

Important!

At Humana, it is important you are treated fairly.

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

- You may file a complaint, also known as a grievance:
Discrimination Grievances, P.O. Box 14618, Lexington, KY 40512-4618
If you need help filing a grievance, call **1-866-427-7478** or if you use a **TTY**, call **711**.
- You can also file a civil rights complaint with the **U.S. Department of Health and Human Services**, Office for Civil Rights electronically through their Complaint Portal, available at **<https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>**, or at **U.S. Department of Health and Human Services**, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, DC 20201, **1-800-368-1019, 800-537-7697 (TDD)**. Complaint forms are available at **<https://www.hhs.gov/ocr/office/file/index.html>**.
- **California residents:** You may also call California Department of Insurance toll-free hotline number: **1-800-927-HELP (4357)**, to file a grievance.

Auxiliary aids and services, free of charge, are available to you. 1-866-427-7478 (TTY: 711)

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

Language assistance services, free of charge, are available to you. 1-866-427-7478 (TTY: 711)

Español (Spanish): Llame al número arriba indicado para recibir servicios gratuitos de asistencia lingüística.

繁體中文 (Chinese): 撥打上面的電話號碼即可獲得免費語言援助服務。

Tiếng Việt (Vietnamese): Xin gọi số điện thoại trên đây để nhận được các dịch vụ hỗ trợ ngôn ngữ miễn phí.

한국어 (Korean): 무료 언어 지원 서비스를 받으려면 위의 번호로 전화하십시오.

Tagalog (Tagalog – Filipino): Tawagan ang numero sa itaas upang makatanggap ng mga serbisyo ng tulong sa wika nang walang bayad.

Русский (Russian): Позвоните по номеру, указанному выше, чтобы получить бесплатные услуги перевода.

Kreyòl Ayisyen (French Creole): Rele nimewo ki pi wo la a, pou resevwa sèvis èd pou lang ki gratis.

Français (French): Appelez le numéro ci-dessus pour recevoir gratuitement des services d'aide linguistique.

Polski (Polish): Aby skorzystać z bezpłatnej pomocy językowej, proszę zadzwonić pod wyżej podany numer.

Português (Portuguese): Ligue para o número acima indicado para receber serviços linguísticos, grátis.

Italiano (Italian): Chiamare il numero sopra per ricevere servizi di assistenza linguistica gratuiti.

Deutsch (German): Wählen Sie die oben angegebene Nummer, um kostenlose sprachliche Hilfsdienstleistungen zu erhalten.

日本語 (Japanese): 無料の言語支援サービスをご要望の場合は、上記の番号までお電話ください。

فارسی (Farsi)

برای دریافت تسهیلات زبانی بصورت رایگان با شماره فوق تماس بگیرید.

Diné Bizaad (Navajo): Wóda hí béésh bee hani'í bee wolta'ígíí bich'í' hódíílnih éí bee t'áá jiik'eh saad bee áká'ánída'áwo'déé nika'adoowoł.

العربية (Arabic)

الرجاء الاتصال بالرقم المبين أعلاه للحصول على خدمات مجانية للمساعدة بلغتك



Administrative Office:
N19W24133 Riverwood Drive Suite 300
Waukesha, WI 53188-1145

Administrative Office:
1100 Employers Boulevard
Green Bay, Wisconsin 54344

Certificate of Coverage

Humana Wisconsin Health Organization Insurance Corporation and Humana Insurance Company

Group Plan Sponsor: NEEENAH JOINT SCHOOL DISTRICT
Group Plan Number: 404461
Effective Date: 01/01/2023
Product Name: FINJSD03 COINSR

Important Notice Concerning Statements in the Enrollment Form for *Your* Insurance

Please read the copy of the enrollment form accompanying this *certificate* which has been otherwise previously delivered to *you* by the *group plan sponsor*. Omissions or misstatements in the enrollment form could cause an otherwise valid claim to be denied. Therefore, carefully check the enrollment form and write to *us* within 10 days if any information shown on the enrollment form is not correct. The insurance coverage was issued on the basis that the answers to all questions and any other material information shown on the enrollment form were correct and complete.

Humana Wisconsin Health Organization Insurance Corporation and Humana Insurance Company have entered into an agreement with the *group plan sponsor* to provide *you* with *health insurance coverage*. In accordance with the terms of the *master group contract* issued to the *group plan sponsor*, Humana Wisconsin Health Organization Insurance Corporation and Humana Insurance Company certify that a *covered person* has coverage for the benefits described in this *certificate*. This *certificate* becomes the Certificate of Coverage and replaces any and all certificates and certificate riders previously issued.

Bruce Broussard
President

**This booklet, referred to as a Benefit Plan Document,
is provided to describe *your*
Humana coverage.**

NOTICE: LIMITED BENEFITS WILL BE PAID WHEN NON-NETWORK PROVIDERS ARE USED

You should be aware that when you elect to utilize the services of a non-network provider for a covered service, benefit payments to such non-network provider are not based upon the amount billed. The basis of your benefit payment will be determined according to your policy's fee schedule, maximum allowable fee (which is determined by comparing charges for similar services adjusted to the geographical area where the services are performed), or other method as defined by the master group contract. YOU RISK PAYING MORE THAN THE COINSURANCE, DEDUCTIBLE AND COPAYMENT AMOUNT DEFINED IN THE MASTER GROUP CONTRACT AFTER THE PLAN HAS PAID ITS REQUIRED PORTION. Non-network providers may bill enrollees for any amount up to the billed charge after the plan has paid its portion of the bill. Network providers have agreed to accept discounted payment for covered services with no additional billing to the enrollee other than copayment, coinsurance and deductible amounts. You may obtain further information about the network status of professional providers and information on out-of-pocket expenses by calling the toll free telephone number on your identification card or by visiting our Website at www.humana.com.

NOTICES

Methodology disclosure notice

The methodology used in determining the *maximum allowable fee* (Usual and Customary) is as follows:

We settle claims based on a specific methodology. The eligible amount of a claim, as determined by the specific methodology, may be less than the provider's billed charge.

If several *surgeries* are performed during one operation, *we* will pay the *maximum allowable fee* for the most complex procedure. For each additional procedure *we* will pay:

- 50% for the secondary procedure; and
- 25% for the third and subsequent procedures.

You may contact *us* before a procedure is performed to determine if the *provider's* estimated charge will be within the *maximum allowable fee*.

Please provide *us* with the following information:

- *Employee* social security number;
- Estimated date of service(s);
- Procedure code of the service(s) being rendered (ie: CPT/CDT code);
- Zip code of the provider performing the service(s); and
- Estimated charge amount.

Please refer to the "Glossary" section of *your certificate* for a further explanation of the definition of *maximum allowable fee*.

If *you* have any questions concerning the methodology used, please contact *our* Claims Department by calling the telephone number listed on *your* identification card.

Quality assurance plan

The purpose of the Quality Improvement Program is to evaluate, monitor and seek to improve the health and quality of life of *our* members by promoting quality, affordable health care and service.

Through its' plans, Humana Wisconsin Health Organization Insurance Corporation offers comprehensive health benefits including inpatient, outpatient, and physician office services, mental health, prescription drugs and care in recovery facilities. Services provided through Humana Wisconsin Health Organization Insurance Corporation plans are subject to quality improvement activities. These activities include the evaluation of the delivery system (provider network), the outcomes of health care delivery, and the effectiveness of administrative services provided by Humana Wisconsin Health Organization Insurance Corporation. The quality program encompasses health care services provided by Humana Wisconsin Health Organization Insurance Corporation.

NOTICES (continued)

You are entitled to the coverage for which *you* are eligible as described in this *certificate*. Various provisions of this *certificate* contain *your* rights and responsibilities. *You* are accountable for understanding and following these rights and responsibilities. If *you* have questions or concerns regarding benefits, procedures, payment practices, eligibility, limitations and exclusions or the grievance procedure, *you* may contact *us* at the telephone number listed on your identification card.

Important notice concerning statements in the enrollment form for your coverage

Your coverage was issued on the basis that the answers to all questions and any other material information shown on the enrollment form are correct and complete. Omissions or misstatements on this form could cause an otherwise valid claim to be denied or void the contract within the contestable period, if such misrepresentation materially affects the acceptance of risk. If *you* wish to obtain a copy of the enrollment form, please contact *us* or call *us* at *our* toll free number within 10 days if any information shown on the form is incorrect or incomplete, or if any requested medical history has not been included.

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UNDERSTANDING YOUR COVERAGE

As *you* read the *certificate*, *you* will see some words are printed in italics. Italicized words may have different meanings in the *certificate* than in general. Please check the "Glossary" sections for the meaning of the italicized words as they apply to *your* plan.

The *certificate* gives *you* information about *your* plan. It tells *you* what is covered and what is not covered. It also tells *you* what *you* must do and how much *you* must pay for services. *Your* plan covers many services, but it is important to remember it has limits. Be sure to read *your certificate* carefully before using *your* benefits.

Essential health benefits

This *certificate* does not apply annual dollar limits or lifetime dollar limits to *covered expenses* that are *essential health benefits*.

Covered and non-covered expenses

We will provide coverage for services, equipment and supplies that are *covered expenses*. All requirements of the *master group contract* apply to *covered expenses*.

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

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

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

How your master group contract works

Covered expenses are subject to the *maximum allowable fee*. *We* will apply the applicable *network provider* or *non-network provider* benefit level to the total amount billed by the *qualified provider*, less any amounts such as:

- Those in excess of the negotiated amount by contract, directly or indirectly, between *us* and the *qualified provider*; or
- Those in excess of the *maximum allowable fee*; and
- Adjustments related to *our* claims processing procedures. Refer to the "Claims" section of this *certificate* for more information on *our* claims processing procedures.

Unless stated otherwise in this *certificate*, *you* will be responsible to pay:

- The applicable *network provider* or *non-network provider copayment*, *deductible* and/or *coinsurance*;
- Any amount over the *maximum allowable fee* to a *non-network provider*; and
- Any amount not paid by *us*.

UNDERSTANDING YOUR COVERAGE (continued)

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

- *Emergency care and air ambulance services;*
- *Ancillary services* while you are at a *network facility*;
- Services that are not considered *ancillary services* while you are at a *network facility*, and you do not consent to the *non-network provider* to obtain such services; and
- *Post-stabilization services* when:
 - The attending *qualified provider* determines you are not able to travel by non-medical transportation to obtain services from a *network provider*; and
 - You do not consent to the *non-network provider* to obtain such services due to your *emergency medical condition*.

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

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

Your choice of providers affects your benefits

We will pay benefits for *covered expenses* at a higher percentage most of the time, if you see a *network provider*, so the amount you pay will be lower. Be sure to check if your *qualified provider* is a *network provider* before seeing them.

We may designate certain *network providers* as preferred providers for specific services. If you do not see the *network provider* designated by us as a preferred provider for these services, we may pay less.

Unless stated otherwise in this *certificate*, we will pay a lower percentage if you see a *non-network provider*, so the amount you pay will be higher. *Non-network providers* have not signed an agreement with us for lower costs for services and they may bill you for any amount over the *maximum allowable fee*. If the *non-network provider* bills you any amount over the *maximum allowable fee*, you will have to pay that amount and any *copayment, deductible and coinsurance* to the *non-network provider*. Any amount you pay over the *maximum allowable fee* will not apply to your *deductible* or any *out-of-pocket limit*.

Some *non-network providers* work with *network facilities*. If possible, you may want to check if all health care providers working with *network facilities* are *network providers*.

UNDERSTANDING YOUR COVERAGE (continued)

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

- *Ancillary services* when you are at a *network facility*;
- Services that are not considered *ancillary services* when you are at a *network facility*, and you do not consent to the *non-network provider* to obtain such services; and
- *Post-stabilization services* when:
 - The attending *qualified provider* determines you are not able to travel by non-medical transportation to obtain services from a *network provider*; and
 - You do not consent to the *non-network provider* to obtain such services.

For all other services you receive from a *non-network provider*, you will be responsible to pay the *non-network provider copayment, deductible and/or coinsurance* and you may also be responsible to pay any amount over the *maximum allowable fee* for covered expenses including:

- Services that are not considered *ancillary services* when you are at a *network facility* and you consent to the *non-network provider* to obtain such services; and
- *Post-stabilization services* when:
 - The attending *qualified provider* determines you are able to travel by non-medical transportation to obtain services from a *network provider*; and
 - You consent to the *non-network provider* to obtain such services.

Refer to the "Schedule of Benefits" sections to see what your *network provider* and *non-network provider* benefits are.

How to find a network provider

You may find a list of *network providers* at Humana.com. This list is subject to change. Please check this list before receiving services from a *qualified provider*. You may also call our customer service department at the number listed on your ID card to determine if a *qualified provider* is a *network provider*, or we can send the list to you. A *network provider* can only be confirmed by us.

How to use your point of service (POS) plan

You may receive services from a *network provider* or *non-network provider* with your POS plan without a referral from your *primary care physician*. Refer to the "Schedule of Benefits" for any *preauthorization* requirements.

UNDERSTANDING YOUR COVERAGE (continued)

Seeking emergency care

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

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

Seeking urgent care

If *you* need *urgent care*, *you* must go to the nearest *urgent care center* or call an *urgent care qualified provider*. *You* must receive *urgent care* services from a *network provider* for the *network provider copayment, deductible* or *coinsurance* to apply.

Continuity of care

Continuity of care is available for services *you* are receiving while undergoing a course of treatment or for a pregnancy if:

- *Your qualified provider* ceases being a *network provider*;
- The terms of the *network provider's* participation in the network changes in a manner that terminates a benefit for a service *you* are receiving during a course of treatment or a pregnancy; or
- The *master group contract* terminates.

While *you* are undergoing a course of treatment, *you* will be able to continue treatment with the same *qualified provider* for the shorter period of the following:

- The remainder of the course of treatment;
- 90 days after the *network provider's* termination with the HMO or 90 days from the date *we* notify *you* the *qualified provider* is no longer a *network provider*, whichever date is later;
- 90 days from the date *we* notify *you* the terms of a *network provider's* participation in the network changes in a manner that terminates a benefit for a service *you* are receiving during a course of treatment; or
- 90 days from the date *we* notify *you* this *master group contract* terminates.

For a pregnancy, continuity of care is available until the completion of postpartum care for the mother and the *dependent* newborn.

If a *covered person* has been assigned to a *primary care physician* and that physician's agreement to provide health services to *covered persons* is terminated, the *covered person* may transfer treatment to another *primary care physician* or may continue services with that *primary care physician* until the earlier of:

- The end of the current calendar year (if no *open enrollment period*); or

UNDERSTANDING YOUR COVERAGE (continued)

- End of the calendar year for which it was represented that the *qualified provider* was or would be participating (if an *open enrollment period*).

Continuity of care is available only if the termination of the *network provider's* contract was not due to misconduct on the part of the *qualified provider*.

Our relationship with qualified providers

Qualified providers are not our agents, employees or partners. All providers are independent contractors. *Qualified providers* make their own clinical judgments or give their own treatment advice without coverage decisions made by us.

The *master group contract* will not change what is decided between you and *qualified providers* regarding your medical condition or treatment options. *Qualified providers* act on your behalf when they order services. You and your *qualified providers* make all decisions about your health care, no matter what we cover. We are not responsible for anything said or written by a *qualified provider* about covered expenses and/or what is not covered under this *certificate*. Call our customer service department at the telephone number listed on your ID card if you have any questions.

Our financial arrangements with network providers

We have agreements with *network providers* that may have different payment arrangements:

- Many *network providers* are paid on a discounted fee-for-services basis. This means they have agreed to be paid a set amount for each *covered expense*;
- Some *network providers* may have capitation agreements. This means the *network provider* is paid a set dollar amount each month to care for each *covered person* no matter how many services a *covered person* may receive from the *network provider*, such as a *primary care physician* or a *specialty care physician*;
- *Hospitals* may be paid on a Diagnosis Related Group (DRG) basis or a flat fee per day basis for *inpatient* services. *Outpatient* services are usually paid on a flat fee per service or procedure or a discount from their normal charges.

The certificate

The *certificate* is part of the insurance *master group contract* and tells you what is covered and not covered and the requirements of the *master group contract*. Nothing in the *certificate* takes the place of or changes any of the terms of the *master group contract*. The final interpretation of any provision in the *certificate* is governed by the *master group contract*. If the *certificate* is different than the *master group contract*, the provisions of the *master group contract* will apply. The benefits in the *certificate* apply if you are a *covered person*.

SCHEDULE OF BENEFITS

Reading the Schedule of Benefits sections will help *you* understand:

- *Preauthorization* requirements;
- The level of benefits *we* generally pay for *covered expenses* and what *you* may be responsible for, including;
 - *Copayments* that may apply for each *covered expense*. *You* may be responsible for more than one *copayment* during the same visit with the same provider;
 - The *covered expenses* that require *you* to meet a *deductible*, if any, before benefits are paid by *us*; and
 - The *coinsurance* *you* are required to pay for *covered expenses*; and
- *Your out-of-pocket limit*.

The Schedule of Benefits sections outline the coverage and limitations provided under the *master group contract*. A more detailed explanation of *your* coverage and its limitations and exclusions for these benefits is provided in the Covered Expenses and Limitations and Exclusions sections of this *certificate*.

The benefits outlined under the "Schedule of Benefits – Behavioral Health," and "Schedule of Benefits – Pharmacy Services" sections are not payable under any other Schedule of Benefits of the *master group contract*. However, all other terms and provisions of the *master group contract* apply, including the *preauthorization* requirements, annual *deductible(s)* and any *out-of-pocket limit(s)*, unless otherwise stated.

Network provider verification

This *certificate* contains multiple benefit levels. Refer to each Schedule of Benefits to see what benefit levels apply to *covered expenses*.

Refer to *our* website at Humana.com for a list of *network providers*. *You* may also contact *our* customer service department at the telephone number shown on *your* ID card. This list is subject to change.

Preauthorization requirements

Preauthorization is required for certain services and supplies. The list of services and supplies that require *preauthorization* is available on *our* website at Humana.com or by calling the customer service telephone number on *your* ID card. The list of services and supplies that require *preauthorization* is subject to change. Coverage provided in the past for services or supplies that did not receive or require *preauthorization*, is not a guarantee of future coverage of the same services or supplies. Benefits are not paid at all for services or supplies that are not *covered expenses*.

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

SCHEDULE OF BENEFITS (continued)

If you receive services or supplies from a *non-network provider* for which *preauthorization* is required and not obtained, the benefit payable for any *covered expenses* incurred will be reduced to 50%, after any applicable *copayments, deductibles* and/or *coinsurance*. -The out-of-pocket amounts incurred by you due to these benefit reductions will not be used to satisfy any *out-of-pocket limits*.

Annual deductible

An annual *deductible* is a specified dollar amount you must pay for *covered expenses* per year, before any applicable *coinsurance* applies and most benefits are paid under the *master group contract*. There are individual and family *network provider* and *non-network provider deductibles*. The *deductible* amount(s) for each *covered person* and each covered family are as follows, and must be satisfied each year, either individually or combined as a covered family.

Covered expenses that apply to the individual *deductible* also apply to the family *deductible*. Once a *covered person* meets the individual *deductible*, the *coinsurance* applies to applicable *covered expenses* for that *covered person*. Once the family *deductible* is met any remaining individual *deductible* for a *covered person* in the family is waived for that year. The *coinsurance* then applies to applicable *covered expenses* for all *covered persons* in the family. Any applicable *copayments* do not apply toward the annual *deductibles*.

Any *deductible* you pay a *network provider* for *covered expenses* is applied to the *network provider deductibles*. Any *deductible* you pay a *non-network provider* for *covered expenses* subject to the *qualified payment amount* is also applied to the *network provider deductibles*. Any other *deductible* you pay a *non-network provider* for *covered expenses* is applied to the *non-network provider deductibles*.

You must meet the *network provider deductibles* for the *coinsurance* to apply to your *covered expenses* for services you receive from a *network provider* or for services you receive from a *non-network provider* that are subject to the *qualified payment amount*. You must meet the *non-network provider deductibles* for the *coinsurance* to apply to your *covered expenses* for all other services you receive from a *non-network provider*.

Any amount you pay a *non-network provider* exceeding the *maximum allowable fee* is not applied to the individual or family *deductibles*.

Only amounts paid by you for *covered expenses* apply to the *deductibles*. Any amount waived by a *qualified provider* is not applied to any *deductible*. Direct support, including coupons or other discounts, from manufactures, their affiliates other third parties may not apply to any *deductible*.

SCHEDULE OF BENEFITS (continued)

Deductible	Deductible amount
Individual <i>network provider deductible</i>	\$3,000
Family <i>network provider deductible</i>	\$6,000
Individual <i>non-network provider deductible</i>	\$6,000
Family <i>non-network provider deductible</i>	\$12,000

Out-of-pocket limit

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

Once the individual *out-of-pocket limit* is satisfied for the *year*, the benefit percentage for *covered expenses* for that *covered person* is payable by *us* at the rate of 100% for the rest of the *year*, subject to any maximum benefit and all other terms, provisions, limitations, and exclusions of the *master group contract*.

Covered expenses that apply to the individual *out-of-pocket limit* also apply to the family *out-of-pocket limit*. Once the family *out-of-pocket limit* is satisfied for the *year*, the benefit percentage for *covered expenses* for all *covered persons* in the family is payable by *us* at the rate of 100% for the rest of the *year*, subject to any maximum benefit and all other terms, provisions, limitations, and exclusions of the *master group contract*.

Any *copayment, deductible* or *coinsurance* you pay a *network provider* for *covered expenses* is applied to the *network provider out-of-pocket limits*. Any *copayment, deductible* or *coinsurance* you pay a *non-network provider* for *covered expenses* subject to the *qualified payment amount* is also applied to the *network provider out-of-pocket limits*. Any other *copayment, deductible* or *coinsurance* you pay a *non-network provider* for *covered expenses* is applied to the *non-network provider out-of-pocket limits* unless otherwise specified in this *certificate*.

SCHEDULE OF BENEFITS (continued)

You must meet the *network provider out-of-pocket limits* for covered expenses to be payable by us at 100% for the rest of the year for services you receive from a *network provider* or for services you receive from a *non-network provider* that are subject to the *qualified payment amount*. You must meet the *non-network out-of-pocket limits* for covered expenses to be payable by us at 100% for the rest of the year for all other services you receive from a *non-network provider*, unless otherwise specified in this *certificate*.

Any amount you pay a *non-network provider* exceeding the *maximum allowable fee* is not applied to the *out-of-pocket limits*. Once the individual or family *non-network provider out-of-pocket limit* is met, you will continue to be responsible to pay a *non-network provider* any amount exceeding the *maximum allowable fee* for covered expenses, other than those subject to the *qualified payment amount*.

Only amounts paid by you for covered expenses apply to the *out-of-pocket limits*. Any amount waived by a *qualified provider* is not applied to any *out-of-pocket limit*. Direct support, including coupons or other discounts from manufacturers, their affiliates or other third parties may not apply to any *out-of-pocket limit*.

Any *non-network provider copayments* you pay or out-of-pocket expenses you pay for covered transplants and *immune effector cell therapy* provided by a *non-network provider* and *prescriptions* and *specialty drugs* obtained from a *non-network pharmacy* or *non-network specialty pharmacy* do not apply to any *out-of-pocket limit*. *Specialty drugs* provided by or obtained from a *non-network provider* do not apply to any *out-of-pocket limit*, except for *specialty drugs* provided for *behavioral health*.

Maximum out-of-pocket limit	Maximum out-of-pocket limit amount
Individual <i>network provider out-of-pocket limit</i>	\$4,000
Family <i>network provider out-of-pocket limit</i>	\$9,000
Individual <i>non-network provider out-of-pocket limit</i>	\$8,000
Family <i>non-network provider out-of-pocket limit</i>	\$18,000

SCHEDULE OF BENEFITS (continued)

Preventive services

Includes prostate screenings (PSA). Does not include drugs, medicines or medications and supplies on the Preventive Medication Coverage *drug list*. Refer to the Pharmacy Services sections in this *certificate*.

<i>Network provider</i>	Covered in full
<i>Non-network provider</i>	30% coinsurance after non-network provider deductible

Preventive vision exam

<i>Network provider</i>	Covered in full
<i>Non-network provider</i>	Covered in full

Health care practitioner office services

Health care practitioner office visit

<i>Primary care physician</i>	20% coinsurance after network provider deductible
<i>Specialty care physician</i>	20% coinsurance after network provider deductible
<i>Non-network health care practitioner</i>	40% coinsurance after non-network provider deductible

SCHEDULE OF BENEFITS (continued)

Diagnostic laboratory and radiology services when performed in the office and billed by the health care practitioner

Does not include *advanced imaging*. Refer to "Advanced imaging when performed in a health care practitioner's office" in this "Schedule of Benefits" section.

<i>Primary care physician</i>	<i>20% coinsurance after network provider deductible</i>
<i>Specialty care physician</i>	<i>20% coinsurance after network provider deductible</i>
<i>Non-network health care practitioner</i>	<i>40% coinsurance after non-network provider deductible</i>

Advanced imaging when performed in a health care practitioner's office

<i>Primary care physician</i>	<i>20% coinsurance after network provider deductible</i>
<i>Specialty care physician</i>	<i>20% coinsurance after network provider deductible</i>
<i>Non-network health care practitioner</i>	<i>40% coinsurance after non-network provider deductible</i>

SCHEDULE OF BENEFITS (continued)

Allergy serum when received in the health care practitioner's office

<i>Primary care physician</i>	<i>20% coinsurance after network provider deductible</i>
<i>Specialty care physician</i>	<i>20% coinsurance after network provider deductible</i>
<i>Non-network health care practitioner</i>	<i>40% coinsurance after non-network provider deductible</i>

Allergy injections when received in a health care practitioner's office

<i>Primary care physician</i>	<i>20% coinsurance after network provider deductible</i>
<i>Specialty care physician</i>	<i>20% coinsurance after network provider deductible</i>
<i>Non-network health care practitioner</i>	<i>40% coinsurance after non-network provider deductible</i>

Injections other than allergy when received in a health care practitioner's office

<i>Primary care physician</i>	<i>20% coinsurance after network provider deductible</i>
<i>Specialty care physician</i>	<i>20% coinsurance after network provider deductible</i>
<i>Non-network health care practitioner</i>	<i>40% coinsurance after non-network provider deductible</i>

SCHEDULE OF BENEFITS (continued)

Surgery performed in the office and billed by the health care practitioner

<i>Primary care physician</i>	<i>20% coinsurance after network provider deductible</i>
<i>Specialty care physician</i>	<i>20% coinsurance after network provider deductible</i>
<i>Non-network health care practitioner</i>	<i>50% coinsurance after non-network provider deductible</i>

Health care practitioner services at a retail clinic

Health care practitioner office visit in a retail clinic

<i>Primary care physician</i>	<i>20% coinsurance after network provider deductible</i>
<i>Non-network health care practitioner</i>	<i>40% coinsurance after non-network provider deductible</i>

Diagnostic laboratory when performed by a health care practitioner in a retail clinic

<i>Primary care physician</i>	<i>20% coinsurance after network provider deductible</i>
<i>Non-network health care practitioner</i>	<i>40% coinsurance after non-network provider deductible</i>

SCHEDULE OF BENEFITS (continued)

Injections other than allergy when received in a retail clinic

<i>Primary care physician r</i>	<i>20% coinsurance after network provider deductible</i>
<i>Non-network health care practitioner</i>	<i>40% coinsurance after non-network provider deductible</i>

Hospital services

Hospital inpatient services

<i>Network hospital</i>	<i>20% coinsurance after network provider deductible</i>
<i>Non-network hospital</i>	<i>40% coinsurance after non-network provider deductible</i>

Health care practitioner inpatient services when provided in a hospital

<i>Primary care physician</i>	<i>20% coinsurance after network provider deductible</i>
<i>Specialty care physician</i>	<i>20% coinsurance after network provider deductible</i>
<i>Non-network health care practitioner</i>	<i>40% coinsurance after non-network provider deductible</i>

SCHEDULE OF BENEFITS (continued)

Hospital outpatient surgical services

Must be performed in a *hospital's outpatient* department.

