TO: Health Plan Participants in the Humana Network

FROM: Nena Peplow, Director of Human Resources

RE: Humana Summary Plan Description

Enclosed is the Summary Plan Description (SPD) for the University health plan administered by Humana. The SPD is the official Plan Document for the health plan and provides information regarding covered benefits and other pertinent details concerning the Plan. This document is also available on University website under the Human Resource link at: 
http://www.bradley.edu

Members may log in to MyHumana at www.humana.com to locate participating providers, verify benefit and prescription drug information or to check the status of a claim. Participants may also contact customer service at the number listed on your ID card if you are in doubt as to whether a provider, facility or service is covered by the plan.

Please keep in mind that not all providers and services listed on the website are covered under Bradley University’s health plan. For example, acupuncture treatments, educational testing, chiropractic services and most cosmetic surgeries are not covered.

Questions concerning this document or the health plan may be directed to Humana at the phone number on your membership card or the Human Resource Department at Ext. 3223.
MASTER PLAN DESCRIPTION

For the

DENTAL, EPO MEDICAL AND PRESCRIPTION DRUG PLAN

Sponsored by

Bradley University

Group Number(s): 548353

Effective: October 1, 2011
INTRODUCTION

THE MASTER PLAN DESCRIPTION – YOUR HEALTH CARE PLAN GUIDE

Welcome to your employer-sponsored health care plan (Plan) administered by Humana Insurance Company and HumanaDental Insurance Company (individually and collectively “Humana”). Your employer has provided you with this Master Plan Description (MPD), which outlines your benefits, as well as your rights and responsibilities under this Plan.

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

DEFINED TERMS

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

PRIVACY

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

CONTACT INFORMATION

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

Claims Submittal Address:  Claims Appeal Address:
   Medical:     Medical:
Humana Claims Office     Humana Grievance and Appeals
P.O. Box 14601           P.O. Box 14546
Lexington, KY 40512-4601  Lexington, KY 40512-4646

   Dental:                        Dental:
HumanaDental Claims Office  HumanaDental Claims Office
P.O. Box 14611             P.O. Box 14638
Lexington, KY  40512-4611   Lexington, KY  40512-4638
SECTION 1, HEALTH RESOURCES AND PRECERTIFICATION........................................................ 5
HEALTH RESOURCES ............................................................... 6
PRECERTIFICATION .................................................................... 10
PREDETERMINATION OF BENEFITS ...................................................... 10
SECTION 2, MEDICAL BENEFITS .......................................................... 11
UNDERSTANDING YOUR COVERAGE .................................................. 12
SCHEDULE OF BENEFITS .............................................................. 13
LIMITATIONS AND EXCLUSIONS ....................................................... 45
COORDINATION OF BENEFITS ......................................................... 51
CLAIM PROCEDURES ....................................................................... 54
SECTION 3, ELIGIBILITY AND EFFECTIVE DATE OF COVERAGE ............................................... 67
TERMINATION OF COVERAGE ............................................................ 74
SECTION 4, GENERAL PROVISIONS AND REIMBURSEMENT/SUBROGATION ..................... 75
GENERAL PROVISIONS ................................................................. 76
REIMBURSEMENT/SUBROGATION ....................................................... 78
SECTION 5, NOTICES ........................................................................ 80
IMPORTANT NOTICE FOR EMPLOYEES AND SPOUSES/DOMESTIC PARTNERS AGE 65 AND OVER .................................................................................................................... 81
PRIVACY OF PROTECTED HEALTH INFORMATION .......................................................... 82
CONTINUATION OF MEDICAL AND DENTAL BENEFITS (COBRA) ................................. 84
THE UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994 (USERRA) .................................................................................................................. 90
STATEMENT OF ERISA RIGHTS .............................................................. 91
ADDITIONAL NOTICES ........................................................................ 93
PLAN DESCRIPTION INFORMATION .................................................... 94
SECTION 6, DEFINITIONS ..................................................................... 96
SECTION 7, PRESCRIPTION DRUG BENEFITS ..................................................... 112
SECTION 8, DENTAL BENEFITS .................................................................... 123
SECTION 1

HEALTH RESOURCES AND PRECERTIFICATION
HEALTH RESOURCES

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

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

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

**MYHUMANA**

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

MyHumana Mobile allows you quick access to important information using your mobile device’s browser. If you log in to MyHumana Mobile, using your existing MyHumana login and password, you can access:

- The urgent care center finder; and
- *Your* member ID card detail information.

**HUMANA HEALTH ASSESSMENT**

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

**HUMANA HEALTH ALERTS**

**PREVENTIVE REMINDERS**

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

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

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

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

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

NEONATAL INTENSIVE CARE UNIT (NICU) MANAGEMENT

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

The Neonatal Case Management program includes:

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

To contact a NICU program representative, call 1-800-622-9529.

PERSONAL NURSE®

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

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

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

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

UTILIZATION MANAGEMENT

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

Precertification and Concurrent Review

Utilization review may include precertification and concurrent review.

Precertification for emergency services is not required.

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

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

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

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

2. Conduct concurrent review as necessary.

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

If it is determined at any time your proposed treatment plan, either partially or totally, is not a covered expense under the terms and provisions of this Plan, benefits for services may be reduced or services may not be covered.
CASE MANAGEMENT

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

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

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

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

CONTINUITY OF CARE

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

TRANSITION OF CARE

Changing health care plans can be stressful, especially for those who are going through intense medical treatment, such as chemotherapy. Humana understands this and does not want to hinder progress or interfere with the doctor-patient relationship. The transition of care process helps covered persons make a smooth transition to Humana from their current health care plan with the least amount of disruption to their care.
NOTE: The provisions in this section may not apply to transplant services. Please refer to the Transplant Services section in the Schedule of Benefits for applicable precertification requirements and penalties.

Precertification for emergency services is not required.

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

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

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

1. Go to Humana’s website (www.humana.com);
2. Click on “Resources & Support”;
3. Click on “Member Guidelines” under Customer Support Center;
4. Click on “Medical Authorizations”;
5. Click on “Commercial Preauthorization and Notification List” for a list of the services that require precertification.

PREDETERMINATION OF BENEFITS

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

If treatment is to commence more than 180 days after the date treatment is authorized, Humana will require you to submit another treatment plan.
SECTION 2

MEDICAL BENEFITS
PARTICIPATING PROVIDERS

This Plan has one (1) level of benefits (unless otherwise specified on the Schedule of Benefits) – participating provider (PAR provider) benefits, payable as shown in the Schedule of Benefits section. You are responsible for any applicable deductibles, coinsurance amounts and/or copayments.

When receiving medical services, you should make sure the provider is a PAR provider for this Plan. Humana may designate limited panels of PAR provider from which certain kinds of services must be obtained. If these services are not obtained from the designated PAR provider, benefits for these services may be reduced or denied. Humana reserves the right, at their discretion, to make changes to the list of PAR provider at any time.

PAR PROVIDER DIRECTORY

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

COVERED AND NON-COVERED EXPENSES

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

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

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

Please refer to the "Schedule of Benefits", “Medical Covered Expenses” and the "Limitations and Exclusions" sections of this Master Plan Description for more information about covered expenses and non-covered expenses.
IMPORTANT INFORMATION ABOUT PLAN BENEFITS

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

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

<table>
<thead>
<tr>
<th>OFFICE VISIT COPAYMENTS, OUT-OF-POCKET LIMITS, AND LIFETIME MAXIMUM BENEFIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified Practitioner Primary Care Physician (PCP) Office Visit Copayment</td>
</tr>
<tr>
<td>Qualified Practitioner Specialist Office Visit Copayment</td>
</tr>
</tbody>
</table>

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

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

<table>
<thead>
<tr>
<th>Individual Out-of-Pocket Limit</th>
<th>$2,000 per covered person</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee plus 1 Out-of-Pocket Limit</td>
<td>$4,000 per covered family</td>
</tr>
<tr>
<td>Family Out-of-Pocket Limit</td>
<td>$5,000 per covered family</td>
</tr>
<tr>
<td>Lifetime Maximum Benefit</td>
<td>Unlimited</td>
</tr>
<tr>
<td>Plan Year Maximum Benefit</td>
<td>$2,000,000 per covered person</td>
</tr>
</tbody>
</table>
OFFICE VISIT COPAYMENTS, OUT-OF-POCKET LIMITS, AND LIFETIME MAXIMUM BENEFIT

Out-of-Network claims are generally not covered, however the following claims may be covered:

Emergency Room Care; Urgent Care; Ambulance; or When the member has an approved referral.

In these instances, the corresponding claim should process as if the provider were an in-network participating provider.

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

<table>
<thead>
<tr>
<th>MEDICAL SERVICES</th>
<th>PARTICIPATING PROVIDER BENEFIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine Child Care Examination (including routine vision and hearing screening when part of an examination)</td>
<td>100%</td>
</tr>
<tr>
<td>School Examinations and Services</td>
<td>100%</td>
</tr>
<tr>
<td>Routine Child Care Laboratory and X-ray</td>
<td>100%</td>
</tr>
<tr>
<td>Routine Child Care Immunizations</td>
<td>100%</td>
</tr>
<tr>
<td>Routine Child Care HPV Vaccine (e.g. Gardasil) (covered beginning at age 9 for females only)</td>
<td>100%</td>
</tr>
<tr>
<td>Routine Child Care Meningitis Vaccine</td>
<td>100%</td>
</tr>
</tbody>
</table>
### ROUTINE/PREVENTIVE CHILD CARE SERVICES
**BIRTH TO AGE 18**
*(Services Received at a Clinic or Outpatient Hospital)*

<table>
<thead>
<tr>
<th>MEDICAL SERVICES</th>
<th>PARTICIPATING PROVIDER BENEFIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine Child Care Flu/Pneumonia Injections</td>
<td>100%</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>MEDICAL SERVICES</th>
<th>PARTICIPATING PROVIDER BENEFIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine Adult Care Examination (including routine vision and hearing screening when part of an examination)</td>
<td>100%</td>
</tr>
<tr>
<td>School Examinations and Services</td>
<td>100%</td>
</tr>
<tr>
<td>Routine Adult Care Laboratory and X-ray</td>
<td>100%</td>
</tr>
<tr>
<td>Routine Adult Care Immunizations</td>
<td>100%</td>
</tr>
<tr>
<td>HPV Vaccine (e.g. Gardasil) covered through age 26 for females only</td>
<td>100%</td>
</tr>
<tr>
<td>Shingles Vaccine (e.g. Zostavax), for covered persons age 55 and over.</td>
<td>100%</td>
</tr>
</tbody>
</table>
### ROUTINE/PREVENTIVE ADULT CARE SERVICES

**AGE 18 AND OVER**

*(Services Received at a Clinic or Outpatient Hospital)*

<table>
<thead>
<tr>
<th>MEDICAL SERVICES</th>
<th>PARTICIPATING PROVIDER BENEFIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine Adult Care Meningitis Vaccine, for <em>covered persons</em> through age 25.</td>
<td>100%</td>
</tr>
<tr>
<td>Routine Adult Care Flu/Pneumonia Injections</td>
<td>100%</td>
</tr>
<tr>
<td>Routine Adult Care Mammograms</td>
<td>100%</td>
</tr>
<tr>
<td>Routine Adult Care Pap Smears</td>
<td>100%</td>
</tr>
<tr>
<td>Routine Adult Care Colonoscopy, Proctosigmoidoscopy and Sigmoidoscopy Screenings</td>
<td>100%</td>
</tr>
<tr>
<td><em>(including related services)</em> <em>(performed at an outpatient facility, <em>ambulatory surgical center</em> or clinic location)</em></td>
<td></td>
</tr>
<tr>
<td>Prostate Specific Antigen (PSA) Testing</td>
<td>100%</td>
</tr>
<tr>
<td>Routine Physical Examination Visit Limit</td>
<td>1 visit per <em>covered person</em></td>
</tr>
<tr>
<td>Well Woman Examination Visit Limit</td>
<td>1 visit per <em>covered person</em></td>
</tr>
</tbody>
</table>
### ROUTINE VISION SERVICES

