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SUMMARY PLAN DESCRIPTION

For the

PLAN C - 80/50 PPO MEDICAL PLAN

Sponsored by

Lexington Fayette Urban County Government

Group Number(s): 707218

Package ID(s): SFLFUCG7

Effective: January 1, 2012

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INTRODUCTION

THE SUMMARY PLAN DESCRIPTION – YOUR HEALTH CARE PLAN GUIDE

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

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

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

This agreement shall be governed and construed under the laws of the Commonwealth of Kentucky.

DEFINED TERMS

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

PRIVACY

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

CONTACT INFORMATION

Customer Service Telephone Number:

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

Claims Submittal Address:

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

Claims Appeal Address:

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

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SECTION 1

HEALTH RESOURCES AND PRECERTIFICATION

HEALTH RESOURCES

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

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

Below is a brief description of this Plan's Health Resources programs. For additional information or questions regarding any of these programs, please contact the customer service telephone number on the back of *your* ID card.

*MY*HUMANA

Go to www.humana.com and click on "log in or register" to receive step by step instructions on how to set up *your My*Humana page. After *you* have set up *your* page, log on anytime to find a participating provider, look up *your* plan benefits or check the status of a claim. *You* can also find *prescription* drug information, information on specific health conditions, financial tools to help with budgeting for health care and more.

HUMANA HEALTH ASSESSMENT

Go to www.humana.com and register for *My*Humana. Once *you* have registered and logged on to *My*Humana, click on the "Health Assessment" link. The Humana Health Assessment is a confidential, online health survey that provides *you* with an overall assessment of *your* health. Upon completion of the assessment, *you* will receive an individualized health score and an action plan on how *you* can improve *your* health. Responses may also result in a referral to another Health Resources program.

HUMANA HEALTH ALERTS

PREVENTIVE REMINDERS

Humana encourages preventive healthcare and may send *you* wellness messages and reminders via a phone call (live and voice activated), mail, email or text message. Humana's messaging campaigns may include, but are not limited to:

- Flu vaccination reminders, targeted to those most at risk;
- Cancer screenings – breast, cervical and colorectal;
- Adolescent vaccination reminders.

GAPS IN CARE

Humana's clinical rules engine leverages expert medical opinions to identify gaps in care that address potential medical errors and instances of sub-optimal medical treatment.

The established clinical rules compare a patients' pharmacy, laboratory and claims data to industry standard Quality of Care guidelines in order to identify patients at risk of highly specific patient-centric problems. Examples include: a misdiagnosis, a flawed surgical treatment or medical management, and lack of follow-up care or preventive treatment. In addition, a variety of preventive and pharmacy rules are included such as drug-to-drug interactions and drug-to-disease interactions.

When gaps in care, drug to drug interaction, drug to disease interaction or a preventive reminder is identified, an alert and a message, if appropriate, are generated to communicate the findings through physician and member messaging.

TRANSPLANT MANAGEMENT

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

UTILIZATION MANAGEMENT

Utilization management is designed to assist *covered persons* in making informed medical care decisions resulting in the delivery of appropriate levels of Plan benefits for each proposed course of treatment. These decisions are based on the medical information provided by the patient and the patient's physician. The patient and his or her physician determine the course of treatment. The assistance provided through these services does not constitute the practice of medicine. Payment of Plan benefits is not determined through these processes.

Precertification and Concurrent Review

Utilization review may include *precertification* and *concurrent review*.

Precertification for *emergency services* is not required.

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

If *you* or *your* covered *dependents* are to receive a *service* which requires *precertification*, *you* or *your qualified practitioner* must contact Humana by telephone or in writing. Refer to the Precertification section for time requirements.

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

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

2. Conduct *concurrent review* as necessary.

If *your admission* is *precertified*, benefits are subject to all Plan provisions and are payable as shown on the Schedule of Benefits.

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.

Penalty for Not Obtaining Precertification

If *you* do not obtain *precertification* for *services* being rendered, *your* benefits may be reduced. Refer to the Precertification section for the applicable penalty. Penalties do not apply to *emergency services*.

CASE MANAGEMENT

The Case Management program provides a higher level of management and involvement for the seriously ill or injured who need intensive, hands-on support. Case Managers, averaging 18 years of experience in nursing, are there to provide condition-specific education, individual assessment, coordination of *services*, benefit plan guidance, communication with the patient's support system, personal support and counseling, and facilitation of discharge planning. Their goal is to contribute to the patient's sense of well-being, address their quality of life, ease the physical and emotional burdens associated with a major medical event and promote the most positive clinical outcomes possible.

Participants for Case Management are identified through a variety of methods, including referrals from other Health Resources programs and services (e.g. a *covered person* is referred to a Case Manager by their Personal Nurse).

Case Management is based on the individual's needs, and may include the following:

- Onsite nurse support at facilities with a high volume of Humana *admissions*;
- Telephone support for persons admitted to facilities where onsite coverage is not provided;
- Post-discharge follow-up for ongoing needs;
- Assistance in finding options and alternatives, such as community resources, social services, *Medicare*/Medicaid, pharmaceutical medication programs, etc.;
- Catastrophic Case Management that focuses on high-dollar, high-complexity, catastrophic type illnesses such as trauma, complex *surgery*, automobile *accidents* and burn injuries.

TRANSITION OF CARE

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

CONTINUITY OF CARE

If *your* provider ceases being a *PAR provider you* may be able to continue treatment with the same provider for up to 90 calendar days if *you* are undergoing active treatment for a chronic or acute medical condition after the *PAR provider's* termination with the *PAR provider's* network. For pregnancy, if *you* are in the 2nd or 3rd trimester, continuity of care is available through a 6 week postpartum period. Continuity of care is available only if the provider continues to practice in the geographical area of the network and the termination of the *PAR provider's* contract was not due to misconduct on the part of the provider.

NURSE LINE

The Nurse Line is a toll-free, 24-hour medical information line, staffed by registered nurses who are available to answer *your* health-related questions and help *you* decide where to best seek treatment. The Nurse Line helps *you* in two ways:

Immediate Medical Concerns: Registered nurses can be of service when *you* are thinking about taking *your* child to the *hospital* for a fever in the middle of the night or deciding if a reaction to a new medication is normal. They can also help with "how-to" questions, like how to change a bandage or how to prepare for lab tests.

Health Planning and Support: When planning a future medical procedure, registered nurses are available to help *you* understand *your* options, choose providers and use *your* health benefits wisely. When additional clinical support is needed, these nurses will connect *you* with specialty programs to address *your* unique needs.

CHRONIC CONDITION MANAGEMENT

The chronic condition management programs support the physician/patient relationship and care plan, emphasize education, promote self-management, evaluate outcomes to improve *your* overall health and offer nurse support.

There are two levels of nurse support – generalists and disease management specialists. The generalist program, Personal Nurse, supports *covered persons* with a variety of chronic conditions. The disease management specialists are nurses that have expertise on a certain condition.

PERSONAL NURSE®

Personal Nurses offers *covered persons* dealing with a condition or illness, following treatment plans, or needing continued guidance in reaching their long-term health goals, the opportunity to develop a long-term partnership with an experienced registered nurse. Personal Nurses provide both personalized education and guidance to resources to help participants better understand their condition or illness and effectively use their benefits. They also teach the benefits of wellness, prevention and disease avoidance, help identify roadblocks to improved health, motivate and support participants' efforts to meet goals and refer participants to other Health Resource programs that may meet their needs.

Participants will speak with the same Personal Nurse every time – whether the call is initiated by the nurse or the *covered person*. Personal Nurses work flexible hours and will provide participants with their direct telephone number. Participants can stay with their Personal Nurse for as long as they remain a member of this Plan.

DISEASE MANAGEMENT

Disease management programs have been developed to help *covered persons* manage specific chronic medical conditions. Nurses are available 24 hours a day to provide individual guidance through coaching, support and service coordination, to help lessen the day-to-day impact of chronic illnesses.

This Plan's disease management programs include:

- **Asthma**: This program provides participants with education to help them better understand their disease and to take a more active role in controlling it. The program helps participants adhere to the treatment plan prescribed by their physician, helps them increase their self-monitoring skills and promotes compliance with controller medications.

- **Cancer (active treatment only)**: The cancer management program offers support and educational services to adults with cancer who have begun or are planning to undergo *surgery*, chemotherapy, radiation therapy or biological therapy, those that have a history of cancer that has recurred and those that have declined further therapy but require supportive management. The program's oncology care managers have an average of 10 years of professional experience in understanding cancer, its symptoms, side effects and treatments.

- **Congestive Heart Failure**: This program focuses on those with moderate to severe heart failure and is delivered primarily through critical care nurses who assist participants through a combination of intervention, monitoring and education.

- **Coronary Artery Disease**: This program helps participants adhere to their physicians' prescription and treatment plan, monitor their health status for complications and decrease cardiovascular risks. Ongoing guidance and education is provided, focusing on clinical and behavioral issues such as high blood pressure, elevated lipid levels, smoking and lack of exercise. Specialized cardiac nurses are available to discuss issues and answer questions.

- **Diabetes:** This program provides ongoing education about disease management and monitoring in the areas of diet, exercise and lifestyle. Registered nurses who have received additional training in diabetes disease management are available to answer questions.

- **End Stage Renal Disease (ESRD)**: The end-stage renal disease program provides case management designed to address quality-of-life issues of those with ESRD and late-stage Chronic Kidney Disease. ESRD staff work closely with participants, local nephrologists and dialysis centers to coordinate services and monitor medical management.

- **Rare Diseases (Amyotrophic Lateral Sclerosis, or Lou Gehrig's Disease; Chronic Inflammatory Demyelinating Polyradiculoneuropathy Disease (CIDP); Cystic Fibrosis; Dermatomyositis; Hemophilia; Multiple Sclerosis; Myasthenia Gravis; Parkinson's Disease; Polymyositis; Rheumatoid Arthritis; Scleroderma; Sickle Cell Disease; and Systemic Lupus)**: Through specific programs for each disease, participants receive information tailored to their individual situation. Each program addresses the individual's medical, educational and psychological needs by providing disease-specific online tools and resources, service coordination and education via telephone contact and access to specially trained nurses.

Specific programs may change at Humana's sole discretion. Some of the disease management programs may not be available in all areas.

HUMANA*BEGINNINGS*®

The Humana*Beginnings*® program educates and guides expectant mothers to make the best choices to achieve a healthy pregnancy and, ultimately, a healthy baby. Participants are offered guidance by phone from the time Humana is notified of the pregnancy through baby's first months. Participation is not limited to those *covered persons* with high-risk pregnancies – it is designed as a resource for all expectant mothers covered under the Plan.

Humana*Beginnings*® includes:

- Education, support and encouragement toward healthy behaviors and decisions related to pregnancy, such as nutrition, exercise, smoking and depression screening. Participants learn more about their pregnancy, their baby's development and how to practice healthy habits during pregnancy.