<i>Network hospital</i>	<i>20% coinsurance after network provider deductible</i>
<i>Non-network hospital</i>	<i>40% coinsurance after non-network provider deductible</i>

Health care practitioner outpatient services when provided in a hospital

Includes *outpatient surgery*.

<i>Primary care physician</i>	<i>20% coinsurance after network provider deductible</i>
<i>Specialty care physician</i>	<i>20% coinsurance after network provider deductible</i>
<i>Non-network health care practitioner</i>	<i>40% coinsurance after non-network provider deductible</i>

Hospital outpatient non-surgical services

Must be performed in a *hospital's outpatient* department. Does not include diagnostic radiology, diagnostic laboratory and *advanced imaging*. Refer to "Hospital outpatient diagnostic radiology and laboratory" and "Hospital outpatient advanced imaging" in this "Schedule of Benefits" section.

<i>Network hospital</i>	<i>20% coinsurance after network provider deductible</i>
<i>Non-network hospital</i>	<i>40% coinsurance after non-network provider deductible</i>

SCHEDULE OF BENEFITS (continued)

Hospital outpatient diagnostic radiology and laboratory

<i>Network hospital</i>	<i>20% coinsurance after network provider deductible</i>
<i>Non-network hospital</i>	<i>40% coinsurance after non-network provider deductible</i>

Hospital outpatient advanced imaging

Must be performed in a *hospital's outpatient* department.

<i>Network hospital</i>	<i>20% coinsurance after network provider deductible</i>
<i>Non-network hospital</i>	<i>40% coinsurance after non-network provider deductible</i>

Pregnancy and newborn benefit

Same as any other *sickness* based upon location of services and the type of provider.

Emergency services

Must be for *emergency care* as defined in the "Glossary" section.

Emergency room services

Does not include *advanced imaging*. Refer to "Emergency room advanced imaging" in this "Schedule of Benefits" section.

<i>Network provider</i>	<i>20% coinsurance after network provider deductible</i>
<i>Non-network provider</i>	<i>20% coinsurance after network provider deductible</i>

SCHEDULE OF BENEFITS (continued)

Emergency room advanced imaging

<i>Network provider</i>	<i>20% coinsurance after network provider deductible</i>
<i>Non-network provider</i>	<i>20% coinsurance after network provider deductible</i>

Emergency room health care practitioner services

<i>Network health care practitioner</i>	<i>20% coinsurance after network provider deductible</i>
<i>Non-network health care practitioner</i>	<i>20% coinsurance after network provider deductible</i>

Ambulance services

<i>Network provider</i>	<i>20% coinsurance after network provider deductible</i>
<i>Non-network provider</i>	<i>20% coinsurance after network provider deductible</i>

Ambulatory surgical center services

Ambulatory surgical center for outpatient surgery

<i>Network provider</i>	<i>20% coinsurance after network provider deductible</i>
<i>Non-network provider</i>	<i>40% coinsurance after non-network provider deductible</i>

SCHEDULE OF BENEFITS (continued)

Health care practitioner outpatient services when provided in an ambulatory surgical center

Includes *outpatient surgery*.

<i>Primary care physician</i>	<i>20% coinsurance after network provider deductible</i>
<i>Specialty care physician</i>	<i>20% coinsurance after network provider deductible</i>
<i>Non-network health care practitioner</i>	<i>40% coinsurance after non-network provider deductible</i>

Durable medical equipment

<i>Network provider</i>	<i>20% coinsurance after network provider deductible</i>
<i>Non-network provider</i>	<i>40% coinsurance after non-network provider deductible</i>

Free-standing facility services

Free-standing facility non-surgical services

Does not include *advanced imaging*. Refer to "Free-standing facility advanced imaging" in this "Schedule of Benefits" section.

<i>Network provider</i>	<i>20% coinsurance after network provider deductible</i>
<i>Non-network provider</i>	<i>40% coinsurance after non-network provider deductible</i>

SCHEDULE OF BENEFITS (continued)

Health care practitioner services provided in a free-standing facility

<i>Primary care physician</i>	<i>20% coinsurance after network provider deductible</i>
<i>Specialty care physician r</i>	<i>20% coinsurance after network provider deductible</i>
<i>Non-network health care practitioner</i>	<i>40% coinsurance after non-network provider deductible</i>

Free-standing facility advanced imaging

<i>Network provider</i>	<i>20% coinsurance after network provider deductible</i>
<i>Non-network provider</i>	<i>40% coinsurance after non-network provider deductible</i>

Home health care services

Limited to a maximum of 100 visits per year.

<i>Network provider</i>	<i>20% coinsurance after network provider deductible</i>
<i>Non-network provider</i>	<i>40% coinsurance after non-network provider deductible</i>

SCHEDULE OF BENEFITS (continued)

Hospice services

<i>Network provider</i>	<i>20% coinsurance after network provider deductible</i>
<i>Non-network provider</i>	<i>40% coinsurance after non-network provider deductible</i>

Jaw joint benefit

Same as any other *sickness* based upon location of service and type of provider.

Physical medicine and rehabilitative services

Physical therapy, occupational therapy, speech therapy, audiology services and cognitive rehabilitation services are limited to a combined maximum of 100 visits per year. *Network provider* and *non-network provider* visit limits accumulate separately.

<i>Network provider</i>	<i>20% coinsurance after network provider deductible</i>
<i>Non-network provider</i>	<i>40% coinsurance after non-network provider deductible</i>

Spinal manipulations/adjustments

<i>Network provider</i>	<i>20% coinsurance after network provider deductible</i>
<i>Non-network provider</i>	<i>40% coinsurance after non-network provider deductible</i>

SCHEDULE OF BENEFITS (continued)

Respiratory or pulmonary rehabilitation services

<i>Network provider</i>	<i>20% coinsurance after network provider deductible</i>
<i>Non-network provider</i>	<i>40% coinsurance after non-network provider deductible</i>

Cardiac rehabilitation services

<i>Network provider</i>	<i>20% coinsurance after network provider deductible</i>
<i>Non-network provider</i>	<i>40% coinsurance after non-network provider deductible</i>

Other therapy

Includes radiation therapy and chemotherapy.

<i>Network provider</i>	<i>20% coinsurance after network provider deductible</i>
<i>Non-network provider</i>	<i>40% coinsurance after non-network provider deductible</i>

SCHEDULE OF BENEFITS (continued)

Skilled nursing facility services

Limited to a maximum of 60 days per *confinement*.

<i>Network provider</i>	<i>20% coinsurance after network provider deductible</i>
<i>Non-network provider</i>	<i>40% coinsurance after non-network provider deductible</i>

Health care practitioner services when provided in a skilled nursing facility

<i>Network health care practitioner</i>	<i>20% coinsurance after network provider deductible</i>
<i>Non-network health care practitioner</i>	<i>40% coinsurance after non-network provider deductible</i>

Specialty drug medical benefit

Specialty drugs provided by or obtained from a qualified provider in a health care practitioner's office, free-standing facility and an urgent care center

<i>Network provider</i>	<i>20% coinsurance after network provider deductible</i>
<i>Non-network provider</i>	<i>50% coinsurance after non-network provider deductible</i>

SCHEDULE OF BENEFITS (continued)

Specialty drugs provided by or obtained from a qualified provider in a home

<i>Network provider</i> designated by us as a preferred provider of specialty drugs	Covered in full after <i>network provider deductible</i>
<i>Network provider</i>	20% coinsurance after <i>network provider deductible</i>
<i>Non-network provider</i>	40% coinsurance after <i>non-network provider deductible</i>

Specialty drugs provided by or obtained from a qualified provider in a hospital, skilled nursing facility, ambulance or emergency room

Same as any other *sickness* based upon location of services and the type of provider.

Transplant services and immune effector cell therapy

<i>Network provider</i> designated by us as an approved transplant facility	Same as any other <i>sickness</i> based on location of services and type of provider
<i>Non-network provider</i>	Same as any other <i>sickness</i> based on location of services and type of provider

Non-medical travel and lodging costs for transplant services and immune effector cell therapy

Transportation and temporary lodging are limited to a combined maximum of \$10,000 per covered transplant and *immune effector cell therapy*.

<i>Network provider</i> designated by us as an approved transplant facility	Covered in full after <i>network provider deductible</i>
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SCHEDULE OF BENEFITS (continued)

Urgent care services

<i>Network provider</i>	<i>20% coinsurance after network provider deductible</i>
<i>Non-network provider</i>	<i>40% coinsurance after non-network provider deductible</i>

Additional covered expenses

Same as any other *sickness* based upon location of services and the type of provider.

SCHEDULE OF BENEFITS - BEHAVIORAL HEALTH

Reading this "Schedule of Benefits – Behavioral Health" section will help *you* understand the level of benefits *we* generally pay for the *mental health services* and *chemical dependency* services under the *master group contract*.

This "Schedule of Benefits – Behavioral Health" outlines the coverage and limitations provided under the *master group contract*. A more detailed explanation of *your* coverage and its limitations and exclusions for these benefits is provided in the "Covered Expenses," "Covered Expenses – Behavioral Health" and "Limitations and Exclusions" sections of this *certificate*. Refer to the "Schedule of Benefits" section for *behavioral health covered expenses* not listed in this section.

Services are subject to all the terms, provisions, limitations, and exclusions of the *master group contract*.

Acute inpatient services

<i>Network hospital</i>	<i>20% coinsurance after network provider deductible</i>
<i>Non-network hospital</i>	<i>40% coinsurance after non-network provider deductible</i>

Acute inpatient health care practitioner services

<i>Network health care practitioner</i>	<i>20% coinsurance after network provider deductible</i>
<i>Non-network health care practitioner</i>	<i>40% coinsurance after non-network provider deductible</i>

SCHEDULE OF BENEFITS - BEHAVIORAL HEALTH (continued)

Emergency services

Must be for *emergency care* as defined in the "Glossary" section.

Emergency room services

Does not include *advanced imaging*. Refer to "Emergency room advanced imaging" in this "Schedule of Benefits – Behavioral Health" section.

<i>Network provider</i>	<i>20% coinsurance after network provider deductible</i>
<i>Non-network provider</i>	<i>20% coinsurance after network provider deductible</i>

Emergency room advanced imaging

<i>Network provider</i>	<i>20% coinsurance after network provider deductible</i>
<i>Non-network provider</i>	<i>20% coinsurance after network provider deductible</i>

Emergency room health care practitioner services

<i>Network health care practitioner</i>	<i>20% coinsurance after network provider deductible</i>
<i>Non-network health care practitioner</i>	<i>20% coinsurance after network provider deductible</i>

SCHEDULE OF BENEFITS - BEHAVIORAL HEALTH (continued)

Urgent care services

<i>Network provider</i>	<i>20% coinsurance after network provider deductible</i>
<i>Non-network provider</i>	<i>50% coinsurance after non-network provider deductible</i>

Outpatient services

Health care practitioner office visit

Does not include *behavioral health* therapy in a *health care practitioner's* office. Refer to "Therapy" in this "Schedule of Benefits – Behavioral Health" section.

<i>Primary care physician</i>	<i>20% coinsurance after network provider deductible</i>
<i>Specialty care physician</i>	<i>20% coinsurance after network provider deductible</i>
<i>Non-network health care practitioner</i>	<i>40% coinsurance after non-network provider deductible</i>

Health care practitioner office visit in a retail clinic

<i>Network health care practitioner</i>	<i>20% coinsurance after network provider deductible</i>
<i>Non-network health care practitioner</i>	<i>40% coinsurance after non-network provider deductible</i>

SCHEDULE OF BENEFITS - BEHAVIORAL HEALTH (continued)

Injections when performed in a health care practitioner's office or retail clinic

Does not include *preventive services* and allergy injections. Refer to "Preventive services" and "Allergy injections when received in a health care practitioner's office" in the "Schedule of Benefits" section.

<i>Network health care practitioner</i>	<i>20% coinsurance after network provider deductible</i>
<i>Non-network health care practitioner</i>	<i>40% coinsurance after non-network provider deductible</i>

Therapy

Includes *outpatient behavioral health* therapy and *behavioral health* therapy in a *health care practitioner's* office. Also includes *behavioral health* physical therapy, occupational therapy, speech therapy, audiology services, cognitive therapy, and nutritional counseling.

<i>Network provider</i>	<i>20% coinsurance after network provider deductible</i>
<i>Non-network provider</i>	<i>40% coinsurance after non-network provider deductible</i>

Intensive outpatient program

<i>Network provider</i>	<i>20% coinsurance after network provider deductible</i>
<i>Non-network provider</i>	<i>40% coinsurance after non-network provider deductible</i>

SCHEDULE OF BENEFITS - BEHAVIORAL HEALTH (continued)

Partial hospitalization services

<i>Network provider</i>	<i>20% coinsurance after network provider deductible</i>
<i>Non-network provider</i>	<i>40% coinsurance after non-network provider deductible</i>

Outpatient hospital non-surgical services

Does not include *outpatient* therapy. Refer to "Therapy" in this "Schedule of Benefits – Behavioral Health" section.

Does not include *advanced imaging*. Refer to "Advanced imaging performed in a health care practitioner's office, hospital outpatient department or free-standing facility" in this "Schedule of Benefits – Behavioral Health" section.

<i>Network hospital</i>	<i>20% coinsurance after network provider deductible</i>
<i>Non-network hospital</i>	<i>40% coinsurance after non-network provider deductible</i>

Advanced imaging performed in a healthcare practitioner's office, hospital outpatient department or free-standing facility

<i>Network provider</i>	<i>20% coinsurance after network provider deductible</i>
<i>Non-network provider</i>	<i>40% coinsurance after non-network provider deductible</i>

SCHEDULE OF BENEFITS - BEHAVIORAL HEALTH
(continued)

Skilled nursing facility services

<i>Network provider</i>	<i>20% coinsurance after network provider deductible</i>
<i>Non-network provider</i>	<i>40% coinsurance after non-network provider deductible</i>

Home health care services

Does not include applied behavioral analysis therapy. Refer to "Applied behavioral analysis therapy during a home health care visit" in this "Schedule of Benefits – Behavioral Health" section.

<i>Network provider</i>	<i>20% coinsurance after network provider deductible</i>
<i>Non-network provider</i>	<i>40% coinsurance after non-network provider deductible</i>

Applied behavioral analysis therapy during a home health care visit

<i>Network provider</i>	<i>20% coinsurance after network provider deductible</i>
<i>Non-network provider</i>	<i>40% coinsurance after non-network provider deductible</i>

SCHEDULE OF BENEFITS - BEHAVIORAL HEALTH
(continued)

Specialty drug benefit

Specialty drugs provided by or obtained from a qualified provider in a health care practitioner's office, free-standing facility and an urgent care center

<i>Network provider</i>	<i>20% coinsurance after network provider deductible</i>
<i>Non-network provider</i>	<i>40% coinsurance after non-network provider deductible</i>

Specialty drugs provided by or obtained from a qualified provider in a home

<i>Network provider designated by us as a preferred provider of specialty drugs</i>	<i>20% coinsurance after network provider deductible</i>
<i>Network provider</i>	<i>20% coinsurance after network provider deductible</i>
<i>Non-network provider</i>	<i>40% coinsurance after non-network provider deductible</i>

Residential treatment facility services

Same as any other *behavioral health* services for *inpatient* or *outpatient* covered expenses.

Autism spectrum disorders

Same as any other *behavioral health* sickness based upon location of services and the type of provider.

SCHEDULE OF BENEFITS - BEHAVIORAL HEALTH (continued)

Transitional treatment

Same as any other *behavioral health sickness* based upon location of services and the type of provider.

Out of area dependent student services

We will pay behavioral health covered expenses received from a non-network provider at the network provider benefit level, subject to the "Out of area dependent student services" provision in the "Covered Expense - Behavioral Health" section of this certificate.

Court ordered mental health services

We will pay behavioral health covered expenses received from a non-network provider at the network provider benefit level, subject to the "Court ordered mental health services" provision in the "Covered Expense - Behavioral Health" section of this certificate.

SCHEDULE OF BENEFITS – PHARMACY SERVICES

Reading this "Schedule of Benefits – Pharmacy Services" section will help *you* understand:

- The level of benefits *we* generally pay for the *prescription* drugs, medicines, medications, and *specialty drugs* covered under the *master group contract*;
- The *copayment* and/or *coinsurance* amount *you* are required to pay;
- The required *deductible* or *prescription drug deductible* amount to be met, if any, before benefits are paid; and
- *Prior authorization* requirements.

This "Schedule of Benefits – Pharmacy Services" outlines the coverage and limitations provided under the *master group contract*. A more detailed explanation of *your* coverage and its limitations and exclusions for these benefits is provided in the "Covered Expenses – Pharmacy Services," "Limitations and Exclusions" and "Limitations and Exclusions – Pharmacy Services" sections of this *certificate*.

Only amounts paid by *you* toward *covered expenses* for *prescription* drugs and *specialty drugs* obtained from a *network pharmacy* under provisions of this benefit apply toward *your out-of-pocket limit*. Any amount waived by a *qualified provider* is not applied to any *out-of-pocket limit*. Direct support, including coupons or other discounts, from manufacturers, their affiliates or other third parties may not apply to any *out-of-pocket limit*.

For the purposes of coordination of benefits, *prescription* drug coverage under this benefit will be considered a separate plan and will therefore only be coordinated with other *prescription* drug coverage.

All terms used in this "Schedule of Benefits – Pharmacy Services" have the meaning given to them in the "Glossary" section, unless otherwise specifically defined in the "Glossary – Pharmacy Services" section of this *certificate*. Services are subject to all terms, provisions, limitations, and exclusions of the *master group contract*.

Prior authorization and step therapy requirements

Prior authorization is required for certain *prescription* drugs, medicines, medications, and *specialty drugs*. *Your health care practitioner* must submit a request for *prior authorization* to Clinical Pharmacy Review and receive *our* approval before benefits are paid by *us*.

Step therapy is another type of *prior authorization* that requires *you* to follow certain steps before benefits are paid by *us*. To receive benefits, *you* are required to first try alternative drugs, medicines, medications, or *specialty drugs* that have been determined to be safe, effective and more cost-effective for *your* condition. Alternatives may include over-the-counter drugs, *generic drugs* and *brand-name drugs*.

Visit *our* website at Humana.com or call the customer service telephone number on *your* ID card to obtain *our drug list* that identifies the *prescription* drugs, medicines, medications, and *specialty drugs* that require *prior authorization* and/or *step therapy*. The *drug list* is subject to change. Coverage provided in the past is not a guarantee of future coverage.

SCHEDULE OF BENEFITS – PHARMACY SERVICES (continued)

Preventive medication coverage

Drugs, medicines or medications and supplies on the Preventive Medication Coverage *drug list* are covered in full when prescribed for preventive purposes and obtained from a *network pharmacy* with a *prescription* from a *health care practitioner*.

Prescription drug cost sharing

You are responsible for any and all *cost share*, when applicable, as specified below. If the dispensing *pharmacy's* charge is less than *your copayment* or *coinsurance* for *prescription* drugs, *you* will be responsible for the dispensing *pharmacy* charge amount. The amount paid by *us* to the dispensing *pharmacy* may not reflect the ultimate cost to *us* for the drug. *Your copayment* or *coinsurance* is made on a per *prescription* fill or refill basis and will not be adjusted if *we* receive any retrospective volume discounts or *prescription* drug rebates.

Prescription synchronization

We will cover a *prescription* dispensed by a *pharmacy* for less than a 30-day supply, when requested by *you*, to synchronize *your prescriptions* that treat a permanent or long-term *sickness* or *bodily injury*. Synchronizing *your prescriptions* is to align the dispensing of multiple *prescriptions* by a *pharmacy*. *Your* prescribing *health care practitioner* or the *pharmacist* will determine if synchronizing the fill or refill of *your prescription* is in *your* best interest.

Retail pharmacy / Specialty pharmacy Coverage for up to 30-day supply

<i>Network pharmacy level 1 drugs</i>	20% <i>coinsurance</i> per <i>prescription</i> fill or refill after <i>network provider deductible</i>
<i>Non-network pharmacy level 1 drugs</i>	40% <i>coinsurance</i> of the <i>default rate</i> after <i>non-network provider deductible</i> per <i>prescription</i> fill or refill

SCHEDULE OF BENEFITS – PHARMACY SERVICES (continued)

90-day Retail pharmacy

Some retail *pharmacies* participate in *our* program, which allows *you* to receive a 90-day supply of a *prescription* fill or refill. After the *deductible* is met, *your* cost is based on the applicable benefit amount specified above. *Specialty drugs* are limited to a 30-day supply from a *specialty pharmacy* or a retail *pharmacy*, unless otherwise determined by *us*.

Specialty drugs are limited to a 30-day supply from a *specialty pharmacy* or a *retail pharmacy*, unless otherwise determined by *us*.

Mail order pharmacy

90-day supply

Does not include *specialty drugs*. Refer to the "Retail pharmacy / Specialty pharmacy" provision in this "Schedule of Benefits – Pharmacy Services" section.

<p><i>Network pharmacy level 1 drugs, level 2 drugs, and level 3 drugs</i></p>	<p>After <i>network provider deductible</i>, then 3 times the applicable <i>copayment</i> per <i>prescription</i> fill or refill, as outlined above under "Retail pharmacy / Specialty pharmacy"</p>
<p><i>Non-network pharmacy level 1 drugs, level 2 drugs, and level 3 drugs</i></p>	<p>50% <i>coinsurance</i> of the <i>default rate</i> after <i>non-network provider deductible</i> and 2.5 times the applicable <i>copayment</i> per <i>prescription</i> fill or refill, as outlined above under "Retail pharmacy / Specialty pharmacy"</p>

Expanded preventive drug benefit

The expanded preventive drug benefit covers certain preventive *prescription* drugs based on guidance from the Treasury Department and the Internal Revenue Service (IRS). Benefits for preventive *prescription* drugs under the expanded preventive drug benefit are payable before the annual *deductible* is met and subject to the applicable *cost share* shown in the schedule of benefits below.

The expanded preventive drug benefit does not include *prescription* drugs covered under the preventive coverage requirements of the Affordable Care Act (ACA) as specified on the Preventive Medication Coverage *drug list*. For *cost share* information for *prescription* drugs on the Preventive Medication Coverage *drug list*, refer to the "Preventive medication coverage" provision in this "Schedule of Benefits - Pharmacy Services" section.

For specific drug information and the *drug list*, visit *our* website at Humana.com and sign in to MyHumana or call the customer service telephone number on *your* ID card.

SCHEDULE OF BENEFITS – PHARMACY SERVICES (continued)

Retail pharmacy expanded preventive drug benefit 30-day supply

<i>Network pharmacy</i>	<i>20% coinsurance per prescription fill or refill</i>
<i>Non-network pharmacy</i>	<i>50% coinsurance of the default rate per prescription fill or refill after non-network provider deductible</i>

90-day Retail pharmacy for the expanded preventive drug benefit

Some retail *pharmacies* participate in *our* program, which allows *you* to receive a 90-day supply of a *prescription* fill or refill. *Your* cost is:

- 3 times the applicable *copayment* outlined above; or
- The applicable *cost share* specified above.

Mail order pharmacy expanded preventive drug benefit 90-day supply

<i>Network pharmacy</i>	<i>3 times the applicable copayment per prescription fill or refill, as outlined above under "Retail pharmacy"</i>
<i>Non-network pharmacy</i>	<i>50% coinsurance of the default rate per prescription fill or refill after non-network provider deductible</i>

SCHEDULE OF BENEFITS – PHARMACY SERVICES (continued)

Oral cancer treatment medications

Your cost share for covered orally administered cancer treatment medications will not exceed \$75 per prescription or refill after any applicable deductible for the year.

Non-network pharmacy claims

When a *non-network pharmacy* is used, *you* must pay for the *prescription* fill or refill at the time it is dispensed. *You* must file a claim for reimbursement with *us*, as described in *your certificate*. In addition to any applicable *cost share* shown above, *you* are also responsible for 100% of the difference between the *default rate* and the *non-network pharmacy's* charge. Any amount *you* pay to a *non-network pharmacy* does not apply toward any *out-of-pocket limit* under the *master group contract*. The charge received from a *non-network pharmacy* for a *prescription* fill or refill may be higher than the *default rate*.

SCHEDULE OF BENEFITS - KIDNEY DISEASE TREATMENT SERVICES

Reading this "Schedule of Benefits – Kidney Disease Treatment Services" section will help *you* understand the level of benefits generally paid for kidney disease treatment services covered under the *master group contract*.

This "Schedule of Benefits – Kidney Disease Treatment Services" outlines the coverage and limitations provided under the *master group contract*. A more detailed explanation of *your* coverage and its limitations and exclusions for these benefits is provided in the "Covered Expenses – Kidney Disease Treatment Services" and "Limitations and Exclusions" sections of this *certificate*.

All services are subject to all of the terms, provisions, limitations and exclusions of the *master group contract*.

Kidney transplants

Please see the "Schedule of Benefits - Transplant Services" for a detailed description of benefits payable for all *organ transplant* services including kidney transplants.

Inpatient kidney disease treatment services other than kidney transplant services

Including dialysis provided on an *inpatient* basis.

<i>Network hospital</i>	Same as any other <i>sickness</i> based upon location of services and the type of provider
<i>Non-network hospital</i>	Same as any other <i>sickness</i> based upon location of services and the type of provider

Inpatient health care practitioner services

<i>Network health care practitioner</i>	Same as any other <i>sickness</i> based upon location of services and the type of provider
<i>Non-network health care practitioner</i>	Same as any other <i>sickness</i> based upon location of services and the type of provider

SCHEDULE OF BENEFITS - KIDNEY DISEASE TREATMENT SERVICES (continued)

Outpatient kidney disease treatment services other than kidney transplant services

Including dialysis provided on an *outpatient* basis performed in a *hospital's outpatient* department or in a *health-care treatment facility*. *Outpatient* kidney disease treatment services include hemodialysis, peritoneal dialysis and self-dialysis.

<i>Network provider</i>	Same as any other <i>sickness</i> based upon location of services and the type of provider
<i>Non-network provider</i>	Same as any other <i>sickness</i> based upon location of services and the type of provider

Outpatient health care practitioner services

<i>Network health care practitioner</i>	Same as any other <i>sickness</i> based upon location of services and the type of provider
<i>Non-network health care practitioner</i>	Same as any other <i>sickness</i> based upon location of services and the type of provider

Other covered expenses for the treatment of kidney disease

<i>Network provider</i>	Same as any other <i>sickness</i> based upon location of services and the type of provider
<i>Non-network provider</i>	Same as any other <i>sickness</i> based upon location of services and the type of provider

COVERED EXPENSES

This "Covered Expenses" section describes the services that will be considered *covered expenses* under the *master group contract* for *preventive services* and medical services for a *bodily injury* and *sickness*. Benefits will be paid as specified in the "How your master group contract works" provision in the "Understanding Your Coverage" section and as shown on the "Schedules of Benefits," subject to any applicable:

- *Preauthorization* requirements;
- *Deductible*;
- *Copayment*;
- *Coinsurance* percentage; and
- Maximum benefit.

Refer to the "Limitations and Exclusions" section listed in this *certificate*. All terms and provisions of the *master group contract* apply.

