Humana

SUMMARY PLAN DESCRIPTION

For the

Plan 1 MEDICAL PLAN

Sponsored by

OHIO PUBLIC EMPLOYEES RETIREMENT SYSTEM

Package ID: Q7918

Plan and Option Number: 098/675

Effective: January 1, 2016 through June 30, 2016

Humana

INTRODUCTION

THE SUMMARY PLAN DESCRIPTION – YOUR HEALTH CARE PLAN GUIDE

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

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

This Plan pays after Medicare. Please present your Medicare card and your Humana Medicare Secondary Plan card to your providers so they can bill Medicare first before submitting charges to this Plan.

You must be enrolled in Medicare Part B to receive coverage under this Plan. If your Medicare Part B is cancelled for any reason your coverage under this Plan will terminate.

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

DEFINED TERMS

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

PRIVACY

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

CONTACT INFORMATION

Customer Service Telephone Number:

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

Website: *You* can access Humana's online services at www.humana.com.

Claims Submittal Address:

Humana Claims Office
P.O. Box 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

HEALTH RESOURCES

Health Resources is a comprehensive set of clinical programs and services available to help *you* better understand *your* health care coverage 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.

Below is a brief description of this Plan's Health Resources programs. All Health Resources programs are subject to change without notice. For additional information or questions regarding any of these programs, please call the toll-free customer service telephone number listed on *your* Humana ID card.

TRANSITION OF CARE

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

CONTINUITY OF CARE

If *you* are receiving treatment from a *PAR provider* and that *provider's contract* to provide *medically necessary services* terminates for reasons other than medical competence or professional behavior, *you* may be entitled to continue treatment with that terminating *PAR provider* if at the time of the *PAR provider's* termination *you* are: a) undergoing active treatment for a chronic or acute medical condition; or b) *you* are in the 2nd or 3rd trimester of *your* pregnancy. If this Plan agrees to the continued treatment, *medically necessary services* provided to *you* by the terminating *PAR provider* will continue to be payable at the *PAR provider* coverage level. The maximum duration of continued treatment under this provision may not exceed: a) 90 days from the date of termination of the *provider's contract*; or b) through the delivery of a child, including immediate post-partum care and the follow-up visit within the first six weeks of delivery, in the case of *you* being in the 2nd or 3rd trimester of pregnancy.

UTILIZATION MANAGEMENT

Utilization Management consists of *preauthorization*, claims review (*retrospective review*), coordination of care and referral processes that ensure Plan *services* are used properly. Utilization Management decisions are made using established criteria and care guidelines along with the medical information provided by the patient and the patient's *qualified practitioner*. The patient and his or her *qualified practitioner* determine the course of treatment. The assistance provided through these *services* does not constitute the practice of medicine. Payment of Plan *services* are not determined through these processes.

Preauthorization Requirements

Preauthorization is required by this Plan for certain *services*. If *you* do not obtain *preauthorization* for *services* being rendered, *your services* may be reduced or a penalty may apply. Refer to the "Preauthorization" section for more information.

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

Concurrent Review

Case managers assess the continuing *medical necessity* and appropriateness of additional days of *hospital confinement* and other health care *services*. To help with *concurrent review*, case managers receive a daily census of all inpatient *admissions* for their assigned facilities along with a notice of any *covered persons* admitted without a *preauthorization*, then, the nurses use priority review criteria and guidelines to prioritize these cases for clinical review.

Retrospective Review

If an *admission* or *service* occurs without *preauthorization*, Humana may complete a *retrospective review* after receiving the claim to determine if both the *admission* and length of stay were medically appropriate.

TRANSPLANT MANAGEMENT

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

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

PREAUTHORIZATION

Humana will provide *preauthorization* as required by this Plan. Visit Humana's website at 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 services* 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*, *services* 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, coverage 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 FOR TRANSPLANT SERVICES

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

PREAUTHORIZATION PENALTY FOR ALL OTHER SERVICES

If *preauthorization* is not received, *services* will be reduced to 50% after any applicable *copayments*.

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

Prior Authorization

Prior authorization is a review process that allows Humana to determine whether a service is medically necessary. Clinical information about your condition and treatment supplied by your doctor is compared against professionally recognized medical criteria for medical appropriateness and safety. For approval, certain criteria must be met. Humana will inform you and your doctor of the outcome of the prior authorization review process.

The Importance of Prior Authorization

The Humana Prior Authorization process is designed to ensure any expenses you incur for medically necessary services are covered under your Humana Plan. Using Medicare and Humana guidelines, Humana verifies whether services are medically necessary and appropriate for coverage. Humana performs the review in advance of the participant receiving the services to minimize the risk of OPERS participant being billed for non-covered services. Traditional Medicare provides the review process for medical necessity after the service has been provided. If Humana were to review for medical necessity after the service has been rendered and the service was determined not to be medically necessary, the claim would be denied for payment. The provider would then absorb the costs for the denied claim which ultimately costs you in the long run through increased provider fees. Prior authorization is Humana's way to ensure you are protected financially so you know in advance that the service that requires prior authorization will be covered under your Humana Medicare Secondary Plan.

Services Requiring Prior Authorization

The most common services that require prior authorization are inpatient hospitalizations. For a complete listing of services needing prior authorization, please call Humana Group Medicare Customer Care Team at 1-877-890-4777, 8:00 a.m.-9:00 p.m. Eastern Time, Monday-Friday.

Initiating the Prior Authorization process with Humana

Typically, your doctor or other health care provider will initiate the Prior Authorization process with Humana. However, if your provider does not obtain prior authorization for one of the required services, you could be financially responsible for the cost of that service. It's always a good idea to check with Humana if your doctor has recommended any of the services that require prior authorization to be sure Humana will cover the service.

Prior Authorization denials

If Humana compares the clinical information your doctor supplied against the medical criteria used to determine medical appropriateness and determines the medical criteria is not met, Humana will deny insurance coverage for the suggested services. In the case of a denial, you may ask Humana to reconsider the decision by filing a "request for reconsideration" or an appeal with Humana.

PREDETERMINATION OF COVERAGE

You or *your qualified practitioner* may submit a written request for a *predetermination of coverage*. 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 coverages are and if the expected charges are within the *maximum allowable fee*. The *predetermination of coverage* is not a guarantee of coverage. *Services* will be subject to all terms and provisions of this Plan applicable at the time treatment is provided.

If *you* have requested a *predetermination of coverage* and treatment is to commence more than 180 days after the date treatment is authorized, Humana will need *you* to submit another treatment plan.

Certain medical services require prior authorization to determine medical necessity.

SECTION 3

MEDICAL COVERAGE

PARTICIPATING AND NON-PARTICIPATING PROVIDERS

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

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

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

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

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

PAR PROVIDER DIRECTORY

An online directory of *PAR providers* is available to *you* and accessible via Humana's website at www.humana.com. This directory is subject to change. Due to the possibility of *PAR providers* changing status, please check the online directory of *PAR providers* prior to obtaining *services*. If *you* do not have access to the online directory, call Humana at the toll-free customer service telephone number listed on *your* Humana ID card prior to *services* being rendered or to request a directory.

COVERED AND NON-COVERED EXPENSES

Services 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 *services* 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 coverage provision is applicable for payment of *covered expenses*.

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

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

CLAIMS PROCESSING EDITS

Payment of *covered expenses* for *services* rendered by a provider is subject to this Plan's claims processing edits. The amount determined to be payable under this Plan's 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 provider is less than if the *service* had been provided in a separate *service* session. For example:
  - Two or more *surgeries* occurring at the same *service* session that do not require two preparation times; or
  - Two or more radiologic imaging views performed on the same body part;
- Whether an assistant surgeon, physician assistant, registered nurse, certified operating room technician or any other health care professional 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 the *covered person*;
- Whether *services* can be billed as a complete set of *services* under one billing code.

This Plan develops claims processing edits 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 Technology (CPT);
- UB-04 Data Specifications Manual;
- 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 certification boards;
- Humana's medical coverage policies; and/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.

