Humana

Appendix A

Description of Plan Benefits
Humana Health Plan

Humana Group No. 721374
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Effective January 1, 2023

This document supersedes any earlier version of Appendix A for the Humana Health Plan

APPENDIX A TO THE SPD

Version 22.3

NO SURPRISES ACT AMENDMENT

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

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

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

No Surprises Act

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

Definitions

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

Ancillary services mean *covered expenses* that are:

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

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

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

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

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

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

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

Recognized amount means the reimbursement rate as determined by:

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

Emergency and non-emergency services

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

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

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

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

Continuity of care

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

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

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

HUMANA.
Guidance when you need it most

INTRODUCTION

APPENDIX A TO THE SPD

This Appendix A outlines the benefits, provisions and limitations of the Humana Health Plan, and is an integral part of the SPD. If there is a conflict between the terms and/or provisions of this Appendix A and the SPD Wrapper or plan document for The Dow Chemical Company Medical Care Program or The Dow Chemical Company Retiree Medical Care Program ("Plan Documents"), the SPD Wrapper and Plan Documents will supersede this Appendix A.

DEFINED TERMS

Italicized terms throughout this *Appendix A to the SPD* are defined in the "Definitions" section. An italicized word may have a different meaning in the context of this *Appendix A to the 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 *Appendix A to the 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 14610
Lexington, KY 40512-4610

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 *covered persons* better understand *your* health care benefits and how to use them, navigate the health care system when *you* need it, understand treatment options and choices, reduce *your* costs and enhance the quality of *your* life.

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

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

WELLNESS PROGRAMS

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

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

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

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

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

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

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

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

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

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

PREAUTHORIZATION

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

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

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

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

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

- Conduct *concurrent review* as necessary.

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

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

PREAUTHORIZATION PENALTY

If *you* receive services or supplies from a *non-network provider* for which *preauthorization* is required and not obtained, the benefit payable for any *covered expenses* incurred will not be covered.

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

PREDETERMINATION OF BENEFITS

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

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

SECTION 2

MEDICAL BENEFITS

NETWORK PROVIDERS

This Plan has one (1) level of benefits – *network provider* benefits, payable as shown in the Schedule of Benefits section. *Network providers* have agreed to provide *covered expenses* at lower costs. *You* must pay any *copayment, deductible* or *coinsurance* you owe to the *network provider*. The *network provider* will accept *your copayment, deductible* or *coinsurance* and the amount negotiated by Humana as the full payment.

Be sure to determine if *your* provider is a *network provider* for this Plan. Humana may designate limited panels of *network providers* from which certain kinds of *services* must be obtained. If these *services* are not obtained from the designated *network providers*, benefits for these *services* may be reduced or denied. Humana reserves the right, at their discretion, to make changes to the list of *network providers* at any time.

NON-NETWORK PROVIDERS

If a *network provider* cannot provide the *covered expenses you* need or they cannot treat *your* condition, *you* must have a referral from *your primary care physician* that is approved by Humana to receive services from a *non-network provider*. Only the services approved by Humana will be a *covered expense*. *Non-network providers* have not signed an agreement with Humana for lower costs for services and they may bill *you* for any amount over the *maximum allowable fee*. *You* will have to pay this amount and any *copayment*, *deductible* and *coinsurance*. Any amount over the *maximum allowable fee* will not apply to *your deductible* or any *medical out-of-pocket limit* or *out-of-pocket limit*.

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

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

Any *copayment, deductible* and/or *coinsurance you* pay for services based on the *qualified payment amount* will be applied to the *network provider out-of-pocket limit*.

For *covered expenses* other than those *you* pay based on the *qualified payment amount, you* will be responsible to pay:

- The applicable *network provider copayment, deductible* and/or *coinsurance*; and
- Any amount over the *maximum allowable fee* to a *non-network provider*.

If an *out-of-pocket limit* applies and it is met, the Plan will pay *covered expenses* at 100% the rest of the *year*, subject to any *maximum benefit* and all other terms, provisions, limitations, and exclusions of the Plan.

No benefits will be provided when *you* consent to the *non-network provider* to receive the following:

- Services that are not considered *ancillary services* from a *non-network provider* when *you* are at a *network facility*; or
- *Post-stabilization services*.

NETWORK PROVIDER DIRECTORY

Your employer will automatically provide, without charge, information to *you* about how *you* can access a directory of *network providers* appropriate to *your service area*. An online directory of *network providers* is available to *you* and accessible via Humana's website at Humana.com. This directory is subject to change. Due to the possibility of *network providers* changing status, please check the online directory of *network providers* prior to obtaining *services*. If *you* do not have access to the online directory, call Humana at the toll-free customer service number listed on *your* Humana ID card prior to *services* being rendered or to request a directory.

PRIMARY CARE PHYSICIAN

A *primary care physician* provides *preventives services*, diagnostic health care services and health care for medical conditions. *You* may select a *primary care physician* who is a *network provider*, for *yourself* and for each covered *dependent*. *You* have the right to designate any *primary care physician* who is a *network provider* and who is available to accept *you* and *your* covered *dependents*. Always discuss *your* medical condition with *your primary care physician*. *Your primary care physician* may refer *you* to a *specialty care physician* or other *network providers* for *your* health care, when needed. *You* may receive services from a *network provider* without a referral from your pri*mary care physician*.

You may change *your primary care physician* at Humana.com or *you* may call Humana at the toll-free customer service telephone number listed on *your* ID card. *You* may contact Humana before receiving *services* from a new *primary care physician*. Humana will send *you* a new ID card with *your* new *primary care physician's* name.

You may need to see another *network provider* named by *your primary care physician* when they cannot see *you*. Please discuss who this *network provider* is with *your primary care physician*.

You may change *your primary care physician* at Humana.com or *you* may call Humana at the customer service number listed on *your* ID card. *You* must contact Humana before receiving services from a new *primary care physician*. Humana will send *you* a new ID card with *your* new *primary care physician's* name.

CONTINUITY OF CARE

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

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

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

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

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

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

- An acute *sickness* or *bodily injury* that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm;

- A chronic *sickness* or *bodily injury* that is a life-threatening condition, degenerative, potentially disabling, or is a *congenital anomaly* and requires specialized medical care over a prolonged period of time;

- *Inpatient* care;

- A scheduled non-elective *surgery* and any related post-surgical care;

- A pregnancy; or

- A terminal illness.

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

Continuity of care is not available if:

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

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

SEEKING EMERGENCY CARE

If *you* need *emergency care*, go to the nearest emergency facility.

You, or someone on *your* behalf, must call Humana within 48 hours after *your admission* to a *non-network hospital* for an *emergency medical condition*. If *your* condition does not allow *you* to call Humana within 48 hours after *your admission*, contact Humana as soon as *your* condition allows. Humana may transfer *you* to a *network hospital* in the *service area* when *your* condition is stable.

SEEKING URGENT CARE

If *you* need *urgent care*, call *your primary care physician* first. If they are not available, go to the nearest *urgent care center* or call an *urgent care qualified provider*. *You* must receive *urgent care* services from a *network provider*.

COVERED AND NON-COVERED EXPENSES

The Plan provides coverage for services, equipment and supplies that are *covered expenses*. All requirements of the Plan apply to *covered expenses*.

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

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

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

COVERAGE OF OUT-OF-AREA DEPENDENTS

Dependents who reside outside of the *service area* because they are enrolled in an educational institution on a full-time basis may be covered under this Plan. Outside the *service area*, only *emergency care* and *urgent care* medical conditions are covered. Payment of those *services* will be made in accordance with the "Seeking Emergency Care" and "Seeking Urgent Care" sections. Non-emergency care *services* will be covered only if rendered by *network providers*.

When an out-of-area *dependent* enters the *service area* on a temporary basis, coverage will be provided under the same terms and conditions as *covered persons* who reside in the *service area*. If the *dependent* moves into the *service area*, or if the *service area* is changed to include the *dependent's* residence, the *dependent* will immediately cease to be considered out-of-area.

MEDICAL SCHEDULE OF BENEFITS

IMPORTANT INFORMATION ABOUT PLAN BENEFITS

Benefits and limits (i.e. visit or dollar limits) are per *plan year*, 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 OUT-OF-POCKET LIMITS, MEDICAL OFFICE VISIT COPAYMENTS AND LIFETIME MAXIMUM BENEFIT

BENEFIT FEATURES	NETWORK PROVIDER BENEFIT
Qualified Provider Primary Care Physician (PCP) Office Visit *Copayment*	$20
Qualified Provider Specialist Office Visit *Copayment*	$35
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 *qualified providers*. One *copayment* will be taken per visit per servicing provider, unless otherwise indicated in this Schedule.	
Single Medical *Out-of-Pocket Limit*	$2,500 per *covered person*
Family Medical *Out-of-Pocket Limit*	$7,500 per covered family
Lifetime Maximum Benefit	Unlimited

MEDICAL AND PRESCRIPTION DRUG PAR PROVIDER PLAN MAXIMUM OUT-OF-POCKET LIMIT	
BENEFIT FEATURES	**NETWORK PROVIDER BENEFIT**
Single *PAR Provider Plan Maximum Out-of-Pocket Limit*	$6,350 per *covered person*
Family *PAR Provider Plan Maximum Out-of-Pocket Limit*	$12,700 per covered family

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

ROUTINE/PREVENTIVE CHILD CARE SERVICES BIRTH TO AGE 18 (*Services* Received at a Clinic or Outpatient *Hospital*)	
MEDICAL SERVICES	**NETWORK PROVIDER BENEFIT**
Routine/Preventive Child Care Immunizations (includes school immunizations) (e.g. HPV Vaccine, Meningitis Vaccine, etc.) Immunizations are covered based on the recommendations by the Department of Health and Human Services - Centers for Disease Control and Prevention	100%
Routine/Preventive Child Care Flu/Pneumonia Immunizations	100%