Preventive services

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

- Services with an A or B rating in the current recommendations of the United States Preventive Services Task Force (USPSTF).
- Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC).
- Preventive care for infants, children and adolescents provided in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA).
- Preventive care for women provided in the comprehensive guidelines supported by HRSA.
- Blood lead tests for *covered persons* under age 6. These tests must be conducted in accordance with the Department of Health and Social Services' recommended levels and intervals.

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

Health care practitioner office services

We will pay the following benefits for *covered expenses* incurred by *you* for *health care practitioner* home and office visit services. *You* must incur the *health care practitioner's* services as the result of a *sickness* or *bodily injury*.

Routine vision services

Covered expenses included charges incurred by *you* for the following services:

- Routine vision examination services.

COVERED EXPENSES (continued)

Health care practitioner office visit

Covered expenses include:

- Home and office visits for the diagnosis and treatment of a *sickness* or *bodily injury*.
- Home and office visits for prenatal care.
- Home and office visits for diabetes.
- Diagnostic laboratory and radiology.
- Allergy testing.
- Allergy serum.
- Allergy injections.
- Injections other than allergy.
- *Surgery*, including anesthesia.
- Second surgical opinions.
- Services received from a nurse practitioner, when provided within the scope of their license.

Health care practitioner services at a retail clinic

We will pay benefits for *covered expenses* incurred by you for *health care practitioner* services at a *retail clinic* for a *sickness* or *bodily injury*.

Hospital services

We will pay benefits for *covered expenses* incurred by you while *hospital confined* or for *outpatient* services. A *hospital confinement* must be ordered by a *health care practitioner*.

For *emergency care* benefits, refer to the "Emergency services" provision of this section.

Hospital inpatient services

Covered expenses include:

- Daily semi-private, ward, intensive care or coronary care *room and board* charges for each day of *confinement*. Benefits for a private or single-bed room are limited to the *maximum allowable fee* charged for a semi-private room in the *hospital* while *confined*.
- Services and supplies, other than *room and board*, provided by a *hospital* while *confined*.

COVERED EXPENSES (continued)

Health care practitioner inpatient services when provided in a hospital

Services that are payable as a *hospital* charge are not payable as a *health care practitioner* charge.

Covered expenses include:

- Medical services furnished by an attending *health care practitioner* to you while you are *hospital confined*.
- *Surgery* performed on an *inpatient* basis.
- Services of an *assistant surgeon*.
- Services of a *surgical assistant*.
- Anesthesia administered by a *health care practitioner* or certified registered anesthetist attendant for a *surgery*.
- Consultation charges requested by the attending *health care practitioner* during a *hospital confinement*. The benefit is limited to one consultation by any one *health care practitioner* per specialty during a *hospital confinement*.
- Services of a pathologist.
- Services of a radiologist.
- Services performed on an emergency basis in a *hospital* if the *sickness* or *bodily injury* being treated results in a *hospital confinement*.

Hospital outpatient services

Covered expenses include *outpatient* services and supplies, as outlined in the following provisions, provided in a *hospital's outpatient* department.

Covered expenses provided in a *hospital's outpatient* department will not exceed the average semi-private room rate when you are in *observation status*.

Hospital outpatient surgical services

Covered expenses include services provided in a *hospital's outpatient* department in connection with *outpatient surgery*.

COVERED EXPENSES (continued)

Health care practitioner outpatient services when provided in a hospital

Services that are payable as a *hospital* charge are not payable as a *health care practitioner* charge.

Covered expenses include:

- *Surgery* performed on an *outpatient* basis.
- Services of an *assistant surgeon*.
- Services of a *surgical assistant*.
- Anesthesia administered by a *health care practitioner* or certified registered anesthetist attendant for a *surgery*.
- Services of a pathologist.
- Services of a radiologist.

Hospital outpatient non-surgical services

Covered expenses include services provided in a *hospital's outpatient* department in connection with non-surgical services.

Hospital outpatient advanced imaging

We will pay benefits for *covered expenses* incurred by you for *outpatient advanced imaging* in a *hospital's outpatient* department.

Pregnancy and newborn benefit

We will pay benefits for *covered expenses* incurred by a *covered person* for a pregnancy.

Covered expenses include:

- A minimum stay in a *hospital* for 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated cesarean section. If an earlier discharge is consistent with the most current protocols and guidelines of the American College of Obstetricians and Gynecologists or the American Academy of Pediatrics and is consented to by the mother and the attending *health care practitioner*, a post-discharge office visit to the *health care practitioner* or a home health care visit within the first 48 hours after discharge is also covered, subject to the terms of this *certificate*.
- For a newborn, *hospital confinement* during the first 48 hours or 96 hours following birth, as applicable and listed above for:
 - *Hospital* charges for *routine nursery care*;
 - The *health care practitioner's* charges for circumcision of the newborn child; and
 - The *health care practitioner's* charges for routine examination of the newborn before release from the *hospital*.

COVERED EXPENSES (continued)

- If the covered newborn must remain in the *hospital* past the mother's *confinement*, services and supplies received for:
 - A *bodily injury* or *sickness*;
 - Care and treatment for premature birth; and
 - Medically diagnosed birth defects and abnormalities.

Covered expenses also include *cosmetic surgery* specifically and solely for:

- Reconstruction due to *bodily injury*, infection or other disease of the involved part; or
- *Congenital anomaly* of a covered *dependent* child that resulted in a *functional impairment*.

The newborn will not be required to satisfy a separate *deductible* and/ or *copayment* for *hospital* or *birthing center* facility charges for the *confinement* period immediately following birth. A *deductible* and/ or *copayment*, if applicable, will be required for any subsequent *hospital admission*.

If determined by the *covered person* and *your health care practitioner*, coverage is available in a *birthing center*. *Covered expenses* in a *birthing center* include:

- An uncomplicated, vaginal delivery; and
- Immediate care after delivery for the *covered person* and the newborn.

Emergency services

We will pay benefits for *covered expenses* incurred by *you* for *emergency care*, including the treatment and stabilization of an *emergency medical condition*.

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

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

COVERED EXPENSES (continued)

Ambulance services

We will pay benefits for *covered expenses* incurred by you for licensed *ambulance* and *air ambulance* services to, from or between medical facilities for an *emergency medical condition*.

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

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

Ambulatory surgical center services

We will pay benefits for *covered expenses* incurred by you for services provided in an *ambulatory surgical center* for the utilization of the facility and ancillary services in connection with *outpatient surgery*.

Health care practitioner outpatient services when provided in an ambulatory surgical center

Services that are payable as an *ambulatory surgical center* charge are not payable as a *health care practitioner* charge.

Covered expenses include:

- *Surgery* performed on an *outpatient* basis.
- Services of an *assistant surgeon*.
- Services of a *surgical assistant*.
- Anesthesia administered by a *health care practitioner* or certified registered anesthetist attendant for a *surgery*.
- Services of a pathologist.
- Services of a radiologist.

COVERED EXPENSES (continued)

Durable medical equipment and diabetes equipment

We will pay benefits for covered expenses incurred by you for durable medical equipment and diabetes equipment.

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

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

- *Manufacturer's warranty is expired, except infusion pumps are limited to one per year; and*
- *Repair or maintenance is not a result of misuse or abuse; and*
- *Repair cost is less than replacement cost.*

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

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

Free-standing facility services

Free-standing facility diagnostic laboratory and radiology services

We will pay benefits for covered expenses for services provided in a free-standing facility.

Health care practitioner services when provided in a free-standing facility

We will pay benefits for outpatient non-surgical services provided by a health care practitioner in a free-standing facility.

Free-standing facility outpatient advanced imaging

We will pay benefits for covered expenses incurred by you for outpatient advanced imaging in a free-standing facility.

COVERED EXPENSES (continued)

Home health care services

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

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

Home health care *covered expenses* are limited to:

- Care provided by a *nurse*;
- Care provided by home health services, which is *medically necessary* as part of the *home health care plan*, under the supervision of a registered nurse or medical social worker;
- Physical, occupational, respiratory, or speech therapy;
- Medical social work and nutrition services;
- Medical supplies, except for *durable medical equipment*; and
- Laboratory services.

Home health care *covered expenses* do not include:

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

Home health care will not be reimbursed unless the *health care practitioner* certifies that:

- Hospitalization or *confinement* in a *skilled nursing facility* would otherwise be required if home care were not provided;
- Necessary care and treatment are not available from members of *your* immediate family or other persons residing with *you* without causing undue hardship. "Immediate family" means *your* spouse, children, parents, grandparents, brothers and sisters and their spouses;
- The home health care services will be provided or coordinated by a state-licensed or Medicare-certified *home health care agency* or certified rehabilitation agency; and

If *you* were hospitalized immediately prior to the commencement of home health care, the *home health care plan* must also be initially approved by the *health care practitioner* who was the primary provider of services during the hospitalization.

If the above criteria are not met, no benefits will be payable under the *master group contract* for home health care.

COVERED EXPENSES (continued)

Hospice services

We will pay benefits for *covered expenses* incurred by you for a *hospice care program*. A *health care practitioner* must certify that the *covered person* is terminally ill with a life expectancy of 18 months or less.

If the above criteria is not met, no benefits will be payable under the *master group contract*.

Hospice care benefits are payable as shown in the "Schedule of Benefits" for the following hospice services:

- *Room and board* at a hospice, when it is for management of acute pain or for an acute phase of chronic symptom management;
- Part-time nursing care provided by or supervised by a registered nurse (R.N.) for up to eight hours in any one day;
- Counseling for the terminally ill *covered person* and his/her immediate covered *family members* by a licensed:
 - Clinical social worker; or
 - Pastoral counselor.
- Medical social services provided to the terminally ill *covered person* or his/her immediate covered *family members* under the direction of a *health care practitioner*, including:
 - Assessment of social, emotional and medical needs, and the home and family situation; and
 - Identification of the community resources available.
- Psychological and dietary counseling;
- Physical therapy;
- Part-time home health aide services for up to eight hours in any one day; and
- Medical supplies, drugs and medicines for *palliative care*.

Hospice care *covered expenses* do not include:

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

COVERED EXPENSES (continued)

Jaw joint benefit

We will pay benefits for *covered expenses* incurred by *you* during a plan of treatment for any jaw joint problem, including temporomandibular joint disorder, craniomaxillary disorder, craniomandibular disorder, head and neck neuromuscular disorder, or other conditions of the joint linking the jaw bone and the skull, subject to the maximum benefit shown in the "Schedule of Benefits," if any. Expenses covered under this jaw joint benefit are not covered under any other provision of this *certificate*.

The following are *covered expenses*:

- A single examination including a history, physical examination, muscle testing, range of motion measurements, and psychological evaluation;
- Diagnostic x-rays;
- Physical therapy of necessary frequency and duration, limited to a multiple modality benefit when more than one therapeutic treatment is rendered on the same date of service;
- Therapeutic injections;
- Appliance therapy utilizing an appliance that does not permanently alter tooth position, jaw position or bite. Benefits for reversible appliance therapy will be based on the *maximum allowable fee* for use of a single appliance, regardless of the number of appliances used in treatment. The benefit for the appliance therapy will include an allowance for all jaw relation and position diagnostic services, office visits, adjustments, training, repair, and replacement of the appliance; and
- Surgical procedures.

Covered expenses do not include charges for:

- Computed Tomography (CT) scans or magnetic resonance imaging except in conjunction with surgical management;
- Electronic diagnostic modalities;
- Occlusal analysis; or
- Any irreversible procedure, including but not limited to: orthodontics, occlusal adjustment, crowns, onlays, fixed or removable partial dentures, and full dentures.

Physical medicine and rehabilitative services

We will pay benefits for *covered expenses* incurred by *you* for the following physical medicine and/or *rehabilitative services* for a documented *functional impairment*, pain or developmental delay or defect as ordered by a *health care practitioner* and performed by a *health care practitioner*:

- Physical therapy services;
- Occupational therapy services;

COVERED EXPENSES (continued)

- Spinal manipulations/adjustments;
- Speech therapy or speech pathology services;
- Audiology services;
- Cognitive rehabilitation services;
- Respiratory or pulmonary rehabilitation services; and
- Cardiac rehabilitation services.

The "Schedule of Benefits" shows the maximum number of visits for physical medicine and/or *rehabilitative services*, if any.

Skilled nursing facility services

We will pay benefits for covered expenses incurred by you for charges made by a skilled nursing facility for room and board and for services and supplies. Your confinement to a skilled nursing facility must be based upon a written recommendation of a health care practitioner.

The "Schedule of Benefits" shows the maximum length of time for which *we will pay benefits for charges made by a skilled nursing facility*, if any.

Health care practitioner services when provided in a skilled nursing facility

Services that are payable as a *skilled nursing facility* charge are not payable as a *health care practitioner* charge.

Covered expenses include:

- Medical services furnished by an attending *health care practitioner* to you while you are *confined* in a *skilled nursing facility*;
- Consultation charges requested by the attending *health care practitioner* during a *confinement* in a *skilled nursing facility*;
- Services of a pathologist; and
- Services of a radiologist.

Specialty drug medical benefit

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

- *Health care practitioner's office;*
- *Free-standing facility;*
- *Urgent care center;*
- *A home;*
- *Hospital;*

COVERED EXPENSES (continued)

- *Skilled nursing facility;*
- *Ambulance;* and
- Emergency room.

Specialty drugs may be subject to *preauthorization* requirements. Refer to the "Schedule of Benefits" in this *certificate* for *preauthorization* requirements and contact *us* prior to receiving *specialty drugs*. Coverage for certain *specialty drugs* administered to *you* by a *qualified provider* in a *hospital's outpatient* department may only be granted as described in the "Access to non-formulary drugs" provision in the "Covered Expenses – Pharmacy Services" section in this *certificate*.

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

Transplant services and immune effector cell therapy

We will pay benefits for *covered expenses* incurred by *you* for covered transplants and *immune effector cell therapies* approved by the United States Food and Drug Administration, including but not limited to Chimeric Antigen Receptor Therapy (CAR-T). The transplant services and *immune effector cell therapy* must be *preauthorized* and approved by *us*.

You or *your health care practitioner* must call *our* Transplant Department at 866-421-5663 to request and obtain *preauthorization* from *us* for covered transplants and *immune effector cell therapies*. *We* must be notified of the initial evaluation and given a reasonable opportunity to review the clinical results to determine if the requested transplant or *immune effector cell therapy* will be covered. *We* will advise *your health care practitioner* once coverage is approved by *us*. Benefits are payable only if the transplant or *immune effector cell therapy* is approved by *us*.

Covered expenses for a transplant include pre-transplant services, transplant inclusive of any integral chemotherapy and associated services, post-discharge services, and treatment of complications after transplantation for or in connection with only the following procedures:

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

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

COVERED EXPENSES (continued)

Corneal transplants and porcine heart valve implants are tissues, which are considered part of regular plan benefits and are subject to other applicable provisions of the *master group contract*.

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

- *Hospital and health care practitioner services.*
- Acquisition of cell therapy products for *immune effector cell therapy*, acquisition of *stem cells* or solid organs for transplants and associated donor costs, including pre-transplant or *immune effector cell therapy* services, the acquisition procedure, and any complications resulting from the harvest and/or acquisition. Donor costs for post-discharge services and treatment of complications will not exceed the treatment period of 365 days from the date of discharge following harvest and/or acquisition.
- Non-medical travel and lodging costs for:
 - The *covered person* receiving the transplant or *immune effector cell therapy*, if the *covered person* lives more than 100 miles from the transplant or *immune effector cell therapy* facility designated by *us*; and
 - One caregiver or support person (two, when the *covered person* receiving the transplant or *immune effector cell therapy* is under 18 years of age), if the caregiver or support person lives more than 100 miles from the transplant or *immune effector cell therapy* facility designated by *us*.

Non-medical travel and lodging costs include:

- Transportation to and from the designated transplant or *immune effector cell therapy* facility where the transplant or *immune effector cell therapy* is performed; and
- Temporary lodging at a prearranged location when requested by the designated transplant or *immune effector cell therapy* facility and approved by *us*.

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

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

Urgent care services

We will pay benefits for *urgent care covered expenses* incurred by *you* for charges made by an *urgent care center* or an *urgent care qualified provider*.

COVERED EXPENSES (continued)

Out-of-area student benefits

We will pay benefits at the *network provider* benefit percentage for *covered expenses* incurred by an *out-of-area student* for:

- Allergy injections;
- Hepatitis B vaccine, for students in health related fields where it is not covered by the educational facility;
- *Emergency* care; and
- *Urgent care* services.

Additional covered expenses

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

- Blood and blood plasma, which is not replaced by donation; administration of the blood and blood products including blood extracts or derivatives.
- Oxygen and rental of equipment for its administration.
- Prosthetic devices and supplies, including but not limited to limbs and eyes. Coverage will be provided for prosthetic devices to:
 - Restore the previous level of function lost as a result of a *bodily injury* or *sickness*; or
 - Improve function caused by a *congenital anomaly*.

Covered expense for prosthetic devices includes repair or replacement, if not covered by the manufacturer, and if due to:

- A change in the *covered person's* physical condition causing the device to become non-functional; or
- Normal wear and tear.
- *Hearing aids* when prescribed by a *health care practitioner* or audiologist for a *covered person*:
 - Certified as deaf or hearing impaired by a *health care practitioner* or audiologist.

Hearing aids are limited to one *hearing aid* per ear per *covered person* every three years.

COVERED EXPENSES (continued)

- *Cochlear implants* are a benefit when approved by *us* for:

A *covered person* 18 years of age or older with bilateral severe to profound sensorineural deafness:

- *Covered expenses* do not include: auditory brain stem implants, or any other implantable instrument or hearing device other than *cochlear implants*.

A *covered person* under 18 years of age that has been certified as deaf or hearing impaired by a *health care practitioner* or an audiologist:

- *Covered expenses* include any implantable instrument or device that is designed to enhance hearing.

Replacement or upgrade of a covered *cochlear implant*, or other approved instrument or device and its external components, may be a *covered expense* if:

- The existing device malfunctions and cannot be repaired;
- Replacement is due to a change in the *covered person's* condition that makes the present device non-functional; or
- The replacement or upgrade is not for cosmetic purposes.

- Orthotics used to support, align, prevent, or correct deformities.

Covered expense does not include:

- Replacement orthotics;
- Dental braces; or
- Oral or dental splints and appliances, unless custom made for the treatment of documented obstructive sleep apnea.

- The following special supplies, dispensed up to a 30 -day supply, when prescribed by *your* attending *health care practitioner*:

- Surgical dressings;
- Catheters;
- Colostomy bags, rings and belts; and
- Flotation pads.

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

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

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

COVERED EXPENSES (continued)

- Certain oral surgical operations as follows:
 - Excision of partially or completely impacted teeth;
 - Surgical preparation of soft tissues and excision of bone or bone tissue performed with or without extraction or excision of erupted, partially erupted or completely un-erupted teeth;
 - Excisions of tumors and cysts of the jaws, cheeks, lips, tongue, roof, and floor of the mouth and related biopsy of bone, tooth, or related tissues when such conditions require pathological examinations;
 - Surgical procedures related to repositioning of teeth, tooth transplantation or re-implantation;
 - Services required to correct accidental injuries of the jaws, cheeks, lips, tongue, roof, and floor of the mouth;
 - Reduction of fractures and dislocation of the jaw;
 - External incision and drainage of cellulitis and abscess;
 - Incision and closure of accessory sinuses, salivary glands or ducts;
 - Frenectomy (the cutting of the tissue in the midline of the tongue); and
 - Orthognathic surgery for a *congenital anomaly*, *bodily injury* or *sickness* causing a *functional impairment*.
 - Male sterilization.
 - For a *covered person*, who is receiving benefits in connection with a mastectomy, service for:
 - Reconstructive *surgery* of the breast on which the mastectomy has been performed;
 - *Surgery* and reconstruction on the non-diseased breast to achieve symmetrical appearance; and
 - Prosthesis and treatment of physical complications for all stages of mastectomy, including lymphedemas.
 - Reconstructive *surgery* resulting from:
 - A *bodily injury*, infection or other disease of the involved part, when a *functional impairment* is present; or
 - A *congenital anomaly* of a covered *dependent* child which resulted in a *functional impairment*.
- Expenses for reconstructive *surgery* due to a psychological condition are not considered a *covered expense*, unless the condition(s) described above are also met.
- Enteral formulas, nutritional supplements and low protein modified foods for use at home by a *covered person* that are prescribed or ordered by a *health care practitioner* and are for the treatment of an inherited metabolic disease, e.g. phenylketonuria (PKU).

COVERED EXPENSES (continued)

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

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

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

Telehealth and *telemedicine* services must comply with:

- Federal and state licensure requirements.
 - Accreditation standards; and
 - Guidelines of the American Telemedicine Association or other qualified medical professional societies to ensure quality of care.
- Clinical trials;
 - *Palliative care*.
 - *Diabetes self-management training*.
 - Routine patient care costs incurred during participation in a qualifying clinical trial for the treatment of:
 - Cancer;
 - Cardiovascular disease (cardiac/stroke);
 - Surgical musculoskeletal disorders of the spine, hip and knees;
 - Other diseases or disorders for which, as *we* determine, a clinical trial meets the qualifying clinical trial criteria stated below.

Covered expenses include the *medically necessary* items and services used to diagnose and treat complications arising from participation in a qualifying clinical trial.

COVERED EXPENSES (continued)

Routine costs include:

- Health care services that are otherwise a *covered expense* if the *covered person* were not participating in a clinical trial;
- *Covered expenses* specifically related to the clinical trial;
- *Covered expenses* needed for the *medically necessary* care arising from the provision of an investigational item or service; and
- Certain promising interventions, as determined by *us*, for a *covered person* with a terminal illness.

Routine costs do not include services or items that are:

- *Experimental, investigational or for research purposes*;
- Items and services provided by the research sponsors free of charge for any person enrolled in the trial;
- Provided only for data collection and analysis that is not directly related to the clinical management of the *covered person*; or
- Inconsistent with widely accepted and established standards of care for a diagnosis.

The *covered person* must be eligible to participate in a clinical trial according to the trial protocol and:

- Referred by a *health care practitioner*; or
- Provide medical and scientific information supporting their participation in the clinical trial is appropriate.

For the routine costs to be considered a *covered expense*, the approved clinical trial must be a Phase I, II, III, or IV clinical trial for the treatment of cancer or a life threatening condition and is:

- Federally funded or approved by the appropriate federal agency;
 - The study or investigation is conducted under an investigational new drug application reviewed by the Federal Food and Drug Administration; or
 - The study or investigation is a drug trial that is exempt from having such an investigational new drug application.
- Services for the treatment of Kidney Disease, including dialysis. See the "Covered expenses - transplant services" section for kidney transplant benefits.
 - *Hospital or free-standing facility* charges, including anesthetics, when provided in conjunction with dental care if any of the following applies:
 - The *covered dependent* is under the age of 5; or
 - The *covered person* has a chronic disability that meets all the conditions in s.230.04(r)(a)2.a., b., and c., Wis. Stat.; or
 - The *covered person* has a medical condition for which it is *medically necessary* to receive *hospitalization* or general anesthesia for dental care.
 - Cost of any routine patient care that is administered in a cancer clinical trial that would have been covered if not enrolled in a cancer clinical trial, as required by applicable state law.

COVERED EXPENSES - BEHAVIORAL HEALTH

This "Covered Expenses – Behavioral Health" section describes the services that will be considered *covered expenses* for *mental health services* and *chemical dependency* services under the *master group contract*. Benefits will be paid as specified in the "How your master group contract works" provision of the "Understanding Your Coverage" section and as shown in the "Schedule of Benefits – Behavioral Health." Refer to the "Schedule of Benefits" for any service not specifically listed in the "Schedule of Benefits – Behavioral Health." Benefits are subject to any applicable:

- *Preauthorization* requirements;
- *Deductible*;
- *Copayment*;
- *Coinsurance* percentage; and
- Maximum benefit.

Refer to the "Limitations and Exclusions" section listed in this *certificate*. All terms and provisions of the *master group contract* apply.

Acute inpatient services

We will pay benefits for covered expenses incurred by you due to an admission or confinement for acute inpatient services for mental health services and chemical dependency services provided in a hospital or health care treatment facility.

Acute inpatient health care practitioner services

We will pay benefits for covered expenses incurred by you for mental health services and chemical dependency services provided by a health care practitioner, including telehealth or telemedicine, in a hospital or health care treatment facility.

Emergency services

We will pay benefits for covered expenses incurred by you for emergency care, including the treatment and stabilization of an emergency medical condition for mental health services and chemical dependency services.

Emergency care provided by a non-network provider will be covered at the network provider benefit level as specified in the "Emergency services" benefit in the "Schedule of Benefits" or "Schedule of Benefits – Behavioral Health" sections of this certificate. However, you will only be responsible to pay the network provider copayment, deductible and/or coinsurance to the non-network provider for emergency care based on the qualified payment amount.

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

COVERED EXPENSES - BEHAVIORAL HEALTH (continued)

Urgent care services

We will pay benefits for *urgent care covered expenses* incurred by you for charges made by an *urgent care center* or an *urgent care qualified provider* for *mental health services* and *chemical dependency services*.

Outpatient services

We will pay benefits for *covered expenses* incurred by you for *mental health services* and *chemical dependency services*, including services in a *health care practitioner office*, *retail clinic*, or *health care treatment facility*. Coverage includes *outpatient therapy*, *intensive outpatient programs*, *partial hospitalization*, *telehealth* and *telemedicine*, and other *outpatient services*.

Skilled nursing facility services

We will pay benefits for *covered expenses* incurred by you in a *skilled nursing facility* for *mental health services* and *chemical dependency services*. Your *confinement* to a *skilled nursing facility* must be based upon a written recommendation of a *health care practitioner*.

Covered expenses also include *health care practitioner services* for *behavioral health* during your *confinement* in a *skilled nursing facility*.

Home health care services

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

Home health care *covered expenses* include services provided by a *health care practitioner* who is a *behavioral health professional*, such as a counselor, psychologist or psychiatrist.

Home health care *covered expenses* do not include:

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

COVERED EXPENSES - BEHAVIORAL HEALTH (continued)

Specialty drug benefit

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

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

Specialty drugs may be subject to *preauthorization* requirements. Refer to the "Schedule of Benefits" in this *certificate* for *preauthorization* requirements and contact us prior to receiving *specialty drugs*. Coverage for certain *specialty drugs* administered to you by a *qualified provider* in a *hospital's outpatient* department may only be granted as described in the "Access to non-formulary drugs" provision in the "Covered Expenses – Pharmacy Services" section in this *certificate*.

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

Residential treatment facility services

We will pay benefits for *covered expenses* incurred by you for *mental health services* and *chemical dependency* services provided while *inpatient* or *outpatient* in a *residential treatment facility*.

Autism spectrum disorder

We will pay benefits for *covered expenses* for treatment of *autism spectrum disorder* if the treatment is prescribed by a *health care practitioner* and provided by any of the following who are qualified to provide *intensive level services* or *non-intensive level services*:

- Psychiatrist;
- Psychologist;
- Social worker who is certified or licensed to practice psychotherapy;
- Behavior analyst;
- Paraprofessional working under any of the above *health care practitioners*;
- Person working under the supervision of an outpatient mental health clinic;
- Speech-language pathologist; or
- Occupational therapist.

