



## *Appendix A*

### *Description of Plan Benefits Humana Health Plan*

*Humana Group No. 721374  
Package IDS SFDCHA02  
SFDCHR02*

*Effective January 1, 2019  
This document supersedes any earlier version  
of Appendix A for the Humana Health Plan*

## **APPENDIX A TO THE SPD**

## **INTRODUCTION**

### **APPENDIX A TO THE SPD**

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

### **DEFINED TERMS**

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

### **PRIVACY**

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

### **CONTACT INFORMATION**

#### **Customer Service Telephone Number:**

Please refer to *your* Humana ID card for the applicable toll-free customer service telephone number.

**Website:** *You* can access Humana’s online services at [www.humana.com](http://www.humana.com).

#### **Claims Submittal Address:**

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

#### **Claims Appeal Address:**

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

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**SECTION 1**

**HEALTH RESOURCES  
AND  
PREAUTHORIZATION**

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## HEALTH RESOURCES

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

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

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

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## PREAUTHORIZATION

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Humana will provide *preauthorization* as required by this Plan. Visit Humana's website at [www.humana.com](http://www.humana.com)\* or call the toll-free customer service telephone number listed on *your* Humana ID card to obtain a list of *services* that require *preauthorization*. The list of *services* that require *preauthorization* is subject to change. Coverage provided in the past for *services* that did not receive or require *preauthorization*, is not a guarantee of future coverage of the same *services*.

*You* are responsible for informing *your qualified practitioner* of this Plan's *preauthorization* requirements. *You* or *your qualified practitioner* must contact Humana at the toll-free customer service telephone number listed on *your* Humana ID card or in writing to request the appropriate authorization. If any required *preauthorization* of *services* is not obtained, *your* benefits may be reduced or a penalty may apply. *Preauthorization* and *preauthorization* penalties do not apply to *emergency services*.

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

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

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

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

### PREAUTHORIZATION PENALTY

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

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

**PREDETERMINATION OF BENEFITS**

*You or your qualified 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**

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## UNDERSTANDING YOUR COVERAGE

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### **PARTICIPATING PROVIDERS**

This Plan has one (1) level of benefits – *participating provider* benefits, payable as shown in the Schedule of Benefits section. *You* are responsible for any applicable *copayments* and/or *deductible* amounts.

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

### **PARTICIPATING PROVIDER DIRECTORY**

*Your employer* will automatically provide, without charge, information to *you* about how *you* can access a directory of *participating providers* appropriate to *your service area*. An online directory of *participating providers* is available to *you* and accessible via Humana's website at [www.humana.com](http://www.humana.com). This directory is subject to change. Due to the possibility of *participating providers* changing status, please check the online directory of *participating 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.

### **PRIMARY CARE PHYSICIAN**

A *primary care physician* is responsible for providing primary medical care and helping to guide any care *you* receive from other medical care providers, including *specialty care physicians*. *You* must select a *primary care physician* who is a *participating provider*, for *yourself* and for each covered *dependent*. *You* have the right to designate any *primary care physician* who is a *participating provider* and who is available to accept *you* and *your* covered *dependents*. A physician who is a *participating provider* specializing in pediatrics is permitted to be selected as the *primary care physician* for a covered *dependent* child. When *your primary care physician* is unavailable, *you* may need to obtain *services* from the back-up *participating provider* designated by *your primary care physician*. Please be sure to discuss these back-up arrangements with *your primary care physician*.

*You* should discuss all of *your* medical needs with *your primary care physician*. If *you* and *your primary care physician* determine *you* need to see a *specialty care physicians*, *your primary care physician* may refer *you* to one. A referral from *your primary care physician* is required to see a *specialty care physicians*. *You* will receive a referral for a period of time or a specific number of visits. The *primary care physician* referral is valid only for the *covered expenses* authorized by the *primary care physician*. A female *covered person* is permitted to receive *services* for obstetrical or gynecological care from a *participating provider* specializing in obstetrics or gynecology without a referral from her *primary care physician*. *Services* received from, or ordered by a *participating provider* for obstetrical or gynecological *services*, are considered authorization from the *primary care physician*.

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## UNDERSTANDING YOUR COVERAGE (continued)

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If *you* have a chronic, disabling or life threatening *sickness*, *you* may apply to Humana to utilize a *specialty care physicians* who is a *participating provider* as *your* primary care provider.

For information on how to select a *primary care physician*, and for a list of *participating providers*, contact Humana at the customer service number on the back of your identification (ID) card or visit our website at [www.humana.com](http://www.humana.com).

### SEEKING EMERGENCY CARE

When seeking *emergency care*, *you* should do the following:

- If *your* medical condition permits, proceed to the nearest *emergency care participating provider* in this Plan.
- If *your* medical condition does not permit going to a *participating provider*, *you* should go to the nearest *emergency care* medical facility. If *you* are admitted to a *non-participating hospital* for *emergency care*, *you* (or someone acting for *you*) must contact Humana within forty-eight (48) hours of *your admission*, or if this is not possible, as soon as *your* medical condition permits.
- *You* may call 911 or *your* local *emergency* telephone number when *you* need on-site *emergency* assistance or *ambulance services*.
- If *you* are admitted to a *non-participating hospital* for *emergency care*, Humana may require *you* be transferred to a *participating hospital* in the *service area* when *your* condition has been stabilized.
- *You* must receive any follow-up *services* from *your primary care physician*.

### SEEKING URGENT CARE

The steps for seeking urgent care are as follows:

- *You* may go to an urgent care center that is a *participating provider* under this Plan.
- If *you* are outside the *service area* and cannot reasonably return to the *service area* for urgent care *services*, *you* may receive the urgent care *services* from a *non-participating provider*. Notify Humana within forty-eight (48) hours after the urgent care *services* were received.
- *You* must receive any follow-up *services* from *your primary care physician*.
- *You* must pay the required *copayment*, if any, for urgent care.

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

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

## **COVERAGE OF OUT-OF-AREA DEPENDENTS**

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

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

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## MEDICAL SCHEDULE OF BENEFITS

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### IMPORTANT INFORMATION ABOUT PLAN BENEFITS

**Plan benefits and limits (i.e. visit or dollar limits) are applicable per *plan year*, unless specifically stated otherwise. Annual limits do not apply to essential health benefits.**

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

<b>MEDICAL OUT-OF-POCKET LIMITS, MEDICAL OFFICE VISIT COPAYMENTS AND LIFETIME MAXIMUM BENEFIT</b>	
<i>Qualified Practitioner Primary Care Physician (PCP) Office Visit Copayment</i>	\$20
<i>Qualified Practitioner Specialist Office Visit Copayment</i>	\$35
<p>Primary Care Physician (PCP) is defined as a family practice physician, pediatrician, doctor of internal medicine, general practitioner, <i>nurse</i> practitioner, physician assistant and registered <i>nurse</i>. A specialist would be all other <i>qualified practitioners</i>.</p> <p>One <i>copayment</i> will be taken per visit per servicing provider, unless otherwise indicated in this Schedule.</p>	
Single Medical <i>Out-of-Pocket Limit</i>	\$2,500 per <i>covered person</i>
Family Medical <i>Out-of-Pocket Limit</i>	\$7,500 per covered family
<i>Lifetime Maximum Benefit</i>	Unlimited

**MEDICAL SCHEDULE OF BENEFITS (continued)**

<b>MEDICAL AND PRESCRIPTION DRUG PAR PROVIDER PLAN MAXIMUM OUT-OF-POCKET LIMIT</b>	
<b>BENEFIT FEATURES</b>	<b>PARTICIPATING PROVIDER BENEFIT</b>
Single <i>PAR Provider Plan Maximum Out-of-Pocket Limit</i>	\$6,350 per covered person
Family <i>PAR Provider Plan Maximum Out-of-Pocket Limit</i>	\$12,700 per covered family

<b>ROUTINE/PREVENTIVE CHILD CARE SERVICES BIRTH TO AGE 18 (Services Received at a Clinic or Outpatient Hospital)</b>	
<b>MEDICAL SERVICES</b>	<b>PARTICIPATING PROVIDER BENEFIT</b>
Routine/Preventive Child Care Examination	100%
Routine/Preventive Child Care Vision Screening	100%
Routine/Preventive Child Care Hearing Screening	100%
Routine/Preventive Child Care Laboratory	100%

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**MEDICAL SCHEDULE OF BENEFITS (continued)**

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

<b>MEDICAL SERVICES</b>	<b>PARTICIPATING PROVIDER BENEFIT</b>
Routine/Preventive Child Care X-ray	100%
Routine/Preventive Child Care Immunizations (includes school immunizations)  (e.g. HPV Vaccine, Meningitis Vaccine, etc.)  Immunizations are covered based on the recommendations by the Department of Health and Human Services - Centers for Disease Control and Prevention	100%
Routine/Preventive Child Care Flu/Pneumonia Immunizations	100%