Non-participating providers may bill *covered persons* for any amount this Plan does not pay even if such amount exceeds these claims processing edits. Any amount that exceeds the claims processing edits paid by the *covered person* will not apply to *out-of-pocket limits* or *PAR provider Plan maximum out-of-pocket limits*, if applicable. The *covered person* will also be responsible for any applicable *coinsurance* amount or *copayment*.

MEDICAL SCHEDULE OF COVERAGE

IMPORTANT INFORMATION ABOUT PLAN COVERAGE

Plan coverage and limits (i.e. visit or dollar limits) are applicable per *calendar year*, unless specifically stated otherwise.

When Plan coverage limits apply (i.e. visit or dollar limits), *PAR* and *Non-PAR provider* coverage accumulate together, unless specifically stated otherwise.

This schedule provides an overview of the medical Plan coverage. For a more detailed description of this Plan's medical coverage, refer to the "Medical Covered Expenses" section.

MEDICAL DEDUCTIBLES, COINSURANCE, OUT-OF-POCKET LIMITS AND OFFICE VISIT COPAYMENTS		
PLAN FEATURES	**What you must pay** when you get these covered services **PAR PROVIDER SERVICES**	**NON-PAR PROVIDER SERVICES**
Single Medical *Deductible*	Not applicable	Not applicable
Family Medical *Deductible*	Not applicable	Not applicable
Medical *Coinsurance*	The Plan pays 92%- 96%, *you* pay 4%-8%.	The Plan pays 92%- 96%, *you* pay 4%-8%.
Single Medical *Out-of-Pocket Limit*	$850 per *covered person*	$850 per *covered person*
Family Medical *Out-of-Pocket Limit*	Not applicable	Not applicable

MEDICAL DEDUCTIBLES, COINSURANCE, OUT-OF-POCKET LIMITS AND OFFICE VISIT COPAYMENTS		
COVERAGE FEATURES	**What you must pay** when you get these covered services **PAR PROVIDER SERVICES**	**NON-PAR PROVIDER SERVICES**
Qualified Practitioner Primary Care Physician (PCP) Office Visit *Copayment*	Not applicable	Not applicable
Qualified Practitioner Specialist Office Visit *Copayment*	Not applicable	Not applicable
Retail Clinic Copayment	Not applicable	Not applicable
Primary Care Physician (PCP) is defined as a family practice physician, pediatrician, doctor of internal medicine, general practitioner, nurse practitioner, physician assistant, registered nurse and OBGYN. A specialist would be all other *qualified practitioners*.		
Lifetime Maximum Coverage	Unlimited	

ROUTINE/PREVENTIVE ADULT CARE SERVICES AGE 18 AND OVER (*Services* Received at a Clinic or Outpatient *Hospital*)		
MEDICAL SERVICES	**What you must pay** when you get these covered services **PAR PROVIDER SERVICES**	**NON-PAR PROVIDER SERVICES**
Routine/Preventive Adult Care Examination	*You* pay nothing	*You* pay nothing
Routine/Preventive Adult Care Vision Screening	*You* pay nothing	*You* pay nothing
Routine/Preventive Adult Care Hearing Screening	*You* pay nothing	*You* pay nothing
Routine/Preventive Adult Care Laboratory	*You* pay nothing	*You* pay nothing
Routine/Preventive Adult Care X-ray	*You* pay nothing	*You* pay nothing
Routine/Preventive Adult Care 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	*You* pay nothing	*You* pay nothing
Routine/Preventive Adult Care Flu/Pneumonia Immunizations	*You* pay nothing	*You* pay nothing

ROUTINE/PREVENTIVE ADULT CARE SERVICES AGE 18 AND OVER (*Services* Received at a Clinic or Outpatient *Hospital*)		
MEDICAL SERVICES	**What you must pay** when you get these covered services **PAR PROVIDER SERVICES**	**NON-PAR PROVIDER SERVICES**
Routine/Preventive Adult Care Mammograms	*You* pay nothing	*You* pay nothing
Routine/Preventive Adult Care Pap Smears	*You* pay nothing	*You* pay nothing
Routine/Preventive Adult Care Colonoscopy, Proctosigmoidoscopy and Sigmoidoscopy Screenings (including related *services*) (performed at an outpatient facility, *ambulatory surgical center* or clinic location) Colonoscopy, Proctosigmoidoscopy and Sigmoidoscopy Screenings are payable under this Routine/Preventive Adult Care Coverage when billed by the *qualified practitioner* with a routine diagnosis.	*You* pay nothing	*You* pay nothing
Routine/Preventive Adult Care Prostate Specific Antigen (PSA) Testing	*You* pay nothing	*You* pay nothing
Breast Feeding Counseling	*You* pay nothing	*You* pay nothing
Breast Feeding Support and Supplies	*You* pay nothing	*You* pay nothing

ROUTINE/PREVENTIVE ADULT CARE SERVICES AGE 18 AND OVER (*Services* Received at a Clinic or Outpatient *Hospital*)		
MEDICAL SERVICES	**What you must pay** when you get these covered services **PAR PROVIDER SERVICES**	**NON-PAR PROVIDER SERVICES**
Contraceptive Methods - devices (e.g. IUD or diaphragms), injections, implant insertion/removal, emergency contraceptives and condoms; Sterilization - tubal ligation and vasectomy (excludes birth control pills/patches and spermicide) For information on *prescription* drug coverage for birth control pills/patches, spermicide, emergency contraceptives and condoms, please see *your prescription* drug coverage.	*You* pay nothing If *services* are not to prevent pregnancy, then they are payable the same as any other *sickness*.	*You* pay nothing If *services* are not to prevent pregnancy, then they are payable the same as any other *sickness*.
Age limits do not apply to routine mammograms and pap smears.		

ROUTINE VISION SERVICES		
MEDICAL SERVICES	**What you must pay** when you get these covered services **PAR PROVIDER SERVICES**	**NON-PAR PROVIDER SERVICES**
Routine Vision Examination	Not Covered	Not Covered
Routine Vision Refraction	Not Covered	Not Covered
Eyeglass Frames and Lenses and Contact Lenses	Not Covered	Not Covered

ROUTINE HEARING SERVICES		
MEDICAL SERVICES	**What you must pay** when you get these covered services **PAR PROVIDER SERVICES**	**NON-PAR PROVIDER SERVICES**
Routine Hearing Examination	Not Covered	Not Covered
Routine Hearing Testing	Not Covered	Not Covered
Hearing Aids and Fitting	Not Covered	Not Covered

QUALIFIED PRACTITIONER SERVICES (Non-Routine/Non-Preventive Care *Services*)		
MEDICAL SERVICES	**What you must pay** when you get these covered services **PAR PROVIDER SERVICES**	**NON-PAR PROVIDER SERVICES**
Diagnostic Office Examination at a Clinic, including Second Surgical Opinion – *Qualified Practitioner* Primary Care Physician	4% *coinsurance*	4% *coinsurance*
Diagnostic Office Examination at a Clinic, including Second Surgical Opinion - *Qualified Practitioner* Specialist	8% *coinsurance*	8% *coinsurance*
Office Examination at *Retail Clinic* including Second Surgical Opinion	4% *coinsurance*	4% *coinsurance*
Office examination *service* applies only to the office examination. All other *services* will be paid based on the *service* listed below. If an office examination is billed from an outpatient location, the *services* will be payable the same as an office examination at a clinic.		
Diagnostic Laboratory at a Clinic	*You* pay nothing	*You* pay nothing
Diagnostic X-ray at a Clinic (other than *advanced imaging*)	4% *coinsurance*	4% *coinsurance*
Independent Laboratory	*You* pay nothing	*You* pay nothing