- Educational materials, including a book and newsletters.

- Guidance for managing health concerns and complications.

- Awareness about premature birth. Women are educated about risk factors, preventive measures and the symptoms of preterm labor.

- Experienced registered nurses who specialize in prenatal care who can address questions and concerns.

A nurse reaches the expectant mother and begins discussions centered on her pregnancy and general health. They plan dates and times for future conversations and follow-up after delivery. Along with scheduled calls, the nurse is available as needed for contact throughout the pregnancy and the postpartum period.

Covered persons can enroll themselves at any time during their pregnancy, but are encouraged to enroll early in their pregnancy in order to get the most from the program. *Covered persons* can enroll in two ways:

- Online at *My*Humana (www.humana.com); or
- Calling toll-free 1-888-847-9960.

NEONATAL INTENSIVE CARE UNIT (NICU) MANAGEMENT

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

The Neonatal Case Management program includes:

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

RADIOLOGY SERVICES REVIEW

Radiology Services Review is a service that offers convenient scheduling of imaging procedures (CT, CTA, MRI, MRA and PET scans). Radiology Services Review is designed to help avoid issues such as inappropriate or unnecessary imaging studies that are costly and inconvenient to the patient, by educating ordering physicians on imaging procedures and best practice guidelines before the procedure is scheduled. Physicians may now call Humana to initiate the consultation and schedule any imaging procedure for a Humana member.

PRECERTIFICATION

NOTE: The provisions in this section may not apply to transplant *services*. Please refer to the Transplant Services section in the Schedule of Benefits for applicable *precertification* requirements and penalties.

Precertification for *emergency services* is not required.

Humana will provide *precertification* as required by this Plan. It is recommended that *you* call the toll-free customer service phone number on the back of *your* ID card as soon as possible to receive proper *precertification*.

Visit Humana's website at www.humana.com or call the toll-free customer service phone number on the back of *your* ID card to obtain a list of *services* that require *precertification*. This list is subject to change. Coverage provided in the past for *services* that did not receive or require *precertification*, is not a guarantee of future coverage of the same *services*.

Please follow the directions below when accessing Humana's website:

1. Go to Humana's website (www.humana.com);

2. Click on "Resources & Support";

3. Click on "Member Guidelines" under Customer Support Center";

4. Click on "Medical Authorizations";

5. Click on "Commercial Preauthorization and Notification List" for a list of the *services* that require *precertification*.

PRECERTIFICATION PENALTY

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

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

Penalties do not apply to *emergency services*.

PREDETERMINATION OF BENEFITS

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

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

SECTION 2

MEDICAL BENEFITS

UNDERSTANDING YOUR COVERAGE

PARTICIPATING AND NON-PARTICIPATING PROVIDERS

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

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

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

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

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

PAR PROVIDER DIRECTORY

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

COVERED AND NON-COVERED EXPENSES

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

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

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

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

SCHEDULE OF BENEFITS

IMPORTANT INFORMATION ABOUT PLAN BENEFITS

Benefits and limits (e.g. visit or dollar limits) are per *calendar year*, unless specifically stated otherwise.

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

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

DEDUCTIBLES, COINSURANCE, OUT-OF-POCKET LIMITS, LIFETIME MAXIMUM BENEFIT AND OFFICE VISIT COPAYMENTS		
BENEFIT FEATURES	**PAR PROVIDER BENEFIT**	**NON-PAR PROVIDER BENEFIT**
Individual *Deductible*	$2,500 per *covered person*	$7,500 per *covered person*
Family *Deductible*	$5,000 per covered family	$15,000 per covered family
Coinsurance	The Plan pays 80%, *you* pay 20%	The Plan pays 50%, *you* pay 50%
Individual *Out-of-Pocket Limit*	$2,500 per *covered person*	$7,500 per *covered person*
Family *Out-of-Pocket Limit*	$5,000 per covered family	$15,000 per covered family
Lifetime Maximum Benefit	Unlimited	Unlimited

DEDUCTIBLES, COINSURANCE, OUT-OF-POCKET LIMITS, LIFETIME MAXIMUM BENEFIT AND OFFICE VISIT COPAYMENTS

BENEFIT FEATURES	PAR PROVIDER BENEFIT	NON-PAR PROVIDER BENEFIT
Qualified Practitioner Primary Care Physician (PCP) Office Visit *Copayment*	$30	Not applicable
Qualified Practitioner Specialist Office Visit *Copayment*	$60	Not applicable

Primary Care Physician (PCP) is defined as a family practice physician, pediatrician, doctor of internal medicine, general practitioner, nurse practitioner, physician assistant, registered nurse, physical therapist, occupational therapist and retail/minute clinic. A specialist would be all other *qualified practitioners*.

One *copayment* will be taken per day per servicing provider, unless otherwise indicated in this Schedule.

ROUTINE/PREVENTIVE CHILD CARE SERVICES BIRTH TO AGE 18 (*Services* Received at a Clinic or Outpatient *Hospital*)

MEDICAL SERVICES	PAR PROVIDER BENEFIT	NON-PAR PROVIDER BENEFIT
Routine Child Care Examination (including routine vision and hearing screening when part of a *qualified practitioner* primary care physician examination)	100%	50% after *deductible*

ROUTINE/PREVENTIVE CHILD CARE SERVICES BIRTH TO AGE 18 (*Services* Received at a Clinic or Outpatient *Hospital*)		
MEDICAL SERVICES	**PAR PROVIDER BENEFIT**	**NON-PAR PROVIDER BENEFIT**
Routine Child Care Laboratory and X-ray	100%	50% after *deductible*
Routine Child Care Immunizations	100%	50% after *deductible*
Routine Child Care HPV Vaccine (e.g. Gardasil) (covered beginning at age 9)	100%	50% after *deductible*
Routine Child Care Meningitis Vaccine	100%	50% after *deductible*
Routine Child Care Flu/Pneumonia Injections	100%	50% after *deductible*

ROUTINE/PREVENTIVE ADULT CARE SERVICES AGE 18 AND OVER (*Services* Received at a Clinic or Outpatient *Hospital*)		
MEDICAL SERVICES	**PAR PROVIDER BENEFIT**	**NON-PAR PROVIDER BENEFIT**
Routine Adult Care Examination	100%	50% after *deductible*
Routine Adult Care Laboratory and X-ray	100%	50% after *deductible*

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

MEDICAL SERVICES	PAR PROVIDER BENEFIT	NON-PAR PROVIDER BENEFIT
Routine Adult Care Immunizations	100%	50% after *deductible*
HPV Vaccine (e.g. Gardasil), covered through age 26	100%	50% after *deductible*
Shingles Vaccine (e.g. Zostavax), for *covered persons* age 55 and over	100%	50% after *deductible*
Routine Adult Care Meningitis Vaccine	100%	50% after *deductible*
Routine Adult Care Flu/Pneumonia Injections	100%	50% after *deductible*
Routine Adult Care Mammograms	100%	50% after *deductible*
Routine Adult Care Pap Smears	100%	50% after *deductible*
Routine Adult Care Colonoscopy, Proctosigmoidoscopy and Sigmoidoscopy Screenings (including related *services*) (performed at an outpatient facility, *ambulatory surgical center* or clinic location)	100%	50% after *deductible*

ROUTINE/PREVENTIVE ADULT CARE SERVICES AGE 18 AND OVER (*Services* Received at a Clinic or Outpatient *Hospital*)		
MEDICAL SERVICES	**PAR PROVIDER BENEFIT**	**NON-PAR PROVIDER BENEFIT**
Prostate Specific Antigen (PSA) Testing	100%	50% after *deductible*

ROUTINE HEARING SERVICES		
MEDICAL SERVICES	**PAR PROVIDER BENEFIT**	**NON-PAR PROVIDER BENEFIT**
Routine Hearing Examination/Screening	100% after a an applicable *Qualified Practitioner copayment*	50% after *deductible*
Routine Hearing Testing	100%	50% after *deductible*
Hearing Aids and Fitting	80% after *deductible*	50% after *deductible*
Cochlear Implants (for *covered members* diagnosed with profound hearing impairment)	80% after *deductible*	50% after *deductible*
Routine Hearing Aids and Fitting Limits	$1,400 maximum benefit per hearing aid, per hearing impaired ear, once every three years	

QUALIFIED PRACTITIONER SERVICES (Other than *Qualified Practitioner Services* covered under the Routine / Preventive Care Benefits)		
MEDICAL SERVICES	**PAR PROVIDER BENEFIT**	**NON-PAR PROVIDER BENEFIT**
Diagnostic Office Examination at a Clinic, including Second Surgical Opinion – *Qualified Practitioner* Primary Care Physician	100% after a $30 *copayment*	50% after *deductible*
Diagnostic Office Examination at a Clinic, including Second Surgical Opinion - *Qualified Practitioner* Specialist	100% after a $60 *copayment*	50% after *deductible*
If an office examination is billed from an outpatient location, the *services* will be payable the same as an office examination at a clinic.		
Diagnostic Laboratory and X-ray at a Clinic (other than *advanced imaging*)	100%	50% after *deductible*
Independent Laboratory	Payable the same as diagnostic laboratory and x-ray.	Payable the same as diagnostic laboratory and x-ray.
Advanced Imaging at a Clinic	80% after *deductible*	50% after *deductible*
Allergy Testing at a Clinic	100%	50% after *deductible*
Allergy Serum/Vials at a Clinic	100%	50% after *deductible*
Allergy Injections at a Clinic	100% after a $5 *copayment*	50% after *deductible*

QUALIFIED PRACTITIONER SERVICES (Other than *Qualified Practitioner Services* covered under the Routine / Preventive Care Benefits)		
MEDICAL SERVICES	**PAR PROVIDER BENEFIT**	**NON-PAR PROVIDER BENEFIT**
Copayments for allergy injections are applied per visit (highest *copayment* will apply).		
Injections at a Clinic (other than routine immunizations, contraceptive injections for birth control reasons and allergy injections)	100% after a $5 *copayment*	50% after *deductible*
Anesthesia at a Clinic	80% after *deductible*	50% after *deductible*
Surgery at a Clinic (including *Qualified Practitioner*, Assistant Surgeon and Physician Assistant)	80% after *deductible*	50% after *deductible*
Medical and Surgical Supplies	80% after *deductible*	50% after *deductible*
Eyeglasses or Contact Lenses after Cataract *Surgery* (initial pair only)	80% after *deductible*	50% after *deductible*
Diabetic Counseling and Diabetic Nutritional Counseling (*Diabetes Self-Management Training*) (all places of *service*)	80% after *deductible*	50% after *deductible*
Diabetes Supplies	Payable under the *prescription* drug benefits.	Payable under the *prescription* drug benefits.