<table>
<thead>
<tr>
<th>MEDICAL SERVICES</th>
<th>PAR PROVIDER BENEFIT</th>
<th>NON-PAR PROVIDER BENEFIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine Vision Examination/Screening</td>
<td>100% per covered person, per 24 months</td>
<td>Same as PAR Provider Benefit</td>
</tr>
<tr>
<td>Routine Vision Refraction</td>
<td>100%</td>
<td>Same as PAR Provider Benefit</td>
</tr>
<tr>
<td>Eyeglass Frames and Lenses and Contact Lenses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lenses:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single Vision – one lens</td>
<td>100% up to $14.50</td>
<td>Same as PAR Provider Benefit</td>
</tr>
<tr>
<td>Single Vision – set</td>
<td>100% up to $29</td>
<td>Same as PAR Provider Benefit</td>
</tr>
<tr>
<td>Bifocal – one lens</td>
<td>100% up to $21.75</td>
<td>Same as PAR Provider Benefit</td>
</tr>
<tr>
<td>Bifocal – set</td>
<td>100% up to $43.50</td>
<td>Same as PAR Provider Benefit</td>
</tr>
<tr>
<td>Trifocal – one lens</td>
<td>100% up to $29</td>
<td>Same as PAR Provider Benefit</td>
</tr>
<tr>
<td>Trifocal – set</td>
<td>100% up to $58</td>
<td>Same as PAR Provider Benefit</td>
</tr>
<tr>
<td>Lenticular – one lens</td>
<td>100% up to $36.30</td>
<td>Same as PAR Provider Benefit</td>
</tr>
<tr>
<td>Lenticular - set</td>
<td>100% up to $72.60</td>
<td>Same as PAR Provider Benefit</td>
</tr>
<tr>
<td>Frames:</td>
<td>100% up to $20.60</td>
<td>Same as PAR Provider Benefit</td>
</tr>
<tr>
<td>Contact Lenses:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>100% up to $21.75</td>
<td>Same as PAR Provider Benefit</td>
</tr>
<tr>
<td>Pair</td>
<td>100% up to $43.50</td>
<td>Same as PAR Provider Benefit</td>
</tr>
</tbody>
</table>

The par and non-par eyeglass frames and lenses and contact lenses dollar limit is combined.

Lenses/Frames & Contact Limitation Period: Every 24 months per covered person
## ROUTINE HEARING SERVICES

<table>
<thead>
<tr>
<th>MEDICAL SERVICES</th>
<th>PARTICIPATING PROVIDER BENEFIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine Hearing Examination/Screening</td>
<td>100%</td>
</tr>
<tr>
<td>Routine Hearing Testing</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Hearing Aids and Fitting</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Routine Hearing Examination Limits</td>
<td>1 visit per covered person</td>
</tr>
</tbody>
</table>

## QUALIFIED PRACTITIONER SERVICES

(Other than Qualified Practitioner Services covered under the Routine / Preventive Care Benefits)

<table>
<thead>
<tr>
<th>MEDICAL SERVICES</th>
<th>PARTICIPATING PROVIDER BENEFIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic Office Examination at a Clinic, including Second Surgical Opinion – Qualified Practitioner Primary Care Physician</td>
<td>100% after a $30 copayment</td>
</tr>
<tr>
<td>Diagnostic Office Examination at a Clinic, including Second Surgical Opinion - Qualified Practitioner Specialist</td>
<td>100% after a $30 copayment</td>
</tr>
</tbody>
</table>

If an office examination is billed from an outpatient location, the services will be payable the same as an office examination at a clinic.
## QUALIFIED PRACTITIONER SERVICES
(Other than Qualified Practitioner Services covered under the Routine / Preventive Care Benefits)

<table>
<thead>
<tr>
<th>MEDICAL SERVICES</th>
<th>PARTICIPATING PROVIDER BENEFIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic Laboratory and X-ray at a Clinic (other than advanced imaging)</td>
<td>100%</td>
</tr>
<tr>
<td>Independent Laboratory</td>
<td>Payable the same as diagnostic laboratory and x-ray.</td>
</tr>
<tr>
<td>Advanced Imaging at a Clinic</td>
<td>100%</td>
</tr>
<tr>
<td>Allergy Testing at a Clinic</td>
<td>100%</td>
</tr>
<tr>
<td>Allergy Serum/Vials at a Clinic</td>
<td>100%</td>
</tr>
<tr>
<td>Allergy Injections at a Clinic</td>
<td>100%</td>
</tr>
<tr>
<td>Injections at a Clinic (other than routine immunizations, HPV vaccine, meningitis vaccine, shingles vaccine, flu/pneumonia injections, contraceptive injections for birth control reasons and allergy injections)</td>
<td>100%</td>
</tr>
<tr>
<td>Anesthesia at a Clinic</td>
<td>100%</td>
</tr>
<tr>
<td>Surgery at a Clinic (including Qualified Practitioner, Assistant Surgeon and Physician Assistant)</td>
<td>100%</td>
</tr>
</tbody>
</table>
### QUALIFIED PRACTITIONER SERVICES
(Other than *Qualified Practitioner Services* covered under the Routine / Preventive Care Benefits)

<table>
<thead>
<tr>
<th>MEDICAL SERVICES</th>
<th>PARTICIPATING PROVIDER BENEFIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical and Surgical Supplies</td>
<td>100%</td>
</tr>
<tr>
<td>Eyeglasses or Contact Lenses after Cataract Surgery</td>
<td>100%</td>
</tr>
<tr>
<td>(initial pair only)</td>
<td></td>
</tr>
<tr>
<td>Diabetic Counseling and Diabetic Nutritional Counseling (Diabetes Self-Management Training) (all places of service)</td>
<td>100%</td>
</tr>
<tr>
<td>Diabetes Supplies</td>
<td>Payable under the <em>prescription</em> drug benefits.</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>MEDICAL SERVICES</th>
<th>PAR PROVIDER BENEFIT</th>
<th>NON-PAR PROVIDER BENEFIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dental/Oral Surgeries</td>
<td>Payable the same as any other sickness.</td>
<td>Same as <em>PAR Provider</em> Benefit</td>
</tr>
</tbody>
</table>

Please refer to the Medical Covered Expenses section, Dental/Oral Surgeries Covered Under the Medical Plan, for a list of oral surgeries covered under this benefit.
**FAMILY PLANNING**

<table>
<thead>
<tr>
<th>MEDICAL SERVICES</th>
<th>PARTICIPATING PROVIDER BENEFIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth Control Pills and Patches</td>
<td>Not covered under the Medical Benefits, please refer to the Prescription Drug Benefit</td>
</tr>
<tr>
<td>Contraceptive Devices (e.g. IUD; Diaphragms)</td>
<td>100%</td>
</tr>
<tr>
<td>Over-the-counter contraceptive devices are not covered.</td>
<td></td>
</tr>
<tr>
<td>Contraceptive Injections</td>
<td>100%</td>
</tr>
<tr>
<td>Contraceptive Implant Systems (e.g. Norplant) – Insertion and Removal</td>
<td>100%</td>
</tr>
<tr>
<td>Sterilization</td>
<td>Payable the same as any other <em>sickness.</em></td>
</tr>
<tr>
<td>Life Threatening Abortions</td>
<td>Payable the same as any other <em>sickness.</em></td>
</tr>
</tbody>
</table>

**MATERNITY**

*(Normal, C-Section and Complications)*

<table>
<thead>
<tr>
<th>MEDICAL SERVICES</th>
<th>PARTICIPATING PROVIDER BENEFIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient <em>Hospital Room and Board and Ancillary Facility Services</em></td>
<td>Payable the same as any other <em>sickness.</em></td>
</tr>
<tr>
<td>Birthing Center Room and Board and Ancillary Services</td>
<td>Payable the same as any other <em>sickness.</em></td>
</tr>
</tbody>
</table>
### MATERNITY
**(Normal, C-Section and Complications)**

<table>
<thead>
<tr>
<th>MEDICAL SERVICES</th>
<th>PARTICIPATING PROVIDER BENEFIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified Practitioner Services</td>
<td>Payable the same as any other sickness.</td>
</tr>
<tr>
<td>Dependent Daughter Maternity</td>
<td>Payable the same as any other sickness.</td>
</tr>
<tr>
<td>Newborn Inpatient Qualified Practitioner Services</td>
<td>100%</td>
</tr>
<tr>
<td>Newborn Inpatient Facility Services</td>
<td>100%</td>
</tr>
</tbody>
</table>

### INPATIENT SERVICES

<table>
<thead>
<tr>
<th>MEDICAL SERVICES</th>
<th>PARTICIPATING PROVIDER BENEFIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Hospital Room and Board and Ancillary Facility Services</td>
<td>100% after a $400 copayment per admission</td>
</tr>
<tr>
<td>Qualified Practitioner Inpatient Hospital Visit</td>
<td>100%</td>
</tr>
<tr>
<td>Qualified Practitioner Inpatient Surgery and Anesthesia</td>
<td>100%</td>
</tr>
<tr>
<td>Qualified Practitioner Inpatient Pathology and Radiology</td>
<td>100%</td>
</tr>
<tr>
<td>Private Duty Nursing (inpatient hospital only)</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>
### SKILLED NURSING SERVICES

<table>
<thead>
<tr>
<th>MEDICAL SERVICES</th>
<th>PARTICIPATING PROVIDER BENEFIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skilled Nursing Room and Board and Ancillary Facility Services</td>
<td>100%</td>
</tr>
<tr>
<td>Skilled Nursing Facility Yearly Limits</td>
<td>120 day(s) per covered person</td>
</tr>
<tr>
<td>Skilled Nursing Qualified Practitioner Visit</td>
<td>100%</td>
</tr>
</tbody>
</table>

### OUTPATIENT AND AMBULATORY SURGICAL CENTER SERVICES

<table>
<thead>
<tr>
<th>MEDICAL SERVICES</th>
<th>PARTICIPATING PROVIDER BENEFIT</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Ambulatory Surgical Center Facility Services</em></td>
<td>100% after a $100 copayment</td>
</tr>
<tr>
<td><em>Ambulatory Surgical Center Ancillary Services</em></td>
<td>100%</td>
</tr>
<tr>
<td>Outpatient Hospital Facility Surgical Services</td>
<td>100% after a $100 copayment</td>
</tr>
<tr>
<td>Outpatient Hospital Facility Non-Surgical Services (e.g. clinic facility services; observation)</td>
<td>100%</td>
</tr>
<tr>
<td>Outpatient Hospital Surgical and Non-Surgical Ancillary Services (e.g. supplies; medication; anesthesia)</td>
<td>100%</td>
</tr>
<tr>
<td>Outpatient Hospital Facility Diagnostic Laboratory and X-ray (other than advanced imaging)</td>
<td>100%</td>
</tr>
</tbody>
</table>
### OUTPATIENT AND AMBULATORY SURGICAL CENTER SERVICES

<table>
<thead>
<tr>
<th>MEDICAL SERVICES</th>
<th>PARTICIPATING PROVIDER BENEFIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient Hospital Facility Advanced Imaging</td>
<td>100%</td>
</tr>
<tr>
<td>Outpatient/Home Private Duty Nursing</td>
<td>100%</td>
</tr>
<tr>
<td>Outpatient Hospital and Ambulatory Surgical Center Qualified Practitioner Visit</td>
<td>100%</td>
</tr>
<tr>
<td>Outpatient Hospital and Ambulatory Surgical Center Surgery (including surgeon; assistant surgeon; and physician assistant) and Anesthesia</td>
<td>100%</td>
</tr>
<tr>
<td>Outpatient Hospital and Ambulatory Surgical Center Pathology and Radiology</td>
<td>100%</td>
</tr>
</tbody>
</table>

