Important!

At Humana, it is important you are treated fairly.

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

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

Auxiliary aids and services, free of charge, are available to you. Call the number on your ID card (TTY: 711)

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

Language assistance services, free of charge, are available to you. Call the number on your ID card (TTY: 711)

ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call the number on your ID card **(TTY: 711)**... ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al número que figura en su tarjeta de identificación **(TTY: 711)**... 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電會員卡上的電話號碼 **(TTY: 711)**... CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số điện thoại ghi trên thẻ ID của quý vị **(TTY: 711)**... 주의 : 한국어를 사용하시는 경우 , 언어 지원 서비스를 무료로 이용하실 수 있습니다 . ID 카드에 적혀 있는 번호로 전화해 주십시오 **(TTY: 711)**... PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tawagan ang numero na nasa iyong ID card **(TTY: 711)**... ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Наберите номер, указанный на вашей карточке-удостоверении **(телетайп: 711)**... ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele nimewo ki sou kat idantite manm ou **(TTY: 711)**... ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le numéro figurant sur votre carte de membre **(ATS: 711)**...UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Proszę zadzwonić pod numer podany na karcie identyfikacyjnej **(TTY: 711)**... ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para o número presente em seu cartão de identificação **(TTY: 711)**... ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero che appare sulla tessera identificativa **(TTY: 711)**... ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Wählen Sie die Nummer, die sich auf Ihrer Versicherungskarte befindet **(TTY: 711)**... 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。お手持ちの ID カードに記載されている電話番号までご連絡ください **(TTY: 711)**...

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با شماره تلفن روی کارت شناسایی تان تماس بگیرید **(TTY: 711)**...

Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, námboo ninaaltsoos yézhí, bee nééh ho'dólzin bikáá'ígíí bee hólne' **(TTY: 711)**...

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم الهاتف الموجود على بطاقة الهوية الخاصة بك **(TTY: 711)**.

Humana Health Plan, Inc.

500 West Main Street
Louisville, Kentucky 40202

READ YOUR CERTIFICATE CAREFULLY

This cover sheet is not the contract.

The provisions of the contract will control. The certificate, as part of the entire contract, sets forth, in detail the rights and obligations between you and us. The certificate provides information on eligibility, how to understand your coverage and describes what services are covered expenses, what portion of the costs you will be required to pay and what is not covered. Please refer to the Table of Contents within the certificate to locate additional information concerning the specific provisions of your coverage.

THEREFORE, IT IS IMPORTANT THAT YOU READ YOUR CERTIFICATE.

Humana.

Administrative Office:
500 West Main Street
Louisville, Kentucky 40202

Certificate of Coverage
Humana Health Plan, Inc.

Group Plan Sponsor: BULLOCK PEN WATER DIST

Group Plan Number: 794595

Effective Date: 01/01/2021

Product Name: KYNF0002 Simplicity

In accordance with the terms of the *master group contract* issued to the *group plan sponsor*, Humana Health Plan, Inc. certifies that a *covered person* has coverage for the benefits described in this *certificate.* This *certificate* becomes the Certificate of Coverage and replaces any and all certificates and certificate riders previously issued.

Bruce Broussard
President

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

TABLE OF CONTENTS

Understanding your coverage **7**

Schedule of benefits **12**

Schedule of benefits - pediatric dental **35**

Schedule of benefits - pediatric vision care **37**

Schedule of benefits - behavioral health **41**

Schedule of benefits - pharmacy services **48**

Covered expenses **53**

Covered expenses - pediatric dental **71**

Covered expenses - pediatric vision care **81**

Covered expenses - behavioral health **85**

Covered expenses - pharmacy services **88**

Limitations and exclusions **93**

Limitations and exclusions - pharmacy services **99**

Eligibility and effective dates **103**

Replacement of coverage **109**

TABLE OF CONTENTS (continued)