DENTAL/ORAL SURGERIES COVERED UNDER THE MEDICAL PLAN		
MEDICAL SERVICES	**PAR PROVIDER BENEFIT**	**NON-PAR PROVIDER BENEFIT**
Dental/Oral *Surgeries*	Payable the same as any other *sickness*.	Payable the same as any other *sickness*.
Dental Anesthesia	(Required Benefit Provision) Mandates coverage for anesthesia and hospital/facility charges for dental procedures for children under age 9, persons with physical conditions, or persons with behavioral problems.	
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	**PAR PROVIDER BENEFIT**	**NON-PAR PROVIDER BENEFIT**
Contraceptive Devices (e.g. IUD; Diaphragms) Over-the-counter contraceptive devices are not covered.	80% after *deductible*	50% after *deductible*
Contraceptive Injections	100% after $5 *copayment*	50% after *deductible*
Contraceptive Implant Systems (e.g. Norplant) – Insertion and Removal	80% after *deductible*	50% after *deductible*
Sterilization	Payable the same as any other *sickness*.	Payable the same as any other *sickness*.

FAMILY PLANNING		
MEDICAL SERVICES	**PAR PROVIDER BENEFIT**	**NON-PAR PROVIDER BENEFIT**
Life Threatening Abortions	Payable the same as any other *sickness*.	Payable the same as any other *sickness*.

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

MATERNITY (Normal, C-Section and Complications)		
MEDICAL SERVICES	**PAR PROVIDER BENEFIT**	**NON-PAR PROVIDER BENEFIT**
Newborn Inpatient Facility *Services*	80% after *deductible* The newborn *deductible* and *copayment* will be waived for facility *services*.	50% after *deductible* The newborn *deductible* and *copayment* will be waived for facility *services*.

INPATIENT SERVICES		
MEDICAL SERVICES	**PAR PROVIDER BENEFIT**	**NON-PAR PROVIDER BENEFIT**
Inpatient *Hospital* Room and Board and Ancillary Facility *Services*	80% after *deductible*	50% after *deductible*
Qualified Practitioner Inpatient *Hospital* Visit	80% after *deductible*	50% after *deductible*
Qualified Practitioner Inpatient *Surgery* and Anesthesia	80% after *deductible*	50% after *deductible*
Qualified Practitioner Inpatient Pathology and Radiology	80% after *deductible*	50% after *deductible*

SKILLED NURSING SERVICES		
MEDICAL SERVICES	**PAR PROVIDER BENEFIT**	**NON-PAR PROVIDER BENEFIT**
Skilled Nursing Room and Board and Ancillary Facility *Services*	80% after *deductible*	50% after *deductible*
Skilled Nursing Facility Yearly Limits	60 day(s) per *covered person*	
Skilled Nursing *Qualified Practitioner* Visit	80% after *deductible*	50% after *deductible*

OUTPATIENT AND AMBULATORY SURGICAL CENTER SERVICES		
MEDICAL SERVICES	**PAR PROVIDER BENEFIT**	**NON-PAR PROVIDER BENEFIT**
Ambulatory Surgical Center Facility *Services*	80% after *deductible*	50% after *deductible*
Ambulatory Surgical Center Ancillary *Services*	80% after *deductible*	50% after *deductible*
Outpatient *Hospital* Facility Surgical *Services*	80% after *deductible*	50% after *deductible*
Outpatient *Hospital* Facility Non-Surgical *Services* (e.g. clinic facility *services*; observation)	80% after *deductible*	50% after *deductible*

OUTPATIENT AND AMBULATORY SURGICAL CENTER SERVICES		
MEDICAL SERVICES	**PAR PROVIDER BENEFIT**	**NON-PAR PROVIDER BENEFIT**
Outpatient *Hospital* Surgical and Non-Surgical Ancillary *Services* (e.g. supplies; medication; anesthesia)	80% after *deductible*	50% after *deductible*
Outpatient *Hospital* Facility Diagnostic Laboratory and X-ray (other than *advanced imaging*)	80% after *deductible*	50% after *deductible*
Outpatient *Hospital* Facility *Advanced Imaging*	80% after *deductible*	50% after *deductible*
Outpatient *Hospital* and *Ambulatory Surgical Center Qualified Practitioner* Visit	80% after *deductible*	50% after *deductible*
Outpatient *Hospital* and *Ambulatory Surgical Center Surgery* (including surgeon; assistant surgeon; and physician assistant) and Anesthesia	80% after *deductible*	50% after *deductible*
Outpatient *Hospital* and *Ambulatory Surgical Center* Pathology and Radiology	80% after *deductible*	50% after *deductible*

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

EMERGENCY AND URGENT CARE SERVICES		
MEDICAL SERVICES	**PAR PROVIDER BENEFIT**	**NON-PAR PROVIDER BENEFIT**
Emergency Room All Physician *Services* (including Radiologist, Pathologist, Anesthesiologist and ancillary *services* billed by an Emergency Room Physician) (non-emergency)	80% after *deductible*	Same as *PAR Provider* Benefit
Urgent Care Center (facility, ancillary *services* and *qualified practitioner services*) Only one *copayment* will be taken per day.	80% after *deductible*	50% after *deductible*
Urgent Care *Qualified Practitioner*	100% after a $100 *copayment*	50% after *deductible*

HOSPICE SERVICES		
MEDICAL SERVICES	**PAR PROVIDER BENEFIT**	**NON-PAR PROVIDER BENEFIT**
Hospice Inpatient Room and Board and Ancillary *Services*	100%	100%
Hospice Outpatient (including hospice home visits)	100%	100%
Hospice *Qualified Practitioner* Visit	100%	100%

HOME HEALTH CARE SERVICES		
MEDICAL SERVICES	**PAR PROVIDER BENEFIT**	**NON-PAR PROVIDER BENEFIT**
Home Health Care *Services*	80% after *deductible*	50% after *deductible*
Home Health Care Yearly Limits	100 visit(s) per *covered person*	
Home therapy benefits will be reimbursed under the home health care benefit. If therapies are done in the home (such as physical or occupational therapy), these therapy *services* will apply to the home health care limits. If therapies and home health visits are done on the same day the *services* will track as one visit per day.		
Home Health Care Ancillary *Services* (excluding *durable medical equipment*, prosthetics and private duty nursing)	80% after *deductible*	50% after *deductible*

DURABLE MEDICAL EQUIPMENT (DME)		
MEDICAL SERVICES	**PAR PROVIDER BENEFIT**	**NON-PAR PROVIDER BENEFIT**
***Precertification* is required for Durable Medical Equipment.**		
Durable Medical Equipment (DME)	80% after *deductible*	50% after *deductible*
Prosthesis	80% after *deductible*	50% after *deductible*

AMBULANCE SERVICES		
MEDICAL SERVICES	**PAR PROVIDER BENEFIT**	**NON-PAR PROVIDER BENEFIT**
Ground *Ambulance* (True Emergency)	80% after *deductible*	Same as *PAR Provider* Benefit
Air *Ambulance* (True Emergency)	80% after *deductible*	Same as *PAR Provider* Benefit
Ground *Ambulance* (Non-Emergency)	Same as *Non-PAR Provider* Benefit	50% after *deductible*
Air *Ambulance* (Non-Emergency)	Same as *Non-PAR Provider* Benefit	50% after *deductible*

MORBID OBESITY SERVICES		
MEDICAL SERVICES	**PAR PROVIDER BENEFIT**	**NON-PAR PROVIDER BENEFIT**
Morbid Obesity	Not Covered	Not Covered

TEMPOROMANDIBULAR JOINT DYSFUNCTION (TMJ)		
MEDICAL SERVICES	**PAR PROVIDER BENEFIT**	**NON-PAR PROVIDER BENEFIT**
Temporomandibular Joint Dysfunction (TMJ) (Other than Splint/Appliances)	Payable the same as any other *sickness*.	Payable the same as any other *sickness*.

TEMPOROMANDIBULAR JOINT DYSFUNCTION (TMJ)		
MEDICAL SERVICES	**PAR PROVIDER BENEFIT**	**NON-PAR PROVIDER BENEFIT**
Temporomandibular Joint Dysfunction (TMJ) Splint/Appliances	Not Covered	Not Covered

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

THERAPY SERVICES		
MEDICAL SERVICES	**PAR PROVIDER BENEFIT**	**NON-PAR 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 a $30 *copayment*	50% after *deductible*
Chiropractic Laboratory and X-ray	100%	50% after *deductible*
Chiropractic Manipulations	100% after a $30 *copayment*	50% after *deductible*

THERAPY SERVICES		
MEDICAL SERVICES	**PAR PROVIDER BENEFIT**	**NON-PAR PROVIDER BENEFIT**
Chiropractic Therapy	100% after a $30 *copayment*	50% after *deductible*
Chiropractic Limits	20 visit(s) per *covered person*	
If *copayments* apply to multiple chiropractic *services*, one *copayment* will apply per day per servicing provider.		
Physical therapy when provided by a chiropractor will deplete the physical therapy limits.		
Physical Therapy (Clinic and Outpatient)	80% after *deductible*	50% after *deductible*
Occupational Therapy (Clinic and Outpatient)	80% after *deductible*	50% after *deductible*
Speech Therapy (Clinic and Outpatient)	80% after *deductible*	50% after *deductible*
Cognitive Therapy (Clinic and Outpatient)	80% after *deductible*	50% after *deductible*
Audiology Therapy (Clinic and Outpatient)	80% after *deductible*	50% after *deductible*
Therapy Limits	45 visit(s) per *covered person*	
Physical, occupational, speech, audiology, cognitive therapies and cardiac rehabilitation are combined and track toward the Therapy Limits. Chiropractic *services* track toward the Chiropractic Limits.		
Respiratory Therapy and Pulmonary Therapy (Clinic and Outpatient)	80% after *deductible*	50% after *deductible*

THERAPY SERVICES		
MEDICAL SERVICES	**PAR PROVIDER BENEFIT**	**NON-PAR PROVIDER BENEFIT**
Chemotherapy (Clinic and Outpatient)	80% after *deductible*	50% after *deductible*
Radiation Therapy (Clinic and Outpatient)	80% after *deductible*	50% after *deductible*
Cardiac Rehabilitation (Phase II) Phase I is covered under the inpatient facility benefits. Phase III, an unsupervised exercise program, is not covered.	80% after *deductible*	50% after *deductible*

TRANSPLANT SERVICES

Precertification **is required, if** ***precertification*** **is not received, organ transplant** ***services*** **will not be covered.**

MEDICAL SERVICES	HUMANA NATIONAL TRANSPLANT NETWORK (NTN) FACILITY (Payable at the *PAR Provider* Benefit Level)	NON-HUMANA NATIONAL TRANSPLANT NETWORK (NTN) FACILITY (Payable at the *Non-PAR Provider* Benefit Level)
Organ Transplant Medical *Services*	Payable the same as any other *sickness*.	Payable the same as any other *sickness*.
Non-Medical *Services* - Lodging	100%	Not Covered
Non-Medical *Services* - Transportation	100%	Not Covered
Organ Transplant Medical *Services* Limits	None	$35,000 per *covered person* per covered transplant
Non-Medical *Services* - Lodging Limits	$10,000 per covered transplant	
Non-Medical *Services* - Transportation Limits	$10,000 per covered transplant	

Lodging and transportation limits are combined.