ROUTINE/PREVENTIVE ADULT CARE SERVICES AGE 18 AND OVER (*Services* Received at a Clinic or Outpatient *Hospital*)	
MEDICAL SERVICES	**NETWORK PROVIDER BENEFIT**
Routine/Preventive Adult Care Examination	100%
Routine/Preventive Adult Care Vision Screening	100%
Routine/Preventive Adult Care Hearing Screening	100%
Routine/Preventive Adult Care Laboratory	100%

ROUTINE/PREVENTIVE ADULT CARE SERVICES AGE 18 AND OVER (*Services* Received at a Clinic or Outpatient *Hospital*)	
MEDICAL SERVICES	**NETWORK PROVIDER BENEFIT**
Routine/Preventive Adult Care X-ray	100%
Routine/Preventive Adult Care Immunizations (includes school immunizations) (e.g. Shingles Vaccine, Meningitis Vaccine, HPV Vaccine, etc.) Immunizations are covered based on the recommendations by the Department of Health and Human Services - Centers for Disease Control and Prevention (www.cdc.gov)	100%
Routine/Preventive Adult Care Flu/Pneumonia Immunizations	100%
Routine/Preventive Adult Care Mammograms	100%
Routine/Preventive Adult Care Pap Smears	100%
Routine/Preventive Adult Care Colonoscopy, Proctosigmoidoscopy and Sigmoidoscopy Screenings (including related *services,* i.e. anesthesia) (performed at an outpatient facility, *ambulatory surgical center* or clinic location)	100%
Routine/Preventive Adult Care Prostate Specific Antigen (PSA) Testing	100%

ROUTINE/PREVENTIVE ADULT CARE SERVICES AGE 18 AND OVER (*Services* Received at a Clinic or Outpatient *Hospital*)	
MEDICAL SERVICES	**NETWORK PROVIDER BENEFIT**
Breast Feeding Counseling	100%
Breast Feeding Support and Supplies	100%
Contraceptive Methods - contraceptive devices (e.g. IUD or diaphragms), injections, implant insertion/removal, emergency contraceptives and condoms; Sterilization - tubal ligation and vasectomy For information on *prescription* drug coverage for birth control pills/patches, emergency contraceptives, condoms and spermicide, please see *your prescription* drug benefits.	100%
Note: 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.	

ROUTINE VISION SERVICES	
MEDICAL SERVICES	**NETWORK PROVIDER BENEFIT**
Routine Vision Examination	Not covered
Routine Vision Refraction	100% after $20 *copayment*
Aphakia (Vision)	100%

ROUTINE VISION SERVICES	
MEDICAL SERVICES	**NETWORK PROVIDER BENEFIT**
Eyeglass Frames and Lenses and Contact Lenses	Not covered
Routine Vision Refraction Visit Limit	One (1) visit per *covered person* (based on diagnosis)

ROUTINE HEARING SERVICES	
MEDICAL SERVICES	**NETWORK PROVIDER BENEFIT**
Routine Hearing Examination	100%
Routine Hearing Testing	Not covered
Hearing Aids and Fitting	80%, for ages 17 and younger, coverage for non-disposable aids, up to $1,400 per hearing aid, every 36th months.
Hearing Impaired Interpreter Expenses (covers qualified interpreter/translator)	100%

QUALIFIED PROVIDER SERVICES (Non-Routine/Non-Preventive Care *Services*)	
MEDICAL SERVICES	**NETWORK PROVIDER BENEFIT**
Diagnostic Office Examination at a Clinic, including Second and Third Surgical Opinion – *Primary Care Physician*	100% after $20 *copayment*
Diagnostic Office Examination at a Clinic, including Second and Third Surgical Opinion - *Qualified Provider Specialist*	100% after $35 *copayment*
Office examination benefit applies only to the office examination. All other *services* will be paid based on the benefits listed below. If an office examination is billed from an outpatient location, the *services* will be payable the same as outpatient *services*.	
Diagnostic Laboratory at a Clinic	100%
Diagnostic X-ray at a Clinic (other than *advanced imaging*)	100%
Independent Laboratory	100%
Advanced Imaging at a Clinic	100%
Allergy Testing at a Clinic	100%
Allergy Serum/Vials at a Clinic	100%
Allergy Injections at a Clinic	100%

QUALIFIED PROVIDER SERVICES (Non-Routine/Non-Preventive Care *Services*)	
MEDICAL SERVICES	**NETWORK PROVIDER BENEFIT**
Injections at a Clinic (other than routine immunizations, contraceptive injections for birth control reasons and allergy injections)	100%
Anesthesia at a Clinic	100%
Surgery at a Clinic (including *Qualified Provider, Assistant Surgeon* and Physician Assistant) • *Primary Care Physician* • *Qualified Practitioner Specialist* • *Assistant Surgeon*	 100% after $20 *copayment* 100% after $35 *copayment* 100%
Multiple Surgical Procedures • Outpatient • In an Office Setting	 100% Subject to applicable office visit *copayment*
Medical and Surgical Supplies	100%
Eyeglasses or Contact Lenses after Cataract *Surgery* (initial pair only)	Not covered
Diabetic Nutritional Counseling (*Diabetes Self-Management Training*) (all places of *service*)	Payable the same as any other *sickness*.
Diabetes Supplies	75% (or covered under pharmacy)

DENTAL/ORAL SURGERIES COVERED UNDER THE MEDICAL PLAN	
MEDICAL SERVICES	**NETWORK PROVIDER BENEFIT**
Dental/Oral *Surgeries* in office visit • *Primary Care Physician* • *Qualified Provider Specialist* Dental/Oral *Surgeries* Outpatient	 100% after $20 *copayment* 100% after $35 *copayment* 100%
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.	

FAMILY PLANNING	
MEDICAL SERVICES	**NETWORK PROVIDER BENEFIT**
Birth Control Pills and Patches	Not covered (Covered under pharmacy)
Contraceptive Devices (e.g. IUD; Diaphragms) – for *services* other than to prevent pregnancy Over-the-counter contraceptive devices are not covered.	50%. Office visit *copayment* will apply if there is an office visit. If obtained at the pharmacy, the pharmacy *copayment* will apply.
Contraceptive Injections– for *services* other than to prevent pregnancy	50%. Office visit *copayment* will apply if there is an office visit. If obtained at the pharmacy, the pharmacy *copayment* will apply.
Contraceptive Implant Systems (e.g. Norplant) – Insertion and Removal – for *services* other than to prevent pregnancy	50%. Office visit *copayment* will apply if there is an office visit. If obtained at the pharmacy, the pharmacy *copayment* will apply.

FAMILY PLANNING	
MEDICAL SERVICES	**NETWORK PROVIDER BENEFIT**
Sterilization Vasectomy • *Primary Care Physician* • *Qualified Provider Specialist* Tubal Ligation, Hysterectomy	 100% after $20 *copayment* 100% after $35 *copayment* Payable the same as any other *sickness*.
Life Threatening Abortions	Payable the same as any other *sickness*.
Elective Abortion	Payable the same as any other *sickness*.
Transportation and Lodging Benefits – ONLY APPLICABLE FOR BARIATRIC SURGERIES AND ABORTIONS. ABORTION LANGUAGE IN BOLD BELOW The provider must be at least 100 miles from your home to be eligible for reimbursement. Covered expenses include lodging up to $50 per night for the patient and an additional $50 per night for a companion, with a maximum of $100 per night. Other covered expenses include coach airfare, bus/train fare, mileage driven in a personal car, tolls and parking fees. **There is a $10,000 per occurrence limit for travel and lodging (this does not include any of the medical expenses associated with the procedure). Travel and lodging for medical services are subject to limits under Code section 213(d).**	

MATERNITY (Normal, C-Section and Complications)	
MEDICAL SERVICES	**NETWORK PROVIDER BENEFIT**
Inpatient *Hospital Room and Board* and Ancillary Facility *Services*	100% after $50 one-time charge at delivery
Birthing Center *Room and Board* and Ancillary *Services*	100% after $50 one-time charge at delivery
Qualified Provider Services (Office visit *copayment* will apply to the initial maternity visit only.)	100% after $50 one-time charge at delivery
Pre-natal Provider Visits	100%
Dependent Daughter Maternity	100% after $50 one-time charge at delivery
Newborn Well/Sick Baby (these benefits apply for the first year of life)	100%
Newborn Inpatient *Qualified Provider Services*	100%
Newborn Inpatient Facility *Services* • Well newborn • Sick newborn	 100% 100% after $200 *copayment* per day up to a maximum of $600 per *admission.*

INPATIENT SERVICES	
MEDICAL SERVICES	**NETWORK PROVIDER BENEFIT**
Inpatient *Hospital Room and Board* and Ancillary Facility *Services*	100% after a $200 *copayment* per day up to a maximum of $600 per *admission*
Qualified Provider Inpatient *Hospital* Visit	100%
Qualified Provider Inpatient *Surgery* and Anesthesia	100%
Qualified Provider Inpatient Pathology and Radiology	100%

INPATIENT SERVICES	
MEDICAL SERVICES	**NETWORK PROVIDER BENEFIT**
Inpatient Physical Rehabilitation	100% after $200 *copayment* per day up to a maximum of $600 per *admission*
Inpatient Physical Rehabilitation Limits	60 days per *covered person*
Private Duty Nursing	Not covered

SKILLED NURSING SERVICES	
MEDICAL SERVICES	**NETWORK PROVIDER BENEFIT**
Skilled Nursing *Room and Board* and Ancillary Facility *Services*	100% after $200 *copayment* per day up to a maximum of $600 per *admission*
Skilled Nursing Facility Yearly Limits	90 day(s) per *covered person*
Skilled Nursing *Qualified Provider* Visit	100%

