIGIBILITY AND EFFECTIVE DATE OF COVERAGE (continued)

Retirees or *dependent(s)* who are enrolled in Medicare parts A & B may enroll in a Medicare Advantage Plan, including the one offered by Knox County. However, if *you* leave this Active Medical Plan, *you* will not be permitted to re-enroll in this Plan; similarly, if *your* covered *dependent* leaves the Plan, the *dependent* will not be permitted to re-enroll.

SPECIAL ENROLLMENT

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

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

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

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

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

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

1. Marriage;
2. Birth;
3. Adoption or placement for adoption;
4. Loss of eligibility due to termination of Medicaid or State Children's Health Insurance Program (SCHIP) coverage; or

ELIGIBILITY AND EFFECTIVE DATE OF COVERAGE (continued)

5. Eligibility for premium assistance subsidy under Medicaid or SCHIP.

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

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

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

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

1. The date this Plan terminates;
2. The end of the period for which any required contribution was due and not paid;
3. For all *employees* or *dependent* spouses the end of the calendar month 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;
4. The end of the calendar month *you* fail to be in an eligible class of persons according to the eligibility requirements of the *employer*;
5. For all *employees*, the end of the calendar month in which *you* terminate employment with *your employer*;
6. For all *employees*, the end of the calendar month *you* retire;
7. The end of the calendar month *you* request termination of coverage to be effective for *yourself*;
8. For any benefit, the date the benefit is removed from this Plan;
9. For *your dependents*, the date *your* coverage terminates;
10. For a *dependent* spouse the end of the calendar month such *covered person* no longer meets the definition of *dependent*.
11. For a *dependent* child, the end of the birth month such *covered person* no longer meets the definition of *dependent*.

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

SECTION 4
GENERAL PROVISIONS
**AND REIMBURSEMENT/
SUBROGATION**

GENERAL PROVISIONS

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

PLAN ADMINISTRATION

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

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

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

RESCISSION

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

CONTESTABILITY

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

RIGHT TO REQUEST OVERPAYMENTS

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

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

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

WORKERS' COMPENSATION NOT AFFECTED

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

WORKERS' COMPENSATION

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

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

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

MEDICAID

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

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

CONSTRUCTION OF PLAN TERMS

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:

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

RIGHT TO COLLECT NEEDED INFORMATION

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

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

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

DUTY TO COOPERATE IN GOOD FAITH

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

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

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

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

SECTION 5

NOTICES

IMPORTANT NOTICES FOR EMPLOYEES AND SPOUSES AGE 65 AND OVER

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

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

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

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

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

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

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

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

PRIVACY OF PROTECTED HEALTH INFORMATION

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

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

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

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

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

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

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

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

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

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;
- Ceasing to be a "*dependent* child" under this Plan;

CONTINUATION OF MEDICAL BENEFITS (continued)

- The *employee* parent becomes entitled to *Medicare* benefits; or
- Termination of the retiree parent's coverage when the former *employer* discontinues retiree coverage within one year before or one year after filing for Chapter 11 bankruptcy.

LOSS OF COVERAGE

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

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

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

NOTICES AND ELECTION

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

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

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

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

CONTINUATION OF MEDICAL BENEFITS (continued)

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

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

On August 6, 2002, The Trade Act of 2002 (TAA), was signed 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. The Plan need not require every available document to establish evidence of TAA. The burden for evidencing TAA eligibility is that of the individual applying for coverage under this Plan.

MAXIMUM COVERAGE PERIOD

Coverage may continue up to:

- 18 months for an *employee* and/or *dependent* whose group coverage ended due to termination of the *employee's* employment or reduction in hours of employment;
- 36 months for a spouse whose coverage ended due to the death of the *employee* or retiree, divorce, or the *employee* becoming entitled to *Medicare* at the time of the initial qualifying event;
- 36 months for a *dependent* child whose coverage ended due to the divorce of the *employee* parent, the *employee* becoming entitled to *Medicare* at the time of the initial qualifying event, the death of the *employee*, or the child ceasing to be a *dependent* under this Plan;
- For the retiree, until the date of death of the retiree who is on continuation due to loss of coverage within one year before or one year after the *employer* filed Chapter 11 bankruptcy.

DISABILITY

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

SECOND QUALIFYING EVENT

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

TERMINATION BEFORE THE END OF MAXIMUM COVERAGE PERIOD

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

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

TYPE OF COVERAGE; PREMIUM PAYMENT

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.

CONTINUATION OF MEDICAL BENEFITS (continued)

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

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

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

OTHER INFORMATION

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

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

PLAN CONTACT INFORMATION

ASI Cobra
P.O. Box 657
Columbia, MO 65205
Telephone: 877-388-8331

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

Knox County Government
400 Main Street, Suite 345
Knoxville, TN 37902
Telephone: 865-2215-2321

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.