Covered expenses for organ transplants performed at a Humana National Transplant Network facility will aggregate toward the Plan *out-of-pocket limits*. *Covered expenses* for organ transplants performed at a facility other than a Humana National Transplant Network facility do not aggregate toward the Plan *out-of-pocket limits*.

BEHAVIORAL HEALTH INPATIENT SERVICES		
MEDICAL SERVICES	**PAR PROVIDER BENEFIT**	**NON-PAR PROVIDER BENEFIT**
Inpatient *Behavioral Health* Room and Board and Ancillary *Services*	Payable the same as medical inpatient *hospital services*.	Payable the same as medical inpatient *hospital services*.
Inpatient *Behavioral Health* Professional *Services*	Payable the same as medical inpatient *qualified practitioner services*.	Payable the same as medical inpatient *qualified practitioner services*.
Behavioral Health Partial Hospitalization	Payable the same as medical outpatient non-surgical *hospital services*.	Payable the same as medical outpatient non-surgical *hospital services*.
Behavioral Health Residential Treatment Facility Services	Payable the same as inpatient *behavioral health services*.	Payable the same as inpatient *behavioral health services*.
Behavioral Health Half-way House *Services*	Not Covered	Not Covered

BEHAVIORAL HEALTH CLINIC, OUTPATIENT AND INTENSIVE OUTPATIENT SERVICES		
MEDICAL SERVICES	**PAR PROVIDER BENEFIT**	**NON-PAR PROVIDER BENEFIT**
Behavioral Health Therapy *Services* (Clinic, Outpatient and *Intensive Outpatient*)	Payable the same as a *qualified practitioner* specialist office visit	Payable the same as a *qualified practitioner* specialist office visit

BEHAVIORAL HEALTH CLINIC, OUTPATIENT AND INTENSIVE OUTPATIENT SERVICES		
MEDICAL SERVICES	**PAR PROVIDER BENEFIT**	**NON-PAR PROVIDER BENEFIT**
Diagnostic Examination (Clinic)	Payable the same as any other *sickness*.	Payable the same as any other *sickness*.
Laboratory and X-ray (Clinic and Outpatient)	Payable the same as any other *sickness*.	Payable the same as any other *sickness*.

AUTISM SERVICES		
MEDICAL SERVICES	**PAR PROVIDER BENEFIT**	**NON-PAR PROVIDER BENEFIT**
Autism Services	Payable the same as any other *sickness*.	Payable the same as any other *sickness*.
Autism Services Limit	$500 monthly benefit (s) per *covered person* age 2-21	

OTHER COVERED EXPENSES		
MEDICAL SERVICES	**PAR PROVIDER BENEFIT**	**NON-PAR PROVIDER BENEFIT**
Other Covered Expenses	Payable the same as any other *sickness*.	Payable the same as any other *sickness*.

MEDICAL COVERED EXPENSES

HOW BENEFITS PAY

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

DEDUCTIBLE

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

The individual *deductible* applies to each *covered person* each *calendar year*. Once a *covered person* meets their individual *deductible*, this Plan will begin to pay benefits for that *covered person*.

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

If *you* and/or *your* covered *dependents* use a combination of *PAR* and *Non-PAR providers*, the *PAR* and *Non-PAR deductibles* will track separately.

COINSURANCE

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

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

OUT-OF-POCKET LIMIT

An *out-of-pocket limit* is a specified dollar amount that must be satisfied, either individually or combined as a covered family, per *calendar year* before a benefit percentage will be increased. The individual and family *out-of-pocket limits* are stated on the Schedule of Benefits.

Once a *covered person* satisfies the separate individual *deductible* and *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.

Once *you* and/or *your* covered *dependents* satisfy the separate family *deductible* and *out-of-pocket limits*, 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.

If *you* and/or *your* covered *dependents* use a combination of *PAR* and *Non-PAR providers*, the *out-of-pocket limits* will track separately.

Penalties, *copayments*, do not apply to the *out-of-pocket limits*.

LIFETIME MAXIMUM BENEFIT

Lifetime maximum means the maximum amount of benefits available while *you* are covered under this Plan. The lifetime maximum benefit is stated on the Schedule of Benefits. Under no circumstances does lifetime mean during the lifetime of the *covered person*. Unless specifically indicated, the lifetime maximum applies to all benefits payable under this Plan.

ROUTINE/PREVENTIVE CHILD CARE SERVICES

Routine/preventive child care *services* are payable as shown on the Schedule of Benefits, if *your* covered *dependent* is not *confined* in a *hospital* or *qualified treatment facility*, and if such expenses are not incurred for diagnosis of a specific *bodily injury* or *sickness*.

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/PREVENTIVE ADULT CARE SERVICES

Routine/preventive adult care *services* are payable as shown on the Schedule of Benefits, if *you* or *your* covered *dependent* are not *confined* in a *hospital* or *qualified treatment facility*, and if such expenses are not incurred for diagnosis of a specific *bodily injury* or *sickness*.

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

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

ROUTINE HEARING SERVICES

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

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

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

QUALIFIED PRACTITIONER SERVICES

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

Second Surgical Opinion

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

Multiple Surgical Procedures

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

1. 50% of the *maximum allowable fee* for the secondary procedure; and
2. 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 20% of the *maximum allowable fee* allowed for the primary surgeon.

Physician Assistant

Physician assistant benefits are payable at 20% of the *maximum allowable fee* allowed for 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 Schedule of Benefits and include the following procedures:

1. Excision of partially or completely unerupted impacted teeth;

2. Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth when such conditions require pathological examination;

3. Surgical procedures required to correct accidental injuries of the jaws, cheeks, lips, tongue, roof and floor of the mouth;

4. Reduction of fractures and dislocations of the jaw;

5. External incision and drainage of cellulitis;

6. Incision of accessory sinuses, salivary glands or ducts;

7. Frenectomy (the cutting of the tissue in the midline of the tongue).

FAMILY PLANNING

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

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

Newborns

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

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

Birthing Centers

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

INPATIENT HOSPITAL

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

SKILLED NURSING FACILITY

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

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

1. Begins while *you* or an eligible *dependent* are covered under this Plan;

2. Begins after discharge from a *hospital confinement* or a prior covered skilled nursing facility *confinement*;

3. Is necessary for care or treatment of the same *bodily injury* or *sickness* which caused the prior *confinement*; and

4. Occurs while *you* or an eligible *dependent* are under the regular care of a physician.

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

1. Permanent and full-time bed care facilities for resident patients;

2. A physician's *services* available at all times;

3. 24-hour-a-day skilled nursing *services* under the full-time supervision of a physician or registered nurse (R.N.);

4. A daily record for each patient;

5. Continuous skilled nursing care for sick or injured persons during their convalescence from *sickness* or *bodily injury*; and

6. A utilization review plan.

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

OUTPATIENT AND AMBULATORY SURGICAL CENTER

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

EMERGENCY AND URGENT CARE SERVICES

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

HOSPICE SERVICES

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

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

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

1. Room and board and other *services* and supplies;

2. Part-time nursing care by, or supervised by, a registered nurse for up to 8 hours per day;

3. Counseling *services* by a *qualified practitioner* for the hospice patient and the immediate family;

4. Medical social *services* provided to *you* or *your* immediate family under the direction of a *qualified practitioner*, which include the following:
   a. Assessment of social, emotional and medical needs, and the home and family situation;
   b. Identification of the community resources available; and
   c. Assistance in obtaining those resources;

5. Nutritional counseling;

6. Physical or occupational therapy;

7. Part-time home health aide service for up to 8 hours in any one day;

8. Medical supplies, drugs and medicines prescribed by a *qualified practitioner*.

Hospice care benefits do NOT include:

1. Private duty nursing *services* when *confined* in a hospice facility;

2. A *confinement* not required for pain control or other acute chronic symptom management;

3. Funeral arrangements;

4. Financial or legal counseling, including estate planning or drafting of a will;

5. Homemaker or caretaker *services*, including a sitter or companion *services*;

6. Housecleaning and household maintenance;

7. *Services* of a social worker other than a licensed clinical social worker;

8. *Services* by volunteers or persons who do not regularly charge for their *services*; or

9. *Services* by a licensed pastoral counselor to a member of his or her congregation when *services* are in the course of the duties to which he or she is called as a pastor or minister.

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

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

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

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

HOME HEALTH CARE

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

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

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

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

1. Hospitalization or *confinement* in a skilled nursing facility would otherwise be required if home care were not provided;

2. Necessary care and treatment are not available from a *family member* or other persons residing with *you*; and

3. The home health care *services* will be provided or coordinated by a state-licensed or *Medicare*-certified home health agency or certified rehabilitation agency.

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

The home health care plan consists of:

1. Care by or under the supervision of a registered nurse (R.N.);

2. Physical, speech, occupational, cognitive and respiratory therapy and home health aide *services*; and

3. Medical supplies, laboratory *services* and nutritional counseling, if such *services* and supplies would have been covered if *you* were *hospital confined*.

Home health care benefits do not include:

1. Charges for mileage or travel time to and from the *covered person's* home;

2. Wage or shift differentials for home health care providers;

3. Charges for supervision of home health care providers;

4. Private duty nursing;

5. *Durable medical equipment* and prosthetics.

DURABLE MEDICAL EQUIPMENT (DME)

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

Prosthetics

Initial prosthetic devices or supplies, including but not limited to, limbs and eyes are payable as shown on the Schedule of Benefits. Coverage will be provided for prosthetic devices necessary to restore minimal basic function. Replacement is a *covered expense* if due to pathological changes. Repair or maintenance of prosthetics is not covered.

AMBULANCE

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

TEMPOROMANDIBULAR JOINT DYSFUNCTION (TMJ)

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

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

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

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

THERAPY SERVICES

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

Chiropractic Care

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

TRANSPLANT SERVICES

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

Precertification

Precertification is required. If *precertification* is not received, transplant *services* will not be covered.