QUALIFIED PRACTITIONER SERVICES (Non-Routine/Non-Preventive Care *Services*)		
MEDICAL SERVICES	**What you must pay** when you get these covered services **PAR PROVIDER SERVICES**	**NON-PAR PROVIDER SERVICES**
Advanced Imaging at a Clinic	4% *coinsurance*	4% *coinsurance*
Allergy Testing at a Clinic	4% *coinsurance*	4% *coinsurance*
Allergy Serum/Vials at a Clinic	4% *coinsurance*	4% *coinsurance*
Allergy Injections at a Clinic	4% *coinsurance*	4% *coinsurance*
Injections at a Clinic (other than routine immunizations, flu or pneumonia immunizations, contraceptive injections for birth control reasons and allergy injections)	4% *coinsurance*	4% *coinsurance*
Anesthesia at a Clinic	4% *coinsurance*	4% *coinsurance*
Surgery at a Clinic (including *Qualified Practitioner*, Assistant Surgeon and Physician Assistant)	4% *coinsurance*	4% *coinsurance*
Medical and Surgical Supplies	*You* pay nothing	*You* pay nothing
Eyeglasses or Contact Lenses after Cataract *Surgery* (initial pair only)	4% *coinsurance*	4% *coinsurance*

QUALIFIED PRACTITIONER SERVICES (Non-Routine/Non-Preventive Care *Services*)		
MEDICAL SERVICES	**What you must pay** when you get these covered services **PAR PROVIDER SERVICES**	**NON-PAR PROVIDER SERVICES**
Diabetic Nutritional Counseling (*Diabetes Self-Management Training*) (all places of *service*)	*You* pay nothing	*You* pay nothing
Diabetes Supplies	*You* pay nothing	*You* pay nothing

DENTAL/ORAL SURGERIES COVERED UNDER THE MEDICAL PLAN		
MEDICAL SERVICES	**What you must pay** when you get these covered services **PAR PROVIDER SERVICES**	**NON-PAR PROVIDER SERVICES**
Dental/Oral *Surgeries*	Payable the same as any other *sickness*.	Payable the same as any other *sickness*.
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 service.		

REVERSAL OF STERILIZATION AND ABORTIONS		
MEDICAL SERVICES	**What you must pay** when you get these covered services **PAR PROVIDER SERVICES**	**NON-PAR PROVIDER SERVICES**
Reversal of Sterilization	Not Covered	Not Covered
Life Threatening Abortions	Payable the same as any other *sickness*.	Payable the same as any other *sickness*.
Elective Abortions	Not Covered	Not Covered

MATERNITY (Normal, C-Section and Complications)		
MEDICAL SERVICES	**What you must pay** when you get these covered services **PAR PROVIDER SERVICE**	**NON-PAR PROVIDER SERVICE**
Inpatient *Hospital* Room and Board and Ancillary Facility *Services*	Payable the same as any other *sickness*.	Payable the same as any other *sickness*.
Birthing Center Room and Board and Ancillary *Services*	Payable the same as any other *sickness*.	Payable the same as any other *sickness*.
Qualified Practitioner Services	Payable the same as any other *sickness*.	Payable the same as any other *sickness*.

MATERNITY (Normal, C-Section and Complications)		
MEDICAL SERVICES	**What you must pay** when you get these covered services **PAR PROVIDER SERVICES**	**NON-PAR PROVIDER SERVICES**
Newborn Inpatient *Qualified Practitioner Services*	4% *coinsurance*	4% *coinsurance*
Newborn Inpatient Facility *Services*	4% *coinsurance*	4% *coinsurance*

INPATIENT SERVICES		
MEDICAL SERVICES	**What you must pay** when you get these covered services **PAR PROVIDER SERVICES**	**NON-PAR PROVIDER SERVICES**
Inpatient *Hospital* Room and Board and Ancillary Facility *Services*	4% *coinsurance*	4% *coinsurance*
Qualified Practitioner Inpatient *Hospital* Visit	4% *coinsurance*	4% *coinsurance*
Qualified Practitioner Inpatient *Surgery* and Anesthesia	4% *coinsurance*	4% *coinsurance*
Qualified Practitioner Inpatient Pathology and Radiology	4% *coinsurance*	4% *coinsurance*

INPATIENT SERVICES		
MEDICAL SERVICES	**What you must pay** when you get these covered services **PAR PROVIDER SERVICES**	**NON-PAR PROVIDER SERVICES**
Private Duty Nursing (inpatient *hospital* only)	4% *coinsurance*	4% *coinsurance*

SKILLED NURSING SERVICES		
MEDICAL SERVICES	**What you must pay** when you get these covered services **PAR PROVIDER SERVICES**	**NON-PAR PROVIDER SERVICES**
Skilled Nursing Room and Board and Ancillary Facility *Services*	*You* pay nothing	*You* pay nothing
Skilled Nursing Facility Yearly Limits	365 days per *covered person*	
Skilled Nursing *Qualified Practitioner* Visit	*You* pay nothing	*You* pay nothing

OUTPATIENT AND AMBULATORY SURGICAL CENTER SERVICES		
MEDICAL SERVICES	**What you must pay** when you get these covered services **PAR PROVIDER SERVICES**	**NON-PAR PROVIDER SERVICES**
Ambulatory Surgical Center Facility *Services*	4% *coinsurance*	4% *coinsurance*
Ambulatory Surgical Center Ancillary *Services*	4% *coinsurance*	4% *coinsurance*
Outpatient *Hospital* Facility Surgical *Services*	4% *coinsurance*	4% *coinsurance*
Outpatient *Hospital* Facility Non-Surgical *Services* (e.g. clinic facility *services*; observation)	4% *coinsurance*	4% *coinsurance*
Outpatient *Hospital* Surgical and Non-Surgical Ancillary *Services* (e.g. supplies; medication; anesthesia)	4% *coinsurance*	4% *coinsurance*
Outpatient *Hospital* Facility Diagnostic Laboratory and X-ray (other than *advanced imaging*)	4% *coinsurance*	4% *coinsurance*
Outpatient *Hospital* Facility *Advanced Imaging*	4% *coinsurance*	4% *coinsurance*
Outpatient *Hospital* and *Ambulatory Surgical Center Qualified Practitioner* Visit	4% *coinsurance*	4% *coinsurance*

OUTPATIENT AND AMBULATORY SURGICAL CENTER SERVICES		
MEDICAL SERVICES	**What you must pay** when you get these covered services **PAR PROVIDER SERVICES**	**NON-PAR PROVIDER SERVICES**
Outpatient *Hospital* and *Ambulatory Surgical Center Surgery* (including surgeon; assistant surgeon; and physician assistant) and Anesthesia	4% *coinsurance*	4% *coinsurance*
Outpatient *Hospital* and *Ambulatory Surgical Center* Pathology and Radiology	4% *coinsurance*	4% *coinsurance*
Outpatient colonoscopy (non-routine)	*You* pay nothing	*You* pay nothing

EMERGENCY AND URGENT CARE SERVICES		
MEDICAL SERVICES	**What you must pay** when you get these covered services **PAR PROVIDER SERVICES**	**NON-PAR PROVIDER SERVICES**
Emergency Room Facility and Ancillary *Services* If *you* are admitted to the *hospital*, the *copayment* will be waived.	*You* pay nothing after $50 *copayment*	Same as *PAR Provider* Service

EMERGENCY AND URGENT CARE SERVICES		
MEDICAL SERVICES	**What you must pay** when you get these covered services **PAR PROVIDER SERVICES**	**NON-PAR PROVIDER SERVICES**
Emergency Room All Physician *Services* (including Emergency Room Physician, Radiologist, Pathologist, Anesthesiologist and ancillary *services* billed by an Emergency Room Physician)	*You* pay nothing	Same as *PAR Provider* Service
Urgent Care Center (facility, ancillary *services* and *qualified practitioner services*) Only one *copayment* will be taken per day.	*You* pay nothing after $50 *copayment*	*You* pay nothing after $50 *copayment*

HOSPICE SERVICES		
MEDICAL SERVICES	**What you must pay** when you get these covered services **PAR PROVIDER SERVICES**	**NON-PAR PROVIDER SERVICES**
Hospice Inpatient Room and Board and Ancillary *Services*	5% *coinsurance*	5% *coinsurance*
Hospice Outpatient (including hospice home visits)	5% *coinsurance*	5% *coinsurance*
Hospice *Qualified Practitioner* Visit	5% *coinsurance*	5% *coinsurance*