COVERED EXPENSES - BEHAVIORAL HEALTH (continued)

Transitional treatment

We will pay benefits for covered expense incurred by you for the mental health services and chemical dependency services provided in a transitional treatment arrangement. Transitional treatment means services that are provided in a less restrictive manner than inpatient hospital services but a more intensive manner than outpatient services. Transitional treatment services received while not confined in a hospital or health care treatment facility include:

- *Mental health services for an adult covered person in a day treatment program offered by a provider certified by the Department of Health and Family Services;*
- *Mental health services for covered dependent children and adolescents in a day treatment program offered by a provider certified by the Department of Health and Family Services;*
- *Services for a covered person with chronic mental illness provided through a community support program certified by the Department of Health and Family Services;*
- *Residential treatment programs certified by the Department of Health and Social Services, for a covered person who is alcohol and/or drug dependent;*
- *Services for alcoholism and other drug problems provided in a day treatment program certified by the Department of Health and Social Services;*
- *Intensive outpatient programs for the treatment of psychoactive substance use disorders provided in accordance with the patient placement criteria of the American Society of Addiction Medicine;*
- *Coordinated emergency mental health services from a program certified by the Department of Health and Family Services, for a covered person experiencing a mental health crisis or in a situation likely to turn into a mental health crisis if support is not received.*

Court ordered mental health services

If a covered person is examined, evaluated, or treated for mental health services by a non-network provider, pursuant to an emergency detention under WIS. STAT. s. 51.15 or a commitment or a court order under WIS. STAT. s.51.20 or 880.33 (4m) or (r), then reimbursement will be made at the network provider percentage level. The covered person and or a representative from the facility must notify us within 72 hours after the initial service was rendered. After we have been notified, we may make arrangements for such services to be rendered by a network provider.

COVERED EXPENSES - BEHAVIORAL HEALTH (continued)

Out of area dependent student services

We will pay benefits for covered expense incurred by an out of area dependent student for outpatient mental health services and chemical dependency as follows:

- The *dependent* must obtain a clinical assessment of the problem from a local psychiatrist or psychologist, who may be designated by *us*;
- If recommended in the clinical assessment, outpatient visits from a *non-network provider* will be covered at the *network provider* benefit level if:
 - *Our* Medical Director determines that the prescribed outpatient treatment will not prevent the student from attending school full-time or on a regular basis; and
 - The student does not terminate enrollment from the school;
- Upon completing the five visits, *our* Medical Director or a mental health representative will determine the need for continuing treatment by the *non-network provider*. This decision is subject to appeal and grievance procedures;
- If *our* Medical Director or mental health representative determines there is a need to continue treatment coverage will continue at the *network provider* benefit level.

COVERED EXPENSES – PHARMACY SERVICES

This "Covered Expenses – Pharmacy Services" section describes *covered expenses* under the *master group contract* for *prescription* drugs, including *specialty drugs*, dispensed by a *pharmacy*. Benefits are subject to applicable *cost share* shown on the "Schedule of Benefits – Pharmacy Services" section of this *certificate*.

Refer to the "Limitations and Exclusions," "Limitations and Exclusions – Pharmacy Services," "Glossary" and "Glossary – Pharmacy Services" sections in this *certificate*. All terms and provisions of the *master group contract* apply, including *prior authorization* requirements specified in the "Schedule of Benefits – Pharmacy Services" of this *certificate*.

Coverage description

We will cover *prescription* drugs that are received by *you* under this "Covered Expenses – Pharmacy Services" section. Benefits may be subject to *dispensing limits*, *prior authorization* and *step therapy* requirements, if any.

Covered *prescription* drugs are:

- Drugs, medicines or medications and *specialty drugs* that under federal or state law may be dispensed only by *prescription* from a *health care practitioner*.
- Drugs, medicines or medications and *specialty drugs* included on *our drug list*.
- Insulin and *diabetes supplies*.
- *Self-administered injectable drugs* approved by *us*.
- Hypodermic needles, syringes or other methods of delivery when prescribed by a *health care practitioner* for use with insulin or *self-administered injectable drugs*. (Hypodermic needles, syringes or other methods of delivery used in conjunction with covered drugs may be available at no cost to *you*).
- Enteral formulas and nutritional supplements for the treatment of phenylketonuria (PKU) or other inherited metabolic disease, or as otherwise determined by *us*.
- Spacers and/or peak flow meters for the treatment of asthma.
- Drugs, medicines or medications or contraceptive methods on the Preventive Medication Coverage *drug list* with a *prescription* from a *health care practitioner*.

Notwithstanding any other provisions of the *master group contract*, we may decline coverage or, if applicable, exclude from the *drug list* any and all *prescriptions* until the conclusion of a review period not to exceed six months following FDA approval for the use and release of the *prescriptions* into the market.

COVERED EXPENSES – PHARMACY SERVICES (continued)

Restrictions on choice of providers

If we determine you are using *prescription* drugs in a potentially abusive, excessive, or harmful manner, we may restrict your coverage of *pharmacy* services in one or more of the following ways:

- By restricting your choice of *pharmacy* to a single *network pharmacy* store or physical location for *pharmacy* services;
- By restricting your choice of *pharmacy* for covered *specialty pharmacy* services to a specific *specialty pharmacy*, if the *network pharmacy* store or physical location for *pharmacy* services is unable to provide or is not contracted with us to provide covered *specialty pharmacy* services; and
- By restricting your choice of a prescribing *network health care practitioner* to a specific *network health care practitioner*.

We will determine if we will allow you to change a selected *network provider*. Only *prescriptions* obtained from the *network pharmacy* store or physical location or *specialty pharmacy* to which you have been restricted will be eligible to be considered *covered expenses*. Additionally, only *prescriptions* prescribed by the *network health care practitioner* to whom you have been restricted will be eligible to be considered *covered expenses*.

About our drug list

Prescription drugs, medicines or medications, including *specialty drugs* and *self-administered injectable drugs* prescribed by *health care practitioners* and covered by us are specified on our printable *drug list*. The *drug list* identifies categories of drugs, medicines or medications by levels and indicates *dispensing limits*, *specialty drug* designation, any applicable *prior authorization* and/or *step therapy* requirements. This information is reviewed on a regular basis by a Pharmacy and Therapeutics committee made up of physicians and *pharmacists*. Placement on the *drug list* does not guarantee your *health care practitioner* will prescribe that *prescription* drug, medicine or medication for a particular medical condition. You can obtain a copy of our *drug list* by visiting our website at Humana.com or calling the customer service telephone number on your ID card..

Access to medically necessary contraceptives

In addition to *preventive services*, contraceptives on our *drug list* and non-formulary contraceptives may be covered at no *cost share* when your *health care practitioner* contacts us. We will defer to the *health care practitioner's* recommendation that a particular method of contraception or FDA-approved contraceptive is determined to be *medically necessary*. The *medically necessary* determination made by your *health care practitioner* may include severity of side effects, differences in permanence and reversibility of contraceptives, and ability to adhere to the appropriate use of the contraceptive item or service.

COVERED EXPENSES – PHARMACY SERVICES (continued)

Access to non-formulary drugs

A drug not included on *our drug list* is a non-formulary drug. If a *health care practitioner* prescribes a clinically appropriate non-formulary drug, *you* can request coverage of the non-formulary drug through a standard exception request or an expedited exception request. If *you* are dissatisfied with *our* decision of an exception request, *you* have the right to an external review as described in the "Non-formulary drug exception request external review" provision of this section.

Non-formulary drug standard exception request

A standard exception request for coverage of a clinically appropriate non-formulary drug may be initiated by *you*, *your* appointed representative, or the prescribing *health care practitioner* by calling the customer service number on *your* ID card, in writing, or electronically by visiting *our* website at Humana.com. *We* will respond to a standard exception request no later than 72 hours after the receipt date of the request.

As part of the standard exception request, the prescribing *health care practitioner* should include an oral or written statement that provides justification to support the need for the prescribed non-formulary drug to treat the *covered person's* condition, including a statement that all covered drugs on the *drug list* on any tier:

- Will be or have been ineffective;
- Would not be as effective as the non-formulary drug; or
- Would have adverse effects.

If *we* grant a standard exception request to cover a prescribed, clinically appropriate non-formulary drug, *we* will cover the prescribed non-formulary drug for the duration of the *prescription*, including refills. Any applicable *cost share* for the *prescription* will apply toward the *out-of-pocket limit*.

If *we* deny a standard exception request, *you* have the right to an external review as described in the "Non-formulary drug exception request external review" provision of this section.

Non-formulary drug expedited exception request

An expedited exception request for coverage of a clinically appropriate non-formulary drug based on exigent circumstances may be initiated by *you*, *your* appointed representative, or *your* prescribing *health care practitioner* by calling the customer service number on *your* ID card, in writing, or *electronically* by visiting *our* website at Humana.com. *We* will respond to an expedited exception request within 24 hours of receipt of the request. An exigent circumstance exists when a *covered person* is:

- Suffering from a health condition that may seriously jeopardize their life, health, or ability to regain maximum function; or
- Undergoing a current course of treatment using a non-formulary drug.

COVERED EXPENSES – PHARMACY SERVICES (continued)

As part of the expedited review request, the prescribing *health care practitioner* should include an oral or written:

- Statement that an exigent circumstance exists and explain the harm that could reasonably be expected to the *covered person* if the requested non-formulary drug is not provided within the timeframes of the standard exception request; and
- Justification supporting the need for the prescribed non-formulary drug to treat the *covered person's* condition, including a statement that all covered drugs on the *drug list* on any tier:
 - Will be or have been ineffective;
 - Would not be as effective as the non-formulary drug; or
 - Would have adverse effects.

If *we* grant an expedited exception request to cover a prescribed, clinically appropriate non-formulary drug based on exigent circumstances, *we* will provide access to the prescribed non-formulary drug:

- Without unreasonable delay; and
- For the duration of the exigent circumstance.

Any applicable *cost share* for the *prescription* will apply toward the *out-of-pocket limit*.

If *we* deny an expedited exception request, *you* have the right to an external review as described in the "Non-formulary drug exception request external review" provision of this section.

Non-formulary drug exception request external review

You, *your* appointed representative or *your* prescribing *health care practitioner* have the right to appeal *our* decision to an external review by an independent review organization if *we* deny a non-formulary drug standard or expedited exception request. To a request an external review, refer to the exception request decision letter for instructions or call the customer service number on *your* ID card for assistance.

Step therapy exception request

Your health care practitioner may submit to *us* a written *step therapy* exception request for a clinically appropriate *prescription* drug. The *health care practitioner* should use the *prior authorization* form on *our* website at Humana.com or call the customer service telephone number on *your* ID card.

COVERED EXPENSES – PHARMACY SERVICES (continued)

From the time a *step therapy* exception request is received by *us*, *we* will either approve or deny the request within:

- 24 hours for an expedited request.
- 72 hours for a standard request.

A written *step therapy* exception request will be approved when the request includes the prescribing *health care practitioner's* written statement and supporting documentation that:

- The *prescription* drug requiring *step therapy* has been ineffective in the treatment of *your* disease or medical condition; or
- Based on sound clinical evidence or medical and scientific evidence, the *prescription* drug requiring *step therapy*:
 - Is expected or likely to be ineffective based on *your* known relevant clinical characteristics and the known characteristics of the *prescription* drug regimen; or
 - Will cause or will likely cause an adverse reaction or physical harm to *you*.

If *we* deny a *step therapy* exception request, *we* will provide *you* or *your* appointed representative, and *your* prescribing *health care practitioner*:

- The reason for the denial;
- An alternative covered medication; and
- The right to appeal *our* decision as described in the "Complaint and Appeals Procedures" section of this *certificate*.

COVERED EXPENSES - KIDNEY DISEASE TREATMENT SERVICES

This "Covered Expenses – Kidney Disease Treatment Services" section describes the services that will be considered *covered expenses* for kidney disease treatment services under the *master group contract*. Benefits for kidney disease treatment services will be paid on a *maximum allowable fee* basis and as shown in the "Schedule of Benefits – Kidney Disease Treatment Services" subject to any applicable:

- *Deductible*;
- *Copayment*;
- *Coinsurance* percentage; and
- Maximum benefit.

Refer to the "Exclusions" provision in this section and the "Limitations and Exclusions" section listed in this *certificate* for services not covered by the *master group contract*. All terms and provisions of the *master group contract*, including *preauthorization* requirements specified in this *certificate*, are applicable to *covered expenses*.

Covered expenses payable under this section of the *certificate* will not be duplicated under any other section of the *certificate*.

Kidney transplants

Please see the "Covered Expenses - Transplant Services" for a detailed description of *covered expenses* and limitations and exclusions that are applicable to all transplant services including kidney transplants. For further details of benefits payable for kidney transplant services please see the "Schedule of Benefits - Transplant Services" and the "Schedule of Benefits - Kidney Disease Treatment Services."

Inpatient kidney disease treatment services other than kidney transplant services

We will pay benefits for *inpatient* care for kidney disease treatment services provided in a *hospital* or *health care treatment facility*. This includes both hemodialysis and peritoneal dialysis provided at the *hospital* or *health care treatment facility* in the course of *inpatient* kidney disease treatment.

The "Schedule of Benefits – Kidney Disease Treatment Services" reflects the benefit limitations for *inpatient* care for kidney disease treatment, if any.

Inpatient health care practitioner services

We will pay benefits for *covered expenses* incurred by *you* for the treatment of kidney disease provided by a *health care practitioner* in a *hospital* or *health care treatment facility*.

COVERED EXPENSES - KIDNEY DISEASE TREATMENT SERVICES (continued)

Outpatient kidney disease treatment services other than kidney transplant services

We will pay benefits for covered expenses incurred by you for kidney disease treatment services while not confined in a hospital or health care treatment facility for outpatient services. This includes hemodialysis, peritoneal dialysis and self-dialysis provided in a hospital's outpatient department or in a health care treatment facility.

The "Schedule of Benefits – Kidney Disease Treatment Services" reflects the benefit limitations for outpatient care for kidney disease treatment, if any.

Exclusions

No benefit will be provided for, or in connection with, services received for kidney disease treatment if:

- The services are covered under any other plan, *Medicare*, or program as permitted by state law.

LIMITATIONS AND EXCLUSIONS

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

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

- Treatments, services, supplies or *surgeries* that are not *medically necessary*, except *preventive services*.
- A *sickness* or *bodily injury* arising out of, or in the course of, any employment for wage, gain or profit. This exclusion applies whether or not *you* have Workers' Compensation coverage.
- Care and treatment given in a *hospital* owned or run by any government entity, unless *you* are legally required to pay for such care and treatment. However, care and treatment provided by military *hospitals* to *covered persons* who are armed services retirees and their *dependents* are not excluded.
- Any service furnished while *you* are *confined* in a *hospital* or institution owned or operated by the United States government or any of its agencies for any military service-connected *sickness* or *bodily injury*.
- Services, or any portion of a service, for which no charge is made.
- Services, or any portion of a service, *you* would not be required to pay for, or would not have been charged for, in the absence of this coverage.
- Any portion of the amount *we* determine *you* owe for a services that the provider waives, rebates or discounts, including *your copayment*, *deductible* or *coinsurance*.
- *Sickness* or *bodily injury* for which *you* are in any way paid or entitled to payment or care and treatment by or through a government program.
- Any service not ordered by a *health care practitioner*.
- Private duty nursing.
- Services rendered by a standby physician, *surgical assistant* or assistant surgeon unless *medically necessary*.
- Any service not rendered by the billing provider.
- Any service not substantiated in the medical records of the billing provider.

LIMITATIONS AND EXCLUSIONS (continued)

- Any amount billed for a professional component of an automated:
 - Laboratory service; or
 - Pathology service.
- Education or training, except for *diabetes self-management training* and *habilitative services*.
- Educational or vocational, therapy, testing, services or schools, including therapeutic boarding schools and other therapeutic environments. Educational or vocational videos, tapes, books and similar materials are also excluded.
- Services provided by a *covered person's family member*.
- *Ambulance* and *air ambulance* services for routine transportation to, from or between medical facilities and/or a *health care practitioner's* office.
- Any drug, biological product, device, medical treatment, or procedure which is *experimental, investigational* or *for research purposes*.
- Vitamins, except for *preventive services* with a *prescription* from a *health care practitioner*, dietary supplements, and dietary formulas, except enteral formulas, nutritional supplements or low protein modified food products for the treatment of an inherited metabolic disease, e.g. phenylketonuria (PKU).
- Over-the-counter, non-prescription medications, unless for drugs, medicines or medications or supplies on the Preventive Medication Coverage drug list with a *prescription* from a *health care practitioner*.
- Over-the-counter medical items or supplies that can be provided or prescribed by a *health care practitioner* but are also available without a written order or *prescription*, except for *preventive services*.
- Growth hormones, except as otherwise specified in the pharmacy services sections of this *certificate*.
- *Prescription* drugs and *self-administered injectable* drugs, except as specified in the "Covered Expenses – Pharmacy Services" section in this *certificate* or unless administered to you:
 - While an *inpatient* in a *hospital, skilled nursing facility, health care treatment facility* or *residential treatment facility*;
 - By the following, when deemed appropriate by us:
 - A *health care practitioner*:
 - During an office visit; or
 - While an *outpatient*; or
 - A *home health care agency* as part of a covered *home health care plan*.

LIMITATIONS AND EXCLUSIONS (continued)

- Certain *specialty drugs* administered by a *qualified provider* in a *hospital's outpatient* department, except as specified in the "Access to non-formulary drugs" provision in the "Covered Expenses - Pharmacy Services" section of this *certificate*.
- Services received in an emergency room, unless required because of *emergency care*.
- Weekend non-emergency *hospital admissions*, specifically *admissions* to a *hospital* on a Friday or Saturday at the convenience of the *covered person* or his or her *health care practitioner* when there is no cause for an emergency *admission* and the *covered person* receives no *surgery* or therapeutic treatment until the following Monday.
- *Hospital inpatient* services when you are in *observation status*.
- *Infertility services*; or reversal of elective sterilization.
- In vitro fertilization regardless of the reason for treatment.
- Services for or in connection with a transplant or *immune effector cell therapy* if:
 - The expense relates to storage of cord blood and stem cells, unless it is an integral part of a transplant approved by *us*.
 - Not approved by *us*, based on *our* established criteria.
 - Expenses are eligible to be paid under any private or public research fund, government program except *Medicaid*, or another funding program, whether or not such funding was applied for or received.
 - The expense relates to the transplantation of any non-human organ or tissue, unless otherwise stated in the *master group contract*.
 - The expense relates to the donation or acquisition of an organ or tissue for a recipient who is not covered by *us*.
 - The expense relates to a transplant or *immune effector cell therapy* performed outside of the United States and any care resulting from that transplant or *immune effector cell therapy*. This exclusion applies even if the *employee* and *dependents* live outside the United States and the *employee* is in *active status* with the *employer* sponsoring the *master group contract*.

LIMITATIONS AND EXCLUSIONS (continued)

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

- *Cosmetic surgery* and cosmetic services or devices,

- Hair prosthesis, hair transplants or implants and wigs.

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

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

- *Custodial care* and *maintenance care*.

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

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

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

LIMITATIONS AND EXCLUSIONS (continued)

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

LIMITATIONS AND EXCLUSIONS (continued)

- Duplicate or similar rentals or purchases of *durable medical equipment* or *diabetes equipment*.
- Therapy and testing for treatment of allergies including, but not limited to, services related to clinical ecology, environmental allergy and allergic immune system dysregulation and sublingual antigen(s), extracts, neutralization tests and/or treatment unless such therapy or testing is approved by:
 - The American Academy of Allergy and Immunology; or
 - The Department of Health and Human Services or any of its offices or agencies.
- Lodging accommodations or transportation.
- Communications or travel time.
- Bariatric *surgery*, any services or complications related to bariatric *surgery*, and other weight loss products or services.
- *Sickness* or *bodily injury* for which no-fault medical payment or expense coverage benefits are paid or payable under any homeowners, premises or any other similar coverage.
- Elective medical or surgical abortion unless:
 - The pregnancy would endanger the life of the mother; or
 - The pregnancy is a result of rape or incest.
- *Alternative medicine*.
- Acupuncture, unless:
 - The treatment is *medically necessary*, appropriate and is provided within the scope of the acupuncturist's license; and
 - *You* are directed to the acupuncturist for treatment by a licensed physician.
- Services rendered in a premenstrual syndrome clinic or holistic medicine clinic.
- Services of a midwife, unless the midwife is licensed.
- Orthoptic/vision training (eye exercises).
- Radial keratotomy, refractive keratoplasty or any other *surgery* or procedure to correct myopia, hyperopia or stigmatic error.

LIMITATIONS AND EXCLUSIONS (continued)

- The purchase or fitting of eyeglasses or contact lenses, except as the result of an accident or following cataract surgery as stated in this *certificate*.
- Services and supplies which are:
 - Rendered in connection with mental illnesses not classified in the International Classification of Diseases of the U.S. Department of Health and Human Services; or
 - Extended beyond the period necessary for evaluation and diagnosis of learning and behavioral disabilities or for mental retardation.
- Marriage counseling, unless for the treatment of *mental health* and/or *chemical dependency* services.
- Expenses for:
 - Employment;
 - School;
 - Sport;
 - Camp;
 - Travel; or
 - The purposes of obtaining insurance.
- Expenses for care and treatment of non-covered procedures or services.
- Expenses for treatment of complications of non-covered procedures or services.
- Expenses incurred for services prior to the *effective date* or after the termination date of *your* coverage under the *master group contract*. Coverage will be extended as described in the "Extension of Benefits" section, as required by state law.
- Expenses for services, *prescriptions*, equipment, or supplies received outside the United States or from a foreign provider unless:
 - For *emergency care*;
 - The *employee* is traveling outside the United States due to employment with the *employer* sponsoring the *master group contract* and the services are not covered under any Workers' Compensation or similar law; or
 - The *employee* and *dependents* live outside the United States and the *employee* is in *active status* with the *employer* sponsoring the *master group contract*.
- *Pre-surgical/procedural testing* duplicated during a *hospital* confinement.

LIMITATIONS AND EXCLUSIONS – PHARMACY SERVICES

This "Limitations and Exclusions – Pharmacy Services" section describes the limitations and exclusions under the *master group contract* that apply to *prescription* drugs, including *specialty drugs*, dispensed by a *pharmacy*. Please refer to the "Limitations and Exclusions" section of this *certificate* for additional limitations.

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

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

- *Legend drugs*, which are not deemed *medically necessary* by *us*.
- *Prescription* drugs not included on the *drug list*.
- Any amount exceeding the *default rate*.
- *Specialty drugs* for which coverage is not approved by *us*.
- Drugs not approved by the FDA.
- Any drug prescribed for intended use other than for:
 - Indications approved by the FDA; or
 - Off-label indications recognized through peer-reviewed medical literature.
- Any drug prescribed for a *sickness* or *bodily injury* not covered under the *master group contract*.
- Any drug, medicine or medication that is either:
 - Labeled "Caution - limited by federal law to investigational use;" or
 - *Experimental, investigational or for research purposes*,even though a charge is made to *you*.
- Allergen extracts.
- Therapeutic devices or appliances, including, but not limited to:
 - Hypodermic needles and syringes (except when prescribed by a *health care practitioner* for use with insulin and *self-administered injectable drugs*, whose coverage is approved by *us*);
 - Support garments;
 - Test reagents;
 - Mechanical pumps for delivery of medications; and
 - Other non-medical substances.

LIMITATIONS AND EXCLUSIONS – PHARMACY SERVICES (continued)

- Dietary supplements and nutritional products, except enteral formulas and nutritional supplements for the treatment of phenylketonuria (PKU) or other inherited metabolic disease. Refer to the "Covered Expenses" section of the *certificate* for coverage of low protein modified foods.
- Non-prescription, over-the-counter minerals, except as specified on the Preventive Medication Coverage *drug list* when obtained from a *network pharmacy* with a *prescription* from a *health care practitioner*.
- Growth hormones for idiopathic short stature or any other condition, unless there is a laboratory confirmed diagnosis of growth hormone deficiency, or as otherwise determined by *us*.
- Herbs and vitamins, except prenatal (including greater than one milligram of folic acid), pediatric multi-vitamins with fluoride and vitamins on the Preventive Medication Coverage *drug list* when obtained from a *network pharmacy* with a *prescription* from a *health care practitioner*.
- Anabolic steroids.
- Any drug used for the purpose of weight loss.
- Any drug used for cosmetic purposes, including, but not limited to:
 - Dermatologicals or hair growth stimulants; or
 - Pigmenting or de-pigmenting agents.
- Any drug or medicine that is lawfully obtainable without a *prescription* (over-the-counter drugs), except:
 - Insulin; and
 - Drugs, medicines or medications and supplies on the Preventive Medication Coverage *drug list* when obtained from a *network pharmacy* with a *prescription* from a *health care practitioner*.
- Compounded drugs that:
 - Are prescribed for a use or route of administration that is not FDA approved or compendia supported;
 - Are prescribed without a documented medical need for specialized dosing or administration;
 - Only contain ingredients that are available over-the-counter;
 - Only contain non-commercially available ingredients; or
 - Contain ingredients that are not FDA approved, including bulk compounding powders.
- Abortifacients (drugs used to induce abortions).
- *Infertility services* including medications.

LIMITATIONS AND EXCLUSIONS – PHARMACY SERVICES (continued)

- Any drug prescribed for impotence and/or sexual dysfunction.
- Any drug, medicine or medication that is consumed or injected at the place where the *prescription* is given, or dispensed by the *health care practitioner*.
- The administration of covered medication(s).
- *Prescriptions* that are to be taken by or administered to *you*, in whole or in part, while *you* are a patient in a facility where drugs are ordinarily provided on an *inpatient* basis by the facility. *Inpatient* facilities include, but are not limited to:
 - *Hospital*;
 - *Skilled nursing facility*; or
 - *Hospice facility*.
- Injectable drugs, including, but not limited to:
 - Immunizing agents, unless for *preventive services* determined by *us* to be dispensed by or administered in a *pharmacy*;
 - Biological sera;
 - Blood;
 - Blood plasma; or
 - *Self-administered injectable drugs* or *specialty drugs* for which *prior authorization* or *step therapy* is not obtained from *us*.
- *Prescription* fills or refills:
 - In excess of the number specified by the *health care practitioner*; or
 - Dispensed more than one year from the date of the original order.
- Any portion of a *prescription* fill or refill that exceeds a 90-day supply when received from a *mail order pharmacy* or a retail *pharmacy* that participates in *our* program, which allows *you* to receive a 90-day supply of a *prescription* fill or refill.
- Any portion of a *prescription* fill or refill that exceeds a 30-day supply when received from a retail *pharmacy* that does not participate in *our* program, which allows *you* to receive a 90-day supply of a *prescription* fill or refill.
- Any portion of a *specialty drug prescription* fill or refill that exceeds a 30-day supply, unless otherwise determined by *us*.

LIMITATIONS AND EXCLUSIONS – PHARMACY SERVICES (continued)

- Any portion of a *prescription* fill or refill that:
 - Exceeds *our* drug-specific *dispensing limit*;
 - Is dispensed to a *covered person*, whose age is outside the drug-specific age limits defined by *us*;
 - Exceeds the duration-specific *dispensing limit*; or
 - Is refilled early, as defined by *us*, except for *prescription* refills of a topical ophthalmic product when:
 - The refill is requested by the *covered person* prior to the last day of the prescribed dosage period and after at least 75% of the predicted days of use; and
 - The prescribing *health care practitioner* on the original *prescription* that refills are permitted and the early refills requested by the *covered person* do not exceed the total number of refills prescribed.
- Any drug for which *we* require *prior authorization* or *step therapy* and it is not obtained.
- Any drug for which a charge is customarily not made.
- Any drug, medicine or medication received by *you*:
 - Before becoming covered; or
 - After the date *your* coverage has ended.
- Any costs related to the mailing, sending or delivery of *prescription* drugs.
- Any intentional misuse of this benefit, including *prescriptions* purchased for consumption by someone other than *you*.
- Any *prescription* fill or refill for drugs, medicines or medications that are lost, stolen, spilled, spoiled, or damaged.
- Drug delivery implants and other implant systems or devices.
- Treatment for onychomycosis (nail fungus).
- Any amount *you* paid for a *prescription* that has been filled, regardless of whether the *prescription* is revoked or changed due to adverse reaction or change in dosage or *prescription*.