**MEDICAL SCHEDULE OF BENEFITS (continued)**

**ROUTINE/PREVENTIVE ADULT CARE SERVICES  
AGE 18 AND OVER**

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

<b>MEDICAL SERVICES</b>	<b>PARTICIPATING PROVIDER BENEFIT</b>
Routine/Preventive Adult Care Examination	100%
Routine/Preventive Adult Care Vision Screening	100%
Routine/Preventive Adult Care Hearing Screening	100%
Routine/Preventive Adult Care Laboratory	100%
Routine/Preventive Adult Care X-ray	100%
Routine/Preventive Adult Care Immunizations (includes school immunizations)  (e.g. Shingles Vaccine, Meningitis Vaccine, HPV Vaccine, etc.)  Immunizations are covered based on the recommendations by the Department of Health and Human Services - Centers for Disease Control and Prevention	100%
Routine/Preventive Adult Care Flu/Pneumonia Immunizations	100%
Routine/Preventive Adult Care Mammograms	100%

**MEDICAL SCHEDULE OF BENEFITS (continued)**

**ROUTINE/PREVENTIVE ADULT CARE SERVICES  
AGE 18 AND OVER**

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

<b>MEDICAL SERVICES</b>	<b>PARTICIPATING PROVIDER BENEFIT</b>
Routine/Preventive Adult Care Pap Smears	100%
Routine/Preventive Adult Care Colonoscopy, Proctosigmoidoscopy and Sigmoidoscopy Screenings (including related <i>services</i> ) (performed at an outpatient facility, <i>ambulatory surgical center</i> or clinic location)	100%
Routine/Preventive Adult Care Prostate Specific Antigen (PSA) Testing	100%
Breast Feeding Counseling	100%
Breast Feeding Support and Supplies	100%
<p>Contraceptive Methods - devices (e.g. IUD or diaphragms), injections, implant insertion/removal, emergency contraceptives and condoms; Sterilization - tubal ligation and vasectomy</p> <p>For information on <i>prescription</i> drug coverage for birth control pills/patches, emergency contraceptives, condoms and spermicide, please see <i>your prescription</i> drug benefits.</p>	100%
<p><b>Note:</b> To the extent required by the Affordable Care Act, age limits do not apply to breast feeding counseling, breast feeding support and supplies, contraceptive methods and sterilization.</p>	

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**MEDICAL SCHEDULE OF BENEFITS (continued)**

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<b>ROUTINE VISION SERVICES</b>	
<b>MEDICAL SERVICES</b>	<b>PARTICIPATING PROVIDER BENEFIT</b>
Routine Vision Examination	Not covered
Routine Vision Refraction	100% after a \$20 <i>copayment</i>
Aphakia (Vision)	100%
Eyeglass Frames and Lenses and Contact Lenses	Not covered
Routine Vision Refraction Visit Limit	One (1) visit per <i>covered person</i> (based on diagnosis)

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

**MEDICAL SCHEDULE OF BENEFITS (continued)**

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

**MEDICAL SCHEDULE OF BENEFITS (continued)**

<b>QUALIFIED PRACTITIONER SERVICES (Non-Routine/Non-Preventive Care Services)</b>	
<b>MEDICAL SERVICES</b>	<b>PARTICIPATING PROVIDER BENEFIT</b>
Injections at a Clinic (other than routine immunizations, contraceptive injections for birth control reasons and allergy injections)	100%
Anesthesia at a Clinic	100%
<p><i>Surgery at a Clinic (including <i>Qualified Practitioner, Assistant Surgeon</i> and Physician Assistant)</i></p> <ul style="list-style-type: none"> <li>• <i>Primary Care Physician</i></li> <li>• <i>Qualified Practitioner Specialist</i></li> <li>• <i>Assistant Surgeon</i></li> </ul>	<p>100% after a \$20 <i>copayment</i></p> <p>100% after a \$35 <i>copayment</i></p> <p>100%</p>
<p>Multiple Surgical Procedures</p> <ul style="list-style-type: none"> <li>• Outpatient</li> <li>• In an Office Setting</li> </ul>	<p>100%</p> <p>Subject to applicable office visit <i>copayment</i></p>
Medical and Surgical Supplies	100%
Eyeglasses or Contact Lenses after Cataract <i>Surgery</i> (initial pair only)	Not covered
Diabetic Nutritional Counseling ( <i>Diabetes Self-Management Training</i> ) (all places of <i>service</i> )	Payable the same as any other <i>sickness</i> .
<i>Diabetes Supplies</i>	75% (or covered under pharmacy)

**MEDICAL SCHEDULE OF BENEFITS (continued)**

<b>DENTAL/ORAL SURGERIES COVERED UNDER THE MEDICAL PLAN</b>	
<b>MEDICAL SERVICES</b>	<b>PARTICIPATING PROVIDER BENEFIT</b>
Dental/Oral <i>Surgeries</i> in office visit <ul style="list-style-type: none"> <li>• <i>Primary Care Physician</i></li> <li>• <i>Qualified Practitioner Specialist</i></li> </ul>	100% after a \$20 <i>copayment</i> 100% after a \$35 <i>copayment</i>
Dental/Oral <i>Surgeries</i> Outpatient	100%
<p><b>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.</b></p>	

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

**MEDICAL SCHEDULE OF BENEFITS (continued)**

<b>FAMILY PLANNING</b>	
<b>MEDICAL SERVICES</b>	<b>PARTICIPATING PROVIDER BENEFIT</b>
Sterilization  Vasectomy <ul style="list-style-type: none"> <li>• <i>Primary Care Physician</i></li> <li>• <i>Qualified Practitioner Specialist</i></li> </ul>	100% after a \$20 <i>copayment</i> 100% after a \$35 <i>copayment</i>
Tubal Ligation, Hysterectomy	Payable the same as any other <i>sickness</i> .
Life Threatening Abortions	Payable the same as any other <i>sickness</i> .

<b>MATERNITY (Normal, C-Section and Complications)</b>	
<b>MEDICAL SERVICES</b>	<b>PARTICIPATING PROVIDER BENEFIT</b>
Inpatient <i>Hospital Room and Board</i> and Ancillary Facility Services	100% after a \$50 one-time charge at delivery
Birthing Center <i>Room and Board</i> and Ancillary Services	100% after a \$50 one-time charge at delivery
<i>Qualified Practitioner Services</i> (Office visit <i>copayment</i> will apply to the initial maternity visit only.)	100% after a \$50 one-time charge at delivery
Pre-natal Provider Visits	100%
<i>Dependent</i> Daughter Maternity	100% after a \$50 one-time charge at delivery

**MEDICAL SCHEDULE OF BENEFITS (continued)**

<b>MATERNITY (Normal, C-Section and Complications)</b>	
<b>MEDICAL SERVICES</b>	<b>PARTICIPATING PROVIDER BENEFIT</b>
Newborn Well/Sick Baby (these benefits apply for the first year of life)	100%
Newborn Inpatient <i>Qualified Practitioner Services</i>	100%
Newborn Inpatient Facility <i>Services</i> <ul style="list-style-type: none"> <li>• Well newborn</li> <li>• Sick newborn</li> </ul>	100% 100% after a \$200 <i>copayment</i> per day up to a maximum of \$600 per <i>admission</i> .

<b>INPATIENT SERVICES</b>	
<b>MEDICAL SERVICES</b>	<b>PARTICIPATING PROVIDER BENEFIT</b>
Inpatient <i>Hospital Room and Board</i> and Ancillary Facility <i>Services</i>	100% after a \$200 <i>copayment</i> per day up to a maximum of \$600 per <i>admission</i>
<i>Qualified Practitioner</i> Inpatient <i>Hospital</i> Visit	100%
<i>Qualified Practitioner</i> Inpatient <i>Surgery</i> and Anesthesia	100%
<i>Qualified Practitioner</i> Inpatient Pathology and Radiology	100%

**MEDICAL SCHEDULE OF BENEFITS (continued)**

<b>INPATIENT SERVICES</b>	
<b>MEDICAL SERVICES</b>	<b>PARTICIPATING PROVIDER BENEFIT</b>
Inpatient Physical Rehabilitation	100% after a \$200 <i>copayment</i> per day up to a maximum of \$600 per <i>admission</i>
Inpatient Physical Rehabilitation Limits	60 days per <i>covered person</i>
Private Duty Nursing	Not covered

<b>SKILLED NURSING SERVICES</b>	
<b>MEDICAL SERVICES</b>	<b>PARTICIPATING PROVIDER BENEFIT</b>
Skilled Nursing <i>Room and Board</i> and Ancillary Facility <i>Services</i>	100% after a \$200 <i>copayment</i> per day up to a maximum of \$600 per <i>admission</i>
Skilled Nursing Facility Yearly Limits	90 day(s) per <i>covered person</i>
Skilled Nursing <i>Qualified Practitioner</i> Visit	100%