HOME HEALTH CARE SERVICES		
MEDICAL SERVICES	**What you must pay** when you get these covered services **PAR PROVIDER SERVICES**	**NON-PAR PROVIDER SERVICES**
Home Health Care *Services*	*You* pay nothing	*You* pay nothing
Home therapy *services* will be reimbursed under the home health care coverage.		
Home Health Care Ancillary *Services* (excluding *durable medical equipment*, prosthetics and private duty nursing)	*You* pay nothing	*You* pay nothing

DURABLE MEDICAL EQUIPMENT (DME)		
MEDICAL SERVICES	**What you must pay** when you get these covered services **PAR PROVIDER SERVICES**	**NON-PAR PROVIDER SERVICES**
Durable Medical Equipment (DME)	4% *coinsurance*	4% *coinsurance*
Prosthesis	4% *coinsurance*	4% *coinsurance*
Wigs for cancer patients with hair loss resulting from chemotherapy and/or radiation therapy	4% *coinsurance*	4% *coinsurance*

SPECIALTY DRUGS		
MEDICAL SERVICES	**What you must pay** when you get these covered services **PAR PROVIDER SERVICES**	**NON-PAR PROVIDER SERVICES**
Specialty Drugs (*Qualified Practitioner's* Office Visit, Freestanding Facility and Urgent Care)	4% *coinsurance*	4% *coinsurance*
Specialty Drugs (Home Health Care) Other Home Health Care	4% *coinsurance* 4% *coinsurance*	4% *coinsurance* 4% *coinsurance*
Specialty Drugs (Emergency Room, *Ambulance*, Inpatient *Hospital*, Outpatient *Hospital* and Skilled Nursing Facility)	Payable the same as any other *sickness*.	Payable the same as any other *sickness*.

AMBULANCE SERVICES		
MEDICAL SERVICES	**What you must pay** when you get these covered services **PAR PROVIDER SERVICES**	**NON-PAR PROVIDER SERVICES**
Ground *Ambulance*	4% *coinsurance*	4% *coinsurance*
Air *Ambulance*	4% *coinsurance*	4% *coinsurance*

MORBID OBESITY SERVICES		
MEDICAL SERVICES	**What you must pay** when you get these covered services **PAR PROVIDER SERVICES**	**NON-PAR PROVIDER SERVICES**
The following *services* will be covered under the *morbid obesity* coverage: examinations/*qualified practitioner* visits, laboratory and x-ray *services* and other diagnostic testing, *bariatric surgery*, inpatient facility *services*, outpatient facility *services*, home health *services*, nutritional counseling and *durable medical equipment*.		
Morbid Obesity	Payable the same as any other *sickness*.	Payable the same as any other *sickness*.

OBESITY SERVICES		
MEDICAL SERVICES	**What you must pay** when you get these covered services **PAR PROVIDER SERVICES**	**NON-PAR PROVIDER SERVICES**
Obesity	Payable the same as any other *sickness*.	Payable the same as any other *sickness*.

TEMPOROMANDIBULAR JOINT DYSFUNCTION (TMJ)		
MEDICAL SERVICES	**What you must pay** when you get these covered services **PAR PROVIDER SERVICES**	**NON-PAR PROVIDER SERVICES**
Temporomandibular Joint Dysfunction (TMJ) (Other than Splint/Appliances)	Payable the same as any other *sickness*.	Payable the same as any other *sickness*.

TEMPOROMANDIBULAR JOINT DYSFUNCTION (TMJ)		
MEDICAL SERVICES	**What you must pay** when you get these covered services **PAR PROVIDER SERVICES**	**NON-PAR PROVIDER SERVICES**
Temporomandibular Joint Dysfunction (TMJ) Splint/Appliances	Payable the same as any other *sickness*.	Payable the same as any other *sickness*.

DENTAL INJURY SERVICES		
MEDICAL SERVICES	**What you must pay** when you get these covered services **PAR PROVIDER SERVICES**	**NON-PAR PROVIDER SERVICES**
Dental Injuries	Payable the same as any other *sickness*.	Payable the same as any other *sickness*.
Please see the "Medical Covered Expenses" section, Dental Injury, for coverage details.		

INFERTILITY SERVICES		
MEDICAL SERVICES	**What you must pay** when you get these covered services **PAR PROVIDER SERVICES**	**NON-PAR PROVIDER SERVICES**
Infertility Counseling and Treatment	Not covered	Not covered

INFERTILITY SERVICES		
MEDICAL SERVICES	**What you must pay** when you get these covered services **PAR PROVIDER SERVICES**	**NON-PAR PROVIDER SERVICES**
Artificial Means of Achieving Pregnancy	Not covered	Not covered
Sexual Dysfunction/Impotence	Payable the same as any other *sickness*.	Payable the same as any other *sickness*.
Sexual Dysfunction/Impotence related to a *Mental* Disorder	Payable the same as any other *sickness*.	Payable the same as any other *sickness*.

THERAPY SERVICES		
MEDICAL SERVICES	**What you must pay** when you get these covered services **PAR PROVIDER SERVICES**	**NON-PAR PROVIDER SERVICES**
Chiropractic Examinations	8% *coinsurance*	8% *coinsurance*
Chiropractic Laboratory and X-ray	4% *coinsurance*	4% *coinsurance*
Chiropractic Manipulations	4% *coinsurance*	4% *coinsurance*
Chiropractic Therapy	4% *coinsurance*	4% *coinsurance*
Physical Therapy (Clinic and Outpatient)	4% *coinsurance*	4% *coinsurance*

THERAPY SERVICES		
MEDICAL SERVICES	**What you must pay** when you get these covered services **PAR PROVIDER SERVICES**	**NON-PAR PROVIDER SERVICES**
Occupational Therapy (Clinic and Outpatient)	4% *coinsurance*	4% *coinsurance*
Speech Therapy (Clinic and Outpatient)	4% *coinsurance*	4% *coinsurance*
Cognitive Therapy (Clinic and Outpatient)	4% *coinsurance*	4% *coinsurance*
Acupuncture	Not covered	Not covered
Respiratory Therapy and Pulmonary Therapy (Clinic and Outpatient)	4% *coinsurance*	4% *coinsurance*
Vision Therapy (eye exercises to strengthen the muscles of the eye) (Clinic and Outpatient)	Not covered	Not covered
Chemotherapy (Clinic and Outpatient)	4% *coinsurance*	4% *coinsurance*
Radiation Therapy (Clinic and Outpatient)	4% *coinsurance*	4% *coinsurance*

THERAPY SERVICES		
MEDICAL SERVICES	**What you must pay** when you get these covered services **PAR PROVIDER SERVICES**	**NON-PAR PROVIDER SERVICES**
Cardiac Rehabilitation (Phase II) Phase I is covered under the inpatient facility coverage. Phase III, an unsupervised exercise program, is not covered.	4% *coinsurance*	4% *coinsurance*

TRANSPLANT SERVICES

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

MEDICAL SERVICES	HUMANA NATIONAL TRANSPLANT NETWORK (NTN) FACILITY (Payable at the *PAR Provider* Services Level)	NON-HUMANA NATIONAL TRANSPLANT NETWORK (NTN) FACILITY (Payable at the *Non-PAR Provider* Services Level)
Organ Transplant Medical *Services*	Payable the same as any other *sickness.*	Payable the same as any other *sickness*.
Organ Transplant Medical *Services* Limits	None	$35,000 per *covered person* per covered transplant
Non-Medical *Services* - Lodging and Transportation	*You* pay nothing	Not Covered
Non-Medical *Services* - Lodging and Transportation Combined Limits	$10,000 per covered transplant	Not applicable – lodging and transportation are not covered for a Non-Humana National Transplant Network provider