Termination provisions **110**

Extension of benefits **112**

Continuation **113**

Medical conversion privilege **117**

Coordination of benefits **119**

Claims **126**

Internal appeal and external review **133**

Disclosure provisions **137**

Miscellaneous provisions **140**

Glossary **143**

Glossary - pharmacy services **166**

UNDERSTANDING YOUR COVERAGE

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

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

Covered and non-covered expenses

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

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

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

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

How your master group contract works

You may have to pay a *deductible* before *we* pay for certain *covered expenses*. If a *deductible* applies, and it is met, *we* will pay *covered expenses* at the *coinsurance* amount. Refer to the "Schedule of Benefits" to see when the *deductible* applies and the *coinsurance* amount *we* pay. *You* will be responsible for the *coinsurance* amount *we* do not pay.

If an *out-of-pocket limit* applies, and it is met, *we* will pay *covered expenses* at 100% the rest of the *year*, subject to the *maximum allowable fee*.

Our payment for *covered expenses* is calculated by applying any *deductible* and *coinsurance* to what *we* allow. For a *covered expense, we* will allow the total amount billed by the *qualified provider*, less any amounts such as:

- Those negotiated by contract, directly or indirectly, between *us* and the *qualified provider*;
- Those in excess of the *maximum allowable fee*; or
- Adjustments related to *our* claims processing procedures.

The service and diagnostic information submitted on the *qualified provider's* bill will be used to determine which provision of the "Schedule of Benefits" applies.

Preauthorization decisions

Certain services and supplies require *preauthorization* as described in the "Preauthorization requirements and penalty" provision on the "Schedule of Benefits." *Preauthorization* requests are submitted to *us* for review. *Our* decision on a *preauthorization* request will be provided to *you, your* appointed representative, or *your health care practitioner*.

If *you* are not satisfied with *our* decision, additional rights may be available to *you* as described in the "Internal Appeal and External Review" section of this certificate.

- No later than 24 hours after obtaining all necessary information to make the *preauthorization* decision concerning urgent health care services; and
- Within five (5) days of obtaining all necessary information to make the preauthorization decision of non-urgent health care services.

For the purpose of *preauthorization,* urgent health care services means health care or treatment, including requests for *inpatient hospital* admission and *outpatient surgery,* to which the application of the time periods for making non-urgent health care service determinations:

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

- In the opinion of a *health care practitioner* with knowledge of the *covered person's* medical condition, would subject the *covered person* to severe pain that cannot be adequately managed without the care or treatment that is subject of *preauthorization.*

Your choice of providers affects your benefits

We will pay a higher percentage most of the time, if *you* see a *network provider,* so the amount *you* pay will be lower. *You* must pay any *copayment, deductible* or *coinsurance* to the *network provider*. Be sure to check if *your qualified provider* is a *network provider* before seeing them.

We may appoint certain *network providers* for certain kinds of services. If *you* do not see the appointed *network provider* for these services, *we* may pay less.

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

Some *non-network providers* work with *network hospitals. We* will apply the *network provider copayment, deductible* and *coinsurance* to *covered expenses* received by non-network pathologists, anesthesiologists, radiologists, and emergency room physicians working with *network hospitals.* However, *you* may still have to pay these *non-network providers* any amount over the *maximum allowable fee.* If possible, *you* may want to check if all health care providers working with *network hospitals* are *network providers.*

UNDERSTANDING YOUR COVERAGE (continued)

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

How to find a network provider

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

How to use your point of service (POS) plan

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

Continuity of care

If the *covered person* is receiving treatment from a *network provider* and that provider's agreement to provide *medically necessary* services terminates for reasons other than medical competence or professional behavior, the *covered person* may be entitled to continue treatment by the terminating provider if at the time of the *network provider*'s termination the *covered person* is: disabled; being treated for a congenital condition; being treated for a life threatening illness; or past the twenty-fourth week of pregnancy. The treating provider must contact *us* requesting continuity of treatment. If *we* agree to the continued treatment, medically necessary services provided to the *covered person* by the terminating provider will continue to be payable at the *network provider* level of benefit. The maximum duration of continued treatment under this provision may not exceed:

- 90 days from the date of termination of the providers agreement; nine months in the case of the *covered person* being diagnosed with a terminal illness; or
- 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 are past the twenty-fourth week of pregnancy.