**MEDICAL SCHEDULE OF BENEFITS (continued)**

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

**MEDICAL SCHEDULE OF BENEFITS (continued)**

<b>OUTPATIENT AND AMBULATORY SURGICAL CENTER SERVICES</b>	
<b>MEDICAL SERVICES</b>	<b>PARTICIPATING PROVIDER BENEFIT</b>
Outpatient <i>Hospital and Ambulatory Surgical Center Surgery</i> (including surgeon; <i>assistant surgeon</i> ; and physician assistant) and Anesthesia	100%
Outpatient <i>Hospital and Ambulatory Surgical Center Pathology and Radiology</i>	100%

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

**MEDICAL SCHEDULE OF BENEFITS (continued)**

<b>EMERGENCY AND URGENT CARE SERVICES</b>	
<b>MEDICAL SERVICES</b>	<b>PARTICIPATING PROVIDER BENEFIT</b>
Emergency Room All Physician <i>Services</i> (including Radiologist, Pathologist, Anesthesiologist and ancillary <i>services</i> billed by an Emergency Room Physician) (non-emergency)	Not covered
Urgent Care Center (facility and ancillary <i>services</i> )  Urgent Care Center ( <i>qualified practitioner services</i> ) <ul style="list-style-type: none"> <li>• <i>Primary Care Physician</i></li> <li>• <i>Qualified Practitioner Specialist</i></li> </ul> Only one <i>copayment</i> will be taken per day.	100%   100% after a \$20 <i>copayment</i> 100% after a \$35 <i>copayment</i>

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**MEDICAL SCHEDULE OF BENEFITS (continued)**

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<b>HOSPICE SERVICES</b>	
<b>MEDICAL SERVICES</b>	<b>PARTICIPATING PROVIDER BENEFIT</b>
Hospice Inpatient <i>Room and Board</i> and <i>Ancillary Services</i>	100%
Hospice Inpatient Limits	180 day(s) per <i>covered person</i>
Hospice Outpatient (including hospice home visits)	100%
Hospice Outpatient Limits	180 day(s) per <i>covered person</i>
The inpatient and outpatient hospice limits are combined.	
Hospice <i>Qualified Practitioner</i> Visit	100%

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

**MEDICAL SCHEDULE OF BENEFITS (continued)**

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

<b>SPECIALTY DRUGS</b>	
<b>MEDICAL SERVICES</b>	<b>PARTICIPATING PROVIDER BENEFIT</b>
<i>Specialty Drugs (Qualified Practitioner's Office Visit, Freestanding Facility and Urgent Care)</i>	100% after a \$50 <i>copayment</i>
<i>Specialty Drugs (Visit, Home Health Care)</i> <ul style="list-style-type: none"> <li>• RightSource</li> <li>• Other Home Health Care</li> </ul>	100% 100% after a \$50 <i>copayment</i>
<i>Specialty Drugs (Emergency Room, Ambulance, Inpatient Hospital, Outpatient Hospital and Skilled Nursing Facility)</i>	Payable the same as any other <i>sickness</i> .

**MEDICAL SCHEDULE OF BENEFITS (continued)**

<b>AMBULANCE SERVICES</b>	
<b>MEDICAL SERVICES</b>	<b>PARTICIPATING PROVIDER BENEFIT</b>
<i>Ground Ambulance</i>	100%
<i>Air Ambulance</i>	100%

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

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**MEDICAL SCHEDULE OF BENEFITS (continued)**

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<b>TEMPOROMANDIBULAR JOINT DYSFUNCTION (TMJ)</b>	
<b>MEDICAL SERVICES</b>	<b>PARTICIPATING PROVIDER BENEFIT</b>
Temporomandibular Joint Dysfunction (TMJ) (Other than Splint/Appliances)	Payable the same as any other <i>sickness</i>
Temporomandibular Joint Dysfunction (TMJ) Splint/Appliances	Not covered

<b>DENTAL INJURY SERVICES</b>	
<b>MEDICAL SERVICES</b>	<b>PARTICIPATING PROVIDER BENEFIT</b>
<i>Dental Injuries</i>	100%. Office visit <i>copayment</i> may apply.
<b>Please see the “Medical Covered Expenses” section, Dental Injury, for benefit details.</b>	

**MEDICAL SCHEDULE OF BENEFITS (continued)**

<b>INFERTILITY SERVICES</b>	
<b>MEDICAL SERVICES</b>	<b>PARTICIPATING PROVIDER BENEFIT</b>
Infertility (Diagnosis) <ul style="list-style-type: none"> <li>• <i>Primary Care Physician</i></li> <li>• <i>Qualified Practitioner Specialist</i></li> </ul>	100% after a \$20 <i>copayment</i> Not covered
Infertility (Treatment)	50% (In-Network only)
Infertility Counseling and Treatment Yearly Limits	Two year maximum limit
Artificial Means of Achieving Pregnancy	Please refer to the Medical Covered Expenses section of this <i>Appendix A to the SPD</i> .
Sexual Dysfunction/Impotence (medical diagnosis only)	Payable the same as any other <i>sickness</i> .
Sexual Dysfunction/Impotence related to a <i>Mental Health Disorder</i>	Not covered

**MEDICAL SCHEDULE OF BENEFITS (continued)**

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

**MEDICAL SCHEDULE OF BENEFITS (continued)**

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

**MEDICAL SCHEDULE OF BENEFITS (continued)**

<b>TRANSPLANT SERVICES</b>	
<b><i>Preauthorization is required, if preauthorization is not received, organ transplant services will not be covered.</i></b>	
<b>MEDICAL SERVICES</b>	<b>HUMANA NATIONAL TRANSPLANT NETWORK (NTN) FACILITY</b>
Organ Transplant Lifetime Maximum	\$1,000,000
Organ Transplant Medical <i>Services</i> <ul style="list-style-type: none"> <li>• Inpatient <i>Hospital</i></li> <li>• Physician <i>Services</i> (Clinic)</li> <li>• Physician <i>Services</i> (Inpatient/Outpatient)</li> </ul>	100% Subject to applicable office visit <i>copayment</i> 100%
Non-Medical <i>Services</i> - Lodging and Transportation	100%
Non-Medical <i>Services</i> - Lodging Limits	\$50 per day
Immunosuppressant Drugs (applies to transplant lifetime maximum)	Covered under pharmacy

**MEDICAL SCHEDULE OF BENEFITS (continued)**

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

<b>BEHAVIORAL HEALTH PARTIAL HOSPITALIZATION SERVICES</b>	
<b>MEDICAL SERVICES</b>	<b>PARTICIPATING PROVIDER BENEFIT</b>
<i>Behavioral Health Partial Hospitalization Services</i>	100%

**MEDICAL SCHEDULE OF BENEFITS (continued)**

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

<b>DETOXIFICATION SERVICES</b>	
<b>MEDICAL SERVICES</b>	<b>PARTICIPATING PROVIDER BENEFIT</b>
Detoxification	100% after a \$200 <i>copayment</i> per day up to a maximum of \$600 per <i>admission</i>

<b>TRANSGENDER SERVICES</b>	
<b>MEDICAL SERVICES</b>	<b>PARTICIPATING PROVIDER BENEFIT</b>
Transgender Services	Payable the same as any other <i>sickness</i> .

\*Transgender *services* are covered only for active *employees*. *Services* are not covered for *retirees*.

**MEDICAL SCHEDULE OF BENEFITS (continued)**

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

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## MEDICAL COVERED EXPENSES

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### HOW BENEFITS PAY

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

### OUT-OF-POCKET LIMIT

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

Any amount applied to the Prior Plan's *PAR provider out-of-pocket limit* or stop-loss limit will be credited toward the satisfaction of any *PAR provider out-of-pocket limit* of this Plan if the amount applied under the Prior Plan:

- Qualifies as a *covered expense* under this Plan and
- Would have served to partially or fully satisfy the *out-of-pocket limit* under this Plan for the *year* in which *your* coverage becomes effective.

### Single Out-of-Pocket Limits

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

### Family Out-of-Pocket Limit

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

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## MEDICAL COVERED EXPENSES (continued)

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

### PAR PROVIDER PLAN MAXIMUM OUT-OF-POCKET LIMIT

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

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

### ROUTINE/PREVENTIVE SERVICES

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

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

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

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

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## MEDICAL COVERED EXPENSES (continued)

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

### ROUTINE VISION SERVICES

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

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

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

### ROUTINE HEARING SERVICES

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

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

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

### QUALIFIED PRACTITIONER SERVICES

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

#### Second Surgical Opinion

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

#### Multiple Surgical Procedures

If multiple or bilateral surgical procedures are performed during the same day, the *surgeries* will be paid according to the *provider contract* for a *participating provider*. When a *non-participating provider* is utilized, the *surgery* with the highest *maximum allowable fee* monetary amount will be allowed at 100% of the *maximum allowable fee*. For each additional *surgery* for a *non-participating provider* the amount allowed will be: a) 50% of the *maximum allowable fee* for the *surgery* with the second highest *maximum allowable fee* monetary amount; and b) 25% of the *maximum allowable fee* for all the other *surgeries*.