OUTPATIENT AND AMBULATORY SURGICAL CENTER SERVICES	
MEDICAL SERVICES	**NETWORK PROVIDER BENEFIT**
Ambulatory Surgical Center Facility *Services*	100% after $200 *copayment* per admission
Ambulatory Surgical Center Ancillary *Services*	100%
Outpatient *Hospital* Facility Surgical *Services*	100% after $200 *copayment* per admission
Outpatient *Hospital* Facility Non-Surgical *Services* (e.g. clinic facility *services*; observation)	100%
Outpatient *Hospital* Surgical and Non-Surgical Ancillary *Services* (e.g. supplies; medication; anesthesia)	100%
Outpatient *Hospital* Facility Diagnostic Laboratory and X-ray (other than *advanced imaging*)	100%
Pre-Admission/Pre-Surgical Testing	100%
Outpatient *Hospital* Facility *Advanced Imaging*	100%
Outpatient *Hospital* and *Ambulatory Surgical Center Qualified Provider* Visit	100%

OUTPATIENT AND AMBULATORY SURGICAL CENTER SERVICES	
MEDICAL SERVICES	**NETWORK PROVIDER BENEFIT**
Outpatient *Hospital* and *Ambulatory Surgical Center Surgery* (including surgeon; *assistant surgeon*; and physician assistant) and Anesthesia	100%
Outpatient *Hospital* and *Ambulatory Surgical Center* Pathology and Radiology	100%

EMERGENCY CARE AND URGENT CARE SERVICES	
MEDICAL SERVICES	**NETWORK PROVIDER BENEFIT**
Emergency Room Facility and Ancillary *Services* (*emergency care*) If *you* are admitted to the *hospital*, the *copayment* will be waived.	100% after $150 *copayment*
Emergency Room All Physician *Services* (including Radiologist, Pathologist, Anesthesiologist and ancillary *services* billed by an Emergency Room Physician) (*emergency care*)	100%
Emergency Room Facility and Ancillary *Services* (non-emergency)	Not covered

EMERGENCY AND URGENT CARE SERVICES	
MEDICAL SERVICES	**NETWORK PROVIDER BENEFIT**
Emergency Room All Physician *Services* (including Radiologist, Pathologist, Anesthesiologist and ancillary *services* billed by an Emergency Room Physician) (non-emergency)	Not covered
Urgent Care Center (facility and ancillary *services*) Urgent Care Center (*qualified provider services)* • *Primary Care Physician* • *Qualified Provider Specialist* Only one *copayment* will be taken per day.	100% 100% after $20 *copayment* 100% after $35 *copayment*

HOSPICE SERVICES	
MEDICAL SERVICES	**NETWORK PROVIDER BENEFIT**
Hospice Inpatient *Room and Board* and Ancillary *Services*	100%
Hospice Inpatient Limits	180 day(s) per *covered person*
Hospice Outpatient (including hospice home visits)	100%

HOSPICE SERVICES	
MEDICAL SERVICES	**NETWORK PROVIDER BENEFIT**
Hospice Outpatient Limits	180 day(s) per *covered person*
The inpatient and outpatient hospice limits are combined.	
Hospice *Qualified Provider* Visit	100%

HOME HEALTH CARE SERVICES	
MEDICAL SERVICES	**NETWORK PROVIDER BENEFIT**
Home Health Care *Services*	100%
Home Health Care Yearly Limits	60 visit(s) per *covered person*
Home Health Care Ancillary *Services* (excluding *durable medical equipment*, prosthetics and private duty nursing)	100%

DURABLE MEDICAL EQUIPMENT (DME)	
MEDICAL SERVICES	**NETWORK PROVIDER BENEFIT**
Durable Medical Equipment (DME)	80%
Prosthesis	80%
Wigs for cancer patients with hair loss resulting from chemotherapy and/or radiation therapy	80%, subject to *medical necessity*

SPECIALTY DRUGS	
MEDICAL SERVICES	**NETWORK PROVIDER BENEFIT**
Specialty Drugs (*Qualified Provider's* Office Visit, Freestanding Facility and *Urgent Care Center*)	100% after $50 *copayment*
Specialty Drugs (Visit, Home Health Care) • RightSource • Other Home Health Care	 100% 100% after $50 *copayment*
Specialty Drugs (Emergency Room, *Ambulance*, Inpatient *Hospital*, Outpatient *Hospital* and Skilled Nursing Facility)	Payable the same as any other *sickness.*

AMBULANCE SERVICES	
MEDICAL SERVICES	**NETWORK PROVIDER BENEFIT**
Ground *Ambulance*	100%
Air *Ambulance*	100%

MORBID OBESITY SERVICES	
MEDICAL SERVICES	**FACILITIES/QUALIFIED PRACTITIONERS DESIGNATED BY HUMANA AS APPROVED BARIATRIC SERVICES PROVIDERS**
The following *services* will be covered under the *morbid obesity* benefit: examinations/*qualified provider* visits; laboratory and x-ray and other diagnostic testing; *bariatric surgery*; inpatient facility *services*; outpatient facility *services*; *durable medical equipment* and nutritional counseling..	
Morbid Obesity	Payable the same as any other *sickness*

TEMPOROMANDIBULAR JOINT DYSFUNCTION (TMJ)	
MEDICAL SERVICES	**NETWORK PROVIDER BENEFIT**
Temporomandibular Joint Dysfunction (TMJ) (Other than Splint/Appliances)	Payable the same as any other *sickness*
Temporomandibular Joint Dysfunction (TMJ) Splint/Appliances	Not covered

DENTAL INJURY SERVICES	
MEDICAL SERVICES	**NETWORK PROVIDER BENEFIT**
Dental Injuries	100%. Office visit *copayment* may apply.
Please see the "Medical Covered Expenses" section, Dental Injury, for benefit details.	

INFERTILITY SERVICES	
MEDICAL SERVICES	**NETWORK PROVIDER BENEFIT**
Infertility (Diagnosis) • *Primary Care Physician* • *Qualified Practitioner Specialist*	 100% after $20 *copayment* Not covered
Infertility (Treatment)	50% (In-Network only)
Infertility Counseling and Treatment Yearly Limits	Two year maximum limit
Artificial Means of Achieving Pregnancy	Please refer to the Medical Covered Expenses section of this *Appendix A to the SPD.*
Sexual Dysfunction/Impotence (medical diagnosis only)	Payable the same as any other *sickness.*
Sexual Dysfunction/Impotence related to a *Mental Health* Disorder	Not covered

THERAPY SERVICES	
MEDICAL SERVICES	**NETWORK PROVIDER BENEFIT**
Therapy *copayments* apply to therapy *services*, regardless of provider specialty (for example, if a Podiatrist is performing physical therapy, the physical therapy *copayment* will apply).	
Chiropractic Examinations	100% after $20 *copayment*
Chiropractic Laboratory	100%
Chiropractic X-ray	100%
Chiropractic Manipulations	100% after $20 *copayment*
Chiropractic Therapy	100% after $20 *copayment*
If *copayments* apply to multiple chiropractic *services*, one *copayment* will apply per day per servicing provider.	
Physical Therapy (Clinic and Outpatient)	100% after $35 *copayment*
Physical Therapy and Occupational Therapy Limits	No limits apply to except to age 18 for diagnosis of autism)
Occupational Therapy (Clinic and Outpatient)	100% after $35 *copayment*
Speech Therapy (Clinic and Outpatient) (Only covered for illness or injury)	100% after $35 *copayment*
Speech Therapy Limits	No limits apply to age 18 for diagnosis of autism)

THERAPY SERVICES	
MEDICAL SERVICES	**NETWORK PROVIDER BENEFIT**
Cognitive Therapy (Clinic and Outpatient)	100%
Acupuncture	Not covered
Respiratory Therapy and Pulmonary Therapy (Clinic and Outpatient)	100%
Vision Therapy (eye exercises to strengthen the muscles of the eye) (Clinic and Outpatient)	Not covered
Chemotherapy (Clinic and Outpatient)	100%
Radiation Therapy (Clinic and Outpatient)	100%
Cardiac Rehabilitation (Phase II) Phase I is covered under the inpatient facility benefits. Phase III, an unsupervised exercise program, is not covered.	70%
Cardiac Rehabilitation Limits	48 visit(s) per *covered person*

TRANSPLANT SERVICES	
***Preauthorization* is required, if *preauthorization* is not received, organ transplant *services* will not be covered.**	
MEDICAL SERVICES	**HUMANA NATIONAL TRANSPLANT NETWORK (NTN) FACILITY**
Organ Transplant Lifetime Maximum	$1,000,000
Organ Transplant Medical *Services* • Inpatient *Hospital* • Physician *Services* (Clinic) • Physician *Services* (Inpatient/Outpatient)	 100% Subject to applicable office visit *copayment* 100%
Non-Medical *Services* - Lodging and Transportation	100%
Non-Medical *Services* - Lodging Limits	$50 per day
Immunosuppressant Drugs (applies to transplant lifetime maximum)	Covered under pharmacy

BEHAVIORAL HEALTH INPATIENT SERVICES	
MEDICAL SERVICES	**NETWORK PROVIDER BENEFIT**
Inpatient *Behavioral Health Room and Board* and Ancillary *Services*	100% after $200 *copayment* per day up to a maximum of $600 per *admission*
Inpatient *Behavioral Health* Professional *Services*	100%
Behavioral Health Outpatient *Services*	100%
Behavioral Health Outpatient Therapy	100% after $20 *copayment*
Behavioral Health Residential Treatment Facility Services (*Services* are not covered for *retirees*)	Payable the same as medical inpatient *hospital services*.
Behavioral Health Half-way House *Services*	Not covered

BEHAVIORAL HEALTH PARTIAL HOSPITALIZATION SERVICES	
MEDICAL SERVICES	**NETWORK PROVIDER BENEFIT**
Behavioral Health Partial Hospitalization Services	100%

BEHAVIORAL HEALTH CLINIC, OUTPATIENT AND INTENSIVE OUTPATIENT SERVICES	
MEDICAL SERVICES	**NETWORK PROVIDER BENEFIT**
Behavioral Health Therapy *Services* (Clinic, and Office Visit, Outpatient and Intensive Outpatient)	Payable the same as a *qualified provider* primary care physician
Pharmacological *Services*	100% after $35 *copayment*
Behavioral health services not listed above, such as laboratory and x-ray, are payable the same as the *qualified provider* or facility, based on place of *service*.	
Applied Behavioral Analysis (ABA) Therapy ABA Therapy	Payable the same as any other *sickness*.