ELIGIBILITY AND EFFECTIVE DATES

Eligibility date

Employee eligibility date

The *employee* is eligible for coverage on the date:

- The eligibility requirements are satisfied as stated in the Employer Group Application or as otherwise agreed to by the *group plan sponsor* and *us*; and
- The *employee* is in an *active status*.

Dependent eligibility date

Each *dependent* is eligible for coverage on:

- The date the *employee* is eligible for coverage, if he or she has *dependents* who may be covered on that date;
- The date of the *employee's* marriage for any *dependents* (spouse or child) acquired on that date;
- The date of birth of the *employee's* natural-born child;
- The date of birth of the *employee's* grandchild whose parent is under 18 years of age and is covered under this *certificate* as the *employee's* covered *dependent*;
- The date of placement of the child for the purpose of adoption by the *employee*, whether or not a court ultimately makes a final order granting adoption of the child to the *employee*. Placed for adoption means:
 - The department, a county department or licensed child welfare agency places a child in *your* home (which is a licensed foster home) for adoption and enters into an agreement with *you*;
 - A court orders the child placed in *your* home for adoption;
 - A sending agency places the child in *your* home for adoption and *you* take physical custody of the child at any location within the United States;
 - The person bringing the child into Wisconsin has complied with the requirements for interstate placement of children and *you* take physical custody of the child at any location within the United States; or
 - A court of a foreign jurisdiction appoints *you* as guardian of a child who is a citizen of that jurisdiction and the child arrives in *your* home for the purpose of adoption; or
- The date specified in a Qualified Medical Child Support Order (QMCSO), or National Medical Support Notice (NMSN) for a child, or a valid court or administrative order for a spouse, which requires the *employee* to provide coverage for a child or spouse as specified in such orders.

The *employee* may cover his or her *dependents* only if the *employee* is also covered.

ELIGIBILITY AND EFFECTIVE DATES (continued)

Enrollment

Employees and dependents eligible for coverage under the *master group contract* may enroll for coverage as specified in the enrollment provisions outlined below.

Employee enrollment

The *employee* must enroll, as agreed to by the *group plan sponsor* and *us*, within 31 days of the *employee's eligibility date* or within the time period specified in the "Special enrollment" provision.

The *employee* is a *late applicant* if enrollment is requested more than 31 days after the *employee's eligibility date* or later than the time period specified in the "Special enrollment" provision. A *late applicant* must wait to enroll for coverage during the *open enrollment period*, unless the *late applicant* becomes eligible for special enrollment as specified in the "Special enrollment" provision.

We reserve the right to require an eligible *employee* to submit evidence of health status. *We* will not use *health status-related factors* to decline coverage to an eligible *employee* and *we* will administer this provision in a non-discriminatory manner.

Dependent enrollment

If electing *dependent* coverage, the *employee* must enroll eligible *dependents*, as agreed to by the *group plan sponsor* and *us*, within 31 days of the *dependent's eligibility date* or within the time period specified in the "Special enrollment" provision.

The *dependent* is a *late applicant* if enrollment is requested more than 31 days after the *dependent's eligibility date* or later than the time period specified in the "Special enrollment" provision. A *late applicant* must wait to enroll for coverage during the *open enrollment period*, unless the *late applicant* becomes eligible for special enrollment as specified in the "Special enrollment" provision.

We reserve the right to require an eligible *dependent* to submit evidence of health status. No eligible *dependent* will be refused enrollment or charged a different premium than other *group* members based on *health status-related factors*. *We* will administer this provision in a non-discriminatory manner.

Newborn and adopted dependent enrollment

A newborn *dependent* will be covered from the date of birth to 60 days of age. An adopted *dependent* will be automatically covered from the date of adoption or placement of the child with the *employee* for the purpose of adoption, whichever occurs first, for 60 days.

If additional premium is not required to add additional *dependents* and if *dependent* child coverage is in force as of the newborn's date of birth in the case of newborn *dependents* or the earlier of the date of adoption or placement of the child with the *employee* for purposes of adoption in case of adopted *dependents*, coverage will continue beyond the initial 60 days. *You* must notify *us* to make sure *we* have accurate records to administer benefits.

ELIGIBILITY AND EFFECTIVE DATES (continued)

If premium is required to add *dependents* you must enroll the *dependent* child and pay the additional premium within 60 days:

- Of the newborn's date of birth; or
- Of the date of adoption or placement of the child with the *employee* for the purpose of adoption to add the child to *your* plan, whichever occurs first.

If enrollment is requested more than 60 days after the date of birth, date of adoption or placement with the *employee* for the purpose of adoption, and additional premium is required, *you* may continue *dependent* coverage if, within one year after the date of birth, all past due premium with 5 ½ percent interest is paid in full. Otherwise, the newborn or adopted *dependent* is a *late applicant* and must wait to enroll for coverage during the *open enrollment period*, unless the *late applicant* becomes eligible for special enrollment as specified in the "Special enrollment" provision.

Special enrollment

Special enrollment is available if the following apply:

- *You* have a change in family status due to:
 - Marriage;
 - Divorce;
 - A Qualified Medical Child Support Order (QMCSO);
 - A National Medical Support Notice (NMSN); and
 - *You* enroll within 31 days after the *special enrollment date*; or
 - The birth of a natural born child; or
 - The adoption of a child or placement of a child with the *employee* for the purpose of adoption; and
 - *You* enroll within 60 days after the *special enrollment date*; or
- *You* are an *employee* or *dependent* eligible for coverage under the *master group contract*, and:
 - *You* previously declined enrollment stating you were covered under another group health plan or other *health insurance coverage*; and
 - Loss of eligibility of such other coverage occurs, regardless of whether you are eligible for, or elect COBRA; and
 - *You* enroll within 31 days after the *special enrollment date*.

Loss of eligibility of other coverage includes, but is not limited to:

- Termination of employment or eligibility;
- Reduction in number of hours of employment;
- Divorce, legal separation or death of a spouse;
- Loss of dependent eligibility, such as attainment of the limiting age;
- Termination of your employer's contribution for the coverage;

ELIGIBILITY AND EFFECTIVE DATES (continued)

- Loss of individual HMO coverage because you no longer reside, live or work in the service area;
- Loss of group HMO coverage because you no longer reside, live or work in the service area, and no other benefit package is available; or
- The plan no longer offers benefits to a class of similarly situated individuals; or
- You had COBRA continuation coverage under another plan at the time of eligibility, and:
 - Such coverage has since been exhausted; and
 - You stated at the time of the initial enrollment that coverage under COBRA was your reason for declining enrollment; and
 - You enroll within 31 days after the *special enrollment date*; or
- You were covered under an alternate plan provided by the *employer* that terminates, and:
 - You are replacing coverage with the *master group contract*; and
 - You enroll within 31 days after the *special enrollment date*; or
- You are an *employee* or *dependent* eligible for coverage under the *master group contract*, and:
 - Your *Medicaid* coverage or your Children's Health Insurance Program (CHIP) coverage terminated as a result of loss of eligibility; and
 - You enroll within 60 days after the *special enrollment date*; or
- You are an *employee* or *dependent* eligible for coverage under the *master group contract*, and:
 - You become eligible for a premium assistance subsidy under *Medicaid* or CHIP; and
 - You enroll within 60 days after the *special enrollment date*.

The *employee* or *dependent* is a *late applicant* if enrollment is requested later than the time period specified above. A *late applicant* must wait to enroll for coverage during the *open enrollment period*.

Dependent special enrollment

The *dependent* special enrollment is the time period specified in the "Special enrollment" provision.

If *dependent* coverage is available under the *employer's master group contract* or added to the *master group contract*, an *employee* who is a *covered person* can enroll eligible *dependents* during the special enrollment. An *employee*, who is otherwise eligible for coverage and had waived coverage under the *master group contract* when eligible, can enroll himself/herself and eligible *dependents* during the special enrollment.

The *employee* or *dependent* is a *late applicant* if enrollment is requested later than the time period specified above. A *late applicant* must wait to enroll for coverage during the *open enrollment period*.

ELIGIBILITY AND EFFECTIVE DATES (continued)

Open enrollment

Eligible *employees* or *dependents*, who did not enroll for coverage under the *master group contract* following their *eligibility date* or *special enrollment date*, have an opportunity to enroll for coverage during the *open enrollment period*. The *open enrollment period* is also the opportunity for *late applicants* to enroll for coverage.

Eligible *employees* or *dependents*, including *late applicants*, must request enrollment during the *open enrollment period*. If enrollment is requested after the *open enrollment period*, the *employee* or *dependent* must wait to enroll for coverage during the next *open enrollment period*, unless they become eligible for special enrollment as specified in the "Special enrollment" provision.

Effective date

The provisions below specify the *effective date* of coverage for *employees* or *dependents*, if enrollment is requested within 31 days of their *eligibility date* or within the time period specified in the "Special enrollment" provision. If enrollment is requested during an *open enrollment period*, the *effective date* of coverage is specified in the "Open enrollment effective date" provision.

Employee effective date

The *employee's effective date* provision is stated in the Employer Group Application. The *employee's effective date* of coverage may be the date immediately following completion of the *waiting period*, or the first of the month following completion of the *waiting period*, if enrollment is requested within 31 days of the *employee's eligibility date*. The *special enrollment date* is the *effective date* of coverage for an *employee* who requests enrollment within the time period specified in the "Special enrollment" provision. The *employee effective dates* specified in this provision apply to an *employee* who is not a *late applicant*.

Dependent effective date

The *dependent's effective date* is the date the *dependent* is eligible for coverage if enrollment is requested within 31 or 60 days, as applicable, of the *dependent's eligibility date*. The *special enrollment date* is the *effective date* of coverage for the *dependent* who requests enrollment within the time period specified in the "Special enrollment" provision. The *dependent effective dates* specified in this provision apply to a *dependent* who is not a *late applicant*.

In no event will the *dependent's effective date* of coverage be prior to the *employee's effective date* of coverage.

ELIGIBILITY AND EFFECTIVE DATES (continued)

Newborn and adopted dependent effective date

The *effective date* of coverage for a newborn *dependent* is the date of birth if the newborn is not a *late applicant*.

The *effective date* of coverage for an adopted *dependent* is the date of adoption or the date of placement with the *employee* for the purpose of adoption, whichever occurs first, if the *dependent* child is not a *late applicant*.

Premium is due for any period of *dependent* coverage whether or not the *dependent* is subsequently enrolled, unless specifically not allowed by applicable law. Additional premium may not be required when *dependent* coverage is already in force.

Open enrollment effective date

The *effective date* of coverage for an *employee* or *dependent*, including a *late applicant*, who requests enrollment during an *open enrollment period*, is the first day of the *master group contract year* as agreed to by the *group plan sponsor* and *us*.

Retired employee coverage

Retired employee eligibility date

Retired *employees* are an eligible class of *employees* if requested on the Employer Group Application and if approved by *us*. An *employee* who retires while covered under the *master group contract*, is considered eligible for retired *employee* medical coverage on the date of retirement if the eligibility requirements stated in the Employer Group Application are satisfied.

Retired employee enrollment

The *employer* must notify *us* of the *employee's* retirement within 31 days of the date of retirement. If *we* are notified more than 31 days after the date of retirement, the retired *employee* is a *late applicant*. A *late applicant* must wait to enroll for coverage during the *open enrollment period*, unless the *late applicant* becomes eligible for special enrollment as specified in the "Special enrollment" provision.

Retired employee effective date

The *effective date* of coverage for an eligible retired *employee* is the date of retirement for an *employee* who retires after the date *we* approve the *employer's* request for a retiree classification, provided *we* are notified within 31 days of the retirement. If *we* are notified more than 31 days after the date of retirement, the *effective date* of coverage for the *late applicant* is the date *we* specify.

REPLACEMENT OF COVERAGE

Applicability

This "Replacement of Coverage" section applies when an *employer's* previous group health plan not offered by *us* or *our* affiliates (Prior Plan) is terminated and replaced by coverage under the *master group contract* and:

- You were covered under the *employer's* Prior Plan on the day before the effective date of the *master group contract*; and
- You are insured for medical coverage on the effective date of the *master group contract*.

Benefits available for *covered expense* under the *policy* will be reduced by any benefits payable by the Prior Plan during an extension period.

Deductible credit

Medical expense incurred while *you* were covered under the Prior Plan may be used to satisfy *your network provider deductible* under the *master group contract* if the medical expense was:

- Incurred in the same calendar year the *master group contract* first becomes effective; and
- Applied to the network deductible amount under the Prior Plan.

Waiting period credit

If the *employee* had not completed the initial *waiting period* under the *group plan sponsor's* Prior Plan on the day that it ended, any period of time that the *employee* satisfied will be applied to the appropriate *waiting period* under the *master group contract*, if any. The *employee* will then be eligible for coverage under the *master group contract* when the balance of the *waiting period* has been satisfied.

Out-of-pocket limit

Any medical expense amount applied to the Prior Plan's network *out-of-pocket limit* or stop-loss limit will be credited to *your network provider out-of-pocket limit* under the *master group contract* if the medical expense was incurred in the same calendar year the *master group contract* becomes effective.

TERMINATION PROVISIONS

Termination of insurance

The date of termination, as described in this "Termination Provisions" section, may be the actual date specified or the end of that month, as selected by *your employer* on the Employer Group Application (EGA).

You and *your employer* must notify *us* as soon as possible if *you* or *your dependent* no longer meets the eligibility requirements of the *master group contract*. Notice must be provided to *us* within 31 days of the change.

When *we* receive notification of a change in eligibility status in advance of the effective date of the change, coverage will terminate on the actual date specified by the *employer* or *employee* or at the end of that month, as selected by *your employer* on the EGA.

When *we* receive the *employer's* request to terminate coverage retroactively, the *employer's* termination request is their representation to *us* that *you* did not pay any premium or make contribution for coverage past the requested termination date.

Otherwise, coverage terminates on the earliest of the following:

- The date the *master group contract* terminates;
- The end of the period for which required premiums were paid to *us*;
- The date the *employee* terminated employment with the *employer*;
- The date the *employee* no longer qualified as an *employee*;
- The date *you* fail to be in an eligible class of persons as stated in the EGA;
- The date the *employee* entered full-time military, naval or air service;
- The date the *employee* retired, except if the EGA provides coverage for a retiree class of *employees* and the retiree is in an eligible class of retirees, selected by the *employer*;
- The date of an *employee* request for termination of coverage for the *employee* or *dependents*;
- For a *dependent*, the date the *employee's* coverage terminates;
- For a *dependent*, the date the *employee* ceases to be in a class of *employees* eligible for *dependent* coverage;
- The date *your dependent* no longer qualifies as a *dependent*;

TERMINATION PROVISIONS (continued)

- For any benefit, the date the benefit is deleted from the *master group contract*; or
- The date fraud or an intentional misrepresentation of a material fact has been committed by *you*. For more information on fraud and intentional misrepresentation, refer to the "Fraud" provision in the "Miscellaneous Provisions" section of this *certificate*.

Termination for cause

We will terminate *your* coverage for cause under the following circumstances:

- If *you* allow an unauthorized person to use *your* identification card or if *you* use the identification card of another *covered person*. Under these circumstances, the person who receives the services provided by use of the identification card will be responsible for paying *us* any amount *we* paid for those services.
- If *you* or the *group plan sponsor* perpetrate fraud or intentional misrepresentation on claims, identification cards or other identification in order to obtain services or a higher level of benefits. This includes, but is not limited to, the fabrication or alteration of a claim, identification card or other identification.

EXTENSION OF BENEFITS

Extension of health insurance for total disability

We extend limited coverage if:

- The *master group contract* terminates while *you* are *totally disabled* due to a *bodily injury* or *sickness* that occurs while the *master group contract* is in effect; and
- *Your* coverage is not replaced by other group coverage providing substantially equivalent or greater benefits than those provided for the disabling conditions by the *master group contract*.

Benefits are payable only for those expenses incurred for the same *sickness* or *bodily injury* which caused *you* to be *totally disabled*. Coverage for the disabling condition continues, but not beyond the earliest of the following dates:

- The date *your health care practitioner* certifies *you* are no longer *totally disabled*; or
- The date any maximum benefit is reached; or
- The last day of a 12 consecutive month period following the date the *master group contract* terminated.

No insurance is extended to a child born as a result of a *covered person's* pregnancy.

The "Extension of coverage for total disability" provision does not apply to covered retired persons.

CONTINUATION

Continuation options in the event of termination

If coverage terminates:

- It may be continued as described in the "State continuation of coverage " provision; or
- It may be continued under the continuation provisions as provided by the Consolidated Omnibus Budget Reconciliation Act (COBRA), if applicable.

A complete description of the "State continuation of coverage " provision follows.

State continuation of coverage

A *covered person* whose coverage terminates shall have the right to continuation under the *master group contract* as follows.

If an *employee* was covered for *dependent* coverage when his or her health coverage terminated, an *employee* may choose to continue health coverage for any *dependent* who was covered by the *master group contract*. The same terms with regard to the availability of continued health coverage described below will apply to *dependents*.

In order to be eligible for this option:

- The *employee* must have been continuously covered under the *master group contract* for at least 3 consecutive months prior to termination; and
- The *employee's* eligibility for group coverage terminates for any other reason other than misconduct on the job;
- The *covered person* is the former spouse of an *employee* whose marriage ended due to divorce or annulment while covered under the *master group contract*, and the *employee* continues to be covered under the *master group contract*; or
- The *covered person* is a surviving *dependent* spouse or child of an *employee* who died while covered under the *master group contract*. No child may be insured without a parent insured, unless only a *dependent* child survives the *employee's* death.

The *employer* is required by law to provide *you* with a written notice of these rights. *You* must receive the notice within 5 days after the date the *employer* knows *your* eligibility for coverage will terminate.

Written application and payment of the first premium for continuation must be made within 31 days after the date coverage terminates or within 31 days after the *covered person* has been given the required notice. The premium rate will not exceed the *group* premium. The premium will be payable in advance to the *group plan sponsor* on a monthly basis. A new enrollment form must be completed for continuation of coverage of a former *dependent* spouse or a surviving *dependent*.

CONTINUATION (continued)

Medical coverage under the *master group contract* continues under this option until the earliest of:

- The end of 18 consecutive months from the date *you* elected this option. This period of time is measured from the exact date this option is elected to the same calendar date of the next succeeding months;
- The date on which the *covered person* is eligible for similar benefits under another group plan;
- The date timely premium payments are not made on *your* behalf;
- The date on which the *covered person* is no longer a Wisconsin resident; or
- For a *covered person* who is the former spouse of an *employee*, the date the *employee* is no longer covered by the *master group contract*.

The *group plan sponsor* is responsible for sending *us* the premium payments for those individuals who choose to continue their coverage. If the *group plan sponsor* fails to make proper payment of the premiums to *us*, *we* are relieved of all liability for any coverage that was continued and the liability will rest with the *group plan sponsor*.

If the *employee* returns to *active status* while insured under this continuation privilege, he or she must re-enroll for *employee* coverage.

COORDINATION OF BENEFITS

This "Coordination of Benefits" (COB) provision applies when a person has health care coverage under more than one *plan*. The order of benefit determination rules below determine which *plan* will pay as the *primary plan*. The *primary plan* pays first without regard to the possibility another *plan* may cover some expenses. A *secondary plan* pays after the *primary plan* and may reduce the benefits it pays so that payments from all *plans* do not exceed 100% of the total *allowable expense*.

Definitions

The following definitions are used exclusively in this provision.

Plan means any of the following that provide benefits or services for medical or dental care or treatment. However, if separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered part of the same *plan* and there is no COB among those separate contracts.

Plan includes:

- Group and nongroup insurance contracts, health maintenance organization (HMO) contracts, closed panel or other forms of group or group-type coverage (whether insured or uninsured);
- Medical care components of long-term care contracts, such as skilled nursing care;
- Medical benefits under group or individual automobile contracts, including "No Fault" and Medical Payments coverages; and
- *Medicare* or other governmental benefits, as permitted by law.

Plan does not include:

- Individual or family insurance;
- Closed panel or other individual coverage (except for group-type coverage);
- Hospital indemnity benefits;
- School accident type coverage;
- Benefits for non-medical care components of group long-term care contracts;
- Medicare supplement policies;
- A state plan under *Medicaid*; and
- Coverage under other governmental plans, unless permitted by law.

Each contract for coverage is a separate *plan*. If a *plan* has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate *plan*.

Notwithstanding any statement to the contrary, for the purposes of COB, prescription drug coverage under this *plan* will be considered a separate *plan* and will therefore only be coordinated with other prescription drug coverage.

COORDINATION OF BENEFITS (continued)

Primary/secondary means the order of benefit determination stating whether this *plan* is *primary* or *secondary* covering the person when compared to another *plan* also covering the person.

When this *plan* is *primary*, its benefits are determined before those of any other *plan* and without considering any other *plan's* benefits. When this *plan* is *secondary*, its benefits are determined after those of another *plan* and may be reduced because of the *primary plan's* benefits.

Allowable expense means a health care service or expense, including deductibles, if any, and copayments, that is covered at least in part by any of the *plans* covering the person. When a *plan* provides benefits in the form of services (e.g. an HMO), the reasonable cash value of each service will be considered an *allowable expense* and a benefit paid. An expense or service that is not covered by any of the *plans* is not an *allowable expense*. The following are examples of expenses or services that are not *allowable expenses*:

- If a *covered person* is confined in a private *hospital* room, the difference between the cost of a semi-private room in the *hospital* and the private room, (unless the patient's stay in a private *hospital* room is medically necessary in terms of generally accepted medical practice, or one of the *plans* routinely provides coverage for *hospital* private rooms) is not an *allowable expense*.
- If a person is covered by two or more *plans* that compute their benefits payments on the basis of usual and customary fees, any amount in excess of the highest usual and customary fees for a specific benefit is not an *allowable expense*.
- If a person is covered by two or more *plans* that provide benefits or services on the basis of negotiated fees, any amount in excess of the highest of the fees is not an *allowable expense*.
- If a person is covered by one *plan* that calculates its benefits or services on the basis of usual and customary fees and another *plan* that provides its benefits or services on the basis of negotiated fees, the *primary plan's* payment arrangement shall be the *allowable expense* for all *plans*.
- The amount a benefit is reduced by the *primary plan* because a *covered person* does not comply with the *plan* provisions. Examples of these provisions are second opinions, precertification of *admissions* and preferred provider arrangements.

Claim determination period means a calendar year. However, it does not include any part of a year during which a person has no coverage under this *plan*, or before the date this COB provision or a similar provision takes effect.

Closed panel plan is a *plan* that provides health benefits to covered persons primarily in the form of services through a panel of providers that has contracted with or are employed by the *plan*, and that limits or excludes benefits for services provided by other providers, except in the cases of emergency or referral by a panel member.

Custodial parent means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

COORDINATION OF BENEFITS (continued)

Order of determination rules

General

When two or more *plans* pay benefits, the rules for determining the order of payment are as follows:

- The *primary plan* pays or provides its benefits as if the *secondary plan* or *plans* did not exist.
- A *plan* that does not contain a COB provision that is consistent with applicable promulgated regulation is always *primary*. There is one exception: coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the *plan* provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base *plan* hospital and surgical benefits, and insurance type coverages that are written in connection with a *closed panel plan* to provide out-of-network benefits.
- A *plan* may consider the benefits paid or provided by another *plan* in determining its benefits only when it is *secondary* to that other *plan*.

Rules

The first of the following rules that describes which *plan* pays its benefits before another *plan* is the rule to use.

- **Non-dependent or dependent.** The *plan* that covers the person other than as a *dependent*, for example as an *employee*, member, subscriber or retiree is *primary* and the *plan* that covers the person as a *dependent* is *secondary*. However, if the person is a *Medicare* beneficiary and, as a result of federal law, *Medicare* is *secondary* to the *plan* covering the person as a *dependent*; and *primary* to the *plan* covering the person as other than a *dependent* (e.g. retired *employee*); then the order of benefits between the two *plans* is reversed so that the *plan* covering the person as an *employee*, member, subscriber or retiree is *secondary* and the other *plan* is *primary*.
- **Dependent child covered under more than one plan.** The order of benefits when a child is covered by more than one *plan* is:
 - The *primary plan* is the *plan* of the parent whose birthday is earlier in the year if:
 - The parents are married;
 - The parents are not separated (whether or not they have been married); or
 - A court decree awards joint custody without specifying that one parent has the responsibility to provide health care coverage.
 - If both the parents have the same birthday, the *plan* that covered either of the parents longer is *primary*.

COORDINATION OF BENEFITS (continued)

- If the specific terms of a court decree state that one parent is responsible for the child's health care expenses or health care coverage and the *plan* of that parent has actual knowledge of those terms, that *plan* is *primary*. This rule applies to *claim determination periods* or plan years commencing after the *plan* is given notice of the court decree.
- If the parents are not married, or are separated (whether or not they ever have been married) or are divorced, the order of benefits is:
 - The *plan* of the *custodial parent*;
 - The *plan* of the spouse of the *custodial parent*;
 - The *plan* of the *non-custodial parent*; and then
 - The *plan* of the spouse of the *non-custodial parent*.
- **Active or inactive employee.** The *plan* that covers a person as an *employee* who is neither laid off nor retired, is *primary*. The same would hold true if a person is a *dependent* of a person covered as a retiree and an *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 is ignored.
- **Continuation coverage.** If a person whose coverage is provided under a right of continuation provided by federal or state law also is covered under another *plan*, the *plan* covering the person as an *employee*, member, subscriber or retiree (or as that person's *dependent*) is *primary*, and the continuation coverage is *secondary*. 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 is ignored.
- **Longer or shorter length of coverage.** The *plan* that covered the person as an *employee*, member, subscriber or retiree longer is *primary*.

If the preceding rules do not determine the *primary plan*, the *allowable expenses* shall be shared equally between the *plans* meeting the definition of *plan* under this provision. In addition, this *plan* will not pay more than it would have had it been *primary*.

Effects on the benefits of this plan

When this *plan* is *secondary*, benefits may be reduced to the difference between the *allowable expense* (determined by the *primary plan*) and the benefits paid by any *primary plan* during the *claim determination period*. Payment from all *plans* will not exceed 100% of the total *allowable expense*. The difference between the benefit payments that this *plan* would have paid had it been the *primary plan*, and the benefit payments that it actually paid or provided shall be recorded as a benefit reserve for the *covered person* and used by this *plan* to pay an *allowable expense*, not otherwise paid during the *claim determination period*. As each claim is submitted, this *plan* will determine:

- Its obligation to pay or provide benefits under its contract;
- Whether a benefit reserve has been recorded for the *covered person*; and
- Whether there are any unpaid *allowable expenses* during the *claim determination period*.

COORDINATION OF BENEFITS (continued)

If there is a benefit reserve, the *secondary plan* will use the *covered person's* benefit reserve to pay up to 100% of total *allowable expenses* incurred during the *claim determination period*. At the end of the *claim determination period*, the benefit reserve returns to zero. A new benefit reserve must be created for each new *claim determination period*.

If a *covered person* is enrolled in two or more *closed panel plans* and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one *closed panel plan*, COB shall not apply between that *plan* and the other *closed panel plan*.

Right to receive and release needed information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this *plan* and other *plans*. *We* may get the facts *we* need from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under this *plan* and other *plans* covering the person claiming benefits. *We* need not tell, or get the consent of, any person to do this. Each person claiming benefits under this *plan* must give *us* any facts *we* need to apply those rules and determine benefits payable.

Facility of payment

A payment made under another *plan* may include an amount that should have been paid under this *plan*. If it does, *we* may pay that amount to the organization that made the payment. That amount will then be treated as though it were a benefit paid under this *plan*. *We* will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means a reasonable cash value of the benefits provided in the form of services.