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

BEHAVIORAL HEALTH INPATIENT SERVICES		
MEDICAL SERVICES	**What you must pay** when you get these covered services **PAR PROVIDER SERVICES**	**NON-PAR PROVIDER SERVICES**
Inpatient *Behavioral Health* Room and Board and Ancillary *Services*	Payable the same as medical inpatient *hospital services*.	Payable the same as medical inpatient *hospital services*.
Inpatient *Behavioral Health* Professional *Services*	Payable the same as medical inpatient *qualified practitioner services*.	Payable the same as medical inpatient *qualified practitioner services*.
Behavioral Health Residential Treatment Facility Services	Payable the same as medical inpatient *hospital* and *qualified practitioner services*.	Payable the same as medical inpatient *hospital* and *qualified practitioner services*.
Behavioral Health Half-way House *Services*	Not covered	Not covered

BEHAVIORAL HEALTH PARTIAL HOSPITALIZATION SERVICES		
MEDICAL SERVICES	**What you must pay** when you get these covered services **PAR PROVIDER SERVICES**	**NON-PAR PROVIDER SERVICES**
Behavioral Health Partial Hospitalization Services	Payable the same as medical outpatient non-surgical *hospital services.*	Payable the same as medical outpatient non-surgical *hospital services*.
Behavioral Health Therapy and Office Visit *Services* (Clinic, Outpatient and *Intensive Outpatient*)	Payable the same as a *qualified practitioner* primary care physician office visit.	Payable the same as a *qualified practitioner* primary care physician office visit.

BEHAVIORAL HEALTH PARTIAL HOSPITALIZATION SERVICES		
MEDICAL SERVICES	**What you must pay** when you get these covered services **PAR PROVIDER SERVICES**	**NON-PAR PROVIDER SERVICES**
Behavioral health services not listed above, such as laboratory and x-ray, are payable the same as the *qualified practitioner* or facility, based on place of *service*.		
Applied Behavioral Analysis (ABA) Therapy	Not covered	Not covered

OTHER COVERED EXPENSES		
MEDICAL SERVICES	**What you must pay** when you get these covered services **PAR PROVIDER SERVICES**	**NON-PAR PROVIDER SERVICES**
Other Covered Expenses	Payable the same as any other *sickness*.	Payable the same as any other *sickness*.

MEDICAL COVERED EXPENSES

HOW SERVICES 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 *services* are payable under this Plan, when it is satisfied, this Plan will share the cost of *covered expenses* at the *coinsurance* percentage until *you* have reached any applicable *out-of-pocket limit*. After *you* have met the *out-of-pocket limit*, if any, this Plan will pay *covered expenses* at 100% for the rest of the *calendar year*, subject to the *maximum allowable fee(s)*, any *maximum services* and all other terms, provisions, limitations and exclusions of this Plan. Any applicable *deductible*, *coinsurance*, *out-of-pocket limit* amounts, medical *services* and medical *service* limits are stated on the Medical Schedule of Coverage.

COINSURANCE

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

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

OUT-OF-POCKET LIMIT

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

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 *coinsurance*, *PAR provider copayments* and *Non-PAR provider copayments*.

PAR and Non-PAR Out-of-Pocket Limit Accumulation

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

Penalties, coverage administered by a third party and the plan premium do not apply to the *out-of-pocket limits*.

ROUTINE/PREVENTIVE SERVICES

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

1. Services with an A or B rating in the current recommendations of the U. S. Preventive Services Task Force (USPSTF). The recommendations by the USPSTF for breast cancer screenings, mammography and preventions issued prior to November 2009 will be considered current.

2. Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC).

3. 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 U.S. Department of Health and Human Services (HHS) website at www.healthcare.gov or call the toll-free customer service telephone number listed on *your* Humana ID card.

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

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

QUALIFIED PRACTITIONER SERVICES

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

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. Services for the third opinion are payable the same as for the second opinion. The *qualified practitioner* providing the second or third surgical opinion may confirm the need for *surgery* or present other treatment options. The decision whether or not to have the *surgery* is always *yours*.

Multiple Surgical Procedures

If multiple or bilateral surgical procedures are performed at one operative session, the amount payable for these procedures will be limited to the *maximum allowable fee* for the primary surgical procedure. When a *participating provider* is utilized, subsequent procedures will be paid in accordance with the *provider contract*. When a *non-participating provider* is utilized, the amount payable will be: a) 50% of the *maximum allowable fee* for the secondary procedure; and b) 25% of the *maximum allowable fee* for the third and subsequent procedures. No *services* will be payable for incidental procedures.

Surgical Assistant/Assistant Surgeon

Surgical assistants and/or assistant surgeon will be paid at 20% of the *covered expense* for *surgery*.

Physician Assistant

Physician assistants will be paid at 10% of the *covered expense* for *surgery*.

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 Coverage and include the following procedures:

1. Excision of partially or completely unerupted impacted teeth;

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

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

4. Reduction of fractures and dislocations of the jaw;

5. External incision and drainage of cellulitis;

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

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

8. Dental osteotomies.

REVERSAL OF STERILIZATION AND ABORTIONS

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

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 Coverage.

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

Newborns

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

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

Birthing Centers

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

INPATIENT HOSPITAL

Inpatient *hospital services* are payable as shown on the Medical Schedule of Coverage, 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*. Coverage for a private or single-bed room are limited to the *maximum allowable fee* charged for a semi-private room in the *hospital* while a registered bed patient.

SKILLED NURSING FACILITY

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

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

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

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

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

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

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

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

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

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

4. A daily record for each patient;

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

6. A utilization review plan.

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

OUTPATIENT AND AMBULATORY SURGICAL CENTER

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

EMERGENCY AND URGENT CARE SERVICES

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

HOSPICE SERVICES

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

For hospice *services* only, *your* immediate family is considered to be *your* parent or spouse.
Covered expenses are payable for the following hospice *services*:

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

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

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

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

5. Nutritional counseling;

6. Physical or occupational therapy;

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

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

Hospice care *services* do NOT include:

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

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

3. Funeral arrangements;

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

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

6. Housecleaning and household maintenance;

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

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

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

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

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

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

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

HOME HEALTH CARE

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

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

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

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

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

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

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

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

The home health care plan consists of:

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

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

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

Home health care *services* do not include:

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

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

3. Charges for supervision of home health care providers;

4. Private duty nursing;

5. *Durable medical equipment* and prosthetics.

DURABLE MEDICAL EQUIPMENT (DME)

Durable medical equipment (DME) is payable as shown on the Medical Schedule of Coverage 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 purchased *DME* is a *covered expense* if:

1. The manufacturer's warranty is expired; and

2. Repair or maintenance is not a result of misuse or abuse; and

3. Maintenance is not more frequent than every 6 months; and

4. The repair cost is less than the replacement cost.

Replacement of purchased *DME* is a *covered expense* if:

1. The manufacturer's warranty is expired; and

2. The replacement cost is less than the repair cost; and

3. The replacement is not due to lost or stolen equipment or misuse or abuse of the equipment; or

4. Replacement is required due to a change in condition that makes the current equipment non-functional.

Duplicate *DME* is not covered.

Prosthetics

Initial prosthetic devices or supplies, including but not limited to, limbs and eyes are payable as shown on the Medical Schedule of Coverage. 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 of the basic prosthetic device, including replacing a part or putting together what is broken, is a *covered expense*.

SPECIALTY DRUG MEDICAL COVERAGE

Specialty drugs are payable as shown on the Medical Schedule of Coverage. 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.

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 Coverage. *Ambulance* service must not be provided primarily for the convenience of the patient or the *qualified practitioner*.

MORBID OBESITY

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

Covered persons are eligible for *bariatric surgery* ONLY if:

1. The patient is age 18 or older; and

2. The patient meets the definition of *morbid obesity* as defined in the "Definitions" section; and

3. The patient has been previously unsuccessful with medical treatment for obesity; and

4. The patient has had a recent (within 12 months prior to planned surgical intervention) psychological evaluation in which they are evaluated to rule out psychiatric disorders (e.g. schizophrenia, major depression, chemical dependency) that interfere with adherence to a new lifestyle and are cleared for *surgery*. This is necessary in order to exclude persons who are unable to provide informed consent or who are unable to comply with the pre- and post-operative regimen.