DETOXIFICATION SERVICES	
MEDICAL SERVICES	**NETWORK PROVIDER BENEFIT**
Detoxification	100% after $200 *copayment* per day up to a maximum of $600 per *admission*

TRANSGENDER SERVICES	
MEDICAL SERVICES	**NETWORK PROVIDER BENEFIT**
Transgender Services	Payable the same as any other *sickness*.
*Transgender *services* are covered only for active *employees*. *Services* are not covered for *retirees*.	

OTHER COVERED EXPENSES	
MEDICAL SERVICES	**NETWORK PROVIDER BENEFIT**
Other Covered Expenses	Payable the same as any other *sickness*
Low Protein Food Products and Medical Foods for the Treatment of Metabolical Diseases	100%, up to $200 per month
ADD/Hyperactivity (Diagnosis and Treatment)	Payable the same as any other *sickness*
Bone Mass Measurement	Payable the same as any other *sickness*
Cleft Lip and Cleft Palate (Treatment and Correction)	Payable the same as any other *sickness*
Pain Management Programs	Payable the same as any other *sickness*
Sleep Studies	Payable the same as any other *sickness*
Telemedicine (Provider)	100%
Health Education (Lamaze, Diabetic Education and Smoking Cessation)	100%
Extract teeth for radiation therapy of malignant disease of the head and neck	100%

HOW BENEFITS PAY

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

OUT-OF-POCKET LIMIT

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

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

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

Single Out-of-Pocket Limits

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

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 *participating provider copayments*.

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

PAR PROVIDER PLAN MAXIMUM OUT-OF-POCKET LIMIT

PAR provider Plan maximum out-of-pocket limit is the maximum amount of any *copayments*, *deductibles* and/or *coinsurance* for *PAR provider covered expenses* which must be paid by *you*, either individually or combined as a covered family, per *calendar year* before a benefit percentage for *PAR provider covered expenses* will be increased. The *PAR provider* medical *out-of-pocket limit* applies toward the *PAR provider Plan maximum out-of-pocket limit*. Once the *PAR provider Plan maximum out-of-pocket limit* is met, any remaining *PAR provider* medical *out-of-pocket limit* will be waived for the remainder of the *year*. The *Non-PAR provider medical out-of-pocket limit* and any applicable *preauthorization* penalties do not apply to the *PAR provider Plan maximum out-of-pocket limit*.

There are single and family *PAR provider Plan maximum out-of-pocket limits,* which are outlined in the "Medical Schedule of Benefits" section. After the single *PAR provider Plan maximum out-of-pocket limit* has been satisfied in a *calendar year*, the *PAR provider* benefit percentage for *covered expenses* for that *covered person* will be payable at the rate of 100% for the rest of the *calendar year*, subject to any *maximum benefit* and all other terms, provisions, limitations and exclusions of this Plan. After the family *PAR provider Plan maximum out-of-pocket limit* has been satisfied in a *calendar year*, the *PAR provider* benefit percentage for *covered expenses* will be payable at the rate of 100% for the rest of the *calendar year*, subject to any *maximum benefit* and all other terms, provisions, limitations and exclusions of this Plan.

ROUTINE/PREVENTIVE SERVICES

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

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

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

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

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

ROUTINE VISION SERVICES

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

The exclusion for *services* which are not *medically necessary* does not apply to routine vision refraction.

No benefits are payable under this routine vision benefit for repair, maintenance or supplies for eyeglass frames and lenses and contact lenses, a medical examination for a *bodily injury* or *sickness*, or medical and/or surgical treatment of the eye.

ROUTINE HEARING SERVICES

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

The exclusion for *services* which are not *medically necessary* does not apply to routine hearing examinations.

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

Multiple Surgical Procedures

If multiple or bilateral surgical procedures are performed at one operative session, the amount payable for these procedures will be limited to the *maximum allowable fee* for the primary surgical procedure and:

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

No benefits will be payable for incidental procedures.

Assistant Surgeon

Assistant surgeon benefits are payable at 16% of the *maximum allowable fee* for the *surgery* that would apply if the *assistant surgeon* were the primary surgeon .

Physician Assistant

Physician assistant benefits are payable at 10% of the *maximum allowable fee* for the *surgery* that would apply if the P.A. were the primary surgeon.

DENTAL/ORAL SURGERIES COVERED UNDER THE MEDICAL PLAN

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

- Excision of oral lesions;
- Treatment of TMJ caused by arthritis or trauma.

FAMILY PLANNING

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

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

MATERNITY

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

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

Newborns

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

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

Birthing Centers

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

INPATIENT HOSPITAL

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

SKILLED NURSING FACILITY

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

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

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

OUTPATIENT AND AMBULATORY SURGICAL CENTER

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

EMERGENCY SERVICES

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

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

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

URGENT CARE SERVICES

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

HOSPICE SERVICES

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

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

Hospice care benefits are payable for the following hospice services:

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

- Medical social services provided to the terminally ill *covered person* or his/her immediate covered *family members* under the direction of a *health care practitioner*, including:
  - Assessment of social, emotional and medical needs, and the home and family situation; and
  - Identification of the community resources available.

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

Hospice care *covered expenses* do not include:

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

HOME HEALTH CARE

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

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

Home health care *covered expenses* are limited to:

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

Home health care *covered expenses* do not include:

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

DURABLE MEDICAL EQUIPMENT (DME)

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

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

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

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

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

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

SPECIALTY DRUG MEDICAL BENEFIT

The Plan will pay benefits for *covered expenses* incurred by *you* for *specialty drugs* provided by or obtained from a *qualified provider* in the following locations:

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

Specialty drugs may be subject to *preauthorization* requirements. Refer to the Preauthorization provision in this *SPD* for *preauthorization* requirements and contact Humana prior to receiving *specialty drugs*.

Specialty drug benefits do not include the charge for the actual administration of the *specialty drug*. Benefits for the administration of *specialty drugs* are based on the location of the service and type of provider.

AMBULANCE

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

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

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

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

MORBID OBESITY

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

TEMPOROMANDIBULAR JOINT DYSFUNCTION (TMJ)

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

DENTAL INJURY

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

Services for teeth injured as a result of chewing are covered. Biting or chewing injuries as a result of an act of domestic violence or a medical condition (including both physical and mental health conditions) are a *covered expense*.

Services must begin within 30 days after the date of the *dental injury*. *Services* must be completed within one year after the date of the *dental injury*.

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

INFERTILITY

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

Artificial Means of Achieving Pregnancy

Services performed to achieve pregnancy or ovulation by artificial means include artificial insemination and in vitro fertilization gamete intrafallopian transfer (GIFT), zygote intra fallopian transfer (ZIFT), reversal of surgical sterilization, embryo transplantation and extracorporeal insemination.

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 AND IMMUNE EFFECTOR CELL THERAPY

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

Preauthorization

Preauthorization is required. If *preauthorization* is not received, transplant *services* and *immune effector cell therapy* 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 integral chemotherapy and associated *services*, post-discharge *services* and treatment of complications after transplantation for or in connection with only the following procedures:

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

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

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

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

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

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

- Non-medical travel and lodging costs for:
  - The *covered person* receiving the transplant or *immune effector cell therapy*, if the *covered person* lives more than 100 miles from the transplant or *immune effector cell therapy* facility designated by Humana; and
  - One caregiver or support person (two, when the *covered person* receiving the transplant or *immune effector cell therapy* is under 18 years of age), if the caregiver or support person lives more than 100 miles from the transplant or *immune effector cell therapy* facility designated by Humana.

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

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

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

TRANSGENDER COVERAGE

Gender conforming surgery/gender reassignment is covered as listed in the Schedule of Benefits. For additional details, go to www.humana.com to reference Humana's Medical Coverage Policy or call the toll-free customer service telephone number listed on *your* Humana ID card.

BEHAVIORAL HEALTH SERVICES

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

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

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

Inpatient Services

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

Outpatient Services

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

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.