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

1. Proper Name of Plan: Knox County Government

2. *Plan Sponsor:* Knox County Government
400 Main Street, Suite 345
Knoxville, TN 37902
Telephone: 865-215-2321

3. *Employer:* Knox County Government
400 Main Street, Suite 345
Knoxville, TN 37902
Telephone: 865-215-2321

Common Name of *Employer:* Knox County Government

4. *Plan Administrator* and Named Fiduciary:

Knox County Government
400 Main Street, Suite 345
Knoxville, TN 37902
Telephone: 865-215-2321

5. *Employer Identification Number:* 62-6007979

6. This Plan provides medical benefits for participating *employees* and their enrolled *dependents*.

7. Plan benefits described in this booklet are effective January 1, 2016.

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

10. The fiscal year is July 1 through June 30 of each year.

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

Timothy F. Burchett
400 Main Street, Suite 345
Knoxville, TN 37902

11. 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

PLAN DESCRIPTION INFORMATION (continued)

12. This is a self-insured and self-administered health benefit plan. The cost of this Plan is paid with contributions shared by the *employer* and *employee*. Benefits under this Plan are provided from the general assets of the *employer* and are used to fund payment of covered claims under this Plan plus administrative expenses. Please see *your employer* for the method of calculating contributions and the funding mechanism used for the accumulation of assets through which benefits are provided under this Plan.
13. 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.
14. 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.
15. 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.
16. 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.
17. 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* and is exact as to time and place of occurrence.

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

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

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

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

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

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

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

DEFINITIONS (continued)

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

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

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

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

B

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

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

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

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

C

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

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

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

DEFINITIONS (continued)

Coinsurance means the shared financial responsibility for *covered expenses* between the *covered person* and this Plan, expressed as a percentage.

Complications of pregnancy means:

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

Complications of pregnancy do not mean:

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

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

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

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

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

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

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

DEFINITIONS (continued)

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

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

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

D

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

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

Dependent means a covered *employee's*:

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

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

- a. Married;
 - b. A tax dependent;
 - c. A student;
 - d. Employed;
 - e. Residing with or receives financial support from *you*; or
 - f. Eligible for other coverage through employment.
3. 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.

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

DEFINITIONS (continued)

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

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

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

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

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

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

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

E

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

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

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

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

DEFINITIONS (continued)

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

1. Cannot be lawfully marketed without the final approval of the United States Food and Drug Administration (FDA) and which lacks such final FDA approval for the use or proposed use, unless:
 - a. Found to be accepted for that use in the most recently published edition of Clinical Pharmacology, Micromedex DrugDex, National Comprehensive Cancer Network Drugs and Biologics Compendium, and the American Hospital Formulary Service (AHFS) Drug Information for drugs used to treat cancer, and is determined to be covered by this Plan (for additional details, go to www.humana.com, click on “Humana Websites for Providers” along the left hand side of the page, then click “Medical Coverage Policies” under Critical Topics, then click “Medical Coverage Policies” and search for Clinical Trials and Off-Label and Off-Evidence); or
 - b. Found to be accepted for that use in the most recently published edition of the Micromedex DrugDex or AHFS Drug Information for non-cancer drugs, and is determined to be covered by this Plan (for additional details, go to www.humana.com, click on “Humana Websites for Providers” along the left hand side of the page, then click “Medical Coverage Policies” under Critical Topics, then click “Medical Coverage Policies” and search for Clinical Trials and Off-Label and Off-Evidence); or
 - c. Identified by this Plan as safe, widely used and generally accepted as effective for that use as reported in nationally recognized peer reviewed medical literature published in the English language as of the date of service;
2. Is a device required to receive Premarket Approval (PMA) or 510K approval by the FDA but has not received a PMA or 510K approval;
3. Is not identified as safe, widely used and generally accepted as effective for the proposed use as reported in nationally recognized peer reviewed medical literature published in the English language as of the date of service;
4. Is the subject of a National Institute of Health (NIH) Phase I, II or III trial or a treatment protocol comparable to a NIH Phase I, II or III trial, or any trial not recognized by NIH regardless of phase, except for:
 - a. Clinical trials approved by this Plan (for additional details, go to www.humana.com, click on “Humana Websites for Providers” along the left hand side of the page, then click “Medical Coverage Policies” under Critical Topics, then click “Medical Coverage Policies” and search for Clinical Trials and Off-Label and Off-Evidence); or
 - b. Transplants, in which case this Plan would approve requests for *services* that are the subject of a NIH Phase II, Phase III or higher when transplant *services* are appropriate for the treatment of the underlying disease;
5. Is identified as not covered by the Centers for Medicare and Medicaid Services (CMS) Medicare Coverage Issues Manual, a CMS Operational Policy Letter or a CMS National Coverage Decision, except as required by federal law and excluding transplants.