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## MEDICAL COVERED EXPENSES (continued)

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### Assistant Surgeon

Services for an *assistant surgeon*. The *assistant surgeon* will be paid according to the *provider contract* if they are a *network provider*. This Plan will allow the *assistant surgeon* 16% of the *maximum allowable fee* for the *surgery* that would apply if the *assistant surgeon* were the primary surgeon.

### Physician Assistant

Services for a physician assistant (P.A.). The P.A. will be paid according to the *provider contract* if they are a *network provider*. This Plan will allow the P.A. 10% of the *maximum allowable fee* for the *surgery* that would apply if the P.A. were the primary surgeon.

## DENTAL/ORAL SURGERIES COVERED UNDER THE MEDICAL PLAN

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

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

## FAMILY PLANNING

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

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

## MATERNITY

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

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

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## MEDICAL COVERED EXPENSES (continued)

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### 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.

### Birth Centers

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

### INPATIENT HOSPITAL

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

### SKILLED NURSING FACILITY

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

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

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

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## MEDICAL COVERED EXPENSES (continued)

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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:

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

### EMERGENCY AND URGENT CARE SERVICES

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

### HOSPICE SERVICES

Hospice *services* are payable as shown on the Medical Schedule of Benefits, and must be furnished in a hospice facility or in *your* home. A *qualified practitioner* must certify *you* are terminally ill with a life expectancy of 18 months or less.

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

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

- *Room and board* and other *services* and supplies;
- Part-time nursing care by, or supervised by, a registered *nurse* for up to 8 hours in any one day;
- Counseling *services* by a *qualified practitioner* for the hospice patient and the immediate family;

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**MEDICAL COVERED EXPENSES (continued)**

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- Medical social *services* provided to *you* or *your* immediate family under the direction of a *qualified practitioner*, which include the following:
  - Assessment of social, emotional and medical needs, and the home and family situation; and
  - Identification of the community resources available;
- Psychological and dietary counseling;
- Physical therapy;
- Part-time home health aide service for up to 8 hours in any one day;
- Medical supplies, drugs and medicines prescribed by a *qualified practitioner* for *palliative care*.

Hospice care benefits do NOT include:

- A *confinement* not required for pain control or other acute chronic symptom management;
- Bereavement counseling services for family members that are not covered under this Plan.
- Funeral arrangements;
- Financial or legal counseling, including estate planning or drafting of a will;
- Homemaker or caretaker *services*, including a sitter or companion *services*;
- Housecleaning and household maintenance;
- *Services* of a social worker other than a licensed clinical social worker;
- *Services* by volunteers or persons who do not regularly charge for their *services*; or
- *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 care* 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.

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## MEDICAL COVERED EXPENSES (continued)

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

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

### HOME HEALTH CARE

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

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

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

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

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

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## MEDICAL COVERED EXPENSES (continued)

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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:

- Care provided by *nurse*;
- Physical, speech, occupational and respiratory therapy; and
- Medical social work and nutrition services; and
- Medical appliances, equipment and laboratory services.

Home health care benefits do not include:

- Charges for mileage or travel time to and from the *covered person's* home;
- Wage or shift differentials for home health care providers;
- Charges for supervision of home health care providers.

### **DURABLE MEDICAL EQUIPMENT (DME)**

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

### **Prosthetics and Orthotics**

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

### **SPECIALTY DRUG MEDICAL BENEFIT**

*Specialty drugs* are payable as shown on the Medical Schedule of Benefits. For more information regarding the specific *specialty drugs* covered under this Plan, please call the toll-free customer service telephone number listed on *your* Humana ID card or visit Humana's website at [www.humana.com](http://www.humana.com).

## **AMBULANCE**

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

*Ambulance* services for *emergency care* provided by a *Non PAR provider* will be covered at the *PAR provider* benefit, as specified in the Ambulance benefit on the "Schedule of Benefits", subject to the *maximum allowable fee*. *Non-network providers* have not agreed to accept discounted or negotiated fees, and may bill you for charges in excess of the *maximum allowable fee*. You may be required to pay any amount not paid by this Plan.

## **MORBID OBESITY**

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

## **TEMPOROMANDIBULAR JOINT DYSFUNCTION (TMJ)**

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

## **DENTAL INJURY**

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

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

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

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

## **INFERTILITY**

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

## **Artificial Means of Achieving Pregnancy**

*Services* performed to achieve pregnancy or ovulation by artificial means include artificial insemination and in vitro fertilization gamete intrafallopian transfer (GIFT), zygote intra fallopian transfer (ZIFT), reversal of surgical sterilization, embryo transplantation and extracorporeal insemination are not covered.

## **THERAPY SERVICES**

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

### **Chiropractic Care**

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

## **TRANSPLANT SERVICES**

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

### **Preauthorization**

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

### **Covered Organ Transplant**

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

- Heart;
- Lung(s);
- Liver;
- Kidney;
- *Bone Marrow*;
- Intestine;
- Pancreas;
- Auto islet cell;
- Any combination of the above listed organs;
- Any organ not listed above required by federal law.

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## MEDICAL COVERED EXPENSES (continued)

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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:

- It is *experimental, investigational or for research purposes* as defined in the “Definitions” section;
- Humana is not contacted for authorization prior to referral for evaluation of the transplant;
- Humana does not approve coverage for the transplant, based on its established criteria;
- Expenses are eligible to be paid under any private or public research fund, government program, except Medicaid, or another funding program, whether or not such funding was applied for or received;
- The expense relates to the transplantation of any non-human organ or tissue, unless otherwise stated in this Plan;
- The expense relates to the donation or acquisition of an organ for a recipient who is not covered by this Plan;
- 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;
- The *covered person* for whom a transplant is requested has not met pre-transplant criteria as established by Humana.

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## MEDICAL COVERED EXPENSES (continued)

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### Covered Services

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

- *Hospital and qualified practitioner services*, payable as shown on the Medical Schedule of Benefits. If *services* are rendered at a Humana National Transplant Network (NTN) facility, *covered expenses* are paid in accordance to the NTN contracted rates;
- 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*;
- Direct, non-medical costs for the *covered person*, when the transplant is performed at a Humana National Transplant Network facility, will be paid as shown on the Medical Schedule of Benefits, for: (a) transportation to and from the *hospital* where the transplant is performed; and (b) temporary lodging up to \$50 per day at a prearranged location when requested by the *hospital* and approved by Humana. These direct, non-medical costs are only available if the *covered person* lives more than 100 miles from the transplant facility;
- Direct, non-medical costs for one support person of the *covered person* (two persons if the patient is under age 18 years), when the transplant is performed at a Humana National Transplant Network facility, will be paid as shown on the Medical Schedule of Benefits, for: (a) transportation to and from the approved facility where the transplant is performed; and (b) temporary lodging up to \$50 per day at a prearranged location during the *covered person's confinement* in the *hospital*. These direct, non-medical costs are only available if the *covered person's* support person(s) live more than 100 miles from the transplant facility.
- Non-medical costs are not covered if a transplant is performed at a facility that is not a Humana National Transplant Network facility.

### TRANSGENDER COVERAGE

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

## **BEHAVIORAL HEALTH SERVICES**

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

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

### **Inpatient Services**

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

### **Outpatient Services**

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

### **Limitations**

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

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

## SEX REASSIGNMENT SURGERY

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

- *Covered person* is at least 18 years old; **and**
  
- *Covered person* has met criteria for the diagnosis of "true" transsexualism, including:
  - A sense of estrangement from one's own body, so that any evidence of one's own biological sex is regarded as repugnant; and
  - A stable transsexual orientation evidenced by a desire to be rid of one's genitals and to live in society as a member of the other sex for at least 2 years, that is, not limited to periods of stress; and
  - Absence of physical inter-sex of genetic abnormality; and
  - Does not gain sexual arousal from cross-dressing; and
  - Life-long sense of belonging to the opposite sex and of having been born into the wrong sex, often since childhood; and
  - Not due to another biological, chromosomal or associated psychiatric disorder, such as schizophrenia; and
  - Wishes to make his or her body as congruent as possible with the preferred sex through *surgery* and hormone treatment; **and**
  
- *Covered person* is at least 18 years old; **and**
  
- *Covered person* has met criteria for the diagnosis of "true" transsexualism, including:
  - A sense of estrangement from one's own body, so that any evidence of one's own biological sex is regarded as repugnant; and
  - A stable transsexual orientation evidenced by a desire to be rid of one's genitals and to live in society as a member of the other sex for at least 2 years, that is, not limited to periods of stress; and
  - Absence of physical inter-sex of genetic abnormality; and
  - Does not gain sexual arousal from cross-dressing; and
  - Life-long sense of belonging to the opposite sex and of having been born into the wrong sex, often since childhood; and
  - Not due to another biological, chromosomal or associated psychiatric disorder, such as schizophrenia; and
  - Wishes to make his or her body as congruent as possible with the preferred sex through *surgery* and hormone treatment; **and**

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## MEDICAL COVERED EXPENSES (continued)

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

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

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

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

Note on gender specific services for transgender persons:

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

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## MEDICAL COVERED EXPENSES (continued)

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- Breast cancer screening may be *medically necessary* for female to male transgender persons who have not undergone a mastectomy;
- Prostate cancer screening may be *medically necessary* for male to female transgender individuals who have retained their prostate.