SEX REASSIGNMENT SURGERY

Sex reassignment *surgery* is considered *medically necessary* when all of the following criteria are met:

- *Covered person* is at least 18 years old; **and**

- *Covered person* has met criteria for the diagnosis of "true" transsexualism, including:
  - A sense of estrangement from one's own body, so that any evidence of one's own biological sex is regarded as repugnant; and
  - A stable transsexual orientation evidenced by a desire to be rid of one's genitals and to live in society as a member of the other sex for at least 2 years, that is, not limited to periods of stress; and
  - Absence of physical inter-sex of genetic abnormality; and
  - Does not gain sexual arousal from cross-dressing; and

- Life-long sense of belonging to the opposite sex and of having been born into the wrong sex, often since childhood; and
- Not due to another biological, chromosomal or associated psychiatric disorder, such as schizophrenia; and
- Wishes to make his or her body as congruent as possible with the preferred sex through *surgery* and hormone treatment; **and**

- *Covered person* is at least 18 years old; **and**

- *Covered person* has met criteria for the diagnosis of "true" transsexualism, including:
  - A sense of estrangement from one's own body, so that any evidence of one's own biological sex is regarded as repugnant; and
  - A stable transsexual orientation evidenced by a desire to be rid of one's genitals and to live in society as a member of the other sex for at least 2 years, that is, not limited to periods of stress; and
  - Absence of physical inter-sex of genetic abnormality; and
  - Does not gain sexual arousal from cross-dressing; and
  - Life-long sense of belonging to the opposite sex and of having been born into the wrong sex, often since childhood; and
  - Not due to another biological, chromosomal or associated psychiatric disorder, such as schizophrenia; and
  - Wishes to make his or her body as congruent as possible with the preferred sex through *surgery* and hormone treatment; **and**

- *Covered person* has completed a recognized program of transgender identity treatment as evidenced by all of the following:
  - A qualified *mental health* professional* who has been acquainted with the *covered person* for at least 18 months recommends sex reassignment *surgery* documented in the form of a written comprehensive evaluation; and
  - For genital surgical sex reassignment, a second concurring recommendation by another qualified *mental health* professional * must be documented in the form of a written expert opinion**; and
  - For genital surgical sex reassignment, *covered person* has undergone a urological examination for the purpose of identifying and perhaps treating abnormalities of the genitourinary tract, since genital surgical sex reassignment includes the invasion of, and the alteration of, the genitourinary tract (urological examination is not required for persons not undergoing genital reassignment); and
  - C*overed person* has demonstrated an understanding of the proposed male-to-female or female-to-male sex reassignment *surgery* with its attendant costs, required lengths of hospitalization, likely complications, and post-surgical rehabilitation requirements of the planned *surgery*; and
  - Psychotherapy is not an absolute requirement for *surgery* unless the *mental health* professional's initial assessment leads to a recommendation for psychotherapy that specifies the goals of treatment, estimates its frequency and duration throughout the real life experience (usually a minimum of 3 months); and
  - The *covered person* has successfully lived and worked within the desired gender role full-time for at least 12 months (so-called real-life experience), without periods of returning to the original gender; and

- Unless medically contraindicated, *covered person* has received at least 12 months of continuous hormonal sex reassignment therapy recommended by a *mental health* professional and carried out by an endocrinologist (which can be simultaneous with the real-life experience).

* At least one of the two clinical behavioral scientists making the favorable recommendation for surgical (genital) sex reassignment must possess a doctoral degree (e.g., Ph.D., Ed.D., D.Sc., D.S.W., Psy.D., or M.D.). Note: Evaluation of candidacy for sex reassignment *surgery* by a *mental health* professional is covered under the *covered person's* medical benefit, unless the services of a *mental health* professional are necessary to evaluate and treat a *covered person's* problem, in which case the *mental health* professional's *services* are covered under the *covered person's behavioral health* benefit. Please check benefit plan descriptions.

** Either two separate letters or one letter with two signatures is acceptable.

Note: Rhinoplasty, face-lifting, lip enhancement, facial bone reduction, blepharoplasty, liposuction of the waist, reduction thyroid chondroplasty, laryngoplasty or shortening of the vocal cords, which have been used in feminization, are considered cosmetic. Similarly, chin implants, nose implants, and lip reduction, which have been used to assist masculinization, are considered cosmetic.

Note on gender specific services for transgender persons:

- Gender-specific services may be *medically necessary* for transgender persons appropriate to their anatomy. Examples include:

- Breast cancer screening may be *medically necessary* for female to male transgender persons who have not undergone a mastectomy;

- Prostate cancer screening may be *medically necessary* for male to female transgender individuals who have retained their prostate.

OTHER COVERED EXPENSES

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

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

- Oxygen and rental of equipment for its administration.

- Prosthetic devices and supplies, including but not limited to limbs and eyes. Coverage will be provided for prosthetic devices to:
  - Restore the previous level of function lost as a result of a *bodily injury* or *sickness*; or
  - Improve function caused by a *congenital anomaly*.

- *Covered expense* for prosthetic devices includes repair or replacement, if not covered by the manufacturer, and if due to:
  - A change in the *covered person's* physical condition causing the device to become non-functional; or
  - Normal wear and tear.

- Cochlear implants, when approved by this Plan, for a *covered person* with bilateral severe to profound sensorineural deafness.

- Replacement or upgrade of a cochlear implant and its external components may be a *covered expense* if:
  - The existing device malfunctions and cannot be repaired;
  - Replacement is due to a change in the *covered person's* condition that makes the present device non-functional; or
  - The replacement or upgrade is not for cosmetic purposes.

- Orthotics used to support, align, prevent, or correct deformities.
  - Covered *expense* does not include:
    - Replacement orthotics;
    - Dental braces; or
    - Oral or dental splints and appliances, unless custom made for the treatment of documented obstructive sleep apnea.

- The following special supplies, dispensed up to a 30-day supply, when prescribed by *your* attending *health care practitioner*:
  - Surgical dressings;
  - Catheters;
  - Colostomy bags, rings and belts; and
  - Flotation pads.

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

- Dental treatment only if the charges are incurred for treatment of a *dental injury* to a *sound natural tooth*.

- However, benefits will be paid only for the least expensive service that will, in *our* opinion, produce a professionally adequate result.

- Certain oral surgical operations as follows:
  - Excision of partially or completely impacted teeth;
  - Surgical preparation of soft tissues and excision of bone or bone tissue performed with or without extraction or excision of erupted, partially erupted or completely un-erupted teeth;
  - Excisions of tumors and cysts of the jaws, cheeks, lips, tongue, roof, and floor of the mouth, and related biopsy of bone, tooth or related tissues when such conditions require pathological examinations;
  - Surgical procedures related to repositioning of teeth, tooth transplantation or re-implantation;

- Services required to correct accidental injuries of the jaws, cheeks, lips, tongue, roof, and floor of the mouth;
- Reduction of fractures and dislocation of the jaw;
- External incision and drainage of cellulitis and abscess;
- Incision and closure of accessory sinuses, salivary glands or ducts;
- Frenectomy (the cutting of the tissue in the midline of the tongue); and
- Orthognathic *surgery* for a *congenital anomaly*, *bodily injury* or *sickness* causing a *functional impairment*.

- Elective vasectomy.

- For a *covered person*, who is receiving benefits in connection with a mastectomy, service for:
  - Reconstructive *surgery* of the breast on which the mastectomy has been performed;
  - *Surgery* and reconstruction on the non-diseased breast to achieve symmetrical appearance; and
  - Prostheses and treatment of physical complications for all stages of mastectomy, including lymphedemas.

- Reconstructive *surgery* resulting from:
  - A *bodily injury*, infection or other disease of the involved part, when a *functional impairment* is present; or
  - A *congenital anomaly* that resulted in a *functional impairment*.

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

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

- The following *habilitative services*, as ordered and performed by a *health care practitioner*, for a *covered person*, with a developmental delay or defect or *congenital anomaly*:
  - Physical therapy services;
  - Occupational therapy services;
  - Spinal manipulations/adjustments;
  - Speech therapy or speech pathology services; and
  - Audiology services.

- *Habilitative services* apply toward the "Physical medicine and rehabilitative services" maximum *number* of visits specified in the Schedule of Benefits,

- *Telehealth* and *telemedicine* services for the diagnosis and treatment of a *sickness* or *bodily injury*. *Telehealth* or *telemedicine* services must be:
  - Services that would otherwise be a *covered expense* if provided during a face-to-face consultation between a *covered person* and a *health care practitioner*;
  - Provided to a *covered person* at the *originating site*; and
  - Provided by a *health care practitioner* at the *distant site*.

- *Telehealth* and *telemedicine* services must comply with:

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

- *Palliative care*.

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

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

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

- The *covered person* must be eligible to participate in a clinical trial according to the trial protocol and:
  - Referred by a *health care practitioner*; or
  - Provide medical and scientific information supporting their participation in the clinical trial is appropriate.

- For the routine costs to be considered a *covered expense*, the approved clinical trial must be a Phase I, II, III, or IV clinical trial for the prevention, detection or treatment of cancer or other life-threatening condition or disease and is:
  - Federally funded or approved by the appropriate federal agency;
  - The study or investigation is conducted under an investigational new drug application reviewed by the Federal Food and Drug Administration; or
  - The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

LIMITATIONS AND EXCLUSIONS

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

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

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

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

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

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

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

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

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

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

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

- Private duty nursing.

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

- Any service not rendered by the billing provider.

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

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

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

- Educational or vocational therapy, testing, services, or schools, including therapeutic boarding schools and other therapeutic environments. Educational or vocational videos, tapes, books, and similar materials are also excluded.

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

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

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

- Vitamins, except for *preventive services* with a *prescription* from a *health care practitioner*, dietary supplements and dietary formulas, except enteral formulas, nutritional supplements or low protein modified food products for the treatment of an inherited metabolic disease, e.g. phenylketonuria (PKU).

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

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

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

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

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

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

- Weekend non-emergency *hospital admissions*, specifically *admissions* to a *hospital* on a Friday or Saturday at the convenience of the *covered person* or his or her *health care practitioner* when there is no cause for an emergency *admission* and the *covered person* receives no *surgery* or therapeutic treatment until the following Monday.

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

- In vitro fertilization regardless of the reason for treatment.

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

- Services for or in connection with a transplant or *immune effector cell therapy* if:
  - The expense relates to storage of cord blood and s*tem cells*, unless it is an integral part of a transplant approved by this Plan.
  - Not approved by Humana, based on their established criteria.
  - Expenses are eligible to be paid under any private or public research fund, government program except *Medicaid*, or another funding program, whether or not such funding was applied for or received.
  - The expense relates to the transplantation of any non-human organ or tissue, unless otherwise stated in the *SPD*.
  - The expense relates to the donation or acquisition of an organ or tissue for a recipient who is not covered by this Plan.
  - The expense relates to a transplant or *immune effector cell therapy* performed outside of the United States and any care resulting from that transplant or *immune effector cell therapy*. This exclusion applies even if the *employee* and *dependents* live outside the United States and the *employee* is in *active status* with the *employer*.

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

- *Cosmetic surgery* and cosmetic services or devices.

- Hair prosthesis, hair transplants or implants

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

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

- *Custodial care* and *maintenance care*.