5. Surgical procedures for the removal of excess skin and/or fat in conjunction with or resulting from weight loss or weight loss surgery are not covered

You MAY be eligible under this Plan for repeat *bariatric surgery* if:

1. Coverage for *bariatric surgery* is available under this Plan; AND

2. The patient utilizes a Humana preferred facility for the repeat *bariatric surgery*; AND

3. *You* have *medically necessary* complications because of a covered *bariatric surgery* (e.g. anastomotic strictures); OR

4. *You* have inadequate weight loss or weight re-gain after a covered primary *bariatric surgery* that is evidenced by documentation of compliance with postoperative nutritional counseling, exercise recommendations and physician follow-up visits.

OBESITY

Obesity *services* are payable as shown on the Medical Schedule of Coverage.

TEMPOROMANDIBULAR JOINT DYSFUNCTION (TMJ)

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

Services for teeth injured as a result of chewing are covered.

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

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

THERAPY SERVICES

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

Chiropractic Care

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

TRANSPLANT SERVICES

This Plan will pay *services* 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 chemotherapy and associated *services*, post-discharge *services* and treatment of complications after transplantation of the following organs or procedures only:

1. Heart;

2. Lung(s);

3. Liver;

4. Kidney;

5. Bone Marrow*;

6. Intestine;

7. Pancreas;

8. Auto islet cell;

9. Multivisceral;

10. Any combination of the above listed organs;

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

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

Corneal transplants and porcine heart valve implants, which are tissues rather than organs, are considered part of regular plan coverage 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*. *Services* are payable only if the pre-transplant *services*, the transplant and post-discharge *services* are approved by Humana.

Exclusions

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

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

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

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

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

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

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

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

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

Covered Services

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

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

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

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

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

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

BEHAVIORAL HEALTH SERVICES

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

1. Charges made by a *qualified practitioner*;

2. Charges made by a *hospital*;

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

4. Charges for x-ray and laboratory expenses.

Inpatient Services

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

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 Coverage.

Limitations

No *services* 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 *services* are payable under this provision of the Plan.

OTHER COVERED EXPENSES

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

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

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

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

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

5. Routine costs associated with clinical trials, when approved by this Plan. For additional details, go to www.humana.com or call the toll-free customer service telephone number listed on *your* Humana ID card.

6. Cranial banding, when approved by this Plan. For additional details, go to www.humana.com or call the toll-free customer service telephone number listed on *your* Humana ID card

LIMITATIONS AND EXCLUSIONS

This Plan does not provide coverage 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 foreign travel;

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

- *Services* related to gender change;

- *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* 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 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;

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

- Education or training, unless otherwise specified in this Plan;

- 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, 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 participant*;

- 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 *services* under *your* previous dental or medical plan;

- Any expense due to the *covered person's*:
  - Engaging in an illegal 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.

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

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

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

- *Prescription* drugs and *self-administered injectable drugs*, unless administered to *you*:
  - While inpatient in a *hospital*, *qualified treatment facility* or skilled nursing facility; or
  - 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 Coverage;

- 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 (medications, drugs or hormones to stimulate growth);

- 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*;

- 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 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;

- No *services* 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*;
  - Lactation therapy; 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 *services*. 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;

- 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;

- 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:
  - *Services* 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 vision examinations;

- Routine vision refraction;

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

- Vision therapy;

- Routine hearing examinations;

- Routine hearing testing;

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

- 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 Coverage);

- Wigs;

- Obesity *services* other than the covered *services* listed on the Medical Schedule of Coverage. There is no coverage for *bariatric surgery* under this Plan;

- *Morbid obesity services* other than the covered *services* listed on the Medical Schedule of Coverage ;

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

- No *services* 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*.

- Infertility counseling and treatment *services*;

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

- Acupuncture;

- Halfway-house *services*;

- *Applied behavioral analysis (ABA) therapy*.

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*.

SUBJECT TO THIS PROVISION

Coverage described in this Plan is coordinated with coverage provided by other plans under which *you* are also covered. This is to prevent duplication of coverage and a resulting increase in the cost of medical or dental coverage. *Prescription* drug coverage under the *Prescription* Drug coverage, if applicable, is not subject to these coordination provisions and will therefore only be coordinated with other *prescription* drug coverage.

For this purpose, a plan is one which covers medical or dental expenses and provides coverage 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. A plan also includes any coverage provided through the following:

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

This Coordination of Coverage 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 coverage 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 coverage paid.

EFFECT ON COVERAGE

One of the plans involved will pay Coverage 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 coverage payable will not exceed 100% of the total allowable expenses incurred under this Plan and any other plans included under this provision.

ORDER OF COVERAGE DETERMINATION

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

- The plan has no coordination of Coverage provision;
- The plan covers the person as a retiree;
- If a person is retired or is a *dependent* of such person, that plan covers after the plan covering such person as a retiree or *dependent* of such retiree. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of coverage, 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 COVERAGE WITH MEDICARE

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

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

CALCULATION AND PAYMENT OF COVERAGE

Medicare Part B services are payable before any coverage is payable by this Plan. The coverage of this Plan will then be reduced by the full amount of all *Medicare* coverage the *covered person* is entitled to receive. This Plan pays primary for hospital coverages unless otherwise defined in the Order of Coverage Determination section above.

RIGHT OF RECOVERY

This Plan reserves the right to recover 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 coverage due for the same allowable expense under any other plan.

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

CLAIM PROCEDURES

SUBMITTING A CLAIM

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

- 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. Claims must be filed as soon as reasonably possible after they are incurred, and in no event later than 15 months after the date the claim was incurred for *Non-PAR provider* claims, except if *you* were legally incapacitated. Claims should be submitted by a *PAR provider* in accordance with the timely filing period outlined in that *provider's contract* with Humana (typically 180 days for physicians and 90 days for facilities and ancillary providers, however, a provider's contractual timely filing period may vary). Plan coverage is 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.

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 Sponsor*.

Mail medical claims and correspondence to:

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

MISCELLANEOUS MEDICAL CHARGES

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

PROCEDURAL DEFECTS

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

ASSIGNMENTS AND REPRESENTATIVES

A *covered person* may assign his or her right to receive Plan coverage 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 coverage.

If coverage is assigned in accordance with the foregoing paragraph and a health care provider submits claims on behalf of a *covered person*, coverage 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 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 coverage 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 coverage determination* within a reasonable time appropriate to the medical circumstances, but no later than 15 days after receipt of the claim by this Plan.

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

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

Urgent Care Claims

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

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

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

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

TIMES FOR DECISIONS

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

PAYMENT OF CLAIMS

Many health care providers will request an assignment of coverage 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 coverage 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 *plan participant*," and send it directly to Humana. *You* will receive a written explanation of an *adverse coverage determination*. Humana reserves the right to request any information required to determine coverage or process a claim. *You* or the provider of *services* will be contacted if additional information is needed to process *your* claim.

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

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

Humana will rely upon an affidavit to determine coverage 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 coverage determination* or *final internal adverse coverage 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 coverage determination* or *final internal adverse coverage 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 coverage 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 coverage determination* or *final internal adverse coverage 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 coverage 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 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 coverage 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 COVERAGE DETERMINATIONS

A *claimant* must *appeal* an *adverse coverage 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 coverage 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 coverage 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 coverage determination* being appealed, as permitted under applicable law.

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

TIME PERIOD FOR DECISIONS ON APPEAL

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

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

APPEAL DENIAL NOTICES

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

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

- Relied on in making the determination;
- Submitted, considered or generated in the course of making the coverage 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 coverage determination* is required to be provided to give the *claimant* a reasonable opportunity to respond prior to that date.

Before a *final internal adverse coverage 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 coverage 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. Additional information may be available from a local U.S. Department of Labor Office.