### OTHER COVERED EXPENSES

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

- 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;
- 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*;
- 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*;
- Reconstructive *services* following a covered mastectomy, including but not limited to:
  - Reconstruction of the breast on which the mastectomy was performed;
  - *Surgery* and reconstruction of the other breast to achieve symmetrical appearance;
  - Prosthesis; and
  - Treatment of physical complications of all stages of the mastectomy, including lymphedemas;
- Routine costs associated with clinical trials, when approved by this Plan in accordance with the requirements of the Affordable Care Act. For additional details, go to [www.humana.com](http://www.humana.com) or call the toll-free customer service telephone number listed on *your* Humana ID card.
- Cranial banding, when approved by this Plan. For additional details, go to [www.humana.com](http://www.humana.com) or call the toll-free customer service telephone number listed on *your* Humana ID card.
- Trimming of the corns, calluses & nails is covered for specific diagnosis only.

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## LIMITATIONS AND EXCLUSIONS

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This Plan does not provide benefits for:

- *Services:*
  - Not furnished by a *qualified practitioner* or *qualified treatment facility*;
  - Not authorized or prescribed by a *qualified practitioner*;
  - Not specifically covered by this Plan whether or not prescribed by a *qualified practitioner*;
  - Which are not provided;
  - 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;
  - Furnished by or payable under any plan or law through any government or any political subdivision (this does not include *Medicare* or *Medicaid*);
  - 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;
  - Performed in association with a *service* that is not covered under this Plan.
- Immunizations required for travel and vocational;
- Radial keratotomy, refractive keratoplasty or any other *surgery* to correct myopia, hyperopia or stigmatic error;
- *Cosmetic surgery* and *cosmetic services* or devices, unless for reconstructive *surgery*:
  - Resulting from a *bodily injury*, infection or other disease of the involved part, when *functional impairment* is present; or
  - 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;
- Hair prosthesis, hair transplants or hair implants;
- 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 (including removal of impacted wisdom teeth) and orthodontic procedures, unless specifically provided under this Plan;
- *Services* which are:
  - 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;
  - Extended beyond the period necessary for evaluation and diagnosis of learning and behavioral disabilities or for mental retardation.
- Marriage counseling;
- Education or training, unless otherwise specified in this Plan;

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## LIMITATIONS AND EXCLUSIONS (continued)

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- 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;
- 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:
  - Common household items including air conditioners, air purifiers, water purifiers, vacuum cleaners, waterbeds, hypoallergenic mattresses or pillows or exercise equipment;
  - Motorized transportation equipment (e.g. scooters), escalators, elevators, ramps or modifications or additions to living/working quarters or transportation vehicles;
  - Personal hygiene equipment including bath/shower chairs and transfer equipment or supplies;
  - Personal comfort items including cervical pillows, gravity lumbar reduction chairs, swimming pools, whirlpools, spas or saunas;
  - Medical equipment including blood pressure monitoring devices, unless prescribed by a *qualified practitioner* for *preventive services* and ambulatory blood pressure monitoring is not available to confirm diagnosis of hypertension, PUVA lights and stethoscopes;
  - Communication system, telephone, television or computer systems and related equipment or similar items or equipment;
  - Communication devices, except after surgical removal of the larynx or a diagnosis of permanent lack of function of the larynx.
- Any medical treatment, procedure, drug, biological product or device which is *experimental, investigational or for research purposes*, unless otherwise specified in this Plan;
- *Services* that are not *medically necessary*, except routine/preventive *services*;
- Charges in excess of the *maximum allowable fee* for the *service*;
- *Services* provided by a person who ordinarily resides in *your* home or who is a *family member*;
- 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;
- *Expenses incurred* for which *you* are entitled to receive benefits under *your* previous dental or medical plan;
- *Services* relating to a *sickness* or *bodily injury* as a result of:
  - Engaging in an illegal profession or occupation; or
  - Commission of or an attempt to commit a criminal act.
- Any loss caused by or contributed to:
  - War or any act of war, whether declared or not;
  - Insurrection; or
  - Any act of armed conflict, or any conflict involving armed forces of any authority.

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## LIMITATIONS AND EXCLUSIONS (continued)

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- Treatment of nicotine habit or addiction, including, but not limited to hypnosis, smoking cessation products or tapes, unless otherwise determined by this Plan;
- Vitamins, except for *preventive services* with a *prescription* from a *qualified practitioner*, dietary supplements and dietary formulas except enteral formulas, nutritional supplements or low protein modified food products for the treatment of an inherited metabolic disease, e.g. phenylketonuria (PKU);
- *Prescription* drugs and *self-administered injectable drugs*, unless administered to you:
  - While inpatient in a *hospital*, *qualified treatment facility*, *residential treatment facility* or skilled nursing facility;
  - 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.
- Any drug prescribed, except:
  - FDA approved drugs utilized for FDA approved indications; or
  - 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.
- *Off-evidence drug indications*;
- Over-the-counter, non-prescription medications, unless for drugs, medicines or medications on the Women's Healthcare Drug List with a *prescription* from a *qualified practitioner*. See the Prescription Drug Benefit;
- Over-the-counter medical items or supplies that can be provided or prescribed by a *qualified practitioner* but are also available without a written order or *prescription*, except for *preventive services* (with a *prescription* from a *qualified practitioner*);
- Growth hormones, except as otherwise specified in the pharmacy services sections of this *SPD*;
- 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:
  - The American Academy of Allergy and Immunology, or
  - The Department of Health and Human Services or any of its offices or agencies.
- Professional pathology or radiology charges, including but not limited to, blood counts, multi-channel testing, and other clinical chemistry tests, when:
  - The *services* do not require a professional interpretation, or
  - The *qualified practitioner* did not provide a specific professional interpretation of the test results of the *covered person*.
- *Services* that are billed incorrectly or billed separately, but are an integral part of another billed *service*;

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## LIMITATIONS AND EXCLUSIONS (continued)

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- 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;
- *Alternative medicine;*
- *Services* rendered in a premenstrual syndrome clinic or holistic medicine clinic;
- *Services* of a midwife, unless provided by a Certified *Nurse* Midwife;
- The following types of care of the feet:
  - Shock wave therapy of the feet.
  - The treatment of weak, strained, flat, unstable or unbalanced feet.
  - Hygienic care, and the treatment of superficial lesions of the feet, such as corns, calluses & nails, unless specifically provided under this Plan, or hyperkeratosis.
  - The treatment of tarsalgia, metatarsalgia, or bunion, except surgically.
  - The cutting of toenails, except the removal of the nail matrix.
  - The provision of heel wedges, lifts or shoe inserts.
  - The provision of arch supports or orthopedic shoes. Arch supports and orthopedic shoes are covered if *medically necessary* because of diabetes or hammertoe.
- *Custodial care and maintenance care;*
- Weekend non-emergency *hospital admissions*, specifically *admissions* to a *hospital* on a Friday or Saturday at the convenience of the *covered person* or his or her *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;
- *Hospital inpatient services* when you are in *observation status;*
- *Services* rendered by a standby physician, surgical assistant, *assistant surgeon*, physician assistant, registered *nurse* or certified operating room technician unless *medically necessary;*
- *Ambulance services* for routine transportation to, from or between medical facilities and/or a *qualified practitioner's* office;
- *Preadmission testing/procedural testing* duplicated during a *hospital confinement;*
- Lodging accommodations or transportation, unless specifically provided under this Plan;
- Communications or travel time;

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## LIMITATIONS AND EXCLUSIONS (continued)