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

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

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

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

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

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

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

- Therapy and testing for treatment of allergies including, but not limited to, services related to clinical ecology, environmental allergy and allergic immune system dysregulation and sublingual antigen(s), extracts, neutralization tests and/or treatment unless such therapy or testing is approved by:
  - The American Academy of Allergy and Immunology; or
  - The Department of Health and Human Services or any of its offices or agencies.

- Lodging accommodations or transportation.

- Communications or travel time.

- *Sickness* or *bodily injury* for which no-fault medical payment or expense coverage benefits are paid or payable under any automobile, homeowners, premises or any other similar coverage.

- *Alternative medicine*.

- Acupuncture, unless:
  - The treatment is *medically necessary*, appropriate and is provided within the scope of the acupuncturist's license; and
  - *You* are directed to the acupuncturist for treatment by a licensed physician.

- Services rendered in a premenstrual syndrome clinic or holistic medicine clinic.

- Services of a midwife, unless the midwife is licensed.

- Vision examinations or testing for the purposes of prescribing corrective lenses.

- Orthoptic/vision training (eye exercises).

- Radial keratotomy, refractive keratoplasty or any other *surgery* or procedure to correct myopia, hyperopia or stigmatic error.

- The purchase or fitting of eyeglasses or contact lenses, except as the result of an *accident* or following cataract *surgery* as stated in this *SPD*.

- Services and supplies which are:
  - Rendered in connection with mental illnesses not classified in the International Classification of Diseases of the U.S. Department of Health and Human Services; or
  - Extended beyond the period necessary for evaluation and diagnosis of learning and behavioral disabilities or for mental retardation.

- Marriage counseling.

- Expenses for employment, school, sport or camp physical examinations, or for the purposes of obtaining insurance.

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

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

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

- Any care, treatment, services, equipment, or supplies received outside of the *service area*:
  - If *you* could have reasonably foreseen or anticipated their need prior to departure from the *service area*; and
  - Which are not authorized by the Plan or to the extent they exceed the *maximum allowable fee*.
- Expenses for services, *prescriptions*, equipment, or supplies received outside the United States or from a foreign provider unless:
  - For *emergency care*;
  - The *employee* is traveling outside the United States due to employment with the *employer* and the services are not covered under any Workers' Compensation or similar law; or
  - The *employee* and *dependents* live outside the United States and the *employee* is in *active status* with the *employer*.

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

COORDINATION OF BENEFITS

BENEFITS SUBJECT TO THIS PROVISION

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

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

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

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

EFFECT ON BENEFITS

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

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

ORDER OF BENEFIT DETERMINATION

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

- The plan has no coordination of benefits provision;
- The plan covers the person as an *employee*;
- For a child who is covered under both parents' plans, the plan covering the parent whose birthday (month and day) occurs first in the *calendar year* pays before the plan covering the other parent. If the birthdates of both parents are the same, the plan which has covered the person for the longer period of time will be determined the primary plan;
- If a plan other than this Plan does not include bullet 3, then the gender rule will be followed to determine which plan is primary.

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

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

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

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

GENERAL COORDINATION OF BENEFITS WITH MEDICARE

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

RIGHT OF RECOVERY

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

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

- Any other insurance companies, or organizations which according to these provisions, owe benefits due for the same allowable expense under any other plan.

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

CLAIM PROCEDURES

SUBMITTING A CLAIM

Network providers will submit claims to Humana on *your* behalf. If *you* utilize a *non-network provider* for *covered expenses*, *you* may have to submit a notice of claim to Humana. Notice of claim must be given to Humana in writing or by *electronic mail* as required by the plan, or as soon as is reasonably possible thereafter. Notice must be sent to Humana at the mailing address shown on *your* ID card or at Humana.com.

Claims must be complete. At a minimum a claim must contain:

- Name of the *covered person*, who incurred the *covered expenses*;
- Name and address of the provider;
- Diagnosis;
- Procedure or nature of the treatment;
- Place of service;
- Date of service; and
- Billed amount.

If *you* receive services outside the United States or from a foreign provider, *you* must also submit the following information along with *your* complete claim:

- *Your* proof of payment to the provider for the services received outside the United States or from a foreign provider;
- Complete medical information and medical records;
- *Your* proof of travel outside of the United States, such as airline tickets or passport stamps, if *you* traveled to receive the services; and
- The foreign provider's fee schedule if the provider uses a billing agency.

The forms necessary for filing proof of loss are available at Humana.com. When requested by *you*, Humana will send *you* the forms for filing proof of loss. If the requested forms are not sent to *you* within 15 days, *you* will have met the proof of loss requirements by sending a written or *electronic* statement of the nature and extent of the loss containing the above elements within the time limit stated in the "Proof of loss" provision.

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*.

PROOF OF LOSS

You must give written or *electronic* proof of loss within 90 days after the date *you* incur such loss. *Your* claims will not be reduced or denied if it was not reasonably possible to give such proof within that time period.

Your claims may be reduced or denied if written or *electronic* proof of loss is not provided to Humana within one year after the date proof of loss is required, unless *your* failure to timely provide that proof of loss is due to *your* legal incapacity as determined by an appropriate court of law.

MISCELLANEOUS MEDICAL CHARGES

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

OTHER PROGRAMS AND PROCEDURES

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

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

CLAIMS PROCESSING EDITS

Qualified provider services are subject to Humana's claims processing procedures. Humana uses claims processing procedures to determine payment of *covered expenses*. The claims processing procedures include, but are not limited to, claim processing edits and claims payment policies, as determined by Humana. *Your qualified provider* may access the claims processing edits and claim payment policies on Humana's Website at Humana.com by clicking on "For Providers" and "Claims Resources."

Claims processing procedures include the interaction of a number of factors. The amount determined to be payable for a *covered expense* may be different for each claim because the mix of factors may vary. Accordingly, it is not feasible to provide an exhaustive description of the claims processing procedures, but examples of the most commonly used factors are:

- The complexity of a service;
- Whether a service is one of multiple same-day services such that the cost of the service to the *qualified provider* is less than if the service had been provided on a different day. For example:
  - Two or more *surgeries* performed the same day;
  - Two or more endoscopic procedures performed during the same day; or
  - Two or more therapy services performed the same day;

- Whether a *co-surgeon*, *assistant surgeon*, *surgical assistant* or any other *qualified provider*, who is billing independently is involved;
- When a charge includes more than one claim line, whether any service is part of or incidental to the primary service that was provided, or if these services cannot be performed together;
- Whether the service is reasonably expected to be provided for the diagnosis reported;
- Whether a service was performed specifically for *you*; or
- Whether services can be billed as a complete set of services under one billing code.

Humana develops claims processing procedures in its' sole discretion based on their review of correct coding initiatives, national benchmarks, industry standards, and industry sources such as the following, including any successors of the same:

- *Medicare* laws, regulations, manuals and other related guidance;
- Federal and state laws, rules and regulations, including instructions published in the Federal Register;
- National Uniform Billing Committee (NUBC) guidance including the UB-04 Data Specifications Manual;
- American Medical Association's (AMA) Current Procedural Terminology (CPT®) and associated AMA publications and services;
- Centers for Medicare & Medicaid Services' (CMS) Healthcare Common Procedure Coding System (HCPCS) and associated CMS publications and services;
- International Classification of Diseases (ICD);
- American Hospital Association's Coding Clinic Guidelines;
- Uniform Billing Editor;
- American Psychiatric Association's (APA) Diagnostic and Statistical Manual of Mental Disorders (DSM) and associated APA publications and services;
- Food and Drug Administration guidance;
- Medical and surgical specialty societies and associations;
- Industry-standard utilization management criteria and/or care guidelines;
- *Our* medical and pharmacy coverage policies; and
- Generally accepted standards of medical, behavioral health and dental practice based on credible scientific evidence recognized in published peer reviewed literature.

Changes to any one of the sources may or may not lead Humana to modify current or adopt new claims processing procedures.

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

You should discuss *our* claims processing edits, claims payment policies and medical or pharmacy coverage policies and their availability with any *qualified provider* prior to receiving any services. *You* or *your qualified provider* may access the claims processing edits and claims payment policies on Humana's Website at Humana.com by clicking on "For Providers" and "Coverage Policies." The medical and pharmacy coverage policies may be accessed at Humana.com under "Medical Resources" by clicking "Coverage Policies." *You* or *your qualified provider* may also call Humana's toll-free customer service number listed on *your* ID card to obtain a copy of a claims processing edit, claims payment policy or coverage policy.

PROCEDURAL DEFECTS

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

ASSIGNMENTS AND REPRESENTATIVES

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

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

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

- Humana's AOR Form must be submitted to Humana at the time or prior to the date an authorized representative commences a course of action on behalf of a *claimant*. At the same time, the authorized representative should also provide notice of commencement of the action on behalf of the *claimant* to the *claimant*, which Humana may verify with the *claimant* prior to recognizing the authorized representative status.
- When a health care provider intends to appeal on behalf of the member for a non-urgent care claim, the provider must indicate in the appeal request that they are appealing on behalf of the member and include a completed Humana AOR form. If an AOR is not included with the request, the form will be sent to the provider.
- In any event, a health care provider with knowledge of a *claimant's* medical condition acting in connection with an *urgent care claim* will be recognized by this Plan as the *claimant's* authorized representative.

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

CLAIMS DECISIONS

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

Pre-Service Claims

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

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

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

Urgent Care Claims

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

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

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

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

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

    - This Plan's receipt of the specified information; or
    - The end of the period afforded the *claimant* to provide the specified additional information.

Concurrent Care Decisions

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

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

Post-Service Claims

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

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

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

TIMES FOR DECISIONS

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

PAYMENT OF CLAIMS

Many health care providers will request an assignment of benefits as a matter of convenience to both provider and patient. Also as a matter of convenience, Humana will, in its sole discretion, assume that an assignment of benefits has been made to certain *network providers*. In those instances, Humana will make direct payment to the *hospital*, clinic or physician's office, unless Humana is advised in writing that *you* have already paid the bill. If *you* have paid the bill, please indicate on the original statement, "paid by *employee*," and send it directly to Humana. *You* will receive a written explanation of *adverse benefit determination*. Humana reserves the right to request any information required to determine benefits or process a claim. *You* or the provider of *services* will be contacted if additional information is needed to process *your* claim.