Right of recovery

If the amount of the payments made by *us* is more than *we* should have paid under this COB provision, *we* may recover the excess from one or more of the persons *we* have paid or for whom we have paid; or any other person or organization that may be responsible for the benefits or services provided for the *covered person*. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

General coordination of benefits with Medicare

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

CLAIMS

Notice of claim

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

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

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

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

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

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

Proof of loss

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

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

CLAIMS (continued)

Claims processing procedures

Qualified provider services are subject to *our* claims processing procedures. *We* use *our* claims processing procedures to determine payment of *covered expenses*. *Our* claims processing procedures include, but are not limited to, claims processing edits and claim payment policies, as determined by *us*. *Your qualified provider* may access *our* claims processing edits and claim payment policies on *our* website at Humana.com by clicking on "For Providers" and "Claims Resources."

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

- The complexity of a service;
- Whether a service is one of multiple same day services such that the cost of the service to the *qualified provider* is less than if the service had been provided on a different day. For example:
 - Two or more *surgeries* performed the same day;
 - Two or more endoscopic procedures performed during the same day; or
 - Two or more therapy services performed the day;
- Whether a *co-surgeon, assistant surgeon, surgical assistant*, or any other *qualified provider*, who is billing independently is involved;
- When a charge includes more than one claim line, whether any service is part of or incidental to the primary service that was provided, or if these services cannot be performed together;
- Whether the service is reasonably expected to be provided for the diagnosis reported;
- Whether a service was performed specifically for *you*; or
- Whether services can be billed as a complete set of services under one billing code.

We develop *our* claims processing procedures in *our* sole discretion based on *our* review of correct coding initiatives, national benchmarks, industry standards, and industry sources, including any successors of the same:

- *Medicare* laws, regulations, manuals, and other related guidance;
- Federal and state laws, rules and regulations, including instructions published in the Federal Register;
- National Uniform Billing Committee (NUBC) guidance including the UB-04 Data Specifications Manual;
- American Medical Association's (AMA) Current Procedural Terminology (CPT[®]) and associated AMA publications and services;
- Centers for Medicare & Medicaid Services (CMS)/Healthcare Common Procedure Coding System (HCPCS) and associated CMS publications and services;
- International Classification of Diseases (ICD);

CLAIMS (continued)

- International Classification of Diseases (ICD);
- American Hospital Association's Coding Clinic Guidelines;
- Uniform Billing Editor;
- American Psychiatric Association's (APA) Diagnostic and Statistical Manual of Mental Disorders (DSM) and associated APA publications and services;
- Food and Drug Administration guidance;
- Medical and surgical specialty societies and associations;
- Industry standard utilization management criteria and/or care guidelines;
- *Our* medical and pharmacy coverage policies; and
- Generally accepted standards of medical, behavioral health and dental practice based on credible scientific evidence recognized in published peer reviewed medical or dental literature.

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

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

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

Other programs and procedures

We may introduce new programs and procedures that apply to *your* coverage under the *master group contract*. *We* may also introduce limited pilot or test programs including, but not limited to, disease management, care management, expanded accessibility, or wellness initiatives.

We reserve the right to discontinue or modify a program or procedure at any time.

Right to require medical examinations

We have the right to require a medical examination on any *covered person* as often as *we* may reasonably require. If *we* require a medical examination, it will be performed at *our* expense. *We* also have a right to request an autopsy in the case of death, if state law so allows.

CLAIMS (continued)

To whom benefits are payable

If you receive services from a *network provider*, we will pay the provider directly for all *covered expenses*. You will not have to submit a claim for payment.

Benefit payments for *covered expenses* rendered by a *non-network provider* are due and owing solely to you. You are responsible for all payments to the *non-network provider*. However, we will pay the *non-network provider* directly if for the amount we owe if:

- You request we direct a payment of selected medical benefits to the health care provider on whose charge the claim is based and we consent to this request; or
- Your responsibility for the *covered expenses* is based off the *qualified payment amount*.

Any payment made directly to the *non-network provider* will not constitute the assignment of any legal obligation to the *non-network provider*.

Except as specified above, if you submit a claim for payment to us, we will pay you directly for the *covered expenses*.

You are responsible to pay all charges to the provider when we pay you directly for *covered expenses*.

If any *covered person* to whom benefits are payable is a minor or, in our opinion, not able to give a valid receipt for any payment due him or her, such payment will be made to his or her parent or legal guardian. However, if no request for payment has been made by the parent or legal guardian, we may, at our option, make payment to the person or institution appearing to have assumed his or her custody and support.

Time of payment of claims

Payments due under the *master group contract* will be paid no more than 30 days after receipt of written or *electronic* proof of loss.

Right to request overpayments

We reserve the right to recover any payments made by us that were:

- Made in error;
- Made to you or any party on your behalf, where we determine such payment made is greater than the amount payable under the *master group contract*;
- Made to you and/or any party on your behalf, based on fraudulent or misrepresented information; or
- Made to you and/or any party on your behalf for charges that were discounted, waived or rebated.

We reserve the right to adjust any amount applied in error to the *deductible*, *out-of-pocket limit* or *copayment limit*, if any.

CLAIMS (continued)

Right to collect needed information

You must cooperate with *us* and when asked, assist *us* by:

- Authorizing the release of medical information including the names of all providers from whom *you* received medical attention;
- Obtaining medical information or records from any provider as requested by *us*;
- Providing information regarding the circumstances of *your sickness, bodily injury or accident*;
- 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;
- Providing copies of claims and settlement demands submitted to third parties in relation to a *bodily injury or sickness*;
- Disclosing details of liability settlement agreements reached with third parties in relation to a *bodily injury or sickness*; and
- Providing information *we* request to administer the *master group contract*.

If *you* fail to cooperate or provide the necessary information, *we* may recover payments made by *us* and deny any pending or subsequent claims for which the information is requested.

Exhaustion of time limits

If *we* fail to complete a claim determination or appeal within the time limits set forth in the *master group contract*, the claim shall be deemed to have been denied, and *you* may proceed to the next level in the review process outlined under the "Complaint and Appeal Procedures" section of this *certificate* or as required by law.

Recovery rights

You as well as *your dependents* agree to the following, as a condition of receiving benefits under the *master group contract*.

Duty to cooperate in good faith

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

You will do whatever is necessary to enable *us* to enforce *our* recovery rights and will do nothing after loss to prejudice *our* recovery rights.

CLAIMS (continued)

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

In the event that *you* fail to cooperate with *us*, *we* shall be entitled to recover from *you* any payments made by *us*.

Duplication of benefits/other insurance

We will not provide duplicate coverage for benefits under the *master group contract* when a person is covered by *us* and has, or is entitled to, benefits as a result of their injuries from any other coverage including, but not limited to, first party uninsured or underinsured motorist coverage, any no-fault insurance, medical payment coverage (auto, homeowners or otherwise), Workers' Compensation settlement or awards, other group coverage (including student plans), direct recoveries from liable parties, premises medical pay or any other insurer providing coverage that would apply to pay *your* medical expenses, except another "plan," as defined in the "Coordination of Benefits" section (e.g., group health coverage), in which case priority will be determined as described in the "Coordination of Benefits" section.

Where there is such coverage, *we* will not duplicate other coverage available to *you* and shall be considered secondary, except where specifically prohibited. Where double coverage exists, *we* shall have the right to be repaid from whomever has received the overpayment from *us* to the extent of the duplicate coverage.

We will not duplicate coverage under the *master group contract* whether or not *you* have made a claim under the other applicable coverage.

When applicable, *you* are required to provide *us* with authorization to obtain information about the other coverage available, and to cooperate in the recovery of overpayments from the other coverage, including executing any assignment of rights necessary to obtain payment directly from the other coverage available.

Workers' compensation

This *master group contract* excludes coverage for *sickness* or *bodily injury* for which Workers' Compensation or similar coverage is available.

If benefits are paid by *us*, and *we* determine that the benefits were for treatment of *bodily injury* or *sickness* that arose from or was sustained in the course of, any occupation or employment for compensation, profit or gain, *we* have the right to recover as described below.

We shall have first priority to recover amounts *we* have paid and the reasonable value of services and benefits provided under a managed care agreement from any funds that are paid or payable by Workers' Compensation or similar coverage as a result of any *sickness* or *bodily injury*, and *we* shall not be required to contribute to attorney fees or recovery expenses under a Common Fund or similar doctrine.

CLAIMS (continued)

Our right to recover from funds that are paid or payable by Workers' Compensation or similar coverage will apply even though:

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

As a condition to receiving benefits from *us*, *you* hereby agree, in consideration for the coverage provided by the *master group contract*, *you* will notify *us* of any Workers' Compensation claim *you* make, and *you* agree to reimburse *us* as described above. If *we* are precluded from exercising *our* recovery rights to recover from funds that are paid by Workers' Compensation or similar coverage *we* will exercise *our* right to recover against *you*.

Right of subrogation

As a condition to receiving benefits from *us*, *you* agree to transfer to *us* any rights *you* may have to make a claim, take legal action or recover any expenses paid under the *master group contract*. *We* will be subrogated to *your* rights to recover, to the extent that *we* have provided benefits for such injury, illness or other loss under the *master group contract*, from any funds paid or payable as a result of a personal injury claim or any reimbursement of expenses by:

- Any legally liable person or their carrier, including self-insured entities;
- Any uninsured motorist or underinsured motorist coverage;
- Medical payments/expense coverage under any automobile, homeowners, premises, or similar coverages;
- Workers' Compensation or other similar coverage; and
- No-fault or other similar coverage.

We may enforce *our* subrogation rights by asserting a claim to any coverage to which *you* may be entitled. *We* shall be entitled to recover amounts *we* have paid and the reasonable value of services and benefits provided under a managed care agreement from any funds that are paid or payable as a result of any *sickness* or *bodily injury*. *Our* subrogation right shall only apply to the extent of such payment and only to the extent not limited or precluded by law in the State whose laws govern the *master group contract*, including any "made whole" or similar rule.

If *we* are precluded from exercising *our* rights of subrogation, *we* may exercise *our* right of reimbursement.

CLAIMS (continued)

Right of reimbursement

If benefits are paid under the *master group contract* and *you* recover from any legally responsible person, their insurer, or any uninsured motorist, underinsured motorist, medical payment/expense, Workers' Compensation, no-fault, or other similar coverage, *we* have the right to recover from *you* an amount equal to the amount *we* paid. *Our* reimbursement right shall only apply to the extent of such payment and only to the extent not limited or precluded by law in the State whose laws govern the *master group contract*, including any "made whole" or similar rule.

You shall notify *us*, in writing or by *electronic mail*, within 31 days of any settlement, compromise or judgement. Any *covered person* who waives, abrogates or impairs *our* right of reimbursement or fails to comply with these obligations, relieves *us* from any obligation to pay past or future benefits or expenses until all outstanding lien(s) are resolved.

If, after the inception of coverage with *us*, *you* recover payment from and release any legally responsible person, their insurer, or any uninsured motorist, underinsured motorist, medical payment/expense, Workers' Compensation, no-fault, or other similar insurer from liability for future medical expenses relating to a *sickness* or *bodily injury*, *we* shall have a continuing right to reimbursement from *you* to the extent of the benefits *we* provided with respect to that *sickness* or *bodily injury*. This right, however, shall apply only to the extent of such payment.

The obligation to reimburse *us* in full exists, regardless of whether the settlement, compromise or judgement designates the recovery as including or excluding medical expenses.

Assignment of recovery rights

The *master group contract* contains an exclusion for *sickness* or *bodily injury*, for which there is medical payment/expenses coverage provided under any homeowner's, premises or other similar coverage.

If *your* claim against the other insurer is denied or partially paid, *we* will process *your* claim according to the terms and conditions of the *master group contract*. If payment is made by *us* on *your* behalf, *you* agree to assign to *us* the right *you* have against the other insurer for medical expenses *we* pay.

If benefits are paid under the *master group contract* and *you* recover under any homeowner's, premises or similar coverage, *we* have the right to recover from *you*, or whomever *we* have paid, an amount equal to the amount *we* paid.

Cost of legal representation

The costs of *our* legal representation in matters related to *our* recovery rights shall be borne solely by *us*.

The costs of legal representation incurred by *you* shall be borne solely by *you*. *We* shall not be responsible to contribute to the cost of legal fees or expenses incurred by *you* under any Common Fund or similar doctrine unless *we* were given timely notice of the claim and an opportunity to protect *our* own interests and *we* failed or declined to do so.

COMPLAINT AND APPEAL PROCEDURES

We make every effort to resolve customer dissatisfaction issues at an informal level. *Our* customer service representatives are available to assist *you* with any issue relating to *your* health coverage or any aspect of *your* health coverage or any aspect of *your* plan. *Our* customer service representatives may be reached at the number on *your* identification card.

Definitions

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

- A determination of *your* eligibility to participate in the plan or health insurance coverage;
- A determination that the benefit is not covered;
- The imposition of a source-of-injury exclusion, network exclusion, or other limitation on otherwise covered benefits;
- A determination that a benefit is *experimental, investigational or for research purposes*, or not *medically necessary* or appropriate; or
- A *rescission* of coverage.

An *adverse determination* also includes claims protected under the Federal No Surprises Act.

Authorized representative means someone *you* have appropriately authorized to act on *your* behalf, including *your* health care provider.

Complaint means any dissatisfaction expressed to *us* by *you* or *your authorized representative*, about *us* or one of *our network providers*.

Experimental treatment determination means a determination by *us* or on *our* behalf, which denies in part or in full, requested services to which all of the following apply:

- The proposed treatment has been reviewed;
- Based on the information provided, a determination has been made by *us* or on *our* behalf that the services were considered *experimental, investigational, or for research purposes*; and
- Based on the information provided, *we* have denied either the proposed treatment or payment for the treatment.

Expedited grievance means a *grievance* to which any of the following apply:

- The duration of the standard *grievance* process will result in serious jeopardy to *your* life or health, or *your* ability to regain maximum function;
- *Your health care practitioner* has the opinion that *you* are subject to severe pain that cannot be adequately managed without the care or treatment that is the subject of the *grievance*; or
- *Your health care practitioner* determined that the *grievance* shall be treated as an *expedited grievance*.

COMPLAINT AND APPEAL PROCEDURES (continued)

Grievance means any dissatisfaction, submitted in writing by *you* or *your authorized representative*, relating to how *we* administered any provision of service or claims practice.

Grievance review panel means two or more persons not involved in the initial determination, established to investigate a *grievance*, including:

- One person authorized to take corrective action on the *grievance*;
- One covered person other than the grievant, if available.

Independent Review Organization (IRO) means an organization of medical professionals with no connection to *your* health plan, qualified to review *your* dispute.

Filing a complaint

If *you* have a *complaint* about *us* or *our network providers*, please call *our* Customer Service Department as soon as possible. The toll-free number is identified on *your* identification card. Most problems may be resolved quickly in this manner. At any time, *you* may file a *grievance* as described below.

You may also contact the Office of the Commissioner of Insurance, a state agency that enforces Wisconsin's insurance laws, and file a *complaint*, at any time. *You* have the right to contact the Office of the Commissioner of Insurance by writing to:

**State of Wisconsin Office of the Commissioner of Insurance
Complaints Department
P.O. Box 7873
Madison, WI 53707-7873**

You can file a complaint online at oci.wi.gov or *you* can also call 1-800-236-8517 outside of Madison, or 266-0103 in Madison, and request a Complaint Form.

Filing a grievance

If *you* are dissatisfied with *our* determination of *your* claim, *you* may appeal the decision. *You* should appeal in writing to the address given on the denial letter *you* received or to *us* at the following address:

**Grievance and Appeal Department
P.O. Box 14546
Lexington, KY 40512-4546**

Internal grievance review process

A *grievance* can be submitted to *us* at any time. *We* will acknowledge the receipt of *your grievance* within five business days.

COMPLAINT AND APPEAL PROCEDURES (continued)

A *grievance review panel* will be convened to investigate the *grievance*. When appropriate, the *grievance review panel* will include or consult with, a *health care practitioner* with expertise in the field related to the *grievance* involving a clinical issue. You will be notified in writing of the time and place of the *grievance* meeting at least seven calendar days before the meeting. You or your *authorized representative* may appear in person before the *grievance review panel*, or by teleconference, to present written or oral information. You or your *authorized representative* may submit written questions to the person or persons responsible for making the determination that resulted in the *adverse determination*.

You will be notified in writing of a final determination within 30 calendar days of receipt of the *grievance*. For post-service adverse determination, the time period may be extended an additional 30 calendar days to accommodate your or your *authorized representative's* availability at the *grievance* meeting.

A letter signed by a voting member of the *grievance review panel* and including a written description of the position titles of panel members involved in making a decision will explain the resolution of the *grievance* and the right to request a further review, if applicable.

Internal expedited grievance review process

We will accept requests for an *expedited grievance* review, in writing or orally. If the *grievance* qualifies for an *expedited grievance* review, we will notify you verbally of the resolution within 72 hours of receipt of the *grievance*. A written confirmation of the resolution will be sent within three calendar days.

External independent review organization process

If you disagree with the outcome of our *grievance* decision you, or your *authorized representative*, have the right to request an external review by an *Independent Review Organization (IRO)* if the *grievance* involves an *experimental treatment determination*, *medically necessary* determination, *rescission* of coverage, or a claim protected under the Federal No Surprises Act.

You or your *authorized representative*, must have exhausted the internal *grievance* process before requesting an external review by an *IRO*. If you, or your *authorized representative* wish to file a request for an external review the request must be submitted in writing to the address listed below and received within four months or the next business day followed the four month period from the receipt of the *adverse determination*. For claims protected under the Federal No Surprises Act, refer to our decision letter for instructions on how to request an external review.

**Grievance and Appeal Department
P. O. Box 11268
Green Bay, WI 54307-1268**

COMPLAINT AND APPEAL PROCEDURES (continued)

Within five business days of *our* receipt of the request, an *IRO* will be assigned to *your* case through an unbiased rotating selection process. The assigned *IRO* will send *you* or *your authorized representative* a notice of acceptance which will include notice of the right to submit additional information within ten business days of receipt of the notice from the *IRO*. The assigned *IRO* will also deliver a notice of the final external review decision in writing to *you*, *your authorized representative*, and *us* within 45 days of their receipt of the request.

Should the *IRO* find in *your*, or *your authorized representative's* favor in whole or in part, *we* will take the necessary actions to ensure the implementation of the *IRO* decision.

Request for an expedited review by an external independent review organization

An external expedited review is a review involving cases where the normal duration of the external independent review process would jeopardize a *covered person's* life, health or ability to regain maximum function. This request should be submitted to *us* immediately.

The *IRO* must provide a decision to *you* or *your authorized representative* and to *us* within 72 hours of receipt of the request.

Once the *IRO* makes a final coverage decision, the final coverage decision is binding on *us* and *we* will take the necessary actions to ensure the implementation of the *IRO* decision.

Legal actions and limitations

- No legal action to recover on the *master group contract* may be brought until 60 days after written proof of loss has been given in accordance with the "Proof of loss" provision of the *master group contract*.
- No legal action to recover on the *master group contract* may be brought after three years from the date written proof of loss is required to be given.

DISCLOSURE PROVISIONS

Employee assistance program

We may provide *you* access to an employee assistance program (EAP). The EAP may include confidential, telephonic consultations and work-life services. The EAP provides *you* with short-term, problem solving services for issues that may otherwise affect *your* work, personal life or health. The EAP is designed to provide *you* with information and assistance regarding *your* issue and may also assist *you* with finding a medical provider or local community resource.

The services provided by the EAP are not *covered expenses* under the *master group contract*, therefore the *copayments, deductible* or *coinsurance* do not apply. However, there may be additional costs to *you*, if *you* obtain services from a professional or organization the EAP has recommended or has referred *you* to. The EAP does not provide medical care. *You* are not required to participate in the EAP before using *your* benefits under the *master group contract*, and the EAP services are not coordinated with *covered expenses* under the *master group contract*. The decision to participate in the EAP is voluntary, and *you* may participate at any time during the *year*. Refer to the marketing literature for additional information.

Discount programs

From time to time, *we* may offer or provide access to discount programs to *you*. In addition, *we* may arrange for third party service providers such as pharmacies, optometrists, dentists and alternative medicine providers to provide discounts on goods and services to *you*. Some of these third party service providers may make payments to *us* when *covered persons* take advantage of these discount programs. These payments offset the cost to *us* of making these programs available and may help reduce the costs of *your* plan administration. Although *we* have arranged for third parties to offer discounts on these goods and services, these discount programs are not *covered expenses* under the *master group contract*. The third party service providers are solely responsible to *you* for the provision of any such goods and/or services. *We* are not responsible for any such goods and/or services, nor are *we* liable if vendors refuse to honor such discounts. Further, *we* are not liable to *covered persons* for the negligent provision of such goods and/or services by third party service providers. Discount programs may not be available to persons who "opt out" of marketing communications and where otherwise restricted by law.

Wellness program

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

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

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

DISCLOSURE PROVISIONS (continued)

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

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

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

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

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

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

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

Shared savings program

As a *covered person* under the health benefit plan, *you* may obtain services from *network providers* who participate in the *Point of Service network* or *non-network providers* who do not participate in the *Point of Service network*. If *you* choose a *network provider*, *your* out-of-pocket expenses are normally lower than if *you* choose a *non-network provider*.

If *you* choose to obtain services from a *non-network provider*, the services may be eligible for a discount to *you* under the Shared Savings Program. It is not necessary for *you* to inquire in advance about services that may be discounted. When processing *your* claim, *we* will automatically determine if the services are subject to Shared Savings Program and calculate *your deductible* and *coinsurance* on the discounted amount. Whether the services are subject to the Shared Savings Program is at *our* discretion and *we* apply the discounts in a non-discriminatory manner. *Your* Explanation of Benefits statement will reflect any savings with a remark code that the services have been discounted. The *non-network provider* discounts in the Shared Savings Program may not be as favorable as *network provider* discounts.

DISCLOSURE PROVISIONS (continued)

If *you* would like to inquire in advance to determine if services rendered by a *non-network provider* may be subject to the Shared Savings Program, please contact *our* customer service department at the telephone number shown on *your* ID card. Provider arrangements in the Shared Savings Program are subject to change without notice. *We* cannot guarantee that the services *you* receive from a *non-network provider* are is still subject to the Shared Savings Program at the time services are received. Discounts are dependent upon availability and cannot be guaranteed.

We reserve the right to modify, amend or discontinue the Shared Savings Program at any time.

MISCELLANEOUS PROVISIONS

Entire contract

The entire contract is made up of the *master group contract*, the Employer Group Application of the *group plan sponsor*, incorporated by reference herein, and the applications or enrollment forms, if any, of the *covered persons*. All statements made by the *group plan sponsor* or by a *covered person* are considered to be representations, not warranties. This means that the statements are made in good faith. No statement will void the *master group contract*, reduce the benefits it provides or be used in defense to a claim unless it is contained in a written or *electronic* application or enrollment form and a copy is furnished to the person making such statement or his or her beneficiary.

Additional group plan sponsor responsibilities

In addition to responsibilities outlined in the *master group contract*, the *group plan sponsor* is responsible for:

- Collection of premium; and
- Distributing and providing *covered persons* access to:
 - Benefit plan documents and, the Summary of Benefits and Coverage (SBC);
 - Renewal notices and *master group contract* modification information;
 - Discontinuance notices; and
 - Information regarding continuation rights.

No *group plan sponsor* may change or waive any provision of the *master group contract*.

Certificates

A *certificate* setting forth the benefits available to the *employee* and the *employee's* covered *dependents* will be available at Humana.com or in writing when requested. The *employer* is responsible for providing *employees* access to the *certificate*.

No document inconsistent with the *master group contract* shall take precedence over it. This is true, also, when the *certificate* is incorporated by reference into a summary description of plan benefits by the administrator of a group plan subject to ERISA. If the terms of a summary plan description differ with the terms of this *certificate*, the terms of this *certificate* will control.

Incontestability

No misstatement made by the *group plan sponsor*, except for fraud or an intentional misrepresentation of a material fact made in the application, may be used to void the *master group contract*.

After *you* are insured without interruption for two years, *we* cannot contest the validity of *your* coverage except for:

MISCELLANEOUS PROVISIONS (continued)

- Nonpayment of premiums; or
- Any fraud or intentional misrepresentation of a material fact made by *you*.

At any time, *we* may assert defenses based upon provisions in the *master group contract* which relate to *your* eligibility for coverage under the *master group contract*.

No statement made by *you* can be contested unless it is in a written or *electronic* form signed by *you*. A copy of the form must be given to *you* or *your* beneficiary.

An independent incontestability period begins for each type of change in coverage or when a new application or enrollment form of the *covered person* is completed.

Fraud

Health insurance fraud is a criminal offense that can be prosecuted. Any person(s) who willingly and knowingly engages in an activity intended to defraud *us*, by filing a claim or form that contains a false or deceptive statement, may be guilty of insurance fraud.

If *you* commit fraud against *us* or *your employer* commits fraud pertaining to *you* against *us*, as determined by *us*, *we* reserve the right to *rescind your* coverage after *we* provide *you* a 30 calendar day advance written notice that coverage will be *rescinded*. *You* have the right to appeal the *rescission*.

Clerical error or misstatement

If it is determined that information about a *covered person* was omitted or misstated in error, an adjustment may be made in premiums and/or coverage in effect. This provision applies to *you* and to *us*.

Modification of master group contract

The *master group contract* may be modified by *us*, upon renewal of the *master group contract*, as permitted by state and federal law. The *group plan sponsor* will be notified in writing or *electronically* as follows:

- For a *small employer*, at least 60 days prior to the effective date of the change;
- For a *large employer* at least 31 days prior to the effective date of the change.

The *master group contract* may be modified by agreement between *us* and the *group plan sponsor* without the consent of any *covered person* or any beneficiary. No modification will be valid unless approved by *our* President, Secretary or Vice-President. The approval must be endorsed on or attached to the *master group contract*. No agent has authority to modify the *master group contract*, or waive any of the *master group contract* provisions, to extend the time of premium payment, or bind *us* by making any promise or representation.

MISCELLANEOUS PROVISIONS (continued)

Corrections due to clerical errors or clarifications that do not change benefits are not modifications of the *master group contract* and may be made by *us* at any time without prior consent of, or notice to, the *group plan sponsor*.

Discontinuation of coverage

If *we* decide to discontinue offering a particular group health plan:

- The *group plan sponsor* and the *employees* will be notified of such discontinuation at least 90 days prior to the date of discontinuation of such coverage; and
- The *group plan sponsor* will be given the option to purchase all (or, in the case of a large *employer*, any) other group plans providing medical benefits that are being offered by *us* at such time.

If *we* cease doing business in the *small employer* or the large *employer* group market, the *group plan sponsors*, *covered persons* and the Commissioner of Insurance will be notified of such discontinuation at least 180 days prior to the date of discontinuation of such coverage.

Premium contributions

Your employer must pay the required premium to *us* as they become due. *Your employer* may require *you* to contribute toward the cost of *your* coverage. Failure of *your employer* to pay any required premium to *us* when due may result in the termination of *your* coverage.

Premium rate change

We reserve the right to change any premium rates in accordance with applicable law upon notice to the *employer*. *We* will provide notice to the *employer* of any such premium changes. Questions regarding changes to premium rates should be addressed to the *employer*.

Assignment

The *master group contract* and its benefits may not be assigned by the *group plan sponsor*.

MISCELLANEOUS PROVISIONS (continued)

Emergency declarations

We may alter or waive the requirements of the *master group contract* as a result of a state or federal emergency declaration including, but not limited to:

- *Prior authorization or preauthorization* requirements;
- *Prescription* quantity limits; and
- *Your copayment, deductible and/or coinsurance.*

We have the sole authority to waive any *master group contract* requirements in response to an emergency declaration.