### EMERGENCY AND URGENT CARE SERVICES

<table>
<thead>
<tr>
<th>MEDICAL SERVICES</th>
<th>PARTICIPATING PROVIDER BENEFIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Room Facility Services (true emergency)</td>
<td>100% after a $125 copayment</td>
</tr>
<tr>
<td>If you are admitted to the hospital, the copayment will be waived.</td>
<td></td>
</tr>
<tr>
<td>Emergency Room Ancillary Services (e.g. laboratory; x-ray; supplies) (true emergency)</td>
<td>100%</td>
</tr>
</tbody>
</table>
### EMERGENCY AND URGENT CARE SERVICES

<table>
<thead>
<tr>
<th>MEDICAL SERVICES</th>
<th>PARTICIPATING PROVIDER BENEFIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Room All Physician Services (including Radiologist, Pathologist, Anesthesiologist and ancillary services billed by an Emergency Room Physician) (true emergency)</td>
<td>100%</td>
</tr>
<tr>
<td>Emergency Room Facility Services (non-emergency)</td>
<td>100% after a $125 copayment</td>
</tr>
<tr>
<td>If you are admitted to the hospital, the copayment will be waived.</td>
<td></td>
</tr>
<tr>
<td>Emergency Room Ancillary Services (e.g. laboratory; x-ray; supplies) (non-emergency)</td>
<td>100%</td>
</tr>
<tr>
<td>Emergency Room All Physician Services (including Radiologist, Pathologist, Anesthesiologist and ancillary services billed by an Emergency Room Physician) (non-emergency)</td>
<td>100%</td>
</tr>
<tr>
<td>Urgent Care Center (facility, ancillary services and qualified practitioner services)</td>
<td>100% after a $30 copayment</td>
</tr>
<tr>
<td>Only one copayment will be taken per day.</td>
<td></td>
</tr>
</tbody>
</table>
### HOSPICE SERVICES

<table>
<thead>
<tr>
<th>MEDICAL SERVICES</th>
<th>PARTICIPATING PROVIDER BENEFIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospice Inpatient Room and Board and Ancillary Services</td>
<td>100%</td>
</tr>
<tr>
<td>Hospice Outpatient (including hospice home visits)</td>
<td>100%</td>
</tr>
<tr>
<td>Hospice Qualified Practitioner Visit</td>
<td>100%</td>
</tr>
</tbody>
</table>

### HOME HEALTH CARE SERVICES

<table>
<thead>
<tr>
<th>MEDICAL SERVICES</th>
<th>PARTICIPATING PROVIDER BENEFIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Health Care Services</td>
<td>100% after a $30 copayment</td>
</tr>
<tr>
<td>Home Health Care Yearly Limits</td>
<td>100 visit(s) per covered person</td>
</tr>
</tbody>
</table>

Home therapy benefits will be reimbursed under the home health care benefit.

If therapies are done in the home (such as physical or occupational therapy), these therapy services will apply to the home health care limits.

If therapies and home health visits are done on the same day the services will track as one visit per day.

<table>
<thead>
<tr>
<th>Home Health Care Ancillary Services</th>
<th>100%</th>
</tr>
</thead>
<tbody>
<tr>
<td>(excluding durable medical equipment, prosthetics and private duty nursing)</td>
<td></td>
</tr>
</tbody>
</table>
## Durable Medical Equipment (DME)

<table>
<thead>
<tr>
<th>MEDICAL SERVICES</th>
<th>PARTICIPATING PROVIDER BENEFIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Durable Medical Equipment (DME)</td>
<td>100%</td>
</tr>
<tr>
<td>Prosthesis</td>
<td>100%</td>
</tr>
<tr>
<td>Wigs for cancer patients with hair loss resulting from chemotherapy and/or radiation therapy</td>
<td>100%</td>
</tr>
</tbody>
</table>

## Ambulance Services

<table>
<thead>
<tr>
<th>MEDICAL SERVICES</th>
<th>PARTICIPATING PROVIDER BENEFIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ground Ambulance</td>
<td>100%</td>
</tr>
<tr>
<td>Air Ambulance</td>
<td>100%</td>
</tr>
</tbody>
</table>

## Morbid Obesity Services

<table>
<thead>
<tr>
<th>MEDICAL SERVICES</th>
<th>PARTICIPATING PROVIDER BENEFIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morbid Obesity</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>
## TEMPOROMANDIBULAR JOINT DYSFUNCTION (TMJ)

<table>
<thead>
<tr>
<th>MEDICAL SERVICES</th>
<th>PARTICIPATING PROVIDER BENEFIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Temporomandibular Joint Dysfunction (TMJ) (Other than Splint/Appliances)</td>
<td>100%</td>
</tr>
<tr>
<td>Temporomandibular Joint Dysfunction (TMJ) Splint/Appliances</td>
<td>100%</td>
</tr>
</tbody>
</table>

## DENTAL INJURY SERVICES

<table>
<thead>
<tr>
<th>MEDICAL SERVICES</th>
<th>PARTICIPATING PROVIDER BENEFIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dental Injuries</td>
<td>Payable the same as any other <em>sickness</em>.</td>
</tr>
</tbody>
</table>

Please see the Medical Covered Expenses section, Dental Injury for benefit details.

## INFERTILITY SERVICES

<table>
<thead>
<tr>
<th>MEDICAL SERVICES</th>
<th>PARTICIPATING PROVIDER BENEFIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infertility Counseling and Treatment</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Artificial Means of Achieving Pregnancy</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Sexual Dysfunction/Impotence</td>
<td>Payable the same as any other <em>sickness</em>.</td>
</tr>
</tbody>
</table>
## THERAPY SERVICES

<table>
<thead>
<tr>
<th>MEDICAL SERVICES</th>
<th>PARTICIPATING PROVIDER BENEFIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Therapy copayments apply to therapy services, regardless of provider specialty (for example, if a Podiatrist is performing physical therapy, the physical therapy copayment will apply).</td>
<td></td>
</tr>
<tr>
<td>Chiropractic Examinations</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Chiropractic Laboratory and X-ray</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Chiropractic Manipulations</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Chiropractic Therapy</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Physical Therapy (Clinic and Outpatient)</td>
<td>100% after a $30 copayment</td>
</tr>
<tr>
<td>Occupational Therapy (Clinic and Outpatient)</td>
<td>100% after a $30 copayment</td>
</tr>
<tr>
<td>Speech Therapy (Clinic and Outpatient)</td>
<td>100% after a $30 copayment</td>
</tr>
<tr>
<td>Cognitive Therapy (Clinic and Outpatient)</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

If copayments apply to multiple therapy services, one copayment will apply per day per servicing provider.

<table>
<thead>
<tr>
<th>Acupuncture</th>
<th>Not Covered</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respiratory Therapy and Pulmonary Therapy (Clinic and Outpatient)</td>
<td>100% after a $30 copayment</td>
</tr>
<tr>
<td>Vision Therapy (eye exercises to strengthen the muscles of the eye)</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>
## THERAPY SERVICES

<table>
<thead>
<tr>
<th>MEDICAL SERVICES</th>
<th>PARTICIPATING PROVIDER BENEFIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chemotherapy (Clinic and Outpatient)</td>
<td>100% after a $30 copayment</td>
</tr>
<tr>
<td>Radiation Therapy (Clinic and Outpatient)</td>
<td>100% after a $30 copayment</td>
</tr>
<tr>
<td>Cardiac Rehabilitation (Phase II)</td>
<td>100% after a $30 copayment</td>
</tr>
<tr>
<td>Phase I is covered under the inpatient facility benefits.</td>
<td></td>
</tr>
<tr>
<td>Phase III, an unsupervised exercise program, is not covered.</td>
<td></td>
</tr>
</tbody>
</table>

## TRANSPLANT SERVICES

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

<table>
<thead>
<tr>
<th>MEDICAL SERVICES</th>
<th>HUMANA NATIONAL TRANSPLANT NETWORK (NTN) FACILITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organ Transplant Medical Services</td>
<td>Payable the same as any other sickness.</td>
</tr>
<tr>
<td>Non-Medical Services - Lodging</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Non-Medical Services - Transportation</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Organ Transplant Medical Services Limits</td>
<td>Plan year maximum benefit</td>
</tr>
</tbody>
</table>
BEHAVIORAL HEALTH INPATIENT SERVICES

<table>
<thead>
<tr>
<th>MEDICAL SERVICES</th>
<th>PARTICIPATING PROVIDER BENEFIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Behavioral Health Room and Board and Ancillary Services</td>
<td>Payable the same as medical inpatient hospital services.</td>
</tr>
<tr>
<td>Inpatient Behavioral Health Professional Services</td>
<td>Payable the same as medical inpatient qualified practitioner services.</td>
</tr>
<tr>
<td>Behavioral Health Partial Hospitalization</td>
<td>Payable the same as medical outpatient non-surgical hospital services.</td>
</tr>
<tr>
<td>Behavioral Health Residential Treatment Facility Services</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Behavioral Health Half-way House Services</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

The inpatient behavioral health copayment amounts will reduce the Plan out-of-pocket limits.
The inpatient behavioral health benefits will reduce the plan year maximum.

BEHAVIORAL HEALTH CLINIC, OUTPATIENT AND INTENSIVE OUTPATIENT SERVICES

<table>
<thead>
<tr>
<th>MEDICAL SERVICES</th>
<th>PARTICIPATING PROVIDER BENEFIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral Health Therapy Services (Clinic, Outpatient and Intensive Outpatient)</td>
<td>Payable the same as medical specialist office examination.</td>
</tr>
<tr>
<td>Diagnostic Examination (Clinic)</td>
<td>Payable the same as any other sickness.</td>
</tr>
</tbody>
</table>
### BEHAVIORAL HEALTH CLINIC, OUTPATIENT AND INTENSIVE OUTPATIENT SERVICES

<table>
<thead>
<tr>
<th>MEDICAL SERVICES</th>
<th>PARTICIPATING PROVIDER BENEFIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Laboratory and X-ray (Clinic and Outpatient)</td>
<td>Payable the same as any other sickness.</td>
</tr>
</tbody>
</table>

The clinic, outpatient and intensive outpatient behavioral health copayment amounts will reduce the Plan out-of-pocket limits.

The clinic, outpatient and intensive outpatient behavioral health benefits will reduce the plan year maximum.

### OTHER COVERED EXPENSES

<table>
<thead>
<tr>
<th>MEDICAL SERVICES</th>
<th>PARTICIPATING PROVIDER BENEFIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other Covered Expenses</td>
<td>Payable the same as any other sickness.</td>
</tr>
</tbody>
</table>
OUT-OF-POCKET LIMIT

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

Once a covered person satisfies the individual out-of-pocket limits, this Plan will pay 100% of covered expenses for the remainder of the calendar year for that covered person, unless specifically indicated, subject to any calendar year maximums and the plan year maximum of this Plan.

Once you and/or your covered dependents satisfy the family out-of-pocket limits, this Plan will pay 100% of covered expenses for the remainder of the calendar year for the family, unless specifically indicated, subject to any calendar year maximums and the plan year maximum of this Plan.

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

PLAN YEAR MAXIMUM BENEFIT

The plan year maximum means the maximum amount of benefits available while you are covered under this Plan. The plan year maximum benefit is stated on the Schedule of Benefits.

ROUTINE/PREVENTIVE CHILD CARE SERVICES

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

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

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

ROUTINE/PREVENTIVE ADULT CARE SERVICES

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

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

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

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

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

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

ROUTINE HEARING SERVICES

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

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

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

QUALIFIED PRACTITIONER SERVICES

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

Second Surgical Opinion

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

Multiple Surgical Procedures

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

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

No benefits will be payable for incidental procedures.

Assistant Surgeon

Assistant surgeon benefits are payable at 20% of the maximum allowable fee allowed for the primary surgeon.

Physician Assistant

Physician assistant benefits are payable at 20% of the maximum allowable fee allowed for the primary surgeon.
DENTAL/ORAL SURGERIES COVERED UNDER THE MEDICAL PLAN

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

1. Excision of partially or completely unerupted impacted teeth;
2. Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth when such conditions require pathological examination;
3. Surgical procedures required to correct accidental injuries of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
4. Reduction of fractures and dislocations of the jaw;
5. External incision and drainage of cellulitis;
6. Incision of accessory sinuses, salivary glands or ducts;
7. Frenectomy (the cutting of the tissue in the midline of the tongue);
8. Dental osteotomies.