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- No benefits will be provided for the following, unless otherwise determined by this Plan:
  - Immunotherapy for recurrent abortion;
  - Chemonucleolysis;
  - Biliary lithotripsy;
  - Home uterine activity monitoring;
  - Sleep therapy;
  - Light treatments for Seasonal Affective Disorder (S.A.D.);
  - Immunotherapy for food allergy;
  - Prolotherapy;
  - Hyperhidrosis *surgery*; or
  - Sensory integration therapy;
- 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;
- Surrogate parenting;
- Any *bodily injury* or *sickness* arising from or sustained in the course of any occupation or employment for compensation, profit or gain for which:
  - Benefits are provided or payable under any Workers' Compensation or Occupational Disease Act or Law, or
  - Coverage was available under any Workers' Compensation or Occupational Disease Act or Law regardless of whether such coverage was actually purchased;
- 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;
- The purchase, fitting or repair of eyeglass frames and lenses or contact lenses, unless specifically provided under this Plan;
- Routine vision examinations;
- Vision therapy;
- Routine hearing testing;
- Elective medical or surgical abortion, unless:
  - The pregnancy would endanger the life of the mother; or
  - The pregnancy is a result of rape or incest; or
  - The fetus has been diagnosed with a lethal or otherwise significant abnormality;
- *Services* for a reversal of sterilization;
- Contraceptive pills and patches and spermicide (see the Prescription Drug Benefit for coverage);

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## LIMITATIONS AND EXCLUSIONS (continued)

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- Private duty nursing.
- Wigs, except for cancer patients with hair loss resulting from chemotherapy and/or radiation therapy;
- *Morbid obesity services* other than the covered *services* listed on the Medical Schedule of Benefits;
- Surgical procedures for the removal of excess skin and/or fat in conjunction with or resulting from weight loss or weight loss *surgery*;
- No benefits will be provided for, or on account of, the following items:
  - Expenses for a *bariatric surgery* that are *experimental, investigational or for research purposes*;
  - Expenses for *bariatric surgery* performed outside of the United States;
  - Any care resulting from a non-covered *bariatric surgery*.
- Dental osteotomies;
- Artificial means to achieve pregnancy or ovulation, including, but not limited to, gamete intra fallopian transfer (GIFT), zygote intra fallopian transfer (ZIFT), reversal of surgical sterilization, embryo transplantation and extracorporeal insemination;
- *Services* related to the treatment and/or diagnosis of sexual dysfunction/impotence, if related to a mental health diagnosis;
- Acupuncture;
- Bras for breast prosthesis;
- Dental implants;
- Fitness programs;
- Oral splints;
- Disposable medical supplies;
- Light weight and sport wheelchairs;
- *Hospital beds*;
- Halfway-house *services*.

**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*.

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## COORDINATION OF BENEFITS

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### **BENEFITS SUBJECT TO THIS PROVISION**

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

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

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

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

### **EFFECT ON BENEFITS**

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

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

### **ORDER OF BENEFIT DETERMINATION**

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

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

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## COORDINATION OF BENEFITS (continued)

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

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

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

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

### COORDINATION OF BENEFITS WITH MEDICARE

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

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

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

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

### OPTIONS

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

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

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

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## COORDINATION OF BENEFITS (continued)

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

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

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

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

### CALCULATION AND PAYMENT OF BENEFITS

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

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

### RIGHT OF RECOVERY

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

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

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

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## CLAIM PROCEDURES

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### SUBMITTING A CLAIM

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

- A claim must be filed with Humana in writing and delivered to Humana by mail, postage prepaid. However, a submission to obtain preauthorization may also be filed with Humana by telephone;
- Claims must be submitted to Humana at the address indicated in the documents describing this Plan or *claimant's* Humana ID card. Claims will not be deemed submitted for purposes of these procedures unless and until received at the correct address;
- Also, claims submissions must be in a format acceptable to Humana and compliant with any applicable legal requirements. Claims that are not submitted in accordance with the requirements of applicable federal law respecting privacy of *protected health information* and/or electronic claims standards will not be accepted by this Plan;
- Claims submissions must be timely. All claims must be filed in the same *calendar year* that the *service* was rendered, or during the following *calendar year*. The deadline for filing a claim that *you* were overcharged for coverage is the end of the year following the year for which the premium was paid. Failure to file a claim within the deadline will result in denial of the claim. 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:
  - The name of the *covered person* who incurred the *covered expense*;
  - The name and address of the health care provider;
  - The diagnosis of the condition;
  - The procedure or nature of the treatment;
  - The date of and place where the procedure or treatment has been or will be provided;
  - The amount billed and the amount of the *covered expense* not paid through coverage other than Plan coverage, as appropriate;
  - 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*.

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## CLAIM PROCEDURES (continued)

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Mail medical claims and correspondence to:

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

### MISCELLANEOUS MEDICAL CHARGES

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

### CLAIMS PROCESSING EDITS

Payment of *covered expenses* for *services* rendered by a *qualified practitioner* is subject to this Plan's claims processing edits, as determined by this Plan. The amount determined to be payable after this Plan applies claims processing edits depends on the existence and interaction of several factors. Because the mix of these factors may be different for every claim, the amount paid for a *covered expense* may vary depending on the circumstances. Accordingly, it is not feasible to provide an exhaustive description of the claims processing edits that will be used to determine the amount payable for a *covered expense*, but examples of the most commonly used factors are:

- The intensity and complexity of a *service*;
- Whether a *service* is one of multiple *services* performed at the same *service* session such that the cost of the *service* to the *qualified practitioner* is less than if the *service* had been provided in a separate *service* session. For example:
  - Two or more *surgeries* during the same *service* session; or
  - Two or more radiologic imaging views performed during the same session;
- Whether an *assistant surgeon*, physician assistant, registered *nurse*, certified operating room technician or any other *qualified practitioner*, who is billing independently is involved;
- When a charge includes more than one claim line, whether any *service* is part of or incidental to the primary *service* that was provided, or if these *services* cannot be performed together;
- If the *service* is reasonably expected to be provided for the diagnosis reported;
- Whether a *service* was performed specifically for *you*; or
- Whether *services* can be billed as a complete set of *services* under one billing code.

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## CLAIM PROCEDURES (continued)

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This Plan develops claims processing edits in this Plan's sole discretion based on review of one or more of the following sources, including but not limited to:

- Medicare laws, regulations, manuals and other related guidance;
- Appropriate billing practices;
- National Uniform Billing Committee (NUBC);
- American Medical Association (AMA)/Current Procedural Terminology (CPT);
- Centers for Medicare and Medicaid Services (CMS)/Healthcare Common Procedure Coding System (HCPCS);
- UB-04 Data Specifications Manual, and any successor manuals;
- International Classification of Diseases of the U.S. Department of Health and Human Services and the Diagnostic and Statistical Manual of Mental Disorders;
- Medical and surgical specialty societies and associations;
- This Plan's medical and pharmacy coverage policies; or
- Generally accepted standards of medical, behavioral health and dental practice based on credible scientific evidence recognized in published peer reviewed medical or dental literature.

Changes to any one of the sources may or may not lead this Plan to modify current or adopt new claims processing edits.

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

Your *qualified practitioner* may access this Plan's claims processing edits and medical and pharmacy coverage policies at the "For Providers" link at [www.humana.com](http://www.humana.com). You or your *qualified practitioner* may also call the toll-free customer service number listed on your ID card to obtain a copy of a policy. You should discuss these policies and their availability with any *qualified practitioner*, who are *non-participating providers*, prior to receiving any services.

### 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.

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## CLAIM PROCEDURES (continued)

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

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

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

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

### CLAIMS DECISIONS

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

#### Pre-Service Claims

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

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

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

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## CLAIM PROCEDURES (continued)

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### Urgent Care Claims

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

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

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

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

### Concurrent Care Decisions

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

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

### Post-Service Claims

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

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## CLAIM PROCEDURES (continued)

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

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

### TIMES FOR DECISIONS

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

### PAYMENT OF CLAIMS

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

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

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

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

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

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

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

## **NOTICES – GENERAL INFORMATION**

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

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

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

## **INITIAL DENIAL NOTICES**

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

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

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

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

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## CLAIM PROCEDURES (continued)

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

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

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

### APPEALS OF ADVERSE BENEFIT DETERMINATIONS

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

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

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

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

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

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

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

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**CLAIM PROCEDURES (continued)**

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**TIME PERIOD FOR DECISIONS ON APPEAL**

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

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

**APPEAL DENIAL NOTICES**

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

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

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

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

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## CLAIM PROCEDURES (continued)

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

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

### FULL AND FAIR REVIEW

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

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

### RIGHT TO REQUIRE MEDICAL EXAMINATIONS

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

### EXHAUSTION

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

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## CLAIM PROCEDURES (continued)

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

### LEGAL ACTIONS AND LIMITATIONS

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

### STANDARD EXTERNAL REVIEW

#### Request for an External Review

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

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

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

#### Preliminary Review

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

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

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## CLAIM PROCEDURES (continued)

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- If the *claimant* has exhausted this Plan's *internal appeals* process, when required; and
- If the *claimant* has provided all the information and forms required to process an *external review*.