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

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

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

Preliminary Review

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

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

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

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

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

Referral to an Independent Review Organization (IRO)

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

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 coverage determination* or *final internal adverse coverage 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 coverage determination* or *final internal adverse coverage determination* if this Plan fails to timely provide this information. The *IRO* must notify the *claimant* and Humana within 1 business day of making the decision.

- If the *IRO* receives any information from the *claimant*, the *IRO* must forward it to Humana within 1 business day. After receiving this information, Humana may reconsider its *adverse coverage determination* or *final internal adverse coverage 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*).

- 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 coverage determination* or *final internal adverse coverage determination*, it must immediately provide coverage or payment for the affected claim(s). This includes authorizing or paying coverage.

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 coverage 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 coverage 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 coverage 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 coverage determination* or *final internal adverse coverage determination* to the assigned *IRO* electronically, by telephone/fax, or any other expeditious method.

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

Notice of Final External Review Decision

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

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

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

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

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

Ohio Department of Insurance
Consumer Services Division
50 West Town Street, Third Floor - Suite 300
Columbus, Ohio 43215
(614)-644-2673 or toll free 1-800-686-1526
http://insurance.ohio.gov

SECTION 4

ELIGIBILITY AND EFFECTIVE DATE OF COVERAGE

ELIGIBILITY AND EFFECTIVE DATE OF COVERAGE

PLAN PARTICIPANT ELIGIBILITY

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

- *You* are a *plan participant* who meets the eligibility requirements of OPERS; and

Your eligibility date is determined by OPERS.

DEPENDENT ELIGIBILITY

Each *dependent* is eligible for coverage if he or she meets the eligibility requirements as determined by Ohio Public Employees Retirement System.

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

No *dependent's* effective date will be prior to the covered plan participant's effective date of coverage.

REINSTATEMENT OF COVERAGE

If *your* coverage under this Plan was terminated, *your* coverage is effective as determined by OPERS.

PLAN PARTICIPANT **COVERAGE**

You are eligible for coverage if *you* are a plan participant who meets the eligibility requirements as determined by OPERS. *Your* eligibility date is determined by OPERS.

SURVIVORSHIP COVERAGE

If the plan participant dies while covered under this Plan, *your* eligibility will be determined by OPERS.

SPECIAL ENROLLMENT

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

- Loss of eligibility for the coverage due to any of the following:
  - Legal separation;
  - Divorce;
  - Cessation of *dependent* status (such as attaining the limiting age);
  - Death;
  - Termination of employment;
  - Plan no longer offering coverage to a class of similarly situated individuals, which includes the plan participant;
  - Any loss of eligibility after a period that is measured by reference to any of the foregoing.

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

- OPERS contributions towards the other coverage have been terminated. OPERS contributions include contributions by any current or prior plan (of the individual or another person) that was contributing to coverage for the individual.

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

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

If *you* are a covered plan participant or an otherwise eligible plan participant, who either did not enroll or did not enroll *dependents* when eligible, in addition to annual open enrollment, *you* have the opportunity to enroll *yourself* and/or any previously eligible *dependents* or any newly acquired *dependents* when due to any of the following changes:

1. Marriage;

2. Birth;

3. Adoption or placement for adoption;

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

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

You may elect coverage under this Plan and will be considered a *timely applicant* provided completed enrollment is received within 60 days from the qualifying event. *You* MUST provide proof that the qualifying event has occurred due to one of the reasons listed before coverage under this Plan will be effective. Coverage under this Plan will be effective the date immediately following the qualifying event, unless otherwise specified by OPERS.

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

Please see OPERS for more details.

TERMINATION OF COVERAGE

Coverage terminates on the earliest of the following:

- The date this Plan terminates;
- The end of the period for which any required contribution was due and not paid;
- The date determined by OPERS, when *you* fail to be in an eligible class of persons according to the eligibility requirements of the OPERS;
- As determined by OPERS when *you* request termination of coverage to be effective for *yourself*;
- For any coverage, the date the coverage is removed from this Plan;
- For *your dependents*, the date *your* coverage terminates;
- For a *dependent* spouse as determined by OPERS, when such *covered person* no longer meets the definition of *dependent*;

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

SECTION 5

GENERAL PROVISIONS AND REIMBURSEMENT/ SUBROGATION

GENERAL PROVISIONS

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

PLAN ADMINISTRATION

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

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

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

RESCISSION

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

CONTESTABILITY

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

RIGHT TO REQUEST OVERPAYMENTS

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

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

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

WORKERS' COMPENSATION NOT AFFECTED

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

WORKERS' COMPENSATION

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

- The Workers' Compensation coverage are in dispute or are made by means of settlement or compromise;
- No final determination is made that *bodily injury* or *sickness* was sustained in the course of, or resulted from, *your* employment;
- The amount of Workers' Compensation due to medical or health care is not agreed upon or defined by *you* or the Workers' Compensation carrier;
- The medical or health care coverage are specifically excluded from the Workers' Compensation settlement or compromise.

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

MEDICAID

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

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

REIMBURSEMENT/SUBROGATION

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

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

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

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

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

RIGHT TO COLLECT NEEDED INFORMATION

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

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

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

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

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

- Providing information Humana requests to administer this Plan.

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

DUTY TO COOPERATE IN GOOD FAITH

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

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

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

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

SECTION 6

NOTICES

IMPORTANT NOTICES FOR RETIREES AND SPOUSES AGE 65 AND OVER

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

Generally, the health care plan that has at least 20 retirees must operate in compliance with these rules in providing plan coverage to *plan participants* who are *Medicare* beneficiaries, age 65 and over.

Persons who are plan participant*s* are NOT actively working as follows:

- Individuals receiving disability coverage from OPERS for up to 6 months; or
- Individuals who retain employment rights and have not been terminated by OPERS and for whom OPERS continues to provide coverage under this Plan.

If *you* are a dependent spouse age 65 and over of a plan participant of any age, *your* coverage under this Plan will be provided on the same terms and conditions as are applicable to plan participant*s*.

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

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

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

PRIVACY OF PROTECTED HEALTH INFORMATION

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

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

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

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

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

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

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

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

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

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

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

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

CONTINUATION OF MEDICAL COVERAGE

THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1986 (COBRA)

CONTINUATION OF COVERAGE

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

ELIGIBILITY

A qualified beneficiary under COBRA law means a plan participant, or plan participant*'s* spouse covered by this Plan on the day before a qualifying event.

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

- Divorce or legal separation from the plan participant;
- Termination of a plan participant spouse's coverage when OPERS discontinues plan participant coverage within one year before or one year after filing for Chapter 11 bankruptcy.

LOSS OF COVERAGE

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

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

NOTICES AND ELECTION

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

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

For death of the plan participant, or loss of plan participant coverages due to bankruptcy, it is the *Plan Administrator's* responsibility to notify the *COBRA Service Provider*, who will in turn notify the qualified beneficiary of the right to elect continuation coverage.

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

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

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

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

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

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

MAXIMUM COVERAGE PERIOD

Coverage may continue up to:

- 18 months for an plan participant and/or *dependent* whose group coverage ended due to termination of the plan participant*'s* coverage;
- 36 months for a spouse whose coverage ended due to the death of the plan participant or divorce
- For the plan participant, until the date of death of the plan participant who is on continuation due to loss of coverage within one year before or one year after the *employer* filed Chapter 11 bankruptcy.

DISABILITY

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

SECOND QUALIFYING EVENT

An 18-month extension of coverage will be available to spouses who elect continuation coverage if a second qualifying event occurs during the first 18 months of continuation coverage. The maximum amount of continuation coverage available when a second qualifying event occurs is 36 months. Such second qualifying event may include the death of a covered plan participant, or divorce from the covered plan participant These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under this Plan if the first qualifying event had not occurred. *You* must notify this Plan within 60 days after the second qualifying event occurs if *you* want to extend *your* continuation coverage.