Covered Organ Transplant

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

1. Heart;

2. Lung(s);

3. Liver;

4. Kidney;

5. Bone Marrow*;

6. Intestine;

7. Pancreas;

8. Auto islet cell;

9. Multivisceral;

10. Any combination of the above listed organs;

11. Any organ not listed above required by federal law.

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

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

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

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

Exclusions

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

1. It is *experimental, investigational or for research purposes* as defined in the Definitions section;

2. Humana is not contacted for authorization prior to referral for evaluation of the transplant;

3. Humana does not approve coverage for the transplant, based on its established criteria;

4. Expenses are eligible to be paid under any private or public research fund, government program, except Medicaid, or another funding program, whether or not such funding was applied for or received;

5. The expense relates to the transplantation of any non-human organ or tissue, unless otherwise stated in this Plan;

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

7. A denied transplant is performed; this includes the pre-transplant evaluation, pre-transplant *services*, the transplant procedure, post-discharge *services*, immunosuppressive drugs and complications of such transplant;

8. The *covered person* for whom a transplant is requested has not met pre-transplant criteria as established by Humana.

Covered Services

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

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

2. Organ acquisition and donor costs. Except for bone marrow transplants, donor costs are not payable under this Plan if they are payable in whole or in part by any other group plan, insurance company, organization or person other than the donor's family or estate. Coverage for bone marrow transplants procedures will include costs associated with the donor-patient to the same extent and limitations associated with the *covered person;*

3. Direct, non-medical costs for the *covered person*, when the transplant is performed at a Humana National Transplant Network facility, will be paid as shown on the Schedule of Benefits, for: (a) transportation to and from the *hospital* where the transplant is performed; and (b) temporary lodging at a prearranged location when requested by the *hospital* and approved by Humana. These direct, non-medical costs are only available if the *covered person* lives more than 100 miles from the transplant facility;

4. Direct, non-medical costs for one support person of the *covered person* (two persons if the patient is under age 18 years), when the transplant is performed at a Humana National Transplant Network facility, will be paid as shown on the Schedule of Benefits, for: (a) transportation to and from the approved facility where the transplant is performed; and (b) temporary lodging at a prearranged location during the *covered person's confinement* in the *hospital*. These direct, non-medical costs are only available if the *covered person's* support person(s) live more than 100 miles from the transplant facility.

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

BEHAVIORAL HEALTH SERVICES

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

1. Charges made by a *qualified practitioner*;

2. Charges made by a *hospital*;

3. Charges made by a *qualified treatment facility*;

4. Charges for x-ray and laboratory expenses.

Inpatient Services

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

Autism Services

Covered expenses for *autism* benefits are payable as shown below, subject to the lifetime maximum of the *Plan*.

Covered expenses for *autism* benefits aggregate toward the *out-of-pocket limits* described on the Schedule of Benefits.

Autism benefits are for rehabilitative, therapeutic and respite *services*. There is a $500 monthly benefit for children 2 through 21 years of age. This benefit shall not apply to other health or *mental health conditions* which are not related to the treatment of *autism*.

Limitations

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

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

OTHER COVERED EXPENSES

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

1. Blood and blood plasma are payable as long as it is NOT replaced by donation, and administration of blood and blood products including blood extracts or derivatives;

2. Casts, trusses, crutches, *orthotics*, splints and braces. *Orthotics* must be custom made or custom fitted, made of rigid or semi-rigid material. Oral or dental splints and appliances must be custom made and for the treatment of documented obstructive sleep apnea. Unless specifically stated otherwise, fabric supports, replacement *orthotics* and braces, oral splints and appliances, dental splints and appliances, and dental braces are not a *covered expense*;

3. Reconstructive *surgery* due to *bodily injury*, infection or other disease of the involved part or congenital disease or anomaly of a covered *dependent* child which resulted in a *functional impairment*;

4. Reconstructive *services* following a covered mastectomy, including but not limited to:
   a. Reconstruction of the breast on which the mastectomy was performed;
   b. Reconstruction of the other breast to achieve symmetry;
   c. Prosthesis; and
   d. Treatment of physical complications of all stages of the mastectomy, including lymphedemas;

5. Routine costs associated with clinical trials, when approved by this Plan. For additional details, go to www.humana.com, click on "Humana Websites for Providers" along the left hand side of the page, then click "Medical Coverage Policies" under Critical Topics, then click "Medical Coverage Policies" and search for Clinical Trials;

6. Benefit plans that provide coverage for general anesthesia and hospitalization *services* to a *covered person* shall provide coverage for payment of anesthesia and *hospital* or facility charges for *services* performed in a *hospital* or ambulatory surgical facility in connection with dental procedures for children below the age of 9 years, persons with serious mental or physical conditions, and persons with significant behavioral problems, where the admitting physician or treating dentist certifies that, because of the patient's age, condition or problem, hospitalization or general anesthesia is required in order to safely and effectively perform the procedures. The same *deductibles*, *coinsurance*, network requirements, *medical necessity* provisions, and other limitations as applied to physical *sickness* benefits shall apply to coverage for anesthesia and *hospital* or facility charges covered in this section;

7. *Telehealth* Consultation *services*. Covered *services* include a medical or health consultation for purposes of patient diagnosis or treatment that requires the use of advanced telecommunications technology, including, but not limited to: (a) compressed digital interactive video, audio, or data transmission; and (b) clinical data transmission via computer imaging for teleradiology or telephathology; and (c) other technology that facilitates access to other covered health care *services* or medical specialty expertise;

8. Coverage for *hearing aids* and related services, PAR and Non-PAR provider *covered expenses* aggregate to a maximum of $1,400 limit per *hearing aid*, per hearing impaired ear, once every three years;

9. Cochlear Implants – Coverage for cochlear implants for members diagnosed with profound hearing impairment.

LIMITATIONS AND EXCLUSIONS

This Plan does not provide benefits for:

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

2. Immunizations required for foreign travel;

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

4. *Services* related to gender change;

5. Cosmetic *surgery* and cosmetic *services* or devices, unless for reconstructive *surgery*:
   a. Resulting from a *bodily injury*, infection or other disease of the involved part, when *functional impairment* is present; or
   b. Resulting from a congenital disease or anomaly of a covered *dependent* child which resulted in a *functional impairment*;

   Expense incurred for reconstructive *surgery* performed due to the presence of a psychological condition is not covered, unless the condition(s) described above are also met;

6. Hair prosthesis, hair transplants or hair implants;

7. Dental *services* or appliances for the treatment of the teeth, gums, jaws or alveolar processes, including but not limited to, implants and related procedures, routine dental extractions and orthodontic procedures, unless specifically provided under this Plan;

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

9. Marriage counseling;

10. *Court-ordered mental health* or *substance abuse services*;

11. Education or training, unless otherwise specified in this Plan;

12. 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;

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

14. Any medical treatment, procedure, drug, biological product or device which is *experimental, investigational or for research purposes*, unless otherwise specified in this Plan;

15. *Services* not *medically necessary* for diagnosis and treatment of a *bodily injury* or *sickness*;

16. Charges in excess of the *maximum allowable fee* for the *service*;

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

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

19. *Expenses incurred* for which *you* are entitled to receive benefits under *your* previous dental or medical plan;

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

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

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

23. Treatment of nicotine habit or addiction, including, but not limited to hypnosis, smoking cessation products, classes or tapes, unless otherwise determined by this Plan;

24. Vitamins, dietary supplements and dietary formulas except enteral formulas, nutritional supplements or low protein modified food products for the treatment of an inherited metabolic disease, e.g. phenylketonuria (PKU);

25. *Prescription* drugs and *self-administered injectable drugs*, unless administered to *you*:
    a. While inpatient in a *hospital*, *qualified treatment facility* or skilled nursing facility; or
    b. By the following, when deemed appropriate by this Plan: a *qualified practitioner*, during an office visit, while outpatient, or at a home health care agency as part of a covered home health care plan approved by this Plan.

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

27. *Off-evidence drug indications*;

28. Over-the-counter, non-prescription medications;

29. Growth hormones (medications, drugs or hormones to stimulate growth);

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

31. Professional pathology or radiology charges, including but not limited to, blood counts, multi-channel testing, and other clinical chemistry tests, when:
    a. The *services* do not require a professional interpretation, or
    b. The *qualified practitioner* did not provide a specific professional interpretation of the test results of the *covered person*.

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

33. Expenses for health clubs or health spas, aerobic and strength conditioning, work-hardening programs or weight loss or similar programs, and all related material and product for these programs;

34. *Alternative medicine*;

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

36. *Services* of a midwife, unless provided by a Certified Nurse Midwife;

37. The following types of care of the feet:
    a. Shock wave therapy of the feet.
    b. The treatment of weak, strained, flat, unstable or unbalanced feet.
    c. Hygienic care and the treatment of superficial lesions of the feet, such as corns, calluses or hyperkeratosis.
    d. The treatment of tarsalgia, metatarsalgia, or bunion, except surgically.
    e. The cutting of toenails, except the removal of the nail matrix.
    f. The provision of heel wedges, lifts or shoe inserts.
    g. The provision of arch supports or orthopedic shoes. Arch supports and orthopedic shoes are covered if *medically necessary* because of diabetes or hammertoe.

38. *Custodial care* and *maintenance care*;

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

40. *Hospital* inpatient *services* when *you* are in observation status;

41. *Services* rendered by a standby physician, surgical assistant, assistant surgeon, physician assistant, registered nurse or certified operating room technician unless *medically necessary*;

42. *Ambulance services* for routine transportation to, from or between medical facilities and/or a *qualified practitioner's* office;

43. *Preadmission*/procedural testing duplicated during a *hospital confinement*;

44. Lodging accommodations or transportation, unless specifically provided under this Plan;

45. Communications or travel time;

46. No benefits will be provided for the following, unless otherwise determined by this Plan:
    a. Immunotherapy for recurrent abortion;
    b. Chemonucleolysis;
    c. Biliary lithotripsy;
    d. Home uterine activity monitoring;
    e. Sleep therapy;
    f. Light treatments for Seasonal Affective Disorder (S.A.D.);
    g. Immunotherapy for food allergy;
    h. Prolotherapy;
    i. Cranial banding;
    j. Hyperhidrosis *surgery*;
    k. Lactation therapy; or
    l. Sensory integration therapy;

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

48. Any *bodily injury* or *sickness* arising from or sustained in the course of any occupation or employment for compensation, profit or gain for which:
    a. Benefits are provided or payable under any Workers' Compensation or Occupational Disease Act or Law, or
    b. Coverage was available under any Workers' Compensation or Occupational Disease Act or Law regardless of whether such coverage was actually purchased;

49. Routine physical examinations and related *services* for occupation, employment, school, sports, camp, travel, purchase of insurance or premarital tests or examinations, unless specifically provided under this Plan;

50. Surrogate parenting;

51. Routine vision examinations;

52. Routine vision refraction;

53. The purchase, fitting or repair of eyeglass frames and lenses or contact lenses, unless specifically provided under this Plan;

54. Vision therapy;

55. Elective medical or surgical abortion, unless:
    a. The pregnancy would endanger the life of the mother; or
    b. The pregnancy is a result of rape or incest; or
    c. The fetus has been diagnosed with a lethal or otherwise significant abnormality;

56. Services for a reversal of sterilization;

57. Birth control pills and patches;

58. Private duty nursing;

59. Wigs;

60. Any treatment for weight loss, both surgical and non-surgical, for obesity that is not *morbid obesity*;

61. Any surgical and non-surgical treatment for *morbid obesity*, unless specifically stated otherwise in this Plan;

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

63. Any treatment:
    a. For obesity, which includes *morbid obesity*
    b. For obesity, which includes *morbid obesity*, for the purpose of treating a *sickness* or *bodily injury* caused by, complicated by, or exacerbated by the obesity.