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

- If the request is complete but not eligible for *external review*. The notice must include the reason(s) for its ineligibility and contact information for the Department of Labor (DOL) Employee Benefits Security Administration (EBSA), including this toll-free number: 1-866-444-EBSA (3272) and this e-mail address: [www.askebsa.dol.gov](http://www.askebsa.dol.gov).
- If the request is not complete. The notice must describe the information or materials needed to make it complete, and Humana must allow the *claimant* to perfect the *external review* request within whichever of the following two options is later:
  - The initial 4-month filing period; or
  - The 48-hour period following receipt of the notification.

### **Referral to an Independent Review Organization (IRO)**

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

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

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

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## CLAIM PROCEDURES (continued)

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- If the *IRO* receives any information from the *claimant*, the *IRO* must forward it to Humana within 1 business day. After receiving this information, Humana may reconsider its *adverse benefit determination* or *final internal adverse benefit determination*. If Humana reverses or changes its original determination, Humana must notify the *claimant* and the *IRO*, in writing, within 1 business day. The assigned *IRO* will then terminate the *external review*.
  
- The *IRO* will review all information and documents timely received. In reaching a decision, the *IRO* will not be bound by any decisions or conclusions reached during Humana's internal claims and *appeals* process. The *IRO*, to the extent the information or documents are available and the *IRO* considers them appropriate, will consider the following when reaching a determination:
  - The *claimant's* medical records;
  - The attending health care professional's recommendation;
  - Reports from the appropriate health care professional(s) and other documents submitted by Humana, *claimant*, or *claimant's* treating provider;
  - The terms of the *claimant's* plan to ensure the *IRO's* decision is not contrary, unless the terms are inconsistent with applicable law;
  - Appropriate practice guidelines, including applicable evidence-based standards that may include practice guidelines developed by the federal government, national or professional medical societies, boards, and associations;
  - Any applicable clinical review criteria developed and used by this Plan, unless inconsistent with the terms of this Plan or with applicable law; and
  - The opinion of the *IRO's* clinical reviewer(s) after considering the information described above to the extent the information or documents are available and the reviewer(s) consider them appropriate.
  
- The assigned *IRO* must provide written notice of the *final external review decision* within 45 days after receiving the *external review* request to the *claimant* and Humana. The decision notice must contain the following:
  - A general description of the reason an *external review* was requested, including information sufficient to identify the claim including:
    - The date(s) of service;
    - The health care provider;
    - The claim amount (if applicable); and
    - The reason for the previous denial.
  - The date the *IRO* received assignment to conduct the *external review* and the date of the *IRO* decision;
  - References to the evidence or documentation considered in reaching the decision, including the specific coverage provisions and evidence-based standards;
  - A discussion of the principal reason(s) for its decision, including the rationale and any evidence-based standards relied on in making the decision;
  - A statement that the determination is binding except to the extent that other remedies may be available under state or federal law to either Humana or the *claimant*;
  - A statement that judicial review may be available to the *claimant*; and
  - Current contact information, including telephone number, for any applicable office of health insurance consumer assistance or ombudsman established under PPACA (*section 2793 of PHSA, as amended*).

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## CLAIM PROCEDURES (continued)

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

### Reversal of this Plan's Decision

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

## EXPEDITED EXTERNAL REVIEW

### Request for an Expedited External Review

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

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

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

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

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

### Preliminary Review

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

**Referral to an Independent Review Organization (IRO)**

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

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

**Notice of Final External Review Decision**

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

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

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

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

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

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

# **SECTION 3**

# **DEFINITIONS**

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## DEFINITIONS

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

### A

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

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

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

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

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

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

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

***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.

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## DEFINITIONS (continued)

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**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:

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

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

**Applied behavioral analysis (ABA) therapy** is an intensive behavioral treatment program that attempts to improve cognitive and social functioning.

**Assistant surgeon** means a *qualified practitioner* who assists at *surgery* and is a Doctor of Medicine (MD), Doctor of Osteopathic Medicine (DO), Doctor of Podiatric Medicine (DPM).

## B

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

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

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

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## DEFINITIONS (continued)

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***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*.

***Bone marrow*** means the transplant of human blood precursor cells. Such cells may be derived from bone marrow, circulating blood, or a combination of bone marrow and circulating blood obtained from the patient in an autologous transplant, from a matched related or unrelated donor, or cord blood. The term *bone marrow* includes the harvesting, the transplantation and the integral chemotherapy components.

## 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.

***Complications of pregnancy*** means:

- 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;
- A non-elective cesarean section surgical procedure;
- Terminated ectopic pregnancy; or
- Spontaneous termination of pregnancy which occurs during a period of gestation in which a viable birth is not possible.

***Complications of pregnancy*** do not mean:

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

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

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

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## DEFINITIONS (continued)

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

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

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

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

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

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

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

## D

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

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

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

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

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

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## DEFINITIONS (continued)

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

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

## E

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

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

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

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

- Cannot be lawfully marketed without the final approval of the United States Food and Drug Administration (FDA) and which lacks such final FDA approval for the use or proposed use, unless:
  - 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](http://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
  - 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](http://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
  - 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;
- Is a device required to receive Premarket Approval (PMA) or 510K approval by the FDA but has not received a PMA or 510K approval;

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## DEFINITIONS (continued)

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- 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:
  - Clinical trials approved by this Plan (for additional details, go to [www.humana.com](http://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
  - 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;
- Is identified as not covered by the Centers for Medicare and Medicaid Services (CMS) Medicare Coverage Issues Manual, a CMS Operational Policy Letter or a CMS National Coverage Decision, except as required by federal law and excluding transplants.

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

## F

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

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

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

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

## G

**Gender dysphoria** refers to discomfort or distress that is caused by a discrepancy between a person's gender identity and that person's sex assigned at birth (and the associated gender role and/or primary and secondary sex characteristics). For a person to be diagnosed with gender dysphoria, there must be a marked difference between the individual's expressed/experienced gender and the gender others would assign him or her and it must continue for at least six months. This condition may cause clinically significant distress or impairment in social, occupational or other important areas of functioning.

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## DEFINITIONS (continued)

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### H

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

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

**Hospital** means an institution which:

- Maintains permanent full-time facilities for bed care of resident patients;
- Has a physician and surgeon in regular attendance;
- Provides continuous 24 hour a day nursing *services*;
- Is primarily engaged in providing diagnostic and therapeutic facilities for medical or surgical care of sick or injured persons;
- Is legally operated in the jurisdiction where located; and
- 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
- 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*.

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## DEFINITIONS (continued)

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***Intensive outpatient*** means outpatient *services* providing:

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

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

- *Custodial care*; or
- Day care.

## L

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

## M

***Maintenance care*** means 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.

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## DEFINITIONS (continued)

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**Maximum allowable fee** for a *covered expense*, other than *emergency care services* provided by *Non-PAR providers* in a *hospital's* emergency department, is the lesser of:

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

Unless this Plan utilizes a higher paying shared savings network or pays the *Non-PAR provider* full billed rate, **maximum allowable fee** for a *covered expense* for *emergency care services* provided by *Non-PAR providers* in a *hospital's* emergency department is an amount equal to the greatest of:

- The fee negotiated with *PAR providers*;
- The fee calculated using the same method to determine payments for *Non-PAR provider services*;  
or
- The fee paid by *Medicare* for the same services.

**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*, *PAR Provider Plan Maximum Out-of-Pocket Limit* or *deductible*.

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

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## DEFINITIONS (continued)

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

- In accordance with nationally recognized standards of medical practice;
- Clinically appropriate in terms of type, frequency, extent, site and duration, and considered effective for the patient's *sickness* or *bodily injury*;
- Not primarily for the convenience of the patient, physician or other health care provider;
- Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the patient's *sickness* or *bodily injury*; and
- Performed in the least costly site.

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

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

**Mental health** 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:

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

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## DEFINITIONS (continued)

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### N

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

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

### O

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

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

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

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

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

### P

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

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

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## DEFINITIONS (continued)

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

- For a comprehensive and intensive interdisciplinary psychiatric treatment for minimum of 5 hours a day, 5 days per week;
- 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
- 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 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 U.S. Health and Welfare Leader for The Dow Chemical Company.

**Plan Manager** means Humana Health Plan, Inc. (HHP). The *Plan Manager* provides services to the *Plan Administrator*, as defined under the Plan Management Agreement. The *Plan Manager* is not the *Plan Administrator* or the *Plan Sponsor*. The *Plan Manager* has the same meaning as Claims Administrator with respect to Claims for a Plan Benefit and Appeals Administrator with respect to Claims for a Plan Benefit, as those terms are defined in the body of this Summary Plan Description.

**Plan Sponsor** means The Dow Chemical Company.

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

**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.

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

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## DEFINITIONS (continued)

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

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

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

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

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

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

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

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

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

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

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

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## DEFINITIONS (continued)

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### Q

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

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

### R

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

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

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

**Retail Clinic** means a *qualified treatment facility*, located in a retail store, that is often staffed by *nurse* practitioners and physician assistants who provide minor medical services on a “walk-in” basis (no appointment required).