FAMILY PLANNING

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

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

MATERNITY

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

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

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

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

Birthing Centers

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

INPATIENT HOSPITAL

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

SKILLED NURSING FACILITY

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

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

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

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

1. Permanent and full-time bed care facilities for resident patients;
2. A physician's services available at all times;
3. 24-hour-a-day skilled nursing services under the full-time supervision of a physician or registered nurse (R.N.);

4. A daily record for each patient;

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

6. A utilization review plan.

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

OUTPATIENT AND AMBULATORY SURGICAL CENTER

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

EMERGENCY AND URGENT CARE SERVICES

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

HOSPICE SERVICES

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

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

Covered expenses are payable for the following hospice services:

1. Room and board and other services and supplies;

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

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

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

5. Nutritional counseling;

6. Physical or occupational therapy;

7. Part-time home health aide service for up to 8 hours in any one day;
8. Medical supplies, drugs and medicines prescribed by a qualified practitioner.

Hospice care benefits do NOT include:

1. Private duty nursing services when confined in a hospice facility;
2. A confinement not required for pain control or other acute chronic symptom management;
3. Funeral arrangements;
4. Financial or legal counseling, including estate planning or drafting of a will;
5. Homemaker or caretaker services, including a sitter or companion services;
6. Housecleaning and household maintenance;
7. Services of a social worker other than a licensed clinical social worker;
8. Services by volunteers or persons who do not regularly charge for their services; or
9. Services by a licensed pastoral counselor to a member of his or her congregation when services are in the course of the duties to which he or she is called as a pastor or minister.

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

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

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

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

HOME HEALTH CARE

Expenses incurred for home health care are payable as shown on the Schedule of Benefits. The maximum weekly benefit for such coverage may not exceed the maximum allowable weekly cost for care in a skilled nursing facility.
Each visit by a home health care provider for evaluating the need for, developing a plan, or providing services under a home health care plan will be considered one home health care visit. Up to 4 consecutive hours of service in a 24-hour period is considered one home health care visit. A visit by a home health care provider of 4 hours or more is considered one visit for every 4 hours or part thereof.

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

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

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

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

The home health care plan consists of:

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

Home health care benefits do not include:

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

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

Prosthetics

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

AMBULANCE

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

TEMPOROMANDIBULAR JOINT DYSFUNCTION (TMJ)

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

DENTAL INJURY

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

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

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

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

THERAPY SERVICES

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

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

Precertification

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

Covered Organ Transplant

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

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

*The term bone marrow refers to the transplant of human blood precursor cells which are administered to a patient following high-dose, ablative or myelosuppressive chemotherapy. Such cells may be derived from bone marrow, circulating blood, or a combination of bone marrow and circulating blood obtained from the patient in an autologous transplant or from a matched related or unrelated donor or cord blood. If chemotherapy is an integral part of the treatment involving a transplant of bone marrow, the term bone marrow includes the harvesting, the transplantation and the chemotherapy components. Storage of cord blood and stem cells will not be covered unless as an integral part of a transplant of bone marrow approved by Humana.
Corneal transplants and porcine heart valve implants, which are tissues rather than organs, are considered part of regular plan benefits and are subject to other applicable provisions of this Plan.

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

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

Exclusions

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

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

Covered Services

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

1. Hospital and qualified practitioner services, payable as shown on the Schedule of Benefits. If services are rendered at a Humana National Transplant Network (NTN) facility, covered expenses are paid in accordance to the NTN contracted rates;
2. Organ acquisition and donor costs. Except for bone marrow transplants, donor costs are not payable under this Plan if they are payable in whole or in part by any other group plan, insurance company, organization or person other than the donor's family or estate. Coverage for bone marrow transplants procedures will include costs associated with the donor-patient to the same extent and limitations associated with the covered person.

BEHAVIORAL HEALTH SERVICES

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

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

Inpatient Services

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

Outpatient Services

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

Limitations

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

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

OTHER COVERED EXPENSES

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

1. Blood and blood plasma are payable as long as it is NOT replaced by donation, and administration of blood and blood products including blood extracts or derivatives;
2. Casts, trusses, crutches, orthotics, splints and braces. Orthotics must be custom made or custom fitted, made of rigid or semi-rigid material. Oral or dental splints and appliances must be custom made and for the treatment of documented obstructive sleep apnea. Unless specifically stated otherwise, fabric supports, replacement orthotics and braces, oral splints and appliances, dental splints and appliances, and dental braces are not a covered expense;
3. Reconstructive surgery due to bodily injury, infection or other disease of the involved part or congenital disease or anomaly of a covered dependent child which resulted in a functional impairment;

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

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

6. Professional fees associated with computer automated radiology and pathology services are processed under the primary lab and x-ray fees. This service is automated, with no manual intervention necessary. If a separate professional fee is billed, it is considered an eligible covered expense and will be covered.
LIMITATIONS AND EXCLUSIONS

This Plan does not provide benefits for:

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

2. Immunizations required for foreign travel;

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

4. **Services** related to gender change;

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

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

6. Hair prosthesis, hair transplants or hair implants;

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

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

9. Marriage counseling;

10. *Court-ordered mental health or substance abuse services*;
LIMITATIONS AND EXCLUSIONS (continued)

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

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

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

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

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

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

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

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

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

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

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

22. Any expense incurred for services received outside of the United States except for treatment that is medically necessary for injuries or illness, even if services are not performed at an emergency facility, and emergency care service;
23. Treatment of nicotine habit or addiction, including, but not limited to hypnosis, smoking cessation products, classes or tapes, unless otherwise determined by this Plan;

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

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

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

27. *Off-evidence drug indications*;

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

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

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

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

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

33. *Alternative medicine*;

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

35. *Services* of a midwife, unless provided by a Certified Nurse Midwife;
36. The following types of care of the feet:
   a. Shock wave therapy of the feet;
   b. The treatment of weak, strained, flat, unstable or unbalanced feet;
   c. Hygienic care, and the treatment of superficial lesions of the feet, such as corns, calluses or hyperkeratosis;
   d. The treatment of tarsalgia, metatarsalgia, or bunion, except surgically;
   e. The cutting of toenails, except the removal of the nail matrix;
   f. The provision of heel wedges, lifts or shoe inserts; and
   g. The provision of arch supports or orthopedic shoes, unless medically necessary because of diabetes or hammertoe;

37. Custodial care and maintenance care;

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

39. Hospital inpatient services when you are in observation status;

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

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

42. Preadmission/procedural testing duplicated during a hospital confinement;

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

44. Communications or travel time;

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

46. Any covered expenses to the extent of any amount received from others for the bodily injuries or losses which necessitate such benefits. Without limitation, "amounts received from others" specifically includes, but is not limited to, liability insurance, workers’ compensation, uninsured motorists, underinsured motorists, "no-fault" and automobile med-pay payments or recovery from any identifiable fund regardless of whether the beneficiary was made whole;
47. Any bodily injury or sickness arising from or sustained in the course of any occupation or employment for compensation, profit or gain for which:
   a. Benefits are provided or payable under any Workers' Compensation or Occupational Disease Act or Law, or
   b. Coverage was available under any Workers' Compensation or Occupational Disease Act or Law regardless of whether such coverage was actually purchased;

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

49. Surrogate parenting;

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

51. Vision therapy;

52. Routine hearing testing;

53. Hearing aids, the fitting or repair of hearing aids or advice on their care; implantable hearing devices except for cochlear implants and auditory brain stem implants as determined by this Plan;

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

55. Services for a reversal of sterilization;

56. Birth control pills and patches are not covered under the Medical Benefits, please refer to the Prescription Drug Benefit

57. Private duty nursing in an inpatient hospital;

58. Wigs, except for cancer patients with hair loss resulting from chemotherapy and/or radiation therapy;

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

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

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

63. Chiropractic services;

64. Acupuncture;

65. Half-way house services;

66. Residential treatment facilities;


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

BENEFITS SUBJECT TO THIS PROVISION

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

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

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

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

EFFECT ON BENEFITS

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

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

ORDER OF BENEFIT DETERMINATION

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

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

If a plan other than this Plan does not include provision 3, then the gender rule will be followed to determine which plan is primary.
4. In the case of dependent children covered under the plans of divorced or separated parents, the following rules apply:
   a. The plan of a parent who has custody will pay the benefits first;
   b. The plan of a step-parent who has custody will pay benefits next;
   c. The plan of a parent who does not have custody will pay benefits next;
   d. The plan of a step-parent who does not have custody will pay benefits next.

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

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

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

COORDINATION OF BENEFITS WITH MEDICARE

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

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

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

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

OPTIONS

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

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

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

Each covered employee and each covered spouse/domestic partner will be provided with the choice to elect one of these options at least one month before the covered employee or the covered spouse/domestic partner becomes age 65. All new covered employees and newly covered spouses/domestic partners age 65 or older will also be offered these options. If Option 1 is chosen, its issue is subject to the same requirements as for a covered employee or dependent who is under age 65.
Under Federal law, there are two categories of persons eligible for Medicare. The calculation and payments of benefits by this Plan differs for each category.

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

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

**CALCULATION AND PAYMENT OF BENEFITS**

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

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

**RIGHT OF RECOVERY**

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

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

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

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

SUBMITTING A CLAIM

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

- A claim must be filed with Humana in writing and delivered to Humana by mail, postage prepaid, or by e-mail. However, a submission to obtain pre-authorization may also be filed with Humana by telephone (for dental, only applies with respect to urgent care claims);

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

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

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

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

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

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

Mail medical and dental claims and correspondence to:

<table>
<thead>
<tr>
<th>Medical:</th>
<th>Dental:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Humana Claims Office</td>
<td>HumanaDental Claims Office</td>
</tr>
<tr>
<td>P.O. Box 14601</td>
<td>P.O. Box 14611</td>
</tr>
<tr>
<td>Lexington, KY 40512-4601</td>
<td>Lexington, KY 40512-4611</td>
</tr>
</tbody>
</table>
MISCELLANEOUS MEDICAL CHARGES

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

PROCEDURAL DEFECTS

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

ASSIGNMENTS AND REPRESENTATIVES

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

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

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

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

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

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

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

Pre-Service Claims

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

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

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

Urgent Care Claims

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

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

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

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

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

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

Post-Service Claims

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

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

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

TIMES FOR DECISIONS

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

PAYMENT OF CLAIMS

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

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

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

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

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

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

NOTICES – GENERAL INFORMATION FOR MEDICAL CLAIMS

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

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

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

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

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

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

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

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

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

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

APPEALS OF ADVERSE BENEFIT DETERMINATIONS

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

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

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

Dental:
Humana Dental Claims Office
P.O. Box 14638
Lexington, KY 40512-4638
Appeals of denied claims will be conducted promptly, will not defer to the initial determination, and will not be made by the person who made the initial adverse claim determination or a subordinate of that person. The determination will take into account all comments, documents, records, and other information submitted by the claimant relating to the claim.

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

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

Time Periods for Decisions on Appeal -- First Level

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

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

Time Periods for Decisions on Appeal -- Second Level

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

<table>
<thead>
<tr>
<th>Category</th>
<th>Time Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-Service Claims</td>
<td>Within a reasonable period, but not later than 15 days after Humana receives the appeal request.</td>
</tr>
<tr>
<td>Post-Service Claims</td>
<td>Within a reasonable period, but no later than 30 days after Humana receives the appeal request.</td>
</tr>
</tbody>
</table>

APPEAL DENIAL NOTICES

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

A notice that a claim appeal has been denied will convey the specific reason or reasons for the adverse benefit determination and the specific Plan provisions on which the determination is based.
The notice will also disclose any internal Plan rule, protocol or similar criterion that was relied on to deny the claim. A copy of the rule, protocol or similar criterion relied upon will be provided to a claimant free of charge upon request.