64. No benefits will be provided for, or on account of, the following items:
    a. Expenses for a *bariatric surgery* that are *experimental, investigational or for research purposes*;
    b. *Bariatric services* not approved by this Plan based on this Plan's established criteria;
    c. *Bariatric services* for a *bariatric surgery* denied by this Plan;
    d. *Bariatric services* for which *you* have not met criteria as established by this Plan;
    e. Expenses for *bariatric surgery* performed outside of the United Sates;
    f. Any care resulting from a non-covered *bariatric surgery*;

65. Dental osteotomies;

66. Infertility counseling and treatment *services*;

67. Artificial means to achieve pregnancy or ovulation, including, but not limited to, artificial insemination, in vitro fertilization, spermatogenesis, gamete intra fallopian transfer (GIFT), zygote intra fallopian transfer (ZIFT), tubal ovum transfer, embryo freezing or transfer and sperm banking;

68. Services related to the treatment and/or diagnosis of sexual dysfunction/impotence;

69. Acupuncture;

70. Residential *treatment facilities*, unless specifically provided under this Plan;

71. Halfway-house *services*;

72. Pre-existing conditions.

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

COORDINATION OF BENEFITS

BENEFITS SUBJECT TO THIS PROVISION

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

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

1. Employer, trustee, union, employee benefit, or other association; or

2. Governmental programs, programs mandated by state statute, or sponsored or provided by an educational institution.

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

EFFECT ON BENEFITS

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

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

ORDER OF BENEFIT DETERMINATION

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

1. The plan has no coordination of benefits provision;

2. The plan covers the person as an *employee*;

3. For a child who is covered under both parents' plans, the plan covering the parent whose birthday (month and day) occurs first in the *calendar year* pays before the plan covering the other parent. If the birthdates of both parents are the same, the plan which has covered the person for the longer period of time will be determined the primary plan;

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

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

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

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

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

COORDINATION OF BENEFITS WITH MEDICARE

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

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

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

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

OPTIONS

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

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

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

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

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

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

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

CALCULATION AND PAYMENT OF BENEFITS

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

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

RIGHT OF RECOVERY

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

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

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

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

CLAIM PROCEDURES

SUBMITTING A CLAIM

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

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

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

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

- Claims submissions must be timely. Claims must be filed as soon as reasonably possible after they are incurred, and in no event later than 15 months after the date of loss, except if *you* were legally incapacitated. Plan benefits are only available for claims that are incurred by a *covered person* during the period that he or she is covered under this Plan;

- Claims submissions must be complete. They must contain, at a minimum:
  a. The name of the *covered person* who incurred the *covered expense*;
  b. The name and address of the health care provider;
  c. The diagnosis of the condition;
  d. The procedure or nature of the treatment;
  e. The date of and place where the procedure or treatment has been or will be provided;
  f. The amount billed and the amount of the *covered expense* not paid through coverage other than Plan coverage, as appropriate;
  g. Evidence that substantiates the nature, amount, and timeliness of each *covered expense* in a format that is acceptable according to industry standards and in compliance with applicable law.

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

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

Mail medical claims and correspondence to:

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

MISCELLANEOUS MEDICAL CHARGES

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

PROCEDURAL DEFECTS

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

ASSIGNMENTS AND REPRESENTATIVES

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

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

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

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

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

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

CLAIMS DECISIONS

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

Pre-Service Claims

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

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

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

Urgent Care Claims

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

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

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

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

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

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

Concurrent Care Decisions

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

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

Post-Service Claims

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

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

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

TIMES FOR DECISIONS

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

PAYMENT OF CLAIMS

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

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

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

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

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

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

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

NOTICES – GENERAL INFORMATION

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

1. The date of service;

2. The health care provider;

3. The claim amount, if applicable;

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

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

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

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

INITIAL DENIAL NOTICES

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

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

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

The notice will describe this Plan's review procedures and the time limits applicable to such procedures, including a statement of the *claimant's* right to bring a civil action.

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

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

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

APPEALS OF ADVERSE BENEFIT DETERMINATIONS

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

A first level and second level *appeal* must be made by a *claimant* by means of written application, in person, or by mail (postage prepaid), addressed to:

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

Appeals of denied claims will be conducted promptly, will not defer to the initial determination, and will not be made by the person who made the initial adverse claim determination or a subordinate of that person. The determination will take into account all comments, documents, records, and other information submitted by the *claimant* relating to the claim.

A *claimant* may review relevant documents and may submit issues and comments in writing. A *claimant* on *appeal* may, upon request, discover the identity of medical or vocational experts whose advice was obtained on behalf of this Plan in connection with the *adverse benefit determination* being appealed, as permitted under applicable law.

If the claims denial being appealed is based in whole, or in part, upon a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is *experimental, investigational, or for research purposes*, or not *medically necessary* or appropriate, the person deciding the *appeal* will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The consulting health care professional will not be the same person who decided the initial *appeal* or a subordinate of that person.

Time Periods for Decisions on Appeal -- First Level

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

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

Time Periods for Decisions on Appeal -- Second Level

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

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

APPEAL DENIAL NOTICES

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

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

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

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

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

1. Relied on in making the determination;

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

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

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

RIGHT TO REQUIRE MEDICAL EXAMINATIONS

(Applies only to medical plans)

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

EXHAUSTION

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

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

LEGAL ACTIONS AND LIMITATIONS

No action at law or in equity 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 state/federal limitations period under applicable state/federal law.

STANDARD EXTERNAL REVIEW

Request for an External Review

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

Lexington Fayette Urban County Government
200 E. Main Street
Lexington, KY 40507

Preliminary Review

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

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

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

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

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

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

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

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

Referral to an Independent Review Organization (IRO)

The *Plan Administrator* must assign an independent *IRO* that is accredited by URAC, or another nationally-recognized accreditation organization to conduct the *external review*. The *Plan Administrator* 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 the *Plan Administrator* and the *IRO* must provide for the following:

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

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

3. The *Plan Administrator* 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 the *Plan Administrator* within 1 business day of making the decision.

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

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

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

7. After a *final external review decision*, the *IRO* must maintain records of all claims and notices associated with the *external review* process for 6 years. An *IRO* must make such records available for examination by the *claimant*, the *Plan Administrator***]**, 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 the *Plan Administrator* 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

The *Plan*
meets the reviewability requirements for a standard *external review Administrator* must allow a *claimant* to make a request for an expedited *external review* at the time the *claimant* receives:

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

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

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

Lexington Fayette Urban County Government
200 E. Main Street
Lexington, KY 40507

Preliminary Review

The *Plan Administrator* must determine whether the request immediately upon receiving the request for an expedited *external review*. The *Plan Administrator* 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 the *Plan Administrator* determines that the request is eligible for *external review*, the *Plan Administrator* will assign an *IRO* as required under the Standard External Review, Referral to an Independent Review Organization (IRO) section. The *Plan Administrator* 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 the *Plan Administrator*.

IF YOU HAVE QUESTIONS

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

STATE CONSUMER ASSISTANCE OR OMBUDSMAN

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:

Kentucky Department of Insurance, Consumer Protection Division
P.O. Box 517
Frankfort, KY 40602
(877) 587-7222
http://healthinsurancehelp.ky.gov
DOI.CAPOmbudsman@ky.gov

SECTION 3

ELIGIBILITY AND EFFECTIVE DATE OF COVERAGE

ELIGIBILITY AND EFFECTIVE DATE OF COVERAGE

OPEN ENROLLMENT

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

EMPLOYEE ELIGIBILITY

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

1. *You* are an *employee* who meets the eligibility requirements of the *employer*; and

2. *You* are a full-time or part-time permanent *employee* working 100 hours per month; or

3. *You* are a retired Police Officer or Firefighter.

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

EMPLOYEE EFFECTIVE DATE OF COVERAGE

You must enroll in a manner acceptable to Humana.

1. If *your* completed enrollment is received by Humana before *your* eligibility date or within 31 days after *your* eligibility date, *your* coverage is effective on *your* eligibility date;

2. If *your* completed enrollment is received by Humana more than 31 days after *your* eligibility date, *you* are a *late applicant*. *You* will not be eligible for coverage under this Plan until the next annual Open Enrollment Period.

DEPENDENT ELIGIBILITY

Each *dependent* is eligible for coverage on:

1. The date the *employee* is eligible for coverage, if he or she has *dependents* who may be covered on that date; or

2. The date of the *employee's* marriage for any *dependent* acquired on that date; or

3. The date of birth of the *employee's* natural-born child; or

4. The date a child is placed for adoption under the *employee's* legal guardianship, or the date which the *employee* incurs a legal obligation for total or partial support in anticipation of adoption; or

5. The date a covered *employee's* child is determined to be eligible as an alternate recipient under the terms of a medical child support order.

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

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

DEPENDENT EFFECTIVE DATE OF COVERAGE - WHEN A CHANGE IN THE EMPLOYEE'S LEVEL OF COVERAGE IS NOT REQUIRED:

If the *employee* wishes to add a *dependent* to this Plan and a change in the *employee's* level of coverage is not required, the *dependent's* effective date of coverage is determined as follows:

1. If the completed enrollment is received by Humana before the *dependent's* eligibility date or within 31 days after the *dependent's* eligibility date, that *dependent* is covered on the date he or she is eligible.

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

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

A *dependent* child who becomes eligible for other group coverage through any employment is no longer eligible for coverage under this Plan.

DEPENDENT EFFECTIVE DATE OF COVERAGE - WHEN A CHANGE IN THE EMPLOYEE'S LEVEL OF COVERAGE IS REQUIRED:

If the *employee* wishes to add a *dependent* to this Plan and a change in the *employee's* level of coverage is required, enrollment must be completed and submitted to Humana.

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

1. If the completed enrollment is received by Humana before the *dependent's* eligibility date or within 31 days after the *dependent's* eligibility date, that *dependent* is covered on the date he or she is eligible.

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

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

A *dependent* child who becomes eligible for other group coverage through any employment is no longer eligible for coverage under this Plan.

MEDICAL CHILD SUPPORT ORDERS

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

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

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

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

CREDITABLE COVERAGE

Once *you* or *your dependents* obtain health plan coverage, *you* are entitled to use evidence of that coverage to reduce or eliminate any pre-existing condition limitation period that might otherwise be imposed when *you* become covered under a subsequent health plan. Evidence may include a certificate of prior creditable coverage. The length of any pre-existing condition limitation period under the subsequent health plan must be reduced by the number of days of creditable coverage.