Conformity with statutes

Any provision of the *master group contract* which is not in conformity with applicable state law(s) or other applicable law(s) shall not be rendered invalid, but shall be construed and applied as if it were in full compliance with the applicable state law(s) and other applicable law(s).

GLOSSARY

Terms printed in italic type in this *certificate* have the meaning indicated below. Defined terms are printed in italic type wherever found in this *certificate*.

A

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

Active status means the *employee* is performing all of his or her customary duties, whether performed at the *employer's* business establishment, some other location which is usual for the *employee's* particular duties or another location when required to travel on the job:

- On a regular *full-time* basis or for the number of hours per week determined by the *group plan sponsor*;
- For 48 weeks a year; and
- Is maintaining a bona fide *employer-employee* relationship with the *group plan sponsor* of the *master group contract* on a regular basis.

Each day of a regular vacation and any regular non-working holiday are deemed *active status*, if the *employee* was in *active status* on his or her last regular working day prior to the vacation or holiday. An *employee* is deemed to be in *active status* if an absence from work is due to a *sickness* or *bodily injury*, provided the individual otherwise meets the definition of *employee*.

Acute inpatient services mean care given in a *hospital* or *health care treatment facility* which:

- Maintains permanent full-time facilities for *room and board* of resident patients;
- Provides emergency, diagnostic and therapeutic services with a capability to provide life-saving medical and psychiatric interventions;
- Has physician services, appropriately licensed behavioral health practitioners and skilled nursing services available 24-hours a day;
- Provides direct daily involvement of the physician; and
- Is licensed and legally operated in the jurisdiction where located.

Acute inpatient services are utilized when there is an immediate risk to engage in actions which would result in death or harm to self or others, or there is a deteriorating condition in which an alternative treatment setting is not appropriate.

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

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

GLOSSARY (continued)

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

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

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

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

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

Ancillary services mean *covered expenses* that are:

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

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

Autism spectrum disorder means any of the following:

- Autism disorder;
- Asperger's syndrome; or
- Pervasive development disorder as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

GLOSSARY (continued)

B

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

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

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

C

Certificate means this benefit plan document that describes the benefits, provisions and limitations of the *master group contract*. This *certificate* is part of the *master group contract* and is subject to the terms of the *master group contract*.

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

Cochlear implant means any implantable instrument or device that is designed to enhance hearing.

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

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

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

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

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

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

GLOSSARY (continued)

Covered expense means:

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

- *Preventive services*.

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

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

Covered person means the *employee* or the *employee's dependents*, who are enrolled for benefits provided under the *master group contract*.

Custodial care means services given to *you* if:

- *You* need services including, but not limited to, assistance with dressing, bathing, preparation and feeding of special diets, walking, supervision of medication which is ordinarily self-administered, getting in and out of bed, and maintaining continence;

- The services *you* require are primarily to maintain, and not likely to improve, *your* condition; or

- The services involve the use of skills which can be taught to a layperson and do not require the technical skills of a *nurse*.

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

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

GLOSSARY (continued)

D

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

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

Dependent means a covered *employee's*:

- Legally recognized spouse;
- Natural born child, step-child, legally adopted child, or child placed for adoption, whose age is less than the limiting age;
- Grandchild, as long as the parent of the child is under 18 years of age and is covered under the *master group contract* as the *employee's* covered *dependent*; or
- Child whose age is less than the limiting age and for whom the *employee* has received a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN) to provide coverage, if the *employee* is eligible for family coverage until:
 - Such QMCSO or NMSN is no longer in effect; or
 - The child is enrolled for comparable health coverage, which is effective no later than the termination of the child's coverage under the *master group contract*.

Under no circumstances shall *dependent* mean a great grandchild or foster child, including where the great grandchild, or foster child meets all of the qualifications of a dependent as determined by the Internal Revenue Service.

The limiting age means the end of the month the *dependent* child attains age 26. Each *dependent* child is covered to the limiting age, regardless if the child is:

- Married;
- A tax dependent;
- A student;
- Employed;
- Residing with or receiving financial support from *you*;
- Eligible for other coverage through employment; or
- Residing or working outside of the *service area*.

GLOSSARY (continued)

Coverage will continue for a *dependent* child provided the *dependent* child:

- Was under age 27 when first called to federal active duty in the national guard or in a reserve component of the U.S. armed forces while attending college on a full-time basis at an accredited education institution, and is enrolled in sufficient course credits to maintain full-time status as defined by the school. Full-time status includes periods of regular vacation established by the school if the *dependent* child continues to be a full-time student immediately following such vacation period;
 - Applied to an institution of higher education within 12 months from the date the *dependent* child fulfilled his or her active duty obligation; and
 - Is unmarried; and
 - Is not eligible for coverage under a group health plan that is offered by the *dependent* child's employer and for which the amount of the child's premium contribution is no greater than the premium amount for coverage as a *dependent* under this *certificate*.

Provided the criteria above is met, a covered *dependent* child will continue to be eligible for coverage for up to four months following the close of a school term if enrolled as a full-time student for the following school term.

A *dependent* child who takes a *medically necessary leave of absence* from an accredited educational institution while in full-time status, will continue to be eligible for coverage until the earlier of the following:

- Up to one year after the first day of the *medically necessary leave of absence*; or
- The date coverage would otherwise terminate under this *certificate*.

We must receive written certification from the *dependent* child's *health care practitioner* that the *dependent* child has a serious *bodily injury* or *sickness* requiring a *medically necessary leave of absence*.

A covered *dependent* child, who attains the limiting age while covered under the *master group contract* remains eligible if the covered *dependent* child is:

- Mentally or physically handicapped; and
- Incapable of self-sustaining employment.

In order for the covered *dependent* child to remain eligible as specified above, we must receive notification within 31 days prior to the covered *dependent* child attaining the limiting age.

You must furnish satisfactory proof to us, upon our request, that the conditions, as defined in the bulleted items above, continuously exist on and after the date the limiting age is reached. After two years from the date the first proof was furnished, we may not request such proof more often than annually. If satisfactory proof is not submitted to us, 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 pumps and associated accessories; insulin infusion devices; and podiatric appliances for the prevention of complications associated with diabetes.

GLOSSARY (continued)

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

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

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

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

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

E

Effective date means the date *your* coverage begins under the *master group contract*.

Electronic or **electronically** means relating to technology having electrical, digital, magnetic, wireless, optical, electromagnetic, or similar capabilities.

Electronic mail means a computerized system that allows a user of a network computer system and/or computer system to send and receive messages and documents among other users on the network and/or with a computer system.

Electronic signature means an electronic sound, symbol or process attached to, or logically associated with, a record and executed or adopted by a person with the intent to sign the record.

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

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

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

GLOSSARY (continued)

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

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

Employee means a person, who is in *active status* for the *employer* on a *full-time* basis. The *employee* must be paid a salary or wage by the *employer* that meets the minimum wage requirements of *your* state or federal minimum wage law for work done at the *employer's* usual place of business or some other location which is usual for the *employee's* particular duties.

Employee also includes a sole proprietor, partner or corporate officer, where:

- The *employer* is a sole proprietorship, partnership or corporation;
- The sole proprietorship or other entity (other than a partnership) has at least one common-law employee (other than the business owner and his or her spouse); and
- The sole proprietor, partner or corporate officer is actively performing activities relating to the business, gains their livelihood from the sole proprietorship, partnership or corporation and is in an *active status* at the *employer's* usual place of business or some other location, which is usual for the sole proprietor's, partner's or corporate officer's particular duties.

If specified on the Employer Group Application and approved by *us*, *employee* also includes retirees of the *employer*. A retired *employee* is not required to be in *active status* to be eligible for coverage under the *master group contract*.

Employer means the sponsor of this *group* plan or any subsidiary or affiliate described in the Employer Group Application. An *employer* must either employ at least one common-law employee or be a partnership with a bona fide partner who provides services on behalf of the partnership. A business owner and his or her spouse are not considered common-law employees for this purpose if the entity is considered to be wholly owned by one individual or one individual and his or her spouse.

Endodontic services mean the following dental procedures, related tests or treatment and follow-up care:

- Root canal therapy and root canal fillings;
- Periradicular *surgery*;
- Apicoectomy;
- Partial pulpotomy; or
- Vital pulpotomy.

GLOSSARY (continued)

Essential health benefits mean the following categories, as defined by the United States Health and Human Services (HHS) as set forth by the Affordable Care Act, and federal regulations:

- Ambulatory patient services;
- Emergency services;
- Hospitalization;
- Maternity and newborn care;
- Mental health and substance use disorders, including *behavioral health* treatment;
- *Prescription* drugs;
- Rehabilitative and *habilitative services* and devices;
- Laboratory services;
- Preventive and wellness services and chronic disease management; and
- Pediatric services, including oral and vision care.

Evidence-based means therapy, service and treatment that is based upon medical and scientific evidence and is determined to be an efficacious treatment or strategy and is prescribed to improve the *covered person's* condition or to achieve social, cognitive, communicative, self-care or behavioral goals that are clearly defined within the *covered person's* treatment plan.

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 *us*:

- Cannot be lawfully marketed without the final approval of the United States Food and Drug Administration (FDA) and lacks such final FDA approval for the use or proposed use, unless (a) found to be accepted for that use in the most recently published edition of the United States Pharmacopeia-Drug Information for Healthcare Professional (USP-DI) or in the most recently published edition of the American Hospital Formulary Service (AHFS) Drug Information; (b) identified as safe, widely used and generally accepted as effective for that use as reported in nationally recognized peer reviewed medical literature published in the English language as of the date of service; or (c) is mandated by state law;
- Is a device required to receive Premarket Approval (PMA) or 510K approval by the FDA but has not received a PMA or 510K approval;
- Is not identified as safe, widely used and generally accepted as effective for the proposed use as reported in nationally recognized peer reviewed medical literature published in the English language as of the date of service;
- Is the subject of a National Cancer Institute (NCI) Phase I, II or III trial or a treatment protocol comparable to a NCI Phase I, II or III trial, or any trial not recognized by NCI regardless of phase; or
- Is identified as not covered by the Centers for Medicare & Medicaid Services (CMS) Medicare Coverage Issues Manual, a CMS Operational Policy Letter or a CMS National Coverage Decision, except as required by state or federal law.

GLOSSARY (continued)

F

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

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

Full-time, for an *employee*, means a work week of the number of hours determined by the *group plan sponsor*.

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

G

Group means the persons for whom this health coverage has been arranged to be provided.

Group plan sponsor means the legal entity identified as the *group plan sponsor* on the face page of the *master group contract* or "Certificate of Coverage" who establishes, sponsors and endorses an employee benefit plan for health care coverage.

H

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

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

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

Health insurance coverage means medical coverage under any hospital or medical service policy or certificate, hospital or medical service plan contract or health maintenance organization (HMO) contract offered by a health insurance issuer. "Health insurance issuer" means an insurance company, insurance service or insurance organization (including an HMO) that is required to be licensed to engage in the business of insurance in a state and that is subject to the state law that regulates insurance.

GLOSSARY (continued)

Health status-related factor means any of the following:

- Health status or medical history;
- Medical condition, either physical or mental;
- Claims experience;
- Receipt of health care;
- Genetic information;
- Disability; or
- Evidence of insurability, including conditions arising out of acts of domestic violence.

Hearing aid means any externally wearable, non-disposable instrument or device designed to aid or compensate for impaired hearing, including any parts, attachments, or accessories (excluding batteries and cords).

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

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

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

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

GLOSSARY (continued)

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

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

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

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

I

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

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

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

Inpatient means *you* are *confined* as a registered bed patient.

GLOSSARY (continued)

Intensive level services means an *evidence-based* behavioral therapy that is designed to help a *covered person* with *autism spectrum disorder* overcome with cognitive, social, and behavioral deficits associated with that disorder. *Intensive level services* also means *evidence-based* behavioral therapies that are directly based on, and related to, a *covered person's* therapeutic goals and skills as prescribed by a physician familiar with the *covered person*. *Intensive level services* may include *evidence-based* speech therapy and occupational therapy provide by a qualified therapist when such therapy is based on, or related to, a *covered person's* therapeutic goals and skills, and is concomitant with *evidence-based* behavioral therapy.

Intensive outpatient program means *outpatient* services providing:

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

Intensive outpatient program does not include services that are for:

- *Custodial care*; or
- Day care.

J

K

L

Late applicant means an *employee* or *dependent* other than a newborn or adopted child, who requests enrollment for coverage under the *master group contract* more than 31 days after his or her *eligibility date*, or a newborn or adopted *dependent* who requests enrollment for coverage more than 60 days after the child's date of birth, date of adoption or placement for adoption or later than the time period specified in the "Special enrollment" provision.

M

Maintenance care means services and supplies furnished mainly to:

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

GLOSSARY (continued)

Master group contract means the legal agreement between *us* and the *group plan sponsor*, including the Employer Group Application and *certificate*, together with any riders, amendments and endorsements.

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

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

Medicaid means a state program of medical care, as established under Title 19 of the Social Security Act of 1965, as amended.

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

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

GLOSSARY (continued)

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

Medically necessary leave of absence means a leave of absence for a *dependent* child, who is no longer enrolled for sufficient course credits to maintain full-time status as defined by an accredited secondary school, college or university, or licensed technical school, or had any other change in enrollment at such institution.

The *medically necessary leave of absence* must:

- Begin due to a *bodily injury* or *sickness*;
- Be determined necessary by the *dependent* child's *health care practitioner*, who must send *us* written certification; and
- Cause the *dependent* child to lose full-time student status as defined in the definition of "*dependent*."

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

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

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

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

N

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

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

GLOSSARY (continued)

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

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

Non-intensive level services mean *evidence-based* therapy that occurs after the completion of treatment with *intensive level services* and that is designed to sustain and maximize gains made during treatment with *intensive level services* or, for a *covered person* who has not and will not receive *intensive level services*, *evidence-based* therapy that will improve the *covered person's* condition.

Non-network health care practitioner means a *health care practitioner* who has not been designated by *us* as a *network health care practitioner*.

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

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

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

O

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

Open enrollment period means no less than a 31-day period of time, occurring annually for the *group*, during which *employees* have an opportunity to enroll themselves and their eligible *dependents* for coverage under the *master group contract*.

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

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

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

GLOSSARY (continued)

Out-of-area service means health services provided by *non-network providers* for *covered persons* who are temporarily away from their *service area* for 90 days or less or *out-of-area students*.

Out-of-area student means a *dependent* child who attends school outside of the *service area* at a vocational, technical or adult education school, college or university, or any institution of higher education that grants a bachelors or higher degree.

Out-of-pocket limit means the amount of *copayments*, *deductibles* and *coinsurance* you must pay for *covered expenses*, as specified in the "Out-of-pocket limit" provision in the "Schedule of Benefits" section, either individually or combined as a covered family, per *year* before a benefit percentage is increased. Any amount you pay exceeding the *maximum allowable fee* is not applied to the *out-of-pocket limits*.

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

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

P

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

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

- Has a comprehensive and intensive interdisciplinary psychiatric treatment under the supervision of a psychiatrist for *mental health services* or a psychiatrist or addictionologist for *chemical dependency*, and patients are seen by a psychiatrist or addictionologist, as applicable, at least once a week;
- Provides for social, psychological and rehabilitative training programs with a focus on reintegration back into the community and admits children and adolescents who must have a treatment program designed to meet the special needs of that age range; and
- Has physicians and appropriately licensed behavioral health practitioners readily available for the emergent and urgent needs of the patients.

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

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

GLOSSARY (continued)

Partial hospitalization does not include services that are for:

- *Custodial care*; or
- Day care.

Periodontics means the branch of dentistry concerned with the study, prevention and treatment of diseases of the tissues and bones supporting the teeth. *Periodontics* includes the following dental procedures, related tests or treatment and follow-up care:

- Periodontal maintenance;
- Scaling and root planing;
- Gingivectomy;
- Gingivoplasty; or
- Osseous surgical procedures.

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

Pre-surgical/procedural testing means:

- Laboratory tests or radiological examinations done on an *outpatient* basis in a *hospital* or other facility accepted by the *hospital* before *hospital confinement* or *outpatient surgery* or procedure;
- The tests must be accepted by the *hospital* or *health care practitioner* in place of like tests made during *confinement*; and
- The tests must be for the same *bodily injury* or *sickness* causing you to be *hospital confined* or to have the *outpatient surgery* or procedure.

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

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

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

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

GLOSSARY (continued)

Preventive services means services in the following recommendations appropriate for *you* during *your* plan year:

- Services with an A or B rating in the current recommendations of the USPSTF.
- Immunizations recommended by the Advisory Committee on Immunization Practices of the CDC.
- Preventive care for infants, children and adolescents provided in the comprehensive guidelines supported by the HRSA.
- Preventive care for women provided in the comprehensive guidelines supported by the HRSA.
- Preventive care in accordance with state law.

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

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

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

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

Q

Qualified payment amount means the lesser of:

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

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

GLOSSARY (continued)

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

- *Emergency care* and *air ambulance* services;
- *Ancillary services* while *you* are at a *network facility*;
- Services that are not considered *ancillary services* while *you* are at a *network facility*, and *you* do not consent to the *non-network provider* to obtain such services; and
- *Post-stabilization services* when:
 - The attending *qualified provider* determines *you* are not able to travel by non-medical transportation to obtain services from a *network provider*; and
 - *You* do not consent to the *non-network provider* to obtain such services.

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

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

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

R

Rehabilitation facility means any licensed public or private establishment which has permanent facilities that are equipped and operated primarily to render physical and occupational therapies, diagnostic services and other therapeutic services.

Rehabilitative services means health care services that help a person keep or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Rescission, rescind or rescinded means a cancellation or discontinuance of coverage that has a retroactive effect.

GLOSSARY (continued)

Residential treatment facility means an institution that:

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

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

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

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

Routine nursery care means the charges made by a *hospital* or licensed birthing center for the use of the nursery. It includes normal services and supplies given to well newborn children following birth. *Health care practitioner* visits are not considered *routine nursery care*. Treatment of a *bodily injury*, *sickness*, birth abnormality, or *congenital anomaly* following birth and care resulting from prematurity is not considered *routine nursery care*.

S

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

GLOSSARY (continued)

Serious mental illness means the following psychiatric illnesses as defined by the American Psychiatric Association in the Diagnostic and Statistical Manual (DSM):

- Schizophrenia;
- Paranoid and other psychotic disorders;
- Bipolar disorders (hypomanic, manic, depressive and mixed);
- Major depressive disorders (single episodes or recurrent);
- Schizoaffective disorders (bipolar or depressive);
- Pervasive development disorders;
- Obsessive-compulsive disorders; and
- Depression in childhood and adolescence.

Service area means the geographic area designated by *us*, or as otherwise agreed upon between the *group plan sponsor* and *us* and approved by the Department of Insurance of the state in which the *master group contract* is issued, if such approval is required. The *service area* is the geographic area where the *network provider* services are available to *you*. A description of the *service area* is provided in the provider directories.

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

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

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

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

Small employer means an *employer* who employed an average of one but not more than 50 *employees* on business days during the preceding calendar year and who employs at least one *employee* on the first day of the *year*. All subsidiaries or affiliates of the *group plan sponsor* are considered one *employer* when the conditions specified in the "Subsidiaries or Affiliates" section of the *master group contract* are met.

GLOSSARY (continued)

Sound natural tooth means a tooth that:

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

Special enrollment date means the date of:

- Change in family status after the *eligibility date*;
- Loss of other coverage under another group health plan or other *health insurance coverage*;
- COBRA exhaustion;
- Loss of coverage under *your employer's* alternate plan;
- Termination of *your Medicaid* coverage or *your* Children's Health Insurance Program (CHIP) coverage as a result of loss of eligibility; or
- Eligibility for a premium assistance subsidy under *Medicaid* or CHIP.

To be eligible for special enrollment, *you* must meet the requirements specified in the "Special enrollment" provision within the "Eligibility and Effective Dates" section of this *certificate*.

Specialty care physician means a *health care practitioner* who has received training in a specific medical field other than the specialties listed as primary care.

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

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

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

Surgery means procedures categorized as Surgery in either the:

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

GLOSSARY (continued)

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

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

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

T

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

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

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

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

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

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

GLOSSARY (continued)

U

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

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

V

W

Waiting period means the period of time, elected by the *group plan sponsor*, that must pass before an *employee* is eligible for coverage under the *master group contract*.

We, us or our means the offering company as shown on the cover page of the *master group contract* and *certificate*.

X

Y

Year means the period of time which begins on any January 1st and ends on the following December 31st. When *you* first become covered by the *master group contract*, the first *year* begins for *you* on the *effective date* of *your* insurance and ends on the following December 31st.

You or your means any *covered person*.

Z

GLOSSARY – PHARMACY SERVICES

All terms used in the "Schedule of Benefits – Pharmacy Services," "Covered Expenses – Pharmacy Services" and "Limitations and Exclusions – Pharmacy Services" sections have the same meaning given to them in the "Glossary" section of this *certificate*, unless otherwise specifically defined below:

A

B

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

C

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

Copayment means the specified dollar amount to be paid by *you* toward the cost of each separate *prescription* fill or refill dispensed by a *pharmacy*.

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

D

Default rate means the fee based on rates negotiated by *us* or other payers with one or more *network providers* in a geographic area determined by *us* for the same or similar *prescription* fill or refill.

Dispensing limit means the monthly drug dosage limit and/or the number of months the drug usage is commonly prescribed to treat a particular condition, as determined by *us*.

Drug list means a list of covered *prescription* drugs, medicines or medications and supplies specified by *us*.

GLOSSARY – PHARMACY SERVICES (continued)

E

F

G

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

H

I

J

K

L

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

GLOSSARY – PHARMACY SERVICES (continued)

M

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

N

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

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

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

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

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

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

O

P

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

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

Prior authorization means the required prior approval from *us* for the coverage of certain *prescription* drugs, medicines or medications, including *specialty drugs*. The required prior approval from *us* for coverage includes the dosage, quantity and duration, as *medically necessary* for the *covered person*.

GLOSSARY – PHARMACY SERVICES (continued)

Q

R

S

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

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

T

U

V

W

X

Y

Z

Humana[®]

Toll Free: 800-448-6262
111 West Pleasant Street
Milwaukee, Wisconsin 53212-0359

1100 Employers Boulevard
Green Bay, Wisconsin 54344

OFFERED BY Humana Wisconsin Health Organization Insurance Corporation

You may resolve your problem by taking the steps outlined in your HMO/POS grievance procedure. You may also contact the **OFFICE OF THE COMMISSIONER OF INSURANCE**, a state agency which enforces Wisconsin's Insurance Laws, and file a complaint.

You can file a complaint electronically with the **OFFICE OF THE COMMISSIONER OF INSURANCE** at its website at <http://oci.wi.gov/>,

or by writing to:

Office of the Commissioner of Insurance
Complaints Department
P.O. Box 7873
Madison, WI 53707-7873

or you can call 1-800-236-8517 outside of Madison or 266-0103 in Madison, and request a complaint form.

FEDERAL NOTICES

The following pages contain important information about certain federal laws. There may be differences between the Certificate of Insurance and this Notice packet. There may also be differences between this notice packet and state law. You are eligible for the rights more beneficial to you, unless preempted by state or federal law.

This section includes notices about:

Federal legislation

Women's health and cancer rights act

Statement of rights under the newborns' and mothers' health Protection act

Medical child support orders

General notice of COBRA continuation of coverage rights

Tax equity and fiscal responsibility act of 1982 (TEFRA)

Family and medical leave act (FMLA)

Uniformed services employment and reemployment rights act of 1994 (USERRA)

Your rights under ERISA

Patient protection act

FEDERAL NOTICES (continued)

Federal legislation

Women's health and cancer rights act of 1998

Required coverage for reconstructive surgery following mastectomies

Under federal law, group health plans and health insurance issuers offering group health insurance providing medical and surgical benefits with respect to mastectomy shall provide, in a case of a participant or beneficiary who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with such mastectomy, coverage for:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce symmetrical appearance; and
- Prostheses and physical complications of all stages of mastectomy, including lymphedemas;

in a manner determined in consultation with the attending physician and the patient. Such coverage may be subject to annual deductibles and coinsurance provisions as may be deemed appropriate and as are consistent with those established for other benefits under the plan.

Statement of rights under the newborns' and mothers' health protection act (NMHPA)

If your plan covers normal pregnancy benefits, the following notice applies to you.

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not 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 delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, group health plans and health insurance issuers may not set the level of benefits or out-of-pocket costs so any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a group health plan or health insurance issuer may not, under federal law, require a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain pre-authorization. For information on pre-authorization, contact your plan administrator.

FEDERAL NOTICES (continued)

Medical child support orders

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

A QMCSO is a state-court order or judgment, including approval of a settlement agreement that:

- Provides for support of a covered employee's child;
- Provides for health care coverage for that child;
- Is made under state domestic relations law (including a community property law);
- Relates to benefits under the group health plan; and
- Is "qualified," i.e., it meets the technical requirements of ERISA or applicable state law.

QMCSO also means a state court order or judgment enforcing state Medicaid law regarding medical child support required by the Social Security Act §1908 (as added by Omnibus Budget Reconciliation Act of 1993).

An NMSO is a notice issued by an appropriate agency of a state or local government that is similar to a QMCSO requiring coverage under the group health plan for a dependent child of a non-custodial parent who is (or will become) a covered person by a domestic relations order providing 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.

General notice of COBRA continuation coverage rights

Introduction

You are getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

FEDERAL NOTICES (continued)

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary". You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you to lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced; or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you to lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a "dependent child".

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the employer, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

FEDERAL NOTICES (continued)

When is COBRA coverage available?

The plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- Commencement of a proceeding in bankruptcy with respect to the employer; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs.

How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

- ***Disability extension of 18-month period of continuation coverage*** - If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have 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 COBRA continuation coverage;
- ***Second qualifying event extension of 18-month period of continuation coverage*** - If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

FEDERAL NOTICES (continued)

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period". Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting your group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep your plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information:

Humana
Billing/Enrollment Department
101 E Main Street
Louisville, KY 40201
1-800-872-7207

FEDERAL NOTICES (continued)

Important notice for individuals entitled to Medicare tax equity and fiscal responsibility act of 1982 (TEFRA) options

Where an employer employs more than 20 people, the Tax Equity And Fiscal Responsibility Act of 1982 (TEFRA) allows covered employees in active service who are 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 their group health plan will be payable first and the benefits of Medicare will be payable second.
- **Option 2** - Medicare benefits only. The employee and his or her dependents, if any, will not be insured by the group health plan.

The employer must provide each covered employee and each covered spouse with the choice to elect one of these options at least one month before the covered employee or the insured spouse becomes age 65. All new covered employees and newly covered spouses age 65 or older must be offered these options. If Option 1 is chosen, its issue is subject to the same requirements as for an employee or dependent that is under age 65.

Under TEFRA regulations, there are two categories of persons eligible for Medicare. The calculation and payment of benefits by the group health plan differs for each category.

- **Category 1** Medicare eligibles are:
 - Covered employees in active service who are age 65 or older who choose Option 1;
 - Age 65 or older covered spouses; and
 - Age 65 or older covered spouses of employees in active service who are either under age 65 or age 70 or older;
- **Category 2** Medicare eligibles are any other covered persons entitled to Medicare, whether or not they enrolled. This category includes, but is not limited to:
 - Retired 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 the policy 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 the policy. The benefits of the policy will then be reduced by the full amount of all Medicare benefits the covered person is entitled to receive, whether or not the eligible individual is actually enrolled for Medicare Benefits.