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

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

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

EXHAUSTION

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

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

LEGAL ACTIONS AND LIMITATIONS

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

Request for an External Review

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

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

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

Preliminary Review

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

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

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

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

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

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

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

2. If the request is not complete. The notice must describe the information or materials needed to make it complete, and Humana must allow the claimant to perfect the external review request within whichever of the following two options is later:
   a. The initial 4-month filing period; or
   b. The 48-hour period following receipt of the notification.
Referral to an Independent Review Organization (IRO)

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

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

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

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

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

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

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

f. Any applicable clinical review criteria developed and used by this Plan, unless inconsistent with the terms of this Plan or with applicable law; and

g. The opinion of the IRO's clinical reviewer(s) after considering the information described above to the extent the information or documents are available and the reviewer(s) consider them appropriate.

6. The assigned IRO must provide written notice of the final external review decision within 45 days after receiving the external review request to the claimant and Humana. The decision notice must contain the following:

a. A general description of the reason an external review was requested, including information sufficient to identify the claim including:
   (1) The date(s) of service;
   (2) The health care provider;
   (3) The claim amount (if applicable); and
   (4) The reason for the previous denial.

b. The date the IRO received assignment to conduct the external review and the date of the IRO decision;

c. References to the evidence or documentation considered in reaching the decision, including the specific coverage provisions and evidence-based standards;

d. A discussion of the principal reason(s) for its decision, including the rationale and any evidence-based standards relied on in making the decision;

e. A statement that the determination is binding except to the extent that other remedies may be available under state or federal law to either Humana or the claimant;

f. A statement that judicial review may be available to the claimant; and

g. Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under PPACA (section 2793 of PHSA, as amended).

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

Reversal of this Plan's Decision

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

EXPEDITED EXTERNAL REVIEW FOR MEDICAL CLAIMS

Request for an Expedited External Review

Expedited external reviews are subject to a single level appeal process only.
Humana must allow a claimant to make a request for an expedited external review at the time the claimant receives:

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

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

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

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

Preliminary Review

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

Referral to an Independent Review Organization (IRO)

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

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

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

IF YOU HAVE QUESTIONS

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

STATE CONSUMER ASSISTANCE OR OMBUDSMAN

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

Illinois Department of Insurance
100 W. Randolph St, 9th Floor
Chicago, IL 60601
(877) 527-9431, or

Illinois Department of Insurance
320 W. Washington St, 4th Floor
Springfield, IL 62767
http://www.insurance.illinois.gov
DOL.Director@illinois.gov
SECTION 3

ELIGIBILITY AND EFFECTIVE DATE OF COVERAGE
OPEN ENROLLMENT

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

DUAL CHOICE

During the Open Enrollment Period, you will have the choice of enrolling for group health coverage under one of the administrators/networks offered by your employer. You will be notified in advance when the Open Enrollment Period is to begin and how long it will last.

EMPLOYEE ELIGIBILITY

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

1. You are an employee who meets the eligibility requirements of the employer; and
2. You are in active status.

Your eligibility date is your date of hire.

EMPLOYEE EFFECTIVE DATE OF COVERAGE

You must enroll in a manner acceptable to Humana.

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

EMPLOYEE DELAYED EFFECTIVE DATE

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

DEPENDENT ELIGIBILITY

Each dependent is eligible for coverage on:

1. The date the employee is eligible for coverage, if he or she has dependents who may be covered on that date; or
2. The date of the employee's marriage or domestic partnership for any dependent acquired on that date; or
3. The date of birth of the employee's natural-born child; or
4. The date a child is placed for adoption under the employee's legal guardianship, or the date which the employee incurs a legal obligation for total or partial support in anticipation of adoption; or

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

CREDITABLE COVERAGE

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

SPECIAL PROVISIONS FOR NOT BEING IN ACTIVE STATUS

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

REINSTATEMENT OF COVERAGE FOLLOWING INACTIVE STATUS

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

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

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

RETIREE COVERAGE

If you are at least 55 years old with 10 years or more of service, you may continue coverage under this Plan for you and any of your eligible dependents with the approval of your employer’s President.

If you are a retiree at least 62 years old with 10 years or more of service, you may continue coverage under this Plan for you and any of your eligible dependents provided such coverage was effective at the time of your retirement. Dependents acquired through marriage after your retirement are not eligible for coverage. Please see your employer for more details.

SURVIVORSHIP COVERAGE

If coverage under the Plan would otherwise terminate with respect to a spouse/domestic partner age fifty-five (55) or over of a deceased employee with ten (10) years or more of service with the employer, benefits will continue to be provided for that spouse/domestic partner until the earliest of the following and would include dependent children of the eligible spouse/domestic partner, provided dependent coverage is in place at the time of the employee’s death:

• The date the spouse/domestic partner attains age sixty-five (65);
• The date the spouse/domestic partner becomes eligible for Medicare, except if the surviving spouse/domestic partner is eligible for Medicare on or before the date of the employee’s death, the surviving spouse/domestic partner may continue coverage up to three (3) years from the employee’s death;
• The date the spouse/domestic partner remarries;
• The date the covered spouse/domestic partner has failed to make a contribution required for coverage; or
• The date that other group or individual health coverage is obtained.

Dependent children will be eligible for COBRA continuation coverage upon the happening of an event described in the above.

SPECIAL ENROLLMENT

If you previously declined coverage under this Plan for yourself or any eligible dependents, due to the existence of other health coverage (including COBRA), and that coverage is now lost, this Plan permits you, your dependent spouse/domestic partner, and any eligible dependents to be enrolled for medical or dental benefits under this Plan due to any of the following qualifying events:
1. Loss of eligibility for the coverage due to any of the following:
   a. Legal separation;
   b. Divorce or termination of domestic partnership;
   c. Cessation of dependent status (such as attaining the limiting age);
   d. Death;
   e. Termination of employment;
   f. Reduction in the number of hours of employment;
   g. Meeting or exceeding a lifetime limit on all benefits;
   h. Plan no longer offering benefits to a class of similarly situated individuals, which includes the employee;
   i. Any loss of eligibility after a period that is measured by reference to any of the foregoing.

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

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

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

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

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

1. Marriage;
2. Birth;
3. Adoption or placement for adoption;
4. Loss of eligibility due to termination of Medicaid or State Children’s Health Insurance Program (SCHIP) coverage; or
5. Eligibility for premium assistance subsidy under Medicaid or SCHIP.

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

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

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

Please see your employer for more details.
TERMINATION OF COVERAGE

Coverage terminates on the earliest of the following:

1. The date this Plan terminates;
2. The end of the period for which any required contribution was due and not paid;
3. The date you enter full-time military, naval or air service, except coverage may continue during an approved military leave of absence as indicated in the Special Provisions For Not Being in Active Status provision;
4. The date you fail to be in an eligible class of persons according to the eligibility requirements of the employer;
5. For all employees, immediately following termination of employment with your employer;
6. For all employees immediately following your retirement unless you qualify for retirement health benefits;
7. The date you request termination of coverage to be effective for yourself;
8. For any benefit, the date the benefit is removed from this Plan;
9. For your dependents, the date your coverage terminates;
10. For a dependent child, the birthday such covered person no longer meets the definition of dependent.

If you or any of your covered dependents no longer meet the eligibility requirements, you and your employer are responsible for notifying Humana of the change in status. Coverage will not continue beyond the last date of eligibility even if notice has not been given to Humana.
SECTION 4
GENERAL PROVISIONS AND REIMBURSEMENT/ SUBROGATION
The following provisions are to protect your legal rights and the legal rights of this Plan.

**PLAN ADMINISTRATION**

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

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

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

**RESCISSION FOR MEDICAL ONLY**

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

**CONTESTABILITY**

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

**RIGHT TO REQUEST OVERPAYMENTS**

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

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

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

**WORKERS' COMPENSATION NOT AFFECTED**

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

**WORKERS' COMPENSATION**

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

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

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

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

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

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

MEDICAID

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

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

CONSTRUCTION OF PLAN TERMS

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

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

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

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

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

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

RIGHT TO COLLECT NEEDED INFORMATION

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

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

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

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

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

- Providing information Humana requests to administer this Plan.

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

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

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

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

Failure of the covered person to provide Humana such notice or cooperation, or any action by the covered person resulting in prejudice to this Plan’s rights will be a material breach of this Plan and will result in the covered person being personally responsible to make repayment. In such an event, this Plan may deduct from any pending or subsequent claim made under this Plan any amounts the covered person owes this Plan until such time as cooperation is provided and the prejudice ceases.
SECTION 5

NOTICES
IMPORTANT NOTICES FOR EMPLOYEES AND SPOUSES AGE 65 AND OVER

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

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

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

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

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

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

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

If you have any questions about how coverage under this Plan relates to Medicare coverage, please contact your employer.
This Plan is required by law to maintain the privacy of your protected health information in all forms including written, oral and electronically maintained, stored and transmitted information and to provide individuals with notice of this Plan’s legal duties and privacy practices with respect to protected health information.

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

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

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

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

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

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

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

Individuals who have access to protected health information in connection with their performance of Plan-related functions under the auspices of the Plan Administrator will be trained in these privacy policies and relevant procedures prior to being granted any access to protected health information. Humana and other Plan service providers will be required to safeguard protected health information against improper disclosure through contractual arrangements.
In addition, you should know that the employer/Plan Sponsor may legally have access, on an as-needed basis, to limited health information for the purpose of determining Plan costs, contributions, Plan design, and whether Plan modifications are warranted. In addition, federal regulators such as the Department of Health and Human Services and the Department of Labor may legally require access to protected health information to police federal legal requirements about privacy.

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

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

THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1986 (COBRA)

CONTINUATION OF BENEFITS

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

ELIGIBILITY

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

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

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

SPOUSE OR DOMESTIC PARTNER: A spouse, or domestic partner covered by the employer's Plan has the right to elect continuation coverage if the group coverage is lost due to one of the following qualifying events:

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

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

- The death of the employee parent;
- The termination of the employee parent's employment (for reasons other than gross misconduct, as defined by your employer) or reduction in the employee parent's hours of employment with the employer;
CONTINUATION OF MEDICAL AND DENTAL BENEFITS (continued)

- The employee parent's divorce or legal separation;
- The employee parent's terminate domestic partnership;
- Ceasing to be a "dependent child" under this Plan;
- The employee parent enrolls in Medicare; or
- Termination of the retiree parent's coverage when the former employer discontinues retiree coverage within one year before or one year after filing for Chapter 11 bankruptcy.

LOSS OF COVERAGE

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

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

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

NOTICES AND ELECTION

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

For a qualified beneficiary who is determined under the Social Security Act to be disabled at any time during the first 60 days of COBRA coverage, the continuation coverage period may be extended 11 additional months. The disability that extends the 18-month coverage period must be determined under Title II (Old Age, Survivors, and Disability Insurance) or Title XVI (Supplemental Security Income) of the Social Security Act. To be entitled to the extended coverage period, the disabled qualified beneficiary must provide notice to the COBRA Service Provider and Plan Administrator within the initial 18 month coverage period and within 60 days after the date of the determination of disability under the Social Security Act. Failure to provide this notice will result in the loss of the right to extend the COBRA continuation period.
For termination of employment, reduction in work hours, the death of the employee, the employee becoming covered by Medicare or loss of retiree benefits due to bankruptcy, it is the Plan Administrator's responsibility to notify the COBRA Service Provider, who will in turn notify the qualified beneficiary of the right to elect continuation coverage.

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

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

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

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

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

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

**MAXIMUM COVERAGE PERIOD**

Coverage may continue up to:

- 18 months for an employee and/or dependent whose group coverage ended due to termination of the employee's employment or reduction in hours of employment;
CONTINUATION OF MEDICAL AND DENTAL BENEFITS (continued)

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

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

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

DISABILITY

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

SECOND QUALIFYING EVENT

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

TERMINATION BEFORE THE END OF MAXIMUM COVERAGE PERIOD

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

- The employer no longer provides group health coverage to any of its employees;

- The premium for continuation is not paid timely;

- The individual on continuation becomes covered under another group health plan (as an employee or otherwise); however, if the new plan coverage contains any exclusion or limitation with respect to any pre-existing condition, then continuation coverage will end for this reason only after the exclusion or limitation no longer applies or prior creditable coverage satisfies the exclusion or limitation;
NOTE: The federal Health Insurance Portability and Accountability Act of 1996 requires portability of health care coverage effective for plan years beginning after June 30, 1997, an exclusion or limitation under the other group health plan may not apply at all to the qualified beneficiary, depending on the length of his or her prior creditable coverage. Portability means once you obtain health insurance, you will be able to use evidence of that insurance to reduce or eliminate any pre-existing medical condition limitation period (under certain circumstances) when you move from one health plan to another.