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

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

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

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

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

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

NOTICES – GENERAL INFORMATION

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

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

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

INITIAL DENIAL NOTICES

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

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

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

The notice will describe this Plan's review procedures and the time limits applicable to such procedures.

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

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

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

APPEALS OF ADVERSE BENEFIT DETERMINATIONS

A *claimant* must *appeal* an *adverse benefit determination* within 180 days after receiving written notice of the denial (or partial denial). This Plan uses a one level *appeal* process for all *adverse benefit determinations*. Humana will make the final determination on the *appeal*.

An *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

However, a *claimant* on *appeal* may request an expedited *appeal* of an adverse *urgent care claim* decision, orally or in writing. In such case, all necessary information, including this Plan's benefit determination on review, will be transmitted between this Plan and the *claimant* by telephone, facsimile, or other available similarly expeditious method, to the extent permitted by applicable law.

Appeals of denied claims will be conducted promptly, will not defer to the initial determination, and will not be made by the person that 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 free of charge, and may submit issues and comments in writing. In addition, a *claimant* on *appeal* may, upon request, discover the identity of medical or vocational experts whose advice was obtained on behalf of this Plan in connection with the *adverse benefit determination* being appealed, as permitted under applicable law.

If the claims denial being appealed was based in whole or in part on 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 PERIOD FOR DECISIONS ON APPEAL

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

Urgent Care Claims	As soon as possible, but not later than 72 hours after Humana has received the *appeal* request. If oral notification is given, written notification will follow in hard copy or electronic format within the next three days.
Pre-Service Claims	Within a reasonable period, but not later than 30 days after Humana has received *appeal* request.
Post-Service Claims	Within a reasonable period, but not later than 60 days after Humana has received the *appeal* request.
Concurrent Care Decisions	Within the time periods specified above, depending on the type of claim involved.

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 state the specific reason or reasons for the *adverse benefit determination* and the specific Plan provisions on which the determination is based.

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

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

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

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

FULL AND FAIR REVIEW

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

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

RIGHT TO REQUIRE MEDICAL EXAMINATIONS

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

EXHAUSTION

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

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

LEGAL ACTIONS AND LIMITATIONS

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

STANDARD EXTERNAL REVIEW

Request for an External Review

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

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

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

Preliminary Review

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

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

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

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

- If the request is complete but not eligible for *external review*. The notice must include the reason(s) for its ineligibility and contact information for the Department of Health and Human Services Health Insurance Assistance Team (HIAT), including this number: 1-888-393-2789.

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

Referral to an Independent Review Organization (IRO)

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

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

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

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

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

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

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

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

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

Reversal of this Plan's Decision

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

EXPEDITED EXTERNAL REVIEW

Request for an Expedited External Review

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

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

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

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

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

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

Preliminary Review

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

Referral to an Independent Review Organization (IRO)

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

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

Notice of Final External Review Decision

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

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

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

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:

California Consumer Assistance Program
California Department of Managed Health Care Help Center
980 9th Street, Suite 500
Sacramento, CA 95814
(888) 466-2219
http://www.healthhelp.ca.gov
helpline@dmhc.ca.gov

SECTION 6

DEFINITIONS

DEFINITIONS

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

A

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

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

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

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

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

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

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

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

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

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

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

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

Ancillary services mean *covered expenses* that are:

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

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

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

B

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

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

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

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

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

C

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

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

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

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

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

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

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

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

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

Copayment limit means the amount of *copayments* that must be paid by a *covered person*, either individually or combined as a covered family, per year before *copayments* are no longer required for the remainder of that year.

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

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

Covered expense means *medically necessary services* 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 given to *you* if:

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

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

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

D

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

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

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

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

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

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

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

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

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

E

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

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

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

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

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

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

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

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

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

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

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

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

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

F

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

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

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

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

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

G

H

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

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

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

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

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

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

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

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

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

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

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

I

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

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

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

- Artificial insemination;
- In vitro fertilization;
- Gamete Intrafallopian Transfer (GIFT);
- Zygote Intrafallopian Transfer (ZIFT);
- Tubal ovum transfer;
- Sperm storage or banking;
- Ovum storage or banking;
- Embryo or zygote banking; and
- Any other assisted reproductive techniques or cloning methods.

Intensive outpatient means outpatient *services* providing:

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

Intensive outpatient program does <u>not</u> include services that are for:

- *Custodial care*; or
- Day care.

L

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

M

Maintenance care means services and supplies furnished mainly to:

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

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

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

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

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

- In accordance with generally accepted standards of medical practice;
- Clinically appropriate in terms of type, frequency, extent, site and duration, and considered effective for the patient's *sickness* or *bodily injury*;

- Neither sourced from a location, nor provided primarily for the convenience of the patient, physician or other health care provider;

- Not more costly than an alternative source, service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the patient's *sickness* or *bodily injury*; and

- Performed in the least costly site or sourced from, or provided by the least costly *qualified practitioner*.

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

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

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

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

- 40 kilograms or greater per meter squared (kg/m^2); or

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

N

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

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

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

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

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

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

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

O

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

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

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

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

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 *health care practitioner*.

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

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

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

P

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

PAR Provider Plan Maximum Out-of-Pocket Limit means the maximum amount of any *participating provider covered expenses*, including medical *deductibles*, *coinsurance* amounts and *copayments* and *prescription* drug *copayments*, that must be paid by *you*, either individually or combined as a covered family, per *calendar year* before a benefit percentage for *participating provider covered expenses* will be increased. The *participating provider out-of-pocket limit* and the *prescription drug out-of-pocket limit* apply toward the *PAR provider Plan maximum out-of-pocket limit*. Once the *PAR provider Plan maximum out-of-pocket limit* is met, any remaining *participating provider* medical *out-of-pocket limit* or *prescription drug out-of-pocket limit* will be waived for the remainder of the *year*. Any applicable *preauthorization* penalties do not apply to the *PAR provider Plan maximum out-of-pocket limit*.

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

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

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

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

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

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

Partial hospitalization does <u>not</u> include services that are for:

- *Custodial care*; or
- Day care.

Plan Administrator means U.S. Health and Welfare Leader for The Dow Chemical Company.

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*. The *Plan Manager* has the same meaning as Claims Administrator with respect to Claims for a Plan Benefit and Appeals Administrator with respect to Claims for a Plan Benefit, as those terms are defined in the body of this Summary Plan Description.

Plan Sponsor means The Dow Chemical Company.

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

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

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

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

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

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

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

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

Preventive services means services determined to be effective and accepted for the detection and prevention of disease in persons with no symptoms as recommended by the U.S. Preventive Services Task Force.

Primary care physician means a *network health care practitioner* who provides initial and primary care services to *covered persons*, maintains the continuity of *covered persons'* medical care and helps direct *covered persons* to *specialty care physicians* and other providers.

A *primary care physician* is a *health care practitioner* in one of the following specialties:

- Family medicine/General practice;
- Internal medicine; and
- Pediatrics.

A pediatric subspecialist will be considered a *primary care physician* if the pediatric subspecialist:

- Has signed an agreement with Humana as a *primary care physician*;
- Is available to accept the *covered person* as a patient; and
- Is chosen by the *covered person* as their *primary care physician*.

Primary Care Physician (PCP) means a *network provider* who provides initial and primary care *services* to *covered persons*, maintains the continuity of *covered persons* medical care and helps direct *covered persons* to *specialty care physicians* and other providers.

A *primary care physician* is a *qualified practitioner* in one of the following specialties:

- Family medicine/General practice;
- Internal medicine; and
- Pediatrics.

A pediatric subspecialist will be considered a *primary care physician* if the pediatric subspecialist:

- Has signed an agreement with Humana as a *primary care physician*;
- Is available to accept the *covered person* as a patient; and
- Is chosen by the *covered person* as their *primary care physician*.

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*.

Q

Qualified payment amount means the lesser of:

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

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

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

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

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

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

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

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

R

Residential treatment facility means an institution that:

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

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*.

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

S

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

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

Service area means the geographic area designated by Humana, or as otherwise agreed upon between the *Plan Sponsor* and Humana. The *service area* is the geographic area where the *network provider* services are available to *you*. A description of the *service area* is provided in the provider directories.

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

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

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

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

Sound natural tooth means a tooth that:

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

Specialty care physician means a *qualified provider* who has received training in a specific medical field other than those listed as primary care.

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

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

Stem cell means the transplant of human blood precursor cells. Such cells may be derived from bone marrow, circulating blood, or a combination of bone marrow and circulating blood obtained from the patient in an autologous transplant, from a matched related or unrelated donor, or cord blood. The *stem cell* transplant includes the harvesting, integral chemotherapy components and the *stem cell* infusion. A *stem cell* transplant is commonly referred to as a bone marrow transplant.

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

Surgery means procedures categorized as Surgery in either the:

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

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

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

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

T

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

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

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

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

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

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

U

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

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

V

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

Y

You and your means any *covered person*

SECTION 7

PRESCRIPTION DRUG BENEFIT

PRESCRIPTION DRUG BENEFIT

All defined terms used in this "Prescription Drug Benefit" section have the same meaning given to them in Section 3 of this *Appendix A to the SPD*, unless otherwise specifically defined below.

DEFINITIONS

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

Coinsurance means the amount expressed as a percentage of the *covered expense* that *you* must pay toward the cost of each separate *prescription* fill or refill dispensed by a *pharmacy*.

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

Cost share means any applicable *copayment* and/or *coinsurance* amount that *you* must pay per *prescription* fill or refill.