FEDERAL NOTICES (continued)

Family and Medical Leave Act (FMLA)

If an employee is granted a leave of absence (Leave) by the employer as required by the Federal Family and Medical Leave Act, s/he may continue to be covered under the plan for the duration of the Leave under the same conditions as other employees who are currently employed and covered by the plan. If the employee chooses 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 the employee returns to work immediately following the end of the Leave. Charges incurred after the date of reinstatement will be paid as if the employee had been continuously covered.

Uniformed services employment and reemployment rights act of 1994 (USERRA)

Continuation of benefits

Effective October 13, 1994, federal law requires health plans offer to continue coverage for employees that are absent due to service in the uniformed services and/or dependents.

Eligibility

An employee is eligible for continuation under USERRA if he or she is absent from employment because of voluntary or involuntary performance of duty in the Armed Forces, Army National Guard, Air National Guard, or commissioned corps of the Public Health Service. Duty includes absence for active duty, active duty for training, initial active duty for training, inactive duty training and for the purpose of an examination to determine fitness for duty.

An employee's dependents that have coverage under the plan immediately prior to the date of the employee's covered absence are eligible to elect continuation under USERRA.

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 not longer than 31 days, 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 the plan. This includes the employee's share and any portion previously paid by the employer.

FEDERAL NOTICES (continued)

Duration of coverage

If 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 a return to employment as required by USERRA, after the completion of a period of service.

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

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 change of address.

Your rights under the Employee Retirement Income Security Act of 1974 (ERISA)

Under ERISA, all plan participants covered by ERISA are entitled to certain rights and protections, as described below. Notwithstanding anything in the group health plan or group insurance policy, following are a covered person's minimum rights under ERISA. ERISA requirements do not apply to plans maintained by governmental agencies or churches.

Information about the plan and benefits

Plan participants may:

- Examine, free of charge, all documents governing the plan. These documents are available in the plan administrator's office;
- Obtain, at a reasonable charge, copies of documents governing the plan, including a copy of any updated summary plan description and a copy of the latest annual report for the plan (Form 5500), if any, by writing to the plan administrator;
- Obtain, at a reasonable charge, a copy of the latest annual report (Form 5500) for the plan, if any, by writing to the plan administrator.

FEDERAL NOTICES (continued)

As a plan participant, you will receive a summary of any material changes made in the plan within 210 days after the end of the plan year in which the changes are made unless the change is a material reduction in covered services or benefits, in which case you will receive a summary of the material reduction within 60 days after the date of its adoption.

If the plan is required to file a summary annual financial report, you will receive a copy from the plan administrator.

Responsibilities of plan fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the plan. These people, called "fiduciaries" of the plan, have a duty to act prudently and in the interest of plan participants and beneficiaries.

No one, including an employer, may discharge or otherwise discriminate against a plan participant in any way to prevent the participant from obtaining a benefit to which the participant is otherwise entitled under the plan or from exercising ERISA rights.

Continue group health plan coverage

Participants may be eligible to continue health care coverage for themselves, their spouse or dependents if there is a loss of coverage under the group health plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review the COBRA notice in this document regarding the rules governing COBRA continuation coverage rights.

Claims determinations

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

Enforce your rights

Under ERISA, there are steps participants may take to enforce the above rights. For instance:

- If a participant requests a copy of plan documents and does not receive them within 30 days, the participant may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to \$110 a day until the participant receives the materials, unless the materials were not sent because of reasons beyond the control of the plan administrator;

FEDERAL NOTICES (continued)

- If a claim for benefits is denied or disregarded, in whole or in part, the participant may file suit in a state or Federal court;
- If the participant disagrees with the plan's decision, or lack thereof, concerning the qualified status of a domestic relations order or a medical child support order, the participant may file suit in Federal court;
- If plan fiduciaries misuse the plan's money, or if participants are discriminated against for asserting their rights, they may seek assistance from the U.S. Department of Labor, or may file suit in a Federal court.

The court will decide who should pay court costs and legal fees. If the participant is successful, the court may order the person sued to pay costs and fees. If the participant loses, the court may order the participant to pay the costs and fees.

Assistance with questions

- Contact the group health plan human resources department or the plan administrator with questions about the plan;
- For questions about ERISA rights, contact the nearest area office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or:

The Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue N.W.
Washington, D.C. 20210;

- Call the publications hotline of the Employee Benefits Security Administration to obtain publications about ERISA rights.

Appeal and External Review Notice (continued)

Patient Protection Act

Humana generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For children, you may designate a pediatrician as the primary care provider. For information on how to select a primary care provider, and for a list of the participating primary care providers, visit our Website at www.humana.com or call the customer service telephone number on your identification card.

If your plan provides coverage for obstetric or gynecological care, you do not need prior authorization from us or from any other person (including a primary care provider) in order to obtain access to this care from a health care professional in our network who specialize in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, visit our Website at www.humana.com or call the customer service telephone number on your identification card.

Appeal and External Review Notice

The following pages contain important information about Humana's claims procedures, internal appeals and external review. There may be differences between the Certificate of Insurance or Evidence of Coverage and this Notice packet. There may also be differences between this notice packet and state law. You are eligible for the rights more beneficial to you, unless preempted by state or federal law.

Federal standards

The Employee Retirement Income Security Act of 1974 (ERISA) established minimum requirements for claims procedures. The Patient Protection and Affordable Care Act (PPACA) including all regulation enforcing PPACA established additional requirements for claims procedures, internal *appeal* and *external review* processes. Humana complies with these standards. In addition to the procedures below, you should also refer to your insurance benefit plan documents (e.g., the Certificate of Insurance or Evidence of Coverage).

Definitions

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

- A determination of your eligibility to participate in the plan or health insurance coverage;
- A determination that the benefit is not covered;
- The imposition of a source-of-injury exclusion, network exclusion, or other limitation on otherwise covered benefits; or
- A determination that a benefit is experimental, investigational, or not medically necessary or appropriate.

An *adverse benefit determination* also includes claims protected under the Federal No Surprises Act and any rescission of coverage.

Appeal means a *grievance* requesting reconsideration of an *adverse benefit determination*.

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

Clinical peer reviewer is:

- An expert in the treatment of your medical condition that is the subject of an *external review*;
- Knowledgeable about the recommended healthcare service or treatment through recent or current actual clinical experience treating patients with the same or similar to your medical condition;
- Holds a non-restricted license in a state of the United States and, for physicians, a current certification by a recognized American medical specialty board in the area or areas appropriate to the subject of the *external review*;

Appeal and External Review Notice (continued)

- Has no history of disciplinary actions or sanctions, including loss of staff privileges or participation restrictions, that have been taken or are pending by any hospital, governmental agency or unit, or regulatory body that raise a substantial question as to the *clinical peer reviewer's* physical, mental or professional competence or moral character; and
- Does not have a material professional, family or financial conflict of interest with the *claimant*, Humana and any of the following:
 - The healthcare provider, the healthcare provider's medical group or independent practice association recommending the healthcare service or treatment;
 - The facility at which the recommended healthcare service or treatment would be provided; or
 - The developer or manufacturer of the principal drug, device, procedure or other therapy being recommended.

Commissioner means the Commissioner of Insurance.

Complaint means any dissatisfaction about us or our network providers. A *complaint* does not include issues related to an *adverse benefit determination* of a claim or service denial.

Concurrent-care decision means a decision by the plan to reduce or terminate benefits otherwise payable for a course of treatment that has been approved by the 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 the plan.

Evidence-based standard means the conscientious, explicit and judicious use of the current best evidence based on the overall systematic review of the research in making decisions about the care of individual patients.

External review means a review of an *adverse benefit determination* including a *final adverse benefit determination* conducted by an *Independent review organization (IRO)*.

Final adverse benefit determination means an *adverse benefit determination* that has been upheld by us at the completion of the internal *appeals* process or when the internal *appeals* process has been exhausted.

Grievance means any written dissatisfaction related to how we administer the plan or an *appeal* related to:

- The provision of services;
- Rescissions of coverage;
- Decisions regarding a diagnosis or services for autism spectrum disorders; or
- Claims practices.

Group health plan means an employee welfare benefit plan to the extent the plan provides medical care to employees or their dependents directly (self insured) or through insurance (including HMO plans), reimbursement or otherwise.

Appeal and External Review Notice (continued)

Health insurance issuer means the offering company listed on the face page of your Certificate of Insurance or Evidence of Coverage and referred to in this document as "Humana," "we," "us," or "our."

Independent review organization (IRO) means an entity that conducts independent *external reviews* of *adverse benefit determinations* and *final adverse benefit determinations*. All IRO's must be certified by the *commissioner* and have no conflicts of interest to influence its independence.

Preliminary review means a review by Humana of an *external review* request to determination if:

- You are or were covered under the plan at the time a service was recommended, requested, or provided;
- The service is covered under the plan except when we determine the service is:
 - Not covered because it does not meet plan requirements for medical necessity, appropriateness, healthcare setting, level of care or effectiveness; or
 - Experimental or investigational for a particular medical condition and is not explicitly listed as an excluded benefit under the plan.
- In the case of experimental or investigational treatment:
 - Your treating physician has certified one of the following situations is applicable:
 - Standard services have not been effective in improving your condition;
 - Standard services are not medically appropriate for you; or
 - There is no available standard service covered by the plan that is more beneficial to you than the recommended or requested service.
 - The treating physician certifies in writing:
 - The recommended service is likely to be more beneficial to you, in the physician's opinion, than any available standard services; or
 - Scientifically valid studies using accepted protocols demonstrate the service is likely to be more beneficial to you than any available standard services and the physician is a licensed, board certified or board eligible physician qualified to practice in the area of medicine appropriate to treat your condition.
- The internal *appeals* process has been exhausted as specified under the "Exhaustion of remedies" section;
- You have provided all information required to process an *external review*; including:
 - An *external review* request form provided with the *adverse benefit determination* or *final adverse benefit determination*; and
 - Release forms authorizing us to disclose protected health information that is pertinent to the *external review*.

Appeal and External Review Notice (continued)

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

Pre-service claim means a request for authorization of a benefit for which the plan conditions receipt of the benefit, in whole or in part, on advance approval.

Review panel includes:

- At least one person authorized to take corrective action;
- At least one covered person other than the member, if available;
- One subordinate of the person or persons who made the initial determination, if the panel includes at least three persons;
- Persons not involved in the initial determination.

With respect to an *appeal*, the *review panel* will not include a subordinate of the person or persons who made the initial determination. For *appeals* involving medical necessity or experimental/investigational *adverse benefit determinations*, at least one panel reviewer must:

- Hold an active, unrestricted medical license; and
- Be from the same or similar specialty who typically treats the medical condition or provides the treatment in question.

Urgent-care claim means a claim for covered services to which the application of the time periods for making non-urgent care determinations:

- Could seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function; or
- In the opinion of a physician with knowledge of the covered person's medical condition, would subject the covered person to severe pain that cannot be adequately managed without the service that is the subject of the claim.

Humana will make a determination of whether a claim is an *urgent-care claim*. However, any claim a physician, with knowledge of a covered person's medical condition, determines is an "*urgent-care claim*" will be treated as a "claim involving urgent care."

Appeal and External Review Notice (continued)

Claim procedures

Discretionary authority

With respect to paying claims for benefits or determining eligibility for coverage under a policy issued by Humana, Humana as administrator for claims determinations and as ERISA claims review fiduciary, shall have full and exclusive discretionary authority to:

- Interpret plan provisions;
- Make decisions regarding eligibility for coverage and benefits; and
- Resolve factual questions relating to coverage and benefits.

Submitting a claim

This section describes how a *claimant* files a claim for plan benefits. A claim must be filed in writing and delivered by mail, postage prepaid, by FAX or e-mail. A request for pre-authorization may be filed by telephone. The claim or request for pre-authorization must be submitted to Humana or to Humana's designee at the address indicated in the covered person's benefit plan document or identification card. This is particularly important with respect to mental health coordinators and other providers to whom Humana has delegated responsibility for claims administration. Claims will not be deemed submitted for purposes of these procedures unless and until received at the correct address.

Claims submissions must be in a format acceptable to Humana and compliant with any legal requirements. Claims 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 Humana.

Claims submissions must be timely. Claims must be filed as soon as reasonably possible after they are incurred, and in no event later than the period of time described in the benefit plan document.

Claims submissions must be complete and delivered to the designated address. At a minimum they must include:

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

Presentation of a prescription to a pharmacy does not constitute a claim for benefits under the plan. If a covered person is required to pay the cost of a covered prescription drug, he or she may submit a written claim for plan benefits to Humana.

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

Appeal and External Review Notice (continued)

Failure to provide necessary information

If a *pre-service claim* submission is not made in accordance with the plan's requirements, Humana will notify the *claimant* of the problem and how it may be remedied within five days (or as soon as possible but not more than 24 hours, in the case of an *urgent-care claim*). If a *post-service claim* is not made in accordance with the plan's requirements, it will be returned to the submitter.

Authorized representatives

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

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

When a health care provider intends to *appeal* on behalf of the covered person for a non-urgent care claim, the provider must indicate in their *appeal* request that they are appealing on behalf of the covered person and include a completed Humana AOR form. If an AOR form is not included with the request, the form will be sent to the provider.

In any event, a health care provider with knowledge of a covered person's medical condition acting in connection with an *urgent-care claim* will be recognized by the plan as the covered person'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 a determination on a claim is made, Humana will notify the *claimant* within a reasonable time, as follows:

- **Pre-service claims** - Humana will provide notice of a favorable or *adverse benefit determination* within a reasonable time appropriate to the medical circumstances but no later than 15 days after the plan receives the claim.

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

Appeal and External Review Notice (continued)

If the reason for the extension is because Humana does not have enough information to decide the claim, the notice of extension will describe the required information, and the *claimant* will have at least 45 days from the date the notice is received to provide the necessary information.

- ***Urgent-care claims*** - Humana will determine whether a particular claim is an *urgent-care claim*. This determination will be based on information furnished by or on behalf of a covered person. Humana will exercise its judgment when making the determination with deference to the judgment of a physician with knowledge of the covered person's condition. Humana may require a *claimant* to clarify the medical urgency and circumstances supporting the *urgent-care claim* for expedited decision-making.

Notice of a favorable or *adverse benefit determination* will be made by Humana as soon as possible, taking into account the medical urgency particular to the covered person's situation, but not later than 24 hours after receiving the *urgent-care claim*.

If a claim does not provide sufficient information to determine whether, or to what extent, services are covered under the plan, Humana will notify the *claimant* as soon as possible, but not more than 24 hours after receiving the *urgent-care claim*. The notice will describe the specific information necessary to complete the claim. The *claimant* will have a reasonable amount of time, taking into account the covered person's circumstances, to provide the necessary information – but not less than 48 hours.

Humana will provide notice of the plan's *urgent-care claim* determination as soon as possible but no more than 48 hours after the earlier of:

- The plan receives the specified information; or
 - The end of the period afforded the *claimant* to provide the specified additional information.
- ***Concurrent-care decisions*** - Humana will notify a *claimant* of a *concurrent-care decision* involving a reduction or termination of pre-authorized benefits sufficiently in advance of the reduction or termination to allow the *claimant* to *appeal* and obtain a determination.

Humana will decide *urgent-care claims* involving an extension of a course of treatment as soon as possible taking into account medical circumstances. Humana will notify a *claimant* of the benefit determination, whether adverse or not, within 24 hours after the plan receives the claim, provided the claim is submitted to the plan 24 hours prior to the expiration of the prescribed period of time or number of treatments.

- ***Post-service claims*** - Humana will provide notice of a favorable or *adverse benefit determination* within a reasonable time appropriate to the medical circumstances but no later than 30 days after the plan receives the claim.

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

Appeal and External Review Notice (continued)

If the reason for the extension is because Humana does not have enough information to decide the claim, the notice of extension will describe the required information, and 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 on the earlier of the date on which the *claimant* responds or the expiration of the time allowed for submission of the requested information.

Initial denial notices

Notice of a claim denial (including a partial denial) will be provided to *claimants* by mail, postage prepaid, by FAX or by e-mail, as appropriate, within the time frames noted above. With respect to adverse decisions involving *urgent-care claims*, notice may be provided to *claimants* orally within the time frames noted above. If oral notice is given, written notification must be provided no later than three days after oral notification.

A claims denial notice will convey the specific reason for the *adverse benefit determination* and the specific plan provisions upon which the determination is based. The notice will also include a description of any additional information necessary to perfect the claim and an explanation of why such information is necessary. The notice will disclose if any internal plan rule, protocol or similar criterion was relied upon to deny the claim and a copy of the rule, protocol or similar criterion will be provided to *claimants*, free of charge. In addition to the information provided in the notice, a *claimant* has the right to request the diagnosis and treatment codes and descriptions upon which the determination is based.

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

If an *adverse benefit determination* is based on medical necessity, experimental treatment or similar exclusion or limitation, the notice will provide an explanation of the scientific or clinical basis for the determination, free of charge. The explanation will apply the terms of the plan to the covered person's medical circumstances.

In the case of an adverse decision of an *urgent-care claim*, the notice will provide a description of the plan's expedited review procedures.

Appeal and External Review Notice (continued)

Contact information

For questions about your rights, this notice, or assistance, you can contact: Humana, Inc. at humana.com or the Employee Benefits Security Administration at 1-866-444-EBSA (3272).

You may contact the *commissioner* for assistance at any time at the address and telephone number below:

Wisconsin Office of the Commissioner of Insurance
125 South Webster Street
Madison, WI 53703-3474

Mailing address:
PO Box 7873
Madison, WI 53707-7873

Phone: 608-266-3585 or 608-266-0103 or 800-236-8517
TDD: Dial 711 and ask for 608-266-3586
Fax: 608-264-8115

Email: ociquestions@wisconsin.gov
Website: <http://oci.wi.gov/index.htm>
or
<http://oci.wi.gov/consinfo.htm>

Appeal and External Review Notice (continued)

Filing a complaint

If you have a *complaint* about us or our network providers, please call our Customer Service Department as soon as possible. The toll-free number is identified on your identification card. Most problems may be resolved quickly in this manner. At any time, you may file a *grievance* as described below.

Grievances

Grievance process for dissatisfaction with administration of plan

A *claimant* can submit a *grievance* regarding a dissatisfaction with administration of the plan in writing to us at any time. We will acknowledge the receipt of the *grievance* within five business days.

A *review panel* will meet to investigate the *grievance*. Within seven days before the *review panel* meeting, the *claimant* will receive notice of the meeting. The notice will include the time, place, and the right to appear in person and the right to submit questions to the person or persons responsible for the initial decision.

The *claimant* will be notified in writing of a final determination within 30 days of receipt of the *grievance*. The time period may be extended an additional 30 days to accommodate the *claimant's* availability at the *grievance* meeting.

Notice of the decision will be signed by a voting member of the *review panel* and will include a description of the position titles of the panel members involved in making the decision. The notice will explain the resolution of the *grievance* and the right to request a further review, if applicable.

Grievance process for appeals

A *claimant* can submit a *grievance* in writing at any time to *appeal* an *adverse benefit determination* after receiving written notice of the denial (or partial denial). We will acknowledge the receipt of the *appeal* within five business days.

A *review panel* will meet to investigate the *appeal*. Within seven days before the *review panel* meeting, the *claimant* will receive notice of the meeting. The notice will include the time, place, and the right to appear in person and the right to submit questions to the person or persons responsible for the initial decision.

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

A *claimant* may request an expedited *external review* at the same time a request is made for an expedited internal *appeal* of an *adverse benefit determination* for an *urgent-care claim* or when you are receiving an ongoing course of treatment.

Appeal and External Review Notice (continued)

Determination of *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.

On *appeal*, 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 the plan in connection with the *adverse benefit determination* being appealed, as permitted under applicable law.

If the claims denial is based in whole, or in part, upon a medical judgment, including determinations as to whether a particular treatment, drug, or other service is experimental, investigational, 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.

If new or additional evidence is relied upon or if new or additional rational is used during the internal *appeal* process, Humana will provide the *claimant*, free of charge, the evidence or rational as soon as possible and in advance of the *appeals* decision in order to provide the *claimant* a reasonable opportunity to respond.

Time periods for decisions on appeal

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

- ***Urgent-care claims*** - As soon as possible but not later than 72 hours after Humana receives the *appeal* request;
- ***Pre-service claims*** - Within a reasonable period but not later than 30 days after Humana received the *appeal* request;
- ***Post-service claims*** - Within a reasonable period but not later than 30 days after Humana receives the *appeal* request. This time period may be extended an additional 30 days to accommodate the *claimant's* availability at the *appeal* meeting;
- ***Concurrent-care decisions*** - Within the time periods specified above depending on the type of claim involved.

Appeals denial notices

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

A notice that a claim *appeal* has been denied will include:

- The specific reason or reasons for the *adverse benefit determination*;
- Reference to the specific plan provision upon which the determination is based;

Appeal and External Review Notice (continued)

- If any internal plan rule, protocol or similar criterion was relied upon to deny the claim. A copy of the rule, protocol or similar criterion will be provided to the *claimant*, free of charge;
- The signature of a voting member of the *review panel*, including a description of the position titles of panel members involved in making the decision.
- A statement of the *claimant's* right to *external review*, a description of the *external review* process, and the forms for submitting an *external review* request, including release forms authorizing Humana to disclose protected health information pertinent to the *external review*;
- A statement about the *claimant's* right to bring an action under §502(a) of ERISA;
- If an *adverse benefit determination* is based on medical necessity, experimental treatment or similar exclusion or limitation, the notice will provide an explanation of the scientific or clinical basis for the determination, free of charge. The explanation will apply the terms of the plan to the covered person's medical circumstances.

In addition to the information provided in the notice, a *claimant* has the right to request the diagnosis and treatment codes and descriptions upon which the determination is based.

Exhaustion of remedies

Upon completion of the internal *appeals* process under this section, a *claimant* will have exhausted his or her administrative remedies under the plan. If Humana fails to adhere to all requirements of the internal *appeal* process, except for failures that are based on a minimal error, the claim shall be deemed to have been denied and the *claimant* may request an *external review*.

After exhaustion of remedies, a *claimant* may pursue any other legal remedies available, which may include bringing civil action under ERISA section 502(a) for judicial review of the plan's determination. Additional information may be available from the local U.S. Department of Labor Office.

External review of adverse benefit determinations

Within four months after a *claimant* receives notice of an *adverse benefit determination* or *final adverse benefit determination* the *claimant* may request an *external review* if the determination concerns treatment that is experimental, investigational, not medically necessary, or appropriate, the determination concerns a rescission of coverage, or for claims protected under the Federal No Surprises Act. The request for *external review* must be made in writing to us. Please refer to the section titled "Expedited external review" if the *adverse benefit determination* involves an *urgent-care claim* or an ongoing course of treatment.

Appeal and External Review Notice (continued)

We will complete a *preliminary review* of the request within five business days. Within one business day after we complete the *preliminary review*, we will notify the *claimant* in writing whether:

- The request is complete and is eligible for *external review*;
- The request is not complete and the information or materials needed to make the request complete; or
- The request is not eligible for *external review*, the reasons for ineligibility and the *claimant's* right to contact the Employee Benefits Security Administration.

We will impartially select an *IRO*, on a rotating basis, from a list of contracted *IRO's*. Within five business days from the date the *IRO* is selected, we will provide the *IRO* with all documents and information we considered in making the *adverse benefit determination* or *final adverse benefit determination*.

Upon selection, the *IRO* will notify the *claimant* in writing of the following:

- The eligibility of the request and acceptance for *external review*; and
- The right to submit additional information in writing to the *IRO* and the time limits to submit the information.

Any information received by the *IRO* will be forwarded to Humana within one business day of receipt. Upon receipt of additional information, we may reconsider the *adverse benefit determination* or *final adverse benefit determination*. If we reverse the *adverse benefit determination* or *final adverse benefit determination*, the *external review* will be terminated and we will provide coverage for the service. We will immediately notify the *claimant* and the *IRO* in writing of our decision.

The *IRO* will review all of the information received including, if available and considered appropriate the following:

- Your medical records;
- The attending healthcare professional's recommendation;
- Consulting reports from appropriate healthcare professionals and other documents submitted by Humana, the *claimant*, and treating provider;
- The terms of the coverage under the plan;
- The most appropriate practice guidelines, which will include applicable *evidence-based standards* and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards and associations;
- Any applicable clinical review criteria developed and used by Humana; and
- The opinion of the *IRO's clinical peer reviewer* or reviewers after considering the information and documents listed above.

Appeal and External Review Notice (continued)

The *IRO's* decision to either uphold or reverse the *adverse benefit determination* or *final adverse benefit determination* will be provided in writing to the *claimant* and Humana no later than 45 days after receipt of the request for an *external review*.

The *IRO's* written notice of the decision will include:

- A general description of the reason for the request for *external review*;
- The date the *IRO* received the assignment;
- The date the *external review* was conducted;
- The date of the *IRO's* decision;
- The principal reason for the decision, including applicable *evidence-based standards*, if any, used as a basis for the decision;
- The rationale for the decision; and
- References to the evidence or documentation, including the *evidence-based standards*, considered in reaching the decision.

Immediately upon our receipt of the *IRO's* decision reversing the *adverse benefit determination* or *final adverse determination*, we will approve the service.

Expedited external review

You may request an expedited *external review*:

- At the same time you request an expedited internal *appeal* of an *adverse benefit determination* for an *urgent-care claim*; or
- When you receive an *adverse benefit determination* or *final adverse benefit determination* for an *urgent-care claim* involving treatment:
 - That is experimental, investigational or not appropriate;
 - That is not medically necessary; or
 - For which you received emergency services, but you have not been discharged from the facility .

We will immediately complete a *preliminary review* of the request and notify the *claimant* of the *preliminary review* determination. If we determine the request is not eligible, the notice will advise the *claimant* the right to contact the Employee Benefits Security Administration.

Immediately after we determine the request is eligible for *external review*, we will:

- Impartially select an *IRO* to conduct the expedited *external review*.
- Provide the *IRO* with all necessary documents and information.

The *IRO* will review all of the information received including, if available and considered appropriate, the following:

- Your medical records;
- The attending healthcare professional's recommendation;

Appeal and External Review Notice (continued)

- Consulting reports from appropriate healthcare professionals and other documents submitted by Humana, the *claimant* and treating provider;
- The terms of the coverage under the plan;
- The most appropriate practice guidelines, which will include *evidence-based standards* and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards and associations;
- Any applicable clinical review criteria developed and used by Humana; and
- The opinion of the *IRO's clinical peer reviewer* or reviewers after considering the information and documents listed above.

The *IRO's* decision to either uphold or reverse the *adverse benefit determination* or *final adverse benefit determination* will be provided orally or in writing to the *claimant* and Humana within 72 hours after the *IRO* receives the request for an expedited *external review*.

The *IRO* will send written confirmation within 48 hours of an oral decision and will include:

- A general description of the reason for the request for an expedited *external review*;
- The date the *IRO* received the assignment to conduct the expedited *external review*;
- The date the expedited *external review* was conducted;
- The date of the *IRO's* decision;
- The principal reason for the decision, including applicable *evidence-based standards*, if any, used as a basis for the decision;
- The rationale for the decision;
- References to the evidence or documentation, including the *evidence-based standards*, considered in reaching the decision, except in the case of experimental or investigational treatment; and
- In the case of experimental or investigational treatment, the written opinion and rationale for the recommendation of each *clinical peer reviewer*.

Immediately upon receipt of the *IRO's* decision reversing the *adverse benefit determination* or *final adverse benefit determination*, we will approve the service.

Legal actions and limitations

No lawsuit may be brought with respect to plan benefits until all remedies under the plan have been exhausted.

No lawsuit with respect to plan benefits may be brought after the expiration of the applicable limitations period stated in the benefit plan document. If no limitation is stated in the benefit plan document, then no such suit may be brought after the expiration of the applicable limitations under applicable law.