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

**TYPE OF COVERAGE; PREMIUM PAYMENT**

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

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

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

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

**OTHER INFORMATION**

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

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

Benefit Planning Consultants, Inc.
2110 Clearlake Blvd, Ste 200 P.O. Box 7500
Champaign, IL 61826-7500
Telephone: 1-217-355-2300

Bradley University
1501 West Bradley Avenue
Peoria, IL 61625
Telephone: 1-309-677-3223

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

HumanaDental Insurance Company
P.O. Box 14209
Lexington, KY 40512-4209
Toll-Free: 1-800-232-2006
THE UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994 (USERRA)

CONTINUATION OF BENEFITS

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

ELIGIBILITY

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

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

PREMIUM PAYMENT

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

DURATION OF COVERAGE

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

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

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

OTHER INFORMATION

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

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

RECEIVE INFORMATION ABOUT YOUR PLAN AND BENEFITS

1. Examine, without charge, at the Plan Administrator’s office and at other specified locations all documents governing this Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by this Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

2. Obtain, upon written request from the Plan Administrator, copies of documents governing the operation of this Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Master Plan Description. The administrator may make a reasonable charge for copies.

3. Receive a summary of this Plan’s annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

CONTINUE GROUP HEALTH PLAN COVERAGE

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

2. Reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health Plan, if you have creditable coverage from another Plan. You should be provided a certificate of creditable coverage, free of charge, from your group Plan or insurance issuer when:

   - You lose coverage under this Plan;
   - You become entitled to elect COBRA continuation coverage;
   - Your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage.

   Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late applicants) after your enrollment date.

PRUDENT ACTIONS OF PLAN FIDUCIARIES

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

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

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

ASSISTANCE WITH QUESTIONS

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory (or 1-866-444-3272), or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration or visiting the U.S. Department of Labor website at http://www.dol.gov/ebsa.
THE WOMEN’S HEALTH AND CANCER RIGHTS ACT OF 1998 (WHCRA)

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

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

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

THE NEWBORNS’ AND MOTHERS’ HEALTH PROTECTION ACT OF 1996

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

Contact your employer if you would like more information on The Newborns’ and Mothers’ Health Protection Act.
1. **Proper Name of Plan:** Bradley University EPO Employee Health Benefit Plan

2. **Plan Sponsor:** Bradley University  
   1501 West Bradley Avenue  
   Peoria, IL 61625  
   Telephone: 1-309-677-3223

3. **Employer:** Bradley University  
   1501 West Bradley Avenue  
   Peoria, IL 61625  
   Telephone: 1-309-677-3223

   **Common Name of Employer:** Bradley University

4. **Plan Administrator, Named Fiduciary and Claim Fiduciary**  
   Bradley University  
   1501 West Bradley Avenue  
   Peoria, IL 61625  
   Telephone: 1-309-677-3223

5. **Employer Identification Number:** 37-0661494  
   The Plan number assigned for government reporting purposes is 503.

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

7. Plan benefits described in this booklet are effective October 1, 2011.

8. The **Plan year** is October 1 through September 30 of each year.

9. The fiscal year is June 1 through May 31 of each year.

10. Service of legal process may be served upon the **Plan Administrator** as shown above or the following agent for service of legal process:  
    Bradley University Human Resources Dept  
    1501 West Bradley Avenue  
    Peoria, IL 61625

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

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

   **Dental:**  
   HumanaDental Insurance Company  
   1100 Employers Boulevard  
   Green Bay, WI 54344  
   Telephone: (920) 336-1100  
   Toll-Free: 1-800-233-4013
12. This is a self-insured and self-administered health benefit plan. The cost of this Plan is paid with contributions shared by the employer and employee. Benefits under this Plan are provided from the general assets of the employer and are used to fund payment of covered claims under this Plan plus administrative expenses. Please see your employer for the method of calculating contributions and the funding mechanism used for the accumulation of assets through which benefits are provided under this Plan.

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

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

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

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

17. This Plan is not in lieu of and does not affect any requirement for coverage by Workers' Compensation insurance.
SECTION 6
DEFINITIONS
DEFINITIONS

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

A

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

Active status means the employee is performing on a regular, full-time basis all customary occupational duties for 30 hours per week, at the employer's business locations or when required to travel for the employer's business purposes. Each day of a regular paid vacation and any regular non-working holiday will be deemed active status if you were in an active status on your last regular working day prior to the vacation or holiday.

Admission means entry into a facility as a registered bed patient according to the rules and regulations of that facility. An 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, means Magnetic Resonance Imaging (MRI), Magnetic Resonance Angiography (MRA), Positron Emission Tomography (PET), Single Photon Emission Computed Tomography (SPECT) and Computed Tomography (CT) imaging.

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

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

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

1. The cancellation or discontinuance of coverage has only a prospective effect; or
2. The cancellation or discontinuance of coverage is effective retroactively, to the extent it is attributable to a failure to timely pay premium or costs of coverage.
Alternative medicine means an approach to medical diagnosis, treatment or therapy that has been developed or practiced NOT using the generally accepted scientific methods in the United States of America. For purposes of this definition, alternative medicine shall include, but is not limited to: acupressure, aromatherapy, ayurveda, biofeedback, faith healing, guided mental imagery, herbal medicine, holistic medicine, homeopathy, hypnosis, macrobiotics, naturopathy, ozone therapy, reflexotherapy, relaxation response, rolfing, shiatsu and yoga.

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

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

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

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

B

Behavioral health means mental health services and substance abuse services.

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

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

C

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

Claimant means a covered person (or authorized representative) who files a claim.
**COBRA Service Provider** means a provider of COBRA administrative services retained by Humana or the employer to provide specific COBRA administrative services.

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

**Complications of pregnancy** means:

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

2. A nonelective cesarean section surgical procedure;

3. Terminated ectopic pregnancy; or

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

**Complications of pregnancy** does not mean:

1. False labor;

2. Occasional spotting;

3. Prescribed rest during the period of pregnancy;

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

5. An elective cesarean section.

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

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

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

**Copayment**, if applicable, means the specified dollar amount that you must pay to a provider for certain medical covered expenses regardless of any amounts that may be paid by this Plan as shown in the Schedule of Benefits section.
Cosmetic dentistry means those services provided by dentists solely for the purpose of improving the appearance when form and function are satisfactory and no pathologic conditions exist.

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

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

Covered expense (dental) means the charge for a dentally necessary covered service incurred by you or your covered dependent(s).

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

Covered person means the employee or any of the employee’s covered dependents enrolled for benefits provided under this Plan and is a resident of the United States of America.

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

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

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

Dentally necessary or dental necessity means the extent of care and treatment which is the generally accepted, proven and established practice by most dentists with similar experience and training where the service is provided. To determine dental necessity, Humana may require preoperative dental x-rays and any other pertinent information to help determine if benefits are payable for the service submitted for consideration.

Dentist means an individual who is duly licensed to practice dentistry or perform oral surgery in the state where the dental service is performed and is operating within the scope of that license.

Dependent means a covered employee’s:

1. Legally recognized spouse of the opposite gender and residing in the United States;
2. Domestic partner; domestic partners are individuals of the same gender, who live together in a long-term relationship of 6 months or longer, with an exclusive mutual commitment in which the partners agree to be jointly responsible for each other's common welfare and share financial obligations. The partners may not be related by blood to a degree of closeness which would prohibit legal marriage in the state in which they legally reside;

3. Natural blood related child, step-child, legally adopted child or child placed with the employee for adoption, child for whom the employee has legal guardianship, and children of a domestic partner whose age is less than the limiting age.

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

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

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

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

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

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

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

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


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

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

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

**Emergency** (dental) means the necessary procedures for treatment of pain and/or injury. *Services* include *emergency* procedures for treatment to the teeth and supporting structures.

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

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

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

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

**Expense incurred** (dental) means the actual fee charged for an incurred expense by a *covered person*.

**Expense incurred date** means the date on which:

1. The teeth are prepared for fixed bridges, crowns, inlays, or onlays;
2. The final impression is made for dentures or partials;
3. The pulp chamber of a tooth is opened for root canal therapy;
4. Periodontal surgery is performed;
5. The *service* is performed for *covered expenses* not listed under one (1), two (2), three (3), or four (4) above.
**Experimental, investigational or for research purposes** means a drug, biological product, device, treatment or procedure that meets any one of the following criteria, as determined by this Plan:

1. Cannot be lawfully marketed without the final approval of the United States Food and Drug Administration (FDA) and which lacks such final FDA approval for the use or proposed use, unless:
   a. Found to be accepted for that use in the most recently published edition of Clinical Pharmacology, Micromedex DrugDex, National Comprehensive Cancer Network Drugs and Biologics Compendium, and the American Hospital Formulary Service (AHFS) Drug Information for drugs used to treat cancer, and is determined to be covered by this Plan (for additional details, go to www.humana.com, click on “Humana Websites for Providers” along the left hand side of the page, then click “Medical Coverage Policies” under Critical Topics, then click “Medical Coverage Policies” and search for Clinical Trials and Off-Label and Off-Evidence); or

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

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

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

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

   Is the subject of a National Institute of Health (NIH) Phase I, II or III trial or a treatment protocol comparable to a NIH Phase I, II or III trial, or any trial not recognized by NIH regardless of phase, except for:
   a. Clinical trials approved by this Plan (for additional details, go to www.humana.com, click on “Humana Websites for Providers” along the left hand side of the page, then click “Medical Coverage Policies” under Critical Topics, then click “Medical Coverage Policies” and search for Clinical Trials and Off-Label and Off-Evidence); or

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

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

**External review (for Medical)** means a review of an adverse benefit determination (including a final
DEFINITIONS (continued)

*internal adverse benefit determination*) conducted pursuant to the federal *external review* process or an applicable state *external review* process.

**F**

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

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

*Final internal adverse benefit determination* means an *adverse benefit determination* that has been upheld by this Plan at the completion of the *internal appeals* process.

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

**H**

*Hospital* means an institution which:

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

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

**I**

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

*Intensive outpatient* means outpatient *services* providing:
1. Group therapeutic sessions greater than one hour a day, three days a week;

2. *Behavioral health* therapeutic focus;

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

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

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

*Intensive outpatient program* does not include services that are for:

1. *Custodial care*; or

2. Day care.

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

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

**Master Plan Description (MPD)** means this document which outlines the benefits, provisions and limitations of this Plan.

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

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

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

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

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

5. The fee based upon the provider’s cost for providing the same or similar *services* as reported by such provider in its most recent publicly available *Medicare* cost report submitted to the Centers for Medicare and Medicaid Services (CMS) annually; or
6. The fee based on a percentage determined by this Plan of the fee Medicare allows for the same or similar services provided in the same geographic area.

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

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

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

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

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

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

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

1. 40 kilograms or greater per meter squared (kg/m²); or
2. 35 kilograms or greater per meter squared (kg/m²) 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.
Non-participating (Non-PAR) provider means a hospital, qualified treatment facility, qualified practitioner or any other health services provider who has not entered into an agreement with Humana to provide participating provider services or has not been designated by Humana as a participating provider.

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

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

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

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

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

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

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

Licensed drug abuse rehabilitation programs and alcohol rehabilitation programs accredited by the Joint Commission on the Accreditation of Health Care Organizations or approved by the appropriate state agency are also considered to be partial hospitalization services.
**Partial hospitalization** does not include services that are for custodial care or day care.