SPECIAL PROVISIONS DUE TO LOSS OF ELIGIBILITY

If *your employer* continues to pay required contributions and does not terminate the Plan, *your* coverage will remain in force for:

1. No longer than the end of the month of a layoff;
2. No longer than the end of the month during an approved medical leave of absence;
3. No longer than the end of the month during a period of *total disability*;
4. No longer than the end of the month during an approved non-medical leave of absence;
5. No longer than the end of the month during an approved military leave of absence;
6. No longer than the end of the month during part-time status.

REINSTATEMENT OF COVERAGE FOLLOWING LOSS OF ELIGIBILITY

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

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

FAMILY AND MEDICAL LEAVE ACT (FMLA)

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

RETIREE COVERAGE

If *you* are retired Police Officer or Firefighter with at least 20 years of continuous service, *you* may continue coverage under the Plan with retiree benefits for *you* and any of *your* eligible *dependents* provided such coverage was effective at the time of *your* retirement. *Dependents* acquired through marriage after *your* early retirement may be added by *timely enrollment.* Please see *your employer* for more details.

SURVIVORSHIP COVERAGE

If a Police Officer or Firefighter dies while covered under this Plan, the surviving spouse and any eligible *dependent* children may continue coverage under this Plan as determined by the *employer* and *dependent* children reach 23 years of age, subsequent to the *employee's* date of death. Any *dependents* acquired through the remarriage of the *employee's* surviving spouse will be eligible as determined by the *employer*.

SPECIAL ENROLLMENT

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

1. Loss of eligibility for the coverage due to any of the following:
    a. Legal separation;
    b. Divorce;
    c. Cessation of *dependent* status (such as attaining the limiting age);
    d. Death;
    e. Termination of employment;
    f. Reduction in the number of hours of employment;
    g. Meeting or exceeding a lifetime limit on all benefits;
    h. Plan no longer offering benefits to a class of similarly situated individuals, which includes the *employee*;

i. Any loss of eligibility after a period that is measured by reference to any of the foregoing.

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

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

3. COBRA coverage under the other plan has since been exhausted.

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

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

1. Marriage;

2. Birth;

3. Adoption or placement for adoption;

4. Loss of eligibility due to termination of Medicaid or State Children's Health Insurance Program (SCHIP) coverage; or

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

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

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

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

If *you* apply more than 31 days after a qualifying event or 60 days from such event as identified in #4 and #5 above, *you* are considered a *late applicant*. You will not be eligible for coverage under this Plan until the next annual Open Enrollment Period.

Please see *your employer* for more details.

TERMINATION OF COVERAGE

Coverage terminates on the earliest of the following:

1. The date this Plan terminates;

2. The end of the period for which any required contribution was due and not paid;

3. The end of the calendar month *you* enter full-time military, naval or air service, except coverage may continue during an approved military leave of absence as indicated in the Special Provisions Due to Loss of Eligibility provision;

4. The end of the calendar month *you* fail to be in an eligible class of persons according to the eligibility requirements of the *employer*;

5. For all *employees*, the end of the calendar month in which you terminate employment with *your employer*;

6. For all *employees*, except Police Officers and Firefighters, the end of the calendar month you retire;

7. The end of the calendar month *you* request termination of coverage to be effective for *yourself*;

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

9. For *your dependents*, the date *your* coverage terminates;

10. For a *dependent* child, the birthday such *covered person* no longer meets the definition of *dependent*

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

SECTION 4

GENERAL PROVISIONS AND REIMBURSEMENT/ SUBROGATION

GENERAL PROVISIONS

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

PLAN ADMINISTRATION

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

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

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

RESCISSION

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

CONTESTABILITY

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

RIGHT TO REQUEST OVERPAYMENTS

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

1. Made in error; or

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

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

WORKERS' COMPENSATION NOT AFFECTED

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

WORKERS' COMPENSATION

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

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

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

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

4. The medical or health care benefits are specifically excluded from the Workers' Compensation settlement or compromise.

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

MEDICAID

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

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

CONSTRUCTION OF PLAN TERMS

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

REIMBURSEMENT/SUBROGATION

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

1. This Plan shall be repaid the full amount of the *covered expenses* it pays from any amount received from others for the *bodily injuries* or losses which necessitated such *covered expenses*. Without limitation, "amounts received from others" specifically includes, but is not limited to, liability insurance, worker's compensation, uninsured motorists, underinsured motorists, "no-fault" and automobile med-pay payments or recovery from any identifiable fund regardless of whether the *beneficiary* was made whole.

2. This Plan's right to repayment is, and shall be, prior and superior to the right of any other person or entity, including the *beneficiary*.

3. The right to recover amounts from others for the injuries or losses which necessitate *covered expenses* is jointly owned by this Plan and the *beneficiary*. This Plan is subrogated to the *beneficiary's* rights to that extent. Regardless of who pursues those rights, the funds recovered shall be used to reimburse this Plan as prescribed above; this Plan has no obligation to pursue the rights for an amount greater than the amount that it has paid, or may pay in the future. The rights to which this Plan is subrogated are, and shall be, prior and superior to the rights of any other person or entity, including the *beneficiary*.

4. The *beneficiary* will cooperate with this Plan in any effort to recover from others for the *bodily injuries* and losses which necessitate *covered expense* payments by this Plan. The *beneficiary* will notify this Plan immediately of any claim asserted and any settlement entered into, and will do nothing at any time to prejudice the rights and interests of this Plan. Neither this Plan nor the *beneficiary* shall be entitled to costs or attorney fees from the other for the prosecution of the claim.

RIGHT TO COLLECT NEEDED INFORMATION

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

- Authorizing the release of medical information including the names of all providers from whom *you* received medical attention;

- Obtaining medical information and/or records from any provider as requested by Humana;

- Providing information regarding the circumstances of *your sickness* or *bodily injury*;

- Providing information about other insurance coverage and benefits, including information related to any *bodily injury* or *sickness* for which another party may be liable to pay compensation or benefits; and

- Providing information Humana requests to administer this Plan.

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

DUTY TO COOPERATE IN GOOD FAITH

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

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

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

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

SECTION 5

NOTICES

IMPORTANT NOTICES FOR EMPLOYEES AND SPOUSES AGE 65 AND OVER

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

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

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

- Individuals receiving disability benefits from an employer for up to 6 months; or

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

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

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

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

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

PRIVACY OF PROTECTED HEALTH INFORMATION

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

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

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

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

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

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

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

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

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

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

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

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

CONTINUATION OF MEDICAL BENEFITS

THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1986 (COBRA)

CONTINUATION OF BENEFITS

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

ELIGIBILITY

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

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

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

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

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

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

- The death of the *employee* parent;
- The termination of the *employee* parent's employment (for reasons other than gross misconduct, as defined by *your employer*) or reduction in the *employee* parent's hours of employment with the *employer*;
- The *employee* parent's divorce or legal separation;
- Ceasing to be a "*dependent* child" under this Plan;
- The *employee* parent becomes entitled to *Medicare* benefits; or
- Termination of the retiree parent's coverage when the former *employer* discontinues retiree coverage within one year before or one year after filing for Chapter 11 bankruptcy.

LOSS OF COVERAGE

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

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

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

NOTICES AND ELECTION

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

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

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

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

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

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

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

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

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

MAXIMUM COVERAGE PERIOD

Coverage may continue up to:

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

- 36 months for a spouse whose coverage ended due to the death of the *employee* or retiree, divorce, or the *employee* becoming entitled to *Medicare* at the time of the initial qualifying event;

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

- For the retiree, until the date of death of the retiree who is on continuation due to loss of coverage within one year before or one year after the *employer* filed Chapter 11 bankruptcy.

DISABILITY

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

SECOND QUALIFYING EVENT

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

TERMINATION BEFORE THE END OF MAXIMUM COVERAGE PERIOD

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

- The *employer* no longer provides group health coverage to any of its *employees*;
- The premium for continuation is not paid timely;
- The individual on continuation becomes covered under another group health plan (as an *employee* or otherwise); however, if the new plan coverage contains any exclusion or limitation with respect to any pre-existing condition, then continuation coverage will end for this reason only after the exclusion or limitation no longer applies or prior *creditable coverage* satisfies the exclusion or limitation;

  NOTE: The federal Health Insurance Portability and Accountability Act of 1996 requires portability of health care coverage effective for plan years beginning after June 30, 1997, an exclusion or limitation under the other group health plan may not apply at all to the qualified beneficiary, depending on the length of his or her prior creditable coverage. Portability means once *you* obtain health insurance, *you* will be able to use evidence of that insurance to reduce or eliminate any pre-existing medical condition limitation period (under certain circumstances) when *you* move from one health plan to another.

- The individual on continuation becomes entitled to *Medicare* benefits;

- If there is a final determination under Title II or XVI of the Social Security Act that an individual is no longer disabled; however, continuation coverage will not end until the month that begins more than 30 days after the determination;

- The occurrence of any event (e.g. submission of a fraudulent claim) permitting termination of coverage for cause under this Plan.

TYPE OF COVERAGE; PREMIUM PAYMENT

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

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

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

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

OTHER INFORMATION

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

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

PLAN CONTACT INFORMATION

Ceridian COBRA Continuation Services
3201 34th Street South
St. Petersburg, FL 33711-3828
Toll-Free: 1-800-488-8757

Humana Insurance Company
Billing/Enrollment Department
101 E. Main Street
Louisville, KY 40201
Toll-Free: 1-800-872-7207

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

CONTINUATION OF BENEFITS

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

ELIGIBILITY

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

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

PREMIUM PAYMENT

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

DURATION OF COVERAGE

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

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

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

OTHER INFORMATION

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

ADDITIONAL NOTICES

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

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

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

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

THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996

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

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

PLAN DESCRIPTION INFORMATION

1. Proper Name of Plan: Lexington Fayette Urban County Government Employee Plan

2. *Plan Sponsor*:

   Lexington Fayette Urban County Government
   200 E. Main Street
   Lexington, KY 40507
   Telephone: 859-258-3000

3. *Employer*:

   Lexington Fayette Urban County Government
   200 E. Main Street
   Lexington, KY 40507
   Telephone: 859-258-3000

   Common Name of *Employer*: Lexington Fayette Urban County Government

4. *Plan Administrator*, Named Fiduciary and Claim Fiduciary:

   Lexington Fayette Urban County Government
   200 E. Main Street
   Lexington, KY 40507
   Telephone: 859-258-3000

5. *Employer* Identification Number: 61-0858140

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

7. Plan benefits described in this booklet are effective January 1, 2012.

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

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

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

    Janet Graham, Commissioner of Law
    200 E. Main Street
    Lexington, KY 40507

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

    Humana Insurance Company
    500 West Main Street
    Louisville, KY 40202
    Telephone: Refer to *your* ID card

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

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

14. This Plan's benefits and/or contributions may be modified or amended from time to time, or may be terminated at any time by the *Plan Sponsor*. Significant changes to this Plan, including termination, will be communicated to participants as required by applicable law.