TERMINATION BEFORE THE END OF MAXIMUM COVERAGE PERIOD

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

- OPERS no longer provides group health coverage to any of its plan participants;
- The premium for continuation is not paid timely;
- The individual on continuation becomes covered under another group health plan (as an plan participant or otherwise);
- The individual on continuation becomes entitled to *Medicare* coverages;

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

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

TYPE OF COVERAGE; PREMIUM PAYMENT

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

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

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

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

OTHER INFORMATION

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

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

PLAN CONTACT INFORMATION

Mutual Health Services
PO Box 4138
Akron, OH 44321
Telephone: 330-666-0337 x85096

Humana Health Plan, Inc.
Billing/Enrollment Department
101 E. Main Street
Louisville, KY 40202
Toll-Free: 1-800-872-7207

ADDITIONAL NOTICES

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

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

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

Contact OPERS if *you* would like more information on WHCRA coverage.

THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996

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

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

PLAN DESCRIPTION INFORMATION

- Proper Name of Plan: Ohio Public Employees Retirement System

- *Plan Sponsor*: Ohio Public Employees Retirement System
  277 East Town Street
  Columbus, Ohio 43215-4642
  Telephone: 800-222-7377

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

- Tax Identification Number: 31-0797516

- This Plan provides medical coverage for participating *Medicare* Eligible Benefit Recipients and their *Medicare* Eligible *Dependents* ("*participants*").

- Plan coverage described in this booklet is effective January 1, 2016.

- The *Plan year* is January 1 through June 30, 2016.

- The fiscal year is January 1 through December 31 of each year.

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

  Julie Becker, General Counsel
  277 East Town Street
  Columbus, Ohio 43215-4642

- *Medicare is* responsible for performing certain delegated administrative duties, including the processing of claims. The *Medicare Secondary Plan* is:

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

- This is a self-insured and self-administered health coverage plan. The cost of this Plan is paid with contributions shared by the group and *participants*. Coverage under this Plan is provided from the general assets of the group and is used to fund payment of covered claims under this Plan plus administrative expenses. Please see *the Plan Sponsor* for the method of calculating contributions and the funding mechanism used for the accumulation of assets through which coverage is provided under this Plan.

- Each plan participant of the group who participates in this Plan receives a *Summary Plan Description*, which is this booklet. It contains information regarding eligibility requirements, termination provisions, a description of the coverage provided and other Plan information.

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

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

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

SECTION 7

DEFINITIONS

DEFINITIONS

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

A

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

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

- A determination based on a *covered person's* eligibility to participate in this Plan;
- A determination that a *service* is not a covered *service*;
- The imposition of a source-of-injury exclusion, network exclusion, or other limitation on otherwise covered *services*; 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 coverage determination* includes any rescission of coverage (whether or not, in connection with the rescission, there is an adverse effect on any particular coverage 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.

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 coverage determination*.

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

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.

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

C

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

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

COBRA Service Provider means a provider of COBRA administrative services retained by OPERS to provide specific COBRA administrative services.

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

Complications of pregnancy means:

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

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

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

Copayment 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 Coverage" section.

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

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

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

Covered person means the *plan participant* or any of the *plan participant's* covered *dependents* enrolled for coverage 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 *calendar year* before this Plan pays coverage for certain specified *services*.

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

Dependent means a covered *plan participant's*:

- *Your* legal spouse. *You* must provide a valid marriage license and valid proof of birth;
- If *you* receive a monthly benefit as a surviving spouse or a beneficiary of a deceased plan participant or deceased *participant*, *you* may enroll only those *dependents* that would have been eligible *dependents* of the deceased plan participant or *participant*.
- *You* must notify OPERS in writing, within 30 days of the date *your dependent* no longer meets eligibility requirements and indicate the date *your dependent* is no longer eligible. Monthly contributions do not guarantee coverage if *your dependent* no longer meets the eligibility requirements. Failure to notify OPERS could result in overpaid health claims for which *you* will be responsible.

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.

Diagnostic/Routine **means -** As a general rule any allowable routine *service* would be one that involves preventive care. Most common examples would be preventive check-up in an office setting, flu or pneumonia vaccine, well woman visit, mammogram, prostate exam, etc. Any lab work related to these services should be billed with a routine care diagnosis code. Quite often blood lab work is processed at an independent laboratory or by a hospital lab. In these cases, lab *services* may be billed by a provider who did not actually see the patient. However, lab work related to any treatment should follow the same path of the primary physician services. In cases where a participant is being tested for a known medical condition, lab *services* would be considered diagnostic as *services* are being completed to treat the condition. In cases where a participant is receiving preventive care only all related lab *services* would be considered routine.

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

E

Emergency **(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:

- 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, 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, 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;

- 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, 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 coverage determination* (including a *final internal adverse coverage determination*) conducted pursuant to the federal *external review* process or an applicable state *external review* process.

F

Family Member means *you* or *your* spouse.

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

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

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

H

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 coverage determinations* and *final internal adverse coverage determinations*.

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 <u>not</u> include services that are for:

- *Custodial care*; or
- Day care.

L

Lifetime maximum coverage means the maximum amount of *services* 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.

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

- The fee charged by the provider for the *services*;
- The fee that has been negotiated with the provider whether directly or through one or more intermediaries or shared savings contracts for the *services*;
- The fee established by this Plan by comparing rates from one or more regional or national databases or schedules for the same or similar *services* from a geographical area determined by this Plan;
- The fee based upon rates negotiated by this Plan or other payors with one or more *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.

Note: The bill *you* receive for *services* from *non-participating providers* may be significantly higher than the *maximum allowable fee*. In addition to *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*.

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

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

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

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

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

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

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

N

Non-participating (Non-PAR) provider means a provider who provides services to Medicare patients, but doesn't accept Medicare assignment.

O

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

Off-label drug indications mean prescribing of an FDA-approved medication for a use or at a dose that is not included in the product indications or labeling. This term specifically refers to drugs or dosages used for diagnoses that are not approved by the FDA and may or may not have adequate medical evidence supporting safety and efficacy. Off-label prescribing of traditional drugs is a common clinical practice and many off-label uses are effective, well documented in peer reviewed literature and widely employed as standard of care treatments.***Orthotic*** means a custom-fitted or custom-made braces, splints, casts, supports and other devices used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body when prescribed by a *qualified practitioner*.

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

P

PAR Provider *or* ***Network Provider*** means a provider who provides services to Medicare patients and accepts Medicare assignment**.**

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 (PAR) provider means a provider who provides services to Medicare patients and accepts Medicare assignment.

Plan Administratormeans Humana Insurance Company (HIC).

Plan Participant means an OPERS benefit recipient or eligible Dependent who is enrolled in this Plan and Medicare Part B, but is not eligible for premium-free Medicare Part A.

Plan Sponsor means Ohio Public Employees Retirement System.

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

Post-service claim means any claim for coverage 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 admission*s, surgical procedures, outpatient care, and other health care *services*.

Predetermination of coverage 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*.

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

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

Provider contract means the written agreement between Humana and a Provider, under which the provider agrees to certain terms and conditions related to the provision of services to participants.

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).

Retrospective review means a review conducted after *services* (including outpatient procedures and *services*) have been provided to a *covered person* to validate utilization decisions and/or payment made for the care that was provided.

S

Same as any other sickness means *services* are reimbursed based on the place of *service* and type of *service* provided. For example, organ transplants are covered "same as any other *sickness*". If a claim is received for the organ transplant *surgery*, the claim would be paid under the *Qualified Practitioner* Inpatient *Surgery* and Anesthesia coverage as shown on the Schedule of Coverage. If a claim is received for *hospital* facility *services* for the organ transplant, it would be paid under the Inpatient *Hospital* Room and Board and Ancillary Facility *Services* coverage as shown on the Schedule of Coverage.

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

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

Sound natural tooth means a tooth that:

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

- 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 coverage, provisions and limitations of this Plan.

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

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*.

Administered by:

Humana

Humana Insurance Company
500 West Main Street
Louisville, KY 40202