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

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

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

**Plan Administrator** means Bradley University.

**Plan Manager** means Humana Health Plan, Inc. and HumanaDental Insurance Company (HDIC), collectively “Humana”. The Plan Manager provides services to the Plan Administrator, as defined under the Plan Management Agreement. The Plan Manager is not the Plan Administrator or the Plan Sponsor.

**Plan Sponsor** means Bradley University.

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

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

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

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

**Predetermination of benefits** (dental) means a review by Humana of a dentist's planned treatment and expected charges, including diagnostic charges, prior to the rendering of services.

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

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

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

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

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

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

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

**Residential treatment facility** means an institution which:

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

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

**Retiree** means employees who retire from Bradley University and who qualify to participate in a retiree plan as determined by the employer.

**Services** means procedures, surgeries, examinations, consultations, advice, diagnosis, referrals, treatment, tests, supplies, drugs, devices or technologies.
**Sickness** means a disturbance in function or structure of your body which causes physical signs or symptoms and which, if left untreated, will result in a deterioration of the health state of the structure or system(s) of your body.

**Sound natural tooth** means a tooth that:

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

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

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

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

**Total disability or totally disabled** means:

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

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

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

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

*Utilization review* means the process of assessing the *medical necessity*, appropriateness, or utility of *hospital admissions*, surgical procedures, outpatient care, and other health care *services*. *Utilization review* includes *preciertification* and *concurrent review*.

**Y**

*You and your* means *you* as the *employee* and any of *your* covered *dependents*, unless otherwise indicated.
SECTION 7

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

**DEFINITIONS**

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

*Brand name medication* means a drug, medicine or medication that is manufactured and distributed by only one pharmaceutical manufacturer, or any drug product that has been designated as brand name by an industry-recognized source used by Humana.

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

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

*Drug list* means a list of prescription drugs, medicines, medications and supplies specified by Humana. This list identifies drugs as Level 1, Level 2, or Level 3 and indicates applicable dispensing limits and/or any prior authorization requirements. This list is subject to change without notice. Drugs may move between levels and may be subject to specific time constraints. There may be times when a level contains no drugs at all or a drug may be subject to multiple levels.

*Generic medication* means a drug, medicine or medication that is manufactured, distributed, and available from a pharmaceutical manufacturer and identified by the chemical name, or any drug product that has been designated as generic by an industry-recognized source used by Humana.

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

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

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

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

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

*Non-participating pharmacy* means a pharmacy that has NOT entered into an agreement with Humana or has NOT been designated by Humana to provide services to covered persons.

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

**Orphan drug** means a drug or biological used for the diagnosis, treatment, or prevention of rare diseases or conditions, which:

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

**Participating pharmacy** means a pharmacy that has entered into an agreement with or has been designated by Humana to provide services to covered persons.

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

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

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

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

**Prior authorization**, if applicable, means the required prior approval from Humana for the coverage of prescription drugs, medicines and medications, including the dosage, quantity and duration, as appropriate for the covered person’s diagnosis, age and sex. Certain prescription drugs, medicines or medications may require prior authorization.

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

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

1. Require nursing services or special programs to support patient compliance;
2. Require disease-specific treatment programs;
3. Have limited distribution requirements; or
4. Have special handling, storage or shipping requirements.

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

**Step therapy** means a process that encourages utilization of selected medications for selected diagnoses before other medications are used due to safety and medical appropriateness.

**SCHEDULE OF PRESCRIPTION DRUG BENEFITS**

Additional drug information can be obtained by accessing Humana’s website at www.humana.com.

You are responsible for the following:

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<th>RETAIL AND SPECIALTY PHARMACY*</th>
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<td><strong>Level 1 Drugs</strong></td>
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<td><strong>Level 2 Drugs</strong></td>
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<td><strong>Level 3 Drugs</strong></td>
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Some retail and **specialty pharmacies** participate in a program which allows you to receive a 90 day supply of a **prescription** or refill. Your cost is two (2) times the applicable retail and **specialty pharmacy** copayments as outlined above. **Self-administered injectable drugs** and **specialty drugs** are limited to a 30 day supply from a retail or **specialty pharmacy**.
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**MAIL ORDER PHARMACY**

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SPECIALTY DRUGS ADMINISTERED IN A QUALIFIED PRACTITIONER’S OFFICE*

| Up to a 30 day supply of a prescription or refill for a specialty drug administered in a qualified practitioner’s office | $0 copayment |

*Specialty drugs do not include self-administered injectable drugs.

*Diabetic supplies (blood glucose monitors, test strips, lancets, lancet devices, insulin syringes, alcohol pads, B-D Pens and Novo Pens) have a $0 copayment.

*Pneumonia/Flu Vaccines have a $0 copayment.

$0 copayment on H1N1 vaccine administration fee.

Pre-packaged, extended-supply hormonal products are available at 1 copayment per package (applicable tier copayment) (examples: Seasonale, Seasonique, Fermring).

Medications obtained during foreign travel due to sickness occurring during travel are allowed at the same member copayment as the in-network benefit.

ADDITIONAL PRESCRIPTION DRUG BENEFIT INFORMATION

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

Participating Pharmacy

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

Non-participating Pharmacy

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

If you were required to purchase prescription medications during foreign travel due to sickness which occurred during travel, you may submit your receipts in for reimbursement.

Mail pharmacy receipts to:

Humana Claims Office
Attention: Pharmacy Department
P.O. Box 14601
Lexington, KY 40512-4610

PRIOR AUTHORIZATION

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

STEP THERAPY

Some prescription drugs may be subject to the step therapy process. Call the toll-free customer service phone number on the back of your ID card or visit Humana’s website at www.humana.com for more information.

DISPENSING LIMITS

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

RETAIL AND SPECIALTY PHARMACY

Your Plan provisions include a retail prescription drug benefit. You will receive an identification (ID) card which includes your name, group number and your effective date.

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

MAIL ORDER PHARMACY

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

Mail order pharmacy prescriptions will only be filled with the quantity prescribed by your qualified practitioner and are limited to the day supply per prescription or refill as shown on the Schedule of Prescription Drug Benefits.
Additional mail order pharmacy information can be obtained by calling the toll-free customer service phone number on the back of your ID card or visit Humana’s website at www.humana.com.

SPECIALTY DRUGS ADMINISTERED IN A QUALIFIED PRACTITIONER’S OFFICE

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

MAXIMIZE YOUR BENEFIT

This program provides you with information through letters, phone calls or email regarding possible lower-cost, but equally effective medication alternatives for you to discuss with your doctor.

PRESCRIPTION DRUG COST SHARING

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

You are responsible for payment of:

- The copayment;
- The cost of medication not covered under this Prescription Drug Benefit Plan;
- The cost of any quantity of medication dispensed in excess of the day supply noted on the Schedule of Prescription Drug Benefits.

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

PRESCRIPTION DRUG COVERAGE

Because Humana’s drug list is continually updated with prescription drugs approved or not approved for coverage, you must call the toll-free customer service phone number on the back of your ID card or visit Humana’s website at www.humana.com to verify whether a prescription drug is covered or not covered under this Prescription Drug Benefit Plan.

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

1. Go to Humana's website (www.humana.com) and log-in as a Registered Member;
2. Click on the "Doctors & RX" drop down box located at the top of the page;
3. Click "Pharmacy Tools";
4. Click "Prescription Benefits" to get details about the prescription drug benefits under your Plan, including specific out-of-pocket costs; OR

5. Click "Printable Drug Lists and Forms" to view or download your drug list; OR

6. Click "Drug Pricing" and search for a drug by name, health condition or alphabetically to receive an estimated retail or mail order pharmacy drug price.

Covered prescription drugs, medicine or medications must:

1. Be prescribed by a qualified practitioner for the treatment of a sickness or bodily injury; and

2. Be dispensed by a pharmacist.

Prescription drug expenses covered under this Prescription Drug Benefit are not covered under any other provisions of the Plan. Any amount in excess of the maximum amount provided under the Prescription Drug Benefit is not covered under any other provision of the Plan.

Any expenses incurred under provisions of this Prescription Drug Benefit section are not covered under, or applied to, any medical benefits or maximums. Any expenses incurred under your medical benefits are not covered under, or applied to, any prescription drug benefits or maximums.

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

PRESCRIPTION DRUG LIMITATIONS

Expense incurred will not be payable for the following:

1. Any drug, medicine, medication or supply not approved for coverage under this Prescription Drug Benefit Plan (call the toll-free customer service phone number on the back of your ID card or visit Humana’s website at www.humana.com to verify whether a prescription drug is covered or not covered under this Prescription Drug Benefit Plan);

2. Legend drugs which are not deemed medically necessary by a qualified practitioner;

3. Charges for the administration or injection of any drug;

4. Any drug, medicine or medication labeled “Caution-limited by federal law to investigational use,” or any drug, medicine or medication that is experimental, investigational or for research purposes, even though a charge is made to you;

5. Any drug, medicine or medication that is consumed or injected at the place where the prescription is given, or dispensed by the qualified practitioner;
6. *Prescriptions* that are to be taken by or administered to the *covered person*, in whole or in part, while he or she is a patient in a facility where drugs are ordinarily provided by the facility on an inpatient basis. Inpatient facilities include, but are not limited to:
   a. *Hospital*;
   b. Skilled nursing facility; or
   c. Hospice facility;

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

8. *Off-evidence drug indications*;

9. *Prescription* refills:
   a. In excess of the number specified by the *qualified practitioner*; or
   b. Dispensed more than one year from the date of the original order;

10. Any drug for which a charge is customarily not made;

11. Therapeutic devices or appliances, including, but not limited to: hypodermic needles and syringes (except needles and syringes for use with insulin and covered *self-administered injectable drugs*); support garments; test reagents; mechanical pumps for delivery of medications; and other non-medical substances;

12. Dietary supplements (except for formulas or low protein modified foods necessary for the treatment of phenylketonuria or certain other heritable diseases of amino and organic acids); nutritional products; fluoride supplements; minerals; herbs; and vitamins (except pre-natal vitamins, including greater than one milligram of folic acid, and pediatric multi-vitamins with fluoride);

13. Drug delivery implants;

14. Injectable drugs, including but not limited to: immunizing agents; biological sera; blood; blood plasma; or *self-administered injectable drugs* not covered under this Prescription Drug Benefit Plan;

15. Any drug prescribed for a *sickness* or *bodily injury* not covered under this Plan;

16. Any portion of a *prescription* or refill that exceeds the day supply as shown on the Schedule of Prescription Drug Benefits;

17. Any drug, medicine or medication received by the *covered person*:
   a. Before becoming covered under this Plan; or
   b. After the date the *covered person*’s coverage under this Plan has ended;

18. Any costs related to the mailing, sending, or delivery of *prescription* drugs;
19. Any intentional misuse of this benefit including prescriptions purchased for consumption by someone other than the covered person;

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

21. Repackaged drugs;

22. Any drug or medicine that is:
   a. Lawfully obtainable without a prescription (over the counter drugs), except insulin; or
   b. Available in prescription strength without a prescription;

23. Any drug or biological that has received designation as an orphan drug, unless approved by this Plan;

24. 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;

25. Any portion of a prescription or refill that exceeds the drug specific dispensing limit, is dispensed to a covered person whose age is outside the drug specific age limits, or exceeds the duration-specific dispensing limit, if applicable;

26. Any drug for which prior authorization is required and not obtained, if applicable;

27. More than one prescription or refill within a 23-day period for the same drug or therapeutic equivalent medication prescribed by one or more qualified practitioners and dispensed by one or more pharmacies. For drugs received from a mail order pharmacy, more than one prescription or refill within a 20 day period for a 1-30 day supply or a 60 day period for a 61-90 day supply. For drugs received from a retail or specialty pharmacy that participates in the program which allows you to receive a 90 day supply of a prescription or refill at a retail or specialty pharmacy, more than one prescription or refill within a 20 day period for a 1-30 day supply or a 60 day period for a 61-90 day supply;

28. More than one prescription or refill for the same drug or therapeutic equivalent medication prescribed by one or more qualified practitioners and dispensed by one or more pharmacies until you have used, or should have used, at least 75% of the previous prescription or refill. If the drug or therapeutic equivalent medication is purchased through a mail order pharmacy, until you have used, or should have used, at least 66% of the previous prescription or refill. If the drug or therapeutic equivalent medication is purchased through a retail or specialty pharmacy that participates in the program which allows you to receive a 90 day supply of a prescription or refill at a retail or specialty pharmacy, until you have used, or should have used, at least 66% of the previous prescription or refill. (Based on the dosage schedule prescribed by the qualified practitioner);

29. Prescriptions filled at a non-participating pharmacy.
SECTION 8

DENTAL BENEFITS
You may select any dentist to provide your dental care.