15. Upon termination of this Plan, the rights of the participants to benefits are limited to claims incurred and payable by this Plan up to the date of termination. Plan assets, if any, will be allocated and disposed of for the exclusive benefit of the participating *employees* and their *dependents* covered by this Plan, except that any taxes and administration expenses may be made from this Plan's assets.

16. This Plan does not constitute a contract between the *employer* and any *covered person* and will not be considered as an inducement or condition of the employment of any *employee*. Nothing in this Plan will give any *employee* the right to be retained in the service of the *employer*, or for the *employer* to discharge any *employee* at any time.

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

SECTION 6

DEFINITIONS

DEFINITIONS

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

A

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

Active status means the *employee* is performing on a regular, full-time basis all customary occupational duties for 40 hours per week or part-time basis all customary occupational duties for 100 hours per month, at the *employer's* business locations or when required to travel for the *employer's* business purposes. Each day of a regular paid vacation and any regular non-working holiday will be deemed *active status* if *you* were in an *active status* on *your* last regular working day prior to the vacation or holiday.

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

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

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

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

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

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

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

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

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

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

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

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

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

1. It must be staffed by physicians and a medical staff which includes registered nurses;

2. It must have permanent facilities and equipment for the primary purpose of performing *surgery*;

3. It must provide continuous physicians' *services* on an outpatient basis;

4. It must admit and discharge patients from the facility within a 24-hour period;

5. It must be licensed in accordance with the laws of the jurisdiction where it is located. It must be operated as an *ambulatory surgical center* as defined by those laws;

6. It must not be used for the primary purpose of terminating pregnancies, or as an office or clinic for the private practice of any physician or dentist.

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

Autism means a condition affecting a *covered person* ages two (2) through twenty-one (21) years of age, which includes:

(A) A total of six (6) or more items from subparagraphs 1, 2, and 3 of this paragraph, with at least two (2) from subparagraph 1 and one (1) each from subparagraphs 2 and 3:
   1. Qualitative impairment in social interaction, as manifested by at least two (2) of the following:
      a. Marked impairment in the use of multiple nonverbal behavior such as eye-to-eye gaze, facial express, body postures, and gestures to regulate social interaction;
      b. Failure to develop peer relationships appropriate to developmental level;
      c. A lack of spontaneous seeking to share enjoyment, interests or achievement with other people; or
      d. Lack of social or emotional reciprocity.
   2. Qualitative impairments in communications as manifested by at least one (1) of the following:
      a. Delay in, or total lack of, the development of spoken language;
      b. In individuals with adequate speech, marked impairment in the ability to imitate or sustain a conversation with others;
      c. Stereotyped and repetitive use of language or idiosyncratic language; or
      d. Lack of varied, spontaneous make-believe play or social imitative play appropriate to developmental levels.

3. Restricted repetitive and stereotyped patterns of behavior, interests, and activities, as manifested by at least one (1) of the following:
    a. Encompassing preoccupation with one (1) or more stereotyped and restricted patterns of interest that is abnormal either in intensity or focus;
    b. Apparently inflexible adherence to specific, nonfunctional routines or rituals;
    c. Stereotyped and repetitive motor mannerisms; or
    d. Persistent preoccupation with parts or objects.

(B) Delays or abnormal functioning in at least one (1) of the following areas, with onset prior to age three (3) years;
1. Social interaction;
2. Language as used in social communication; or
3. Symbolic or imaginative play; and

(C) The disturbance is not better accounted for by Rett's Disorder or Childhood Disintegrative Disorder.

B

Bariatric services means the *bariatric surgery* and the post-discharge *services* and expenses related to complications following an approved *bariatric surgery*.

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

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

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

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

C

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

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

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

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

Complications of pregnancy means:

1. Conditions whose diagnoses are distinct from pregnancy but adversely affected by pregnancy or caused by pregnancy. Such conditions include: acute nephritis, nephrosis, cardiac decompensation, hyperemesis gravidarum, puerperal infection, toxemia, eclampsia and missed abortion;

2. A non-elective cesarean section surgical procedure;

3. Terminated ectopic pregnancy; or

4. Spontaneous termination of pregnancy which occurs during a period of gestation in which a viable birth is not possible.

Complications of pregnancy do not mean:

1. False labor;

2. Occasional spotting;

3. Prescribed rest during the period of pregnancy;

4. Conditions associated with the management of a difficult pregnancy but which do not constitute distinct *complications of pregnancy*; or

5. An elective cesarean section.

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

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

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

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

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

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

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.

Creditable coverage means the total time of prior continuous health plan coverage periods used to reduce the length of any pre-existing condition limitation period applicable to *you* or *your dependents* under this Plan where these prior continuous health coverage(s) existed with no more than a 63-consecutive day lapse in coverage.

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

D

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

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

Dependent means a covered *employee's*:

1. Legally recognized spouse;

2. Unmarried natural blood related child, step-child, legally adopted child or child placed with the *employee* for adoption, or child for which the *employee* has legal guardianship whose age is less than the limiting age.

   The limiting age for each *dependent* child is the birthday he or she attains the age of 26 years. *Your* child is covered to the limiting age regardless if the child is:
   a. Married;
   b. A tax dependent;
   c. A student;
   d. Employed; or
   e. Residing with or receives financial support from *you*.

Adopted children and children placed for adoption are subject to all terms and provisions of this Plan, with the exception of the *pre-existing condition* limitation.

3. A covered *employee's* child whose age is less than the limiting age and is entitled to coverage under the provisions of this Plan because of a medical child support order;

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

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

1. Permanently mentally disabled or permanently physically handicapped;

2. Incapable of self-sustaining employment;

3. The child meets all of the qualifications of a *dependent* as determined by the United States Internal Revenue Service;

4. Declared on and legally qualify as a *dependent* on the *employee's* federal personal income tax return filed for each year of coverage; and

5. Unmarried.

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

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

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

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

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

E

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

F

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

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

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

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

H

Hearing aids means any wearable, non-disposable instrument or device designed to aid or compensate for impaired human hearing and any parts, attachments, or accessories, including ear molds, excluding batteries and cords. In addition, *services* necessary to assess, select, and appropriately adjust or fit the *hearing aid* to ensure optimal performance.

Hospital means an institution which:

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

2. Has a physician and surgeon in regular attendance;

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

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

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

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

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

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

I

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

Intensive outpatient means outpatient *services* providing:

1. Group therapeutic sessions greater than one hour a day, three days a week;

2. *Behavioral health* therapeutic focus;

3. Group sessions centered on cognitive behavioral constructs, social/occupational/educational skills development and family interaction;

4. Additional emphasis on recovery strategies, monitoring of participation in 12-step programs and random drug screenings for the treatment of *substance abuse*; and

5. *Qualified practitioner* availability for medical and medication management.

Intensive outpatient program does not include services that are for:

1. *Custodial care*; or

2. Day care.

L

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

M

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

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

1. The fee charged by the provider for the *services*;

2. The fee that has been negotiated with the provider whether directly or through one or more intermediaries or shared savings contracts for the *services*;

3. The fee established by this Plan by comparing rates from one or more regional or national databases or schedules for the same or similar *services* from a geographical area determined by this Plan;

4. The fee based upon rates negotiated by this Plan or other payors with one or more *participating providers* in a geographic area determined by this Plan for the same or similar *services*;

5. The fee based upon the provider's cost for providing the same or similar *services* as reported by such provider in its most recent publicly available *Medicare* cost report submitted to the Centers for Medicare and Medicaid Services (CMS) annually; or

6. The fee based on a percentage determined by this Plan of the fee *Medicare* allows for the same or similar *services* provided in the same geographic area.

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

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

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

1. Performed in the least costly setting required by *your* condition;

2. Not provided primarily for the convenience of the patient or the *qualified practitioner*;

3. Appropriate for and consistent with *your* symptoms or diagnosis of the *sickness* or *bodily injury* under treatment;

4. Furnished for an appropriate duration and frequency in accordance with accepted medical practices, and which are appropriate for *your* symptoms, diagnosis, *sickness* or *bodily injury*; and

5. Substantiated by the records and documentation maintained by the provider of *service*.

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

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

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

1. 40 kilograms or greater per meter squared (kg/m^2); or

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

N

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

O

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

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

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

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

P

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

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

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

3. That has physicians and appropriately licensed *mental health* and *substance abuse* practitioners readily available for the emergent and urgent care needs of the patients.

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

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

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

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

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

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

Plan Administrator means Lexington Fayette Urban County Government.

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

Plan Sponsor means Lexington Fayette Urban County Government.

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

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

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

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

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

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

1. The name and address of the *covered person* for whom the *prescription* is intended;

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

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

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

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

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

Q

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

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

R

Residential treatment facility means an institution which:

1. Is licensed as a 24-hour residential facility for *mental health* and *substance abuse* treatment, although not licensed as a *hospital*;

2. Provides a multidisciplinary treatment plan in a controlled environment, with periodic supervision of a physician or a Ph.D. psychologist; and

3. Provides programs such as social, psychological and rehabilitative training, age appropriate for the special needs of the age group of patients, with focus on reintegration back into the community.

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

S

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

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

Sound natural tooth means a tooth that:

1. Is organic and formed by the natural development of the body (not manufactured);

2. Has not been extensively restored;

3. Has not become extensively decayed or involved in periodontal disease; and

4. Is not more susceptible to injury than a whole natural tooth.

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

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

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

T

Telehealth services mean the use of interactive audio, video, or other electronic media to deliver health care. It includes the use of electronic media for diagnosis, consultation, treatment, transfer of medical data, and medical education. A telehealth consultation shall not be reimbursable if it is provided through the use of an audio-only telephone, facsimile machine, or electronic mail.

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

Total disability *or* ***totally disabled*** means:

1. During the first twelve months of disability *you* or *your* employed covered spouse are at all times prevented by *bodily injury* or *sickness* from performing each and every material duty of *your* respective job or occupation;

2. After the first twelve months, *total disability* or *totally disabled* means that *you* or *your* employed covered spouse are at all times prevented by *bodily injury* or *sickness* from engaging in any job or occupation for wage or profit for which *you* or *your* employed covered spouse are reasonably qualified by education, training or experience;

3. For a non-employed spouse or a child, *total disability* or *totally disabled* means the inability to perform the normal activities of a person of similar age and gender.

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

U

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

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

2. In the opinion of the physician with knowledge of the *claimant's* medical condition, would subject the *claimant* to severe pain that cannot be adequately managed without the care or treatment recommended.

Utilization review means the process of assessing the *medical necessity*, appropriateness, or utility of *hospital admissions*, surgical procedures, outpatient care, and other health care *services*. *Utilization review* includes *precertification* and *concurrent review*.

Y

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

Administered by:

Humana Insurance Company
500 West Main Street
Louisville, KY 40202