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

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

### S

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

**Service area** means the geographic area designated by Humana, or as otherwise agreed upon between the *Plan Sponsor* and Humana. A description of the *service area* is provided in the provider directories.

**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.

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## DEFINITIONS (continued)

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

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

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

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

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

Have special handling, storage or shipping requirements.

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

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

**Surgery** means excision or incision of the skin or mucosal tissues, insertion for exploratory purposes into a natural body opening, insertion of instruments into any body opening, natural or otherwise, done for diagnostic or other therapeutic purposes, treatment of fractures or procedures to repair, remove or replace any body part or foreign object in or on the body.

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## DEFINITIONS (continued)

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### T

**Telehealth** means an audio and video real-time interactive communication between a patient and a *qualified practitioner* at a *distant site*.

**Telemedicine** means services, other than *telehealth*, provided via telephonic or electronic communications.

**Total disability or totally disabled** means:

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

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

### U

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

- Could seriously jeopardize the life or health of the *claimant* or the ability of the *claimant* to regain maximum function; or
- 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.

### Y

**You and your** means any *covered person*

**SECTION 4**

**PRESCRIPTION DRUG  
BENEFIT**

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## PRESCRIPTION DRUG BENEFIT

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

### DEFINITIONS

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

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

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

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

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

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

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

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

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

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

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

**Non-participating pharmacy** means a *pharmacy* that has NOT signed a direct agreement with Humana or has NOT been designated by Humana to provide covered *pharmacy services*, or covered *specialty pharmacy* services or covered *mail order pharmacy* services to *covered persons*, including covered *prescriptions* or refills delivered to *your* home.

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**PRESCRIPTION DRUG BENEFIT (continued)**

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

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

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

- Affects less than 200,000 persons in the United States; or
- 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 signed a direct agreement with Humana or has been designated by Humana to provide covered *pharmacy services*, covered *specialty pharmacy services* or covered *mail order pharmacy services*, as defined by Humana, to *covered persons*, including covered *prescriptions* or refills delivered to *your home*.

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

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

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**PRESCRIPTION DRUG BENEFIT (continued)**

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**Prior authorization** means the required prior approval from Humana for the coverage of *prescription* drugs, medicines and medications, *specialty drugs* including the dosage, quantity and duration, as *medically necessary* for the *covered person*. Certain *prescription* drugs, medicines or medications may require *prior authorization*. Visit Humana's Website at [www.humana.com](http://www.humana.com) or call Humana at the toll-free customer service telephone number listed on *your* Humana ID card to obtain the *drug lists*. The *drug lists* are subject to change without notice.

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

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

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

**Step therapy** means type of *prior authorization*. Humana may require *you* to follow certain steps prior to coverage of some medicines, including *specialty drugs*. Humana may require *you* to try a similar drug, medicine or medication, including *specialty drugs* that has been determined to be safe, effective and less costly for most people with *your* condition. Alternatives may include over-the-counter drugs, *generic medications* and *brand name medications*.

**PRESCRIPTION DRUG BENEFIT (continued)**

**SCHEDULE OF PRESCRIPTION DRUG BENEFITS**

Additional drug information can be obtained by accessing Humana’s website at [www.humana.com](http://www.humana.com) or calling the toll-free customer service number on the back *your* ID card.

*You* are responsible for the following:

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

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

**PRESCRIPTION DRUG BENEFIT (continued)**

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

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

<b>OFFICE-ADMINISTERED SPECIALTY DRUGS</b>	
Up to a 30 day supply of a <i>prescription</i> or refill for office-administered <i>specialty drugs</i> , dispensed directly to the <i>qualified practitioner’s</i> office through Humana <i>Specialty Pharmacy</i>	No <i>cost share</i>

**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 *brand name 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 *cost share*.

### **Non-participating Pharmacy**

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

Mail *pharmacy* receipts to:

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

### **PRIOR AUTHORIZATION**

Some *prescription drugs* are subject to *prior authorization*. To verify if a *prescription drug* requires *prior authorization*, call the toll free customer service telephone number listed on *your* Humana ID card or visit Humana's website at [www.humana.com](http://www.humana.com).

### **STEP THERAPY**

Some *prescription drugs* may be subject to the *step therapy* process. Call the toll-free customer service telephone number listed on *your* Humana ID card or visit Humana's website at [www.humana.com](http://www.humana.com).

### **DISPENSING LIMITS**

Some *prescription drugs* may be subject to *dispensing limits*. To verify if a *prescription drug* has *dispensing limits*, call the toll free customer service telephone number listed on *your* Humana ID card or visit Humana's website at [www.humana.com](http://www.humana.com).

### **RETAIL PHARMACY AND SPECIALTY PHARMACY**

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

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

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

### **MAIL ORDER PHARMACY**

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

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

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## PRESCRIPTION DRUG BENEFIT (continued)

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Additional *mail order pharmacy* information can be obtained by calling the toll free customer service telephone number listed on *your* Humana ID card or visit Humana's website at [www.humana.com](http://www.humana.com).

### OFFICE-ADMINISTERED SPECIALTY DRUGS

*Your qualified practitioner* has access to *specialty drugs* used to treat chronic conditions. These drugs can be ordered by *your qualified practitioner* specifically for *you* through Humana's preferred *specialty pharmacy* vendor 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 Humana at the toll-free customer service telephone number listed on *your* Humana ID card or by visiting Humana's website at [www.humana.com](http://www.humana.com).

### MAXIMIZE YOUR BENEFIT

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

### PRESCRIPTION DRUG COST SHARING

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

*You* are responsible for payment of:

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

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

### PRESCRIPTION DRUG COVERAGE

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

Covered *prescription* drugs, medicine or medications must:

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

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## PRESCRIPTION DRUG BENEFIT (continued)

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

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

### PRESCRIPTION DRUG LIMITATIONS

*Expense incurred* will not be payable for the following, unless specifically provided by this Prescription Drug Benefit Plan:

- Any drug, medicine, medication or supply not approved for coverage under this Plan. Contact Humana by calling the toll-free customer service telephone number listed on *your* Humana ID card or by visiting Humana’s website at [www.humana.com](http://www.humana.com) to verify whether a *prescription* drug is covered or not covered under this Plan. *Your* Humana ID card can be used as a discount card for *prescription* drugs not covered under this Plan;
- *Legend drugs* which are not deemed *medically necessary* by a *qualified practitioner*;
- Charges for the administration or injection of any drug;
- 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*;
- Any drug, medicine or medication that is consumed or injected at the place where the *prescription* is given, or dispensed by the *qualified practitioner*;
- *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:
  - *Hospital*;
  - Skilled nursing facility; or
  - Hospice facility.
- Any drug prescribed, except:
  - FDA approved drugs utilized for FDA approved indications; or
  - 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.
- *Prescription refills*:
  - In excess of the number specified by the *qualified practitioner*; or
  - Dispensed more than one year from the date of the original order.

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**PRESCRIPTION DRUG BENEFIT (continued)**

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- *Off-evidence drug indications;*
- Any drug for which a charge is customarily not made;
- 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*, whose coverage is approved by this Plan); support garments; test reagents; mechanical pumps for delivery of medications; and other non-medical substances;
- Dietary supplements (except enteral formulas and nutritional supplements for the treatment of phenylketonuria (PKU) or other inherited metabolic disease) 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);
- Drug delivery implants;
- Injectable drugs, including but not limited to: immunizing agents; biological sera; blood; blood plasma; or *self-administered injectable drugs* or *specialty drugs* not covered under this Plan;
- Any drug prescribed for a *sickness* or *bodily injury* not covered under this Plan;
- Any portion of a *prescription* or refill that exceeds the day supply as shown on the “Schedule of Prescription Drug Benefits”;
- Any drug, medicine or medication received by the *covered person*:
  - Before becoming covered under this Plan; or
  - After the date the *covered person*’s coverage under this Plan has ended;
- Any costs related to the mailing, sending, or delivery of *prescription* drugs;
- Any intentional misuse of this benefit including *prescriptions* purchased for consumption by someone other than the *covered person*;
- Any *prescription* or refill for drugs, medicines, or medications that are lost, stolen, spilled, spoiled, or damaged;
- Repackaged drugs;
- Any drug or medicine that is:
  - Lawfully obtainable without a *prescription* (over the counter drugs), except insulin; or
  - Available in *prescription* strength without a *prescription*.
- Any drug or biological that has received designation as an *orphan drug*, unless approved by this Plan;

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**PRESCRIPTION DRUG BENEFIT (continued)**

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- 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*;
- 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, is refilled early or exceeds the duration-specific *dispensing limit*, if applicable;
- Any drug for which *prior authorization* or *step therapy* is required and not obtained;
- Based on the dosage schedule prescribed by the *qualified practitioner*, 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;
- *Prescriptions* filled at a *non-participating pharmacy*.

*Administered by:*



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