This schedule provides a brief overview of Plan benefits and is not a complete description. Refer to the text for a detailed description of your Plan benefits.

### SCHEDULE OF DENTAL BENEFITS

<table>
<thead>
<tr>
<th>Individual Maximum Benefit</th>
<th>Preventive, Basic, Major Restorative and Prosthodontic Services</th>
<th>$1,000 per calendar year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calendar Year Deductible</td>
<td>Individual - $50 Family - Three (3) family members</td>
<td></td>
</tr>
<tr>
<td>Preventive Services</td>
<td>Covered expense is payable at 100%, not subject to the deductible.</td>
<td></td>
</tr>
<tr>
<td>Basic Services</td>
<td>After deductible, covered expense is payable at 80%.</td>
<td></td>
</tr>
<tr>
<td>Major Restorative Services</td>
<td>After deductible, covered expense is payable at 80%.</td>
<td></td>
</tr>
<tr>
<td>Prosthodontic Services</td>
<td>After deductible, covered expense is payable at 80%.</td>
<td></td>
</tr>
<tr>
<td>Orthodontic Services</td>
<td>Not covered.</td>
<td></td>
</tr>
</tbody>
</table>

NOTE: Certain services may be covered under your medical plan. The medical plan would pay as primary and the dental Plan would pay as secondary.
DENTAL BENEFITS

PREDETERMINATION OF BENEFITS

If expense incurred in performing a dental service or one (1) series of dental services can reasonably be expected to be $300 or more, the Plan recommends you or the provider submit those charges for a predetermination of benefits. The Plan Manager will advise you and the provider what expenses will be covered under the Plan. The Plan Manager will take into account alternate procedures, services, or courses of treatment based upon professionally endorsed standards of dental care. A predetermination of benefits is not a guarantee of benefits. Services will be subject to all terms and provisions of the Plan at the time treatment is rendered.

If treatment is to commence more than ninety (90) days after the date treatment was reviewed by the Plan Manager, it is recommended that you or your qualified practitioner, submit another treatment plan for review.

Before you schedule dental appointments, you should discuss with your dentist the amount to be paid by the Plan and your financial obligation for the proposed treatment.

ALTERNATE SERVICES

If two (2) or more services are considered to be acceptable to correct the same dental condition, the benefits payable will be based on the covered expenses for the least expensive service which will produce a professionally satisfactory result as determined by the Plan Manager.

If you or your dentist decide on a more costly treatment than the Plan Manager has determined to be satisfactory for treatment of the condition, benefits will be subject to any deductible and coinsurance for the least costly treatment. The excess amount will not be paid by the Plan.

DEDUCTIBLE AND COINSURANCE INFORMATION

This section describes benefits for covered expenses. Covered expense means expense incurred by you for the services stated within. The expense must be incurred while you are covered for that benefit under the Plan. Covered expenses are payable, after satisfaction of the deductible, if any, and coinsurance percentages as shown on the Schedule of Benefits.

DEDUCTIBLE

The deductible applies to each covered person each calendar year. Only charges which qualify as a covered expense may be used to satisfy the deductible. The amount of the deductible is stated on the Schedule of Benefits. Any covered expense incurred during the last three (3) months of the calendar year that is used to satisfy all or part of the deductible for that year may be used to satisfy all or part of the deductible for the following calendar year.

MAXIMUM FAMILY DEDUCTIBLE

The total deductible applied to all covered persons in one (1) family in a calendar year is subject to the maximum shown on the Schedule of Benefits.
COINSURANCE

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

Benefits are payable at the applicable percentage rate shown on the Schedule of Benefits after the deductible is satisfied each calendar year.

DENTAL COVERED EXPENSES

For all covered expenses, the following services will be considered an integral part of the entire dental service. A separate fee for these services is not considered a covered expense.

1. Study models/diagnostic casts
2. Bases
3. Temporary dental services
4. Local anesthesia
5. Treatment plans
6. Irrigation
7. Tissue preparation associated with impression or placement of a restoration

PREVENTIVE SERVICES

Oral evaluations. Limited to two (2) per calendar year.

Cleanings (routine prophylaxis). Limited to two (2) per calendar year.

Bitewing x-rays. Limited to two (2) sets per calendar year.

Full mouth or panoramic x-rays. Limited to one (1) per five (5) calendar years, unless necessary due to an accidental injury.

Topical fluoride treatment for dependent children to age fifteen (15) only. Limited to one (1) per calendar year. A prophylaxis performed in conjunction with a fluoride treatment is considered a separate dental service.

BASIC SERVICES

Problem-focused evaluation (emergency evaluation).

Palliative (emergency) treatment for relief of dental pain. Palliative treatment will be considered as a separate benefit if no other service, except x-rays and/or evaluation, is provided during the visit.

Fillings.

General anesthesia or IV sedation.

Extractions.
Oral surgery, including pre- and post-operative care.

Drug injections, when done in conjunction with oral surgery.

Periodontal evaluations.

Periodontal maintenance. Is not a *covered expense* if performed within three (3) months of periodontal scaling and root planing, and/or periodontal surgery.

Periodontal scaling and root planing. Is not a *covered expense* if performed within three (3) months of periodontal surgery.

Periodontal surgery, including three (3) months post-surgical care. If more than one (1) surgical *service* is performed on the same day, only the most inclusive surgical *service* performed will be considered a *covered expense*.

Full mouth debridement. Limited to once per lifetime.

Pulp tests. Limited to one (1) per *calendar year*.

Endodontics, including but not limited to root canals.

Recementation of crowns, bridges, onlays, inlays and veneers.

Occlusal guards.

Occlusal adjustments, when done in conjunction with periodontal surgery. Limited to a maximum of once per quadrant per three (3) *calendar years*.

Stainless steel crowns.

Harmful habit appliance for *dependent* children to age fifteen (15) only. Limited to the initial appliance only.

Consultations. Limited to one (1) per *calendar year*.

Miscellaneous x-rays including but not limited to periapical x-rays.

Pre-diagnostic detection of abnormal cells (ViziLite).

Space maintainers for *dependent* children to age fifteen (15) only. For fixed or removable appliances to maintain a space.

**MAJOR RESTORATIVE SERVICES**

Crowns and their maintenance/repairs.

Gold foil fillings and their maintenance/repairs.
Inlays or onlays and their maintenance/repairs.

Porcelain/ceramic/resin material.

Post/core build-ups for crowns.

Veneers and their maintenance/repairs. Limited to the upper or lower anterior teeth.

**LIMITATIONS FOR MAJOR RESTORATIVE SERVICES**

The following Major Restorative Services are a covered expense and subject to the following replacement frequencies:

<table>
<thead>
<tr>
<th>Service</th>
<th>Replacement Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Foil</td>
<td>Once per five (5) years and unserviceable.</td>
</tr>
<tr>
<td>Inlays or Onlays</td>
<td>Once per five (5) years and unserviceable.</td>
</tr>
<tr>
<td>Crown</td>
<td>Once per five (5) years and unserviceable.</td>
</tr>
<tr>
<td>Veneer</td>
<td>Once per five (5) years and unserviceable.</td>
</tr>
</tbody>
</table>

The above replacement frequencies will be waived if replaced as a result of an accidental injury.

**PROSTHODONTIC SERVICES**

Installation and maintenance/repairs of removable or fixed bridgework.

Post/core build-ups for bridgework.

Installation and maintenance/repairs of partial and complete dentures, including six (6) months post-installation care.

Procedures to reline and rebase, but not within six (6) months of the initial placement. Denture reline is limited to once per denture per two (2) calendar years.

Tissue conditioning, but not within six (6) months of the initial placement.

Implants, including the abutment, prosthesis replacing a missing tooth, and any adjustments/maintenance/repairs. No alternate service benefit will apply. Includes six (6) months post-installation care.
LIMITATIONS FOR PROSTHODONTIC SERVICES

The following Prosthodontic Services are a covered expense and subject to the following replacement frequencies:

<table>
<thead>
<tr>
<th>Service</th>
<th>Replacement Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bridge</td>
<td>Once per five (5) years and unserviceable.</td>
</tr>
<tr>
<td>Partial Denture</td>
<td>Once per five (5) years and unserviceable.</td>
</tr>
<tr>
<td>Complete Denture</td>
<td>Once per five (5) years and unserviceable.</td>
</tr>
<tr>
<td>Implants</td>
<td>Once per five (5) years and unserviceable.</td>
</tr>
<tr>
<td>Implant Prosthesis</td>
<td>Once per five (5) years and unserviceable.</td>
</tr>
</tbody>
</table>

The above replacement frequencies will be waived if replaced as a result of an accidental injury.

The Plan does not provide benefits for:

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

2. Services and supplies:
   a. For which no charge is made, or for which you would not be required to pay if you were not covered under this Plan unless charges are received from and reimbursable to the United States Government or any of its agencies as required by law; or
   b. Furnished by or payable under any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid); or
   c. Furnished for a military service connected accidental injury by or under an agreement with a department or agency of the United States Government, including the Department of Veterans Affairs;
3. Any loss caused by or contributed to:
   a. War or any act of war, whether declared or not; or
   b. Any act of international armed conflict, or any conflict involving armed forces of any international authority;

4. Completion of forms or failure to keep an appointment with the dentist;

5. Replacement of lost, broken or stolen appliances or duplicate appliances;

6. Any service which is considered cosmetic dentistry, unless such service is necessary as a result of an accidental injury. Personalization or characterization of prosthetic devices are considered cosmetic dentistry;

7. Preventive control programs including but not limited to, oral hygiene instruction, plaque control, take home items or dietary planning;

8. Caries susceptibility testing, lab tests, anaerobic cultures, sensitivity testing;

9. Sterilization/infection control fees;

10. Appliances or restorations for increasing vertical dimension, restoring occlusion, correction of congenital or developmental malformations, replacing tooth structure lost by attrition, abfraction, abrasion, or erosion, or fastening together of two (2) or more teeth for strength or stability by using crowns, inlays, onlays or other restorations;

11. Fees for treatment by other than a dentist, except that scaling or cleaning of teeth and topical application of fluoride may be performed by a licensed dental hygienist. The treatment must be rendered under the supervision and guidance of the dentist in accordance with generally accepted dental standards;

12. Any hospital charges or for services of any anesthesiologist;

13. Prescription drugs or pre-medications;

14. Major Restorative and Prosthodontic Services on other than permanent teeth;

15. Precision or semi-precision attachments;

16. Services not dentally or medically necessary or services which do not have uniform professional endorsement;

17. Orthodontic Services;

18. Any expense incurred prior to your effective date under the Plan or after the date your coverage under this Plan terminates;
19. Diagnosis and treatment of temporomandibular joint dysfunction (TMJ), including but not limited to charges for: TMJ, x-rays and consultations; TMJ surgery, kinesiographic analysis and muscle testing; TMJ splints and appliances; splint equilibration and adjustments or physical therapy for symptoms including but not limited to, headaches;

20. Osteotomies;

21. Provisional splinting;

22. Reline/repair of occlusal guards;

23. Veneers and their maintenance/repairs on posterior teeth;

24. Athletic mouth guards;

25. Stressbreakers;

26. Sealants;

27. Nitrous oxide;

28. Site therapy;

29. Pulp cap;

30. High noble metal. Alternate services will be applied allowing benefits for a noble metal restoration when a more costly material is utilized;

31. Overdentures and their maintenance/repairs;

32. Any service not specifically listed as a covered expense;

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