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

DEFINITIONS (continued)

F

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

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

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

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

H

Hospital means an institution which:

1. Maintains permanent full-time facilities for bed care of resident patients;
2. Has a physician and surgeon in regular attendance;
3. Provides continuous 24 hour a day nursing *services*;
4. Is primarily engaged in providing diagnostic and therapeutic facilities for medical or surgical care of sick or injured persons;
5. Is legally operated in the jurisdiction where located; and
6. Has surgical facilities on its premises or has a contractual agreement for surgical *services* with an institution having a valid license to provide such surgical *services*; or
7. Is a lawfully operated *qualified treatment facility* certified by the First Church of Christ Scientist, Boston, Massachusetts.

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

DEFINITIONS (continued)

I

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

Intensive outpatient means outpatient *services* providing:

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

Intensive outpatient program does not include services that are for:

1. *Custodial care*; or
2. Day care.

L

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

DEFINITIONS (continued)

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

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

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

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

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

1. Performed in the least costly setting required by *your* condition;
2. Not provided primarily for the convenience of the patient or the *qualified practitioner*;
3. Appropriate for and consistent with *your* symptoms or diagnosis of the *sickness* or *bodily injury* under treatment;
4. Furnished for an appropriate duration and frequency in accordance with accepted medical practices, and which are appropriate for *your* symptoms, diagnosis, *sickness* or *bodily injury*; and
5. Substantiated by the records and documentation maintained by the provider of *service*.

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

DEFINITIONS (continued)

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

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

1. 40 kilograms or greater per meter squared (kg/m^2); or
2. 35 kilograms or greater per meter squared (kg/m^2) with an associated comorbid condition such as hypertension, type II diabetes, life-threatening cardiopulmonary conditions; or joint disease that is treatable, if not for the obesity.

N

Non-participating (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*.

O

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

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

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

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

DEFINITIONS (continued)

P

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

1. For a comprehensive and intensive interdisciplinary psychiatric treatment for minimum of 5 hours a day, 5 days per week;
2. That provides for social, psychological and rehabilitative training programs with a focus on reintegration back into the community and admits children and adolescents who must have a treatment program designed to meet the special needs of that age range; and
3. That has physicians and appropriately licensed *mental health* and *substance abuse* practitioners readily available for the emergent and urgent care needs of the patients.

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

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

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

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

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

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

Plan Administrator means Knox County Government.

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 Knox County Government.

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.

DEFINITIONS (continued)

Preauthorization means the process of assessing the *medical necessity*, appropriateness, or utility of proposed non-emergency *hospital admissions*, surgical procedures, outpatient care, and other health care *services*.

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

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

1. The name and address of the *covered person* for whom the *prescription* is intended;
2. The type and quantity of the drug, medicine or medication prescribed, and the directions for its use;
3. The date the *prescription* was prescribed; and
4. The name and address of the prescribing *qualified practitioner*.

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

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

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

Q

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

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

DEFINITIONS (continued)

R

Residential treatment facility means an institution which:

1. Is licensed as a 24-hour residential facility for *mental health* and *substance abuse* treatment, although not licensed as a *hospital*;
2. Provides a multidisciplinary treatment plan in a controlled environment, with periodic supervision of a physician or a Ph.D. psychologist; and
3. Provides programs such as social, psychological and rehabilitative training, age appropriate for the special needs of the age group of patients, with focus on reintegration back into the community.

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

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).

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

Retrospective review means a review conducted after *services* (including outpatient procedures and *services*) have been provided to a *covered person* to validate utilization decisions and/or payment made for the care that was provided.

S

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

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

Sound natural tooth means a tooth that:

1. Is organic and formed by the natural development of the body (not manufactured);
2. Has not been extensively restored;
3. Has not become extensively decayed or involved in periodontal disease; and
4. Is not more susceptible to injury than a whole natural tooth.

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

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

DEFINITIONS (continued)

2. Require disease-specific treatment programs;
3. Have limited distribution requirements; or
4. Have special handling, storage or shipping requirements.

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

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

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

T

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:

1. During the first twelve months of disability *you* or *your* employed covered spouse are at all times prevented by *bodily injury* or *sickness* from performing each and every material duty of *your* respective job or occupation;
2. After the first twelve months, *total disability* or *totally disabled* means that *you* or *your* employed covered spouse are at all times prevented by *bodily injury* or *sickness* from engaging in any job or occupation for wage or profit for which *you* or *your* employed covered spouse are reasonably qualified by education, training or experience;
3. For a non-employed spouse or a child, *total disability* or *totally disabled* means the inability to perform the normal activities of a person of similar age and gender.

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

U

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

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

DEFINITIONS (continued)

Y

You and your means any covered person.

Administered by:

Humana

Humana Health Plan, Inc.
500 West Main Street
Louisville, KY 40202

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