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

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

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

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

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

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

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

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

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

- Covered *pharmacy* services;
- Covered *specialty pharmacy* services; or
- Covered *mail* order *pharmacy* services,

as defined by Humana, to *covered persons*, including covered *prescription* fills or refills delivered to *your* home or health care provider.

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

- Covered *pharmacy* services;
- Covered *specialty pharmacy* services; or
- Covered *mail order pharmacy* services,

as defined by Humana, to *covered persons*, including covered *prescription* fills or refills delivered to *your* home or health care provider.

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

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

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

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

Prior authorization means the required prior approval from Humana for the coverage of certain *prescription* drugs, medicines or medications, including *specialty drugs*. The required prior approval from Humana for coverage includes the dosage, quantity and duration, as *medically necessary* for the *covered person*. Visit Humana's Website at Humana.com or call Humana at the toll-free customer service telephone number listed on *your* Humana ID card to obtain a list of *prescription* drugs, medicines and medications that require *prior authorization.*

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

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

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

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

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

SCHEDULE OF PRESCRIPTION DRUG BENEFITS

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

You are responsible for the following:

RETAIL PHARMACY AND SPECIALTY PHARMACY	
Network pharmacy Level 1 Drugs	$10 *copayment* per *prescription* or refill per 30 day supply
Network pharmacy Level 2 Drugs	$30 *copayment* per *prescription* or refill per 30 day supply
Network pharmacy Level 3 Drugs	$50 *copayment* per *prescription* or refill per 30 day supply
Network pharmacy Level 4 Drugs	25% *copayment* per *prescription* or refill per 30 day supply
Covered Vaccines	No *cost share* (Retail Only)
Drugs, Medicines or Medications on the Women's Healthcare Drug List with a *prescription* from a *health care practitioner*	No *cost share*
Glucometers	No *cost share*
Non-Insulin Needles and Syringes	No *cost share*
Non-Oral Contraceptives	No *cost share*

Mandatory Mail Order: Following the initial fill and one refill of a covered *prescription* drug or therapeutic equivalent medication prescribed by one or more *qualified practitioners* and dispensed by one or more retail or *specialty pharmacies*, all subsequent refills must be obtained through a *mail order pharmacy.*

This plan features Humana's RightSourceRx Preferred Mandatory Mail Order Program. Members are allowed up to two, thirty day retail fills of a maintenance medication. The third and subsequent retail fills of any one maintenance medication, will apply double the applicable member *cost share*.

MAIL ORDER PHARMACY	
Up to a 90 day supply of a *prescription* or refill received from a *mail order pharmacy* *Self-administered injectable drugs* and *specialty drugs* received from a *mail order pharmacy* may be limited to a 30 day supply, as determined by this Plan.	Two and a half (2.5) times the applicable *copayments* outlined under Retail Pharmacy and Specialty Pharmacy. *Level 4 drugs* are not covered.
Drugs, Medicines or Medications on the Women's Healthcare Drug List with a *prescription* from a *health care practitioner*	No *cost share*

OFFICE-ADMINISTERED SPECIALTY DRUGS	
Up to a 30 day supply of a *prescription* or refill for office-administered *specialty drugs*, dispensed directly to the *health care practitioner's* office through Humana *Specialty Pharmacy*	No *cost share*

ADDITIONAL PRESCRIPTION DRUG BENEFIT INFORMATION

If an *employee*/eligible *dependent* purchases a *brand name medication*, and an equivalent *generic medication* is available, the *employee*/eligible *dependent* must pay the difference between the *brand name medication* and the *generic medication* plus any applicable *generic medication copayment*. If the *qualified provider* indicates on the *prescription* "dispense as written", the drug will be dispensed as such, and the *employee*/eligible *dependent* will only be responsible for the *brand name medication copayment*.

Network Pharmacy

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

Non- network Pharmacy

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

Mail *pharmacy* receipts to:

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

PRIOR AUTHORIZATION

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

STEP THERAPY

Some *prescription* drugs may be subject to the *step therapy* process. Call the toll-free customer service telephone number listed on *your* Humana ID card or visit Humana's website at Humana.com.

DISPENSING LIMITS

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

RETAIL PHARMACY AND SPECIALTY PHARMACY

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

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

Following the initial fill and one refill of a covered *prescription* drug or therapeutic equivalent medication prescribed by one or more *qualified practitioners* and dispensed by one or more retail *pharmacies* or *specialty pharmacies*, all subsequent refills must be obtained through a *mail order pharmacy*.

MAIL ORDER PHARMACY

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

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

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

OFFICE-ADMINISTERED SPECIALTY DRUGS

Your health care practitioner has access to *specialty drugs* used to treat chronic conditions. These drugs can be ordered specifically for *you* for administration in his/her office setting. This allows *your health care practitioner* a cost effective and convenient way to obtain high cost, high tech specialty medications and injectables. Additional information can be obtained by calling the toll-free customer service phone number on the back of *your* ID card or visit Humana's website at Humana.com.

MAXIMIZE YOUR BENEFIT

You may receive "Maximize Your Benefit" notifications from Humana regarding possible lower-cost, but equally effective medication alternatives for *you* to discuss with *your* doctor.

PRESCRIPTION DRUG COST SHARING

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

You are responsible for payment of:

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

If the dispensing *pharmacy's* charge is less than the *copayment*, *you* will be responsible for the lesser amount. The amount paid by Humana to the dispensing *pharmacy* may not reflect the ultimate cost to this Plan for the drug. *Your copayment* or *coinsurance* is made on a per *prescription* fill or refill basis and will not be adjusted if this Plan receives any retrospective volume discounts or *prescription* drug rebates.

PRESCRIPTION DRUG COVERAGE

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

Covered *prescription* drugs, medicine or medications must:

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

Any *expenses incurred* under provisions of this "Prescription Drug Benefit" section, when received by a *participating pharmacy* apply towards the *PAR provider Plan maximum out-of-pocket limit* outlined in the "Medical Schedule of Benefits" section. Any *expenses incurred* under provisions of this "Prescription Drug Benefit" section are not covered under any medical benefits. Any *expenses incurred* under *your* medical benefits are not covered under any *prescription drug* benefits.

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

PRESCRIPTION DRUG LIMITATIONS

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

- *Legend drugs*, which are not deemed *medically necessary* by this Plan.
- Any amount exceeding the *default rate*.
- Drugs not approved by the FDA.
- Any drug prescribed for intended use other than for:
    - Indications approved by the FDA; or
    - Off-label indications recognized through peer-reviewed medical literature.
- Any drug prescribed for a *sickness* or *bodily injury* not covered under this Plan.
- Any drug, medicine or medication that is either:
    - Labeled "Caution - limited by federal law to investigational use;" or
    - Experimental, *investigational* or *for research purposes*,

  even though a charge is made to *you*.
- Allergen extracts.

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

    - Hypodermic needles and syringes (except when prescribed by a *health care practitioner* for use with insulin and *self-administered injectable drugs*, whose coverage is approved by this Plan);
    - Support garments;
    - Test reagents;
    - Mechanical pumps for delivery of medications; and
    - Other non-medical substances.

- Dietary supplements and nutritional products, except enteral formulas and nutritional supplements for the treatment of phenylketonuria (PKU) or other inherited metabolic disease. Refer to the "Covered Expenses" section of the SPD for coverage of low protein modified foods.

- Non-prescription, over-the-counter minerals, except as specified on the Preventive Medication Coverage *drug list* when obtained from a *network pharmacy* with a *prescription* from a *health care practitioner*.

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

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

- Anabolic steroids.

- Any drug used for the purpose of weight loss.

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

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

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

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

- Compounded drugs that:
    - Are prescribed for a use or route of administration that is not FDA approved or compendia supported;
    - Are prescribed without a documented medical need for specialized dosing or administration;
    - Only contain ingredients that are available over-the-counter;
    - Only contain non-commercially available ingredients; or
    - Contain ingredients that are not FDA approved, including bulk compounding powders.
- Abortifacients (drugs used to induce abortions).
- *Infertility services* including medications.
- Any drug prescribed for impotence and/or sexual dysfunction.
- Any drug, medicine, medication or *specialty drug* that is consumed or injected at the place where the *prescription* is given or dispensed by the *health care practitioner*.
- The administration of covered medication(s).
- *Prescriptions* that are to be taken by or administered to *you*, in whole or in part, while *you* are a patient in a facility where drugs are ordinarily provided by the facility on an *inpatient* basis. *Inpatient* facilities include, but are not limited to:
    - Hospital;
    - Skilled *nursing facility*; or
    - Hospice facility.
- Injectable drugs, including, but not limited to:
    - Immunizing agents, unless for *preventive services* determined by this Plan to be dispensed by or administered in a *pharmacy*;
    - Biological sera;
    - Blood;
    - Blood plasma; or
    - Self-*administered injectable drugs* or *specialty drugs* for which *prior authorization* or *step therapy* is not approved by this Plan.
- Prescription fills or refills:
    - In excess of the number specified by the *health care practitioner*; or
    - Dispensed more than one year from the date of the original order.
- Any portion of a *prescription* fill or refill that exceeds a 90-day supply when received from a *mail order pharmacy* or a retail *pharmacy* that participates in the program, which allows *you* to receive a 90-day supply of a *prescription* fill or refill.

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

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

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

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

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

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

    - Before becoming covered under this Plan; or
    - After the date *your* coverage under this Plan has ended.

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

- Any intentional misuse of this benefit, including *prescriptions* purchased for consumption by someone other than *you*.

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

- Drug delivery implants and other implant systems or devices.

- Treatment for onychomycosis (nail fungus).

- Any amount *you* paid for a *prescription* that has been filled, regardless of whether the *prescription* is revoked or changed due to adverse reaction or change in dosage or *prescription*.

- *Prescriptions* filled at a *non*-network *pharmacy*, except for *prescriptions* required during an emergency.

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

Administered by:

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