Seeking emergency care

If you have an *emergency medical condition*:

- Go to the nearest *network hospital* emergency room; or
- Find the nearest *hospital* emergency room if *your* condition does not allow *you* to go to a *network hospital*.

You, or someone on *your* behalf, must call *us* within 48 hours after *your admission* to a *non-network hospital* for an *emergency medical condition.* If *your* condition does not allow *you* to call *us* within 48 hours after *your admission,* contact *us* as soon as *your* condition allows. *We* may transfer *you* to a *network hospital* in the *service area* when *your* condition is stable. *You* must receive services from a *network provider* for any follow-up care for the *network provider copayment, deductible* or *coinsurance* to apply.

Seeking urgent care

If *you* need *urgent care, you* must go to the nearest network *urgent care center* for the *network provider* benefit *copayment, deductible* or *coinsurance* to apply. *You* must receive services from a *network provider* for any follow-up care for the *network provider copayment, deductible* or *coinsurance* to apply.

Our relationship with qualified providers

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

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

Our financial arrangements with network providers

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

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

The certificate

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

SCHEDULE OF BENEFITS

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

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

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

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

Network provider verification

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

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

Preauthorization requirements and penalty for services received from a non-network provider

Preauthorization by *us* is required for certain services and supplies. Visit *our* Website at www.humana.com or call the customer service telephone number on *your* ID card to obtain a list of services and supplies that require *preauthorization.* The list of services and supplies that require *preauthorization* is subject to change. Coverage provided in the past for services or supplies that did not receive or require *preauthorization,* is not a guarantee of future coverage of the same services or supplies.

SCHEDULE OF BENEFITS (continued)

You are responsible for informing *your health care practitioner* of the *preauthorization* requirements. *You* or *your health care practitioner* must contact *us* by telephone, *electronic mail,* or in writing to request the appropriate authorization. *Your* ID card will show the *health care practitioner* the telephone number to call to request authorization. Benefits are not paid at all for services or supplies that are not *covered expenses*.

If any required *preauthorization* of services or supplies is not obtained, the benefit payable for any *covered expenses* incurred for the services will be reduced to 50%, after any applicable *deductibles* or *copayments*. If the rendered services are not *covered expenses*, no benefits are payable. The out-of-pocket amounts incurred by *you* due to these benefit reductions may not be used to satisfy any *out-of-pocket limits.* This *preauthorization* penalty will apply if *you* received the services from a *non-network provider* when *preauthorization* is required and not obtained.

Annual deductible

An annual *deductible* is a specified dollar amount *you* must pay for *covered expenses*, except for any *deductible* met for *prescriptions* or *specialty drugs* from a *pharmacy* or *specialty pharmacy,* per *year* before any applicable *coinsurance* and most benefits are paid under the *master group contract.* There are individual and family *network provider* and *non-network provider deductibles.* The *deductible* amount(s) for each *covered person* and each covered family are as follows, and must be satisfied each *year*, either individually or combined as a covered family. *Covered expenses* that apply to the individual *deductible* also apply to the family *deductible.* Once a *covered person* meets the individual *deductible,* the *coinsurance* applies to applicable *covered expenses* for that *covered person.* Once the family *deductible* is met, any remaining individual *deductible* for a *covered person* in the family is waived for that *year*. The *coinsurance* then applies to applicable *covered expenses* for all *covered persons* in the family. *Copayments* do not apply toward the annual *deductible.*

Any amount *you* pay exceeding the *maximum allowable fee* is not applied to the individual or family *deductibles.*

Any expense incurred by *you* for *covered expenses* provided by a *network provider* is applied to the *network provider deductibles.* Any expense incurred by *you* for *covered expenses* provided by a *non-network provider* is applied to the *non-network provider deductibles.*

Deductible	**Deductible amount**
Individual *network provider deductible*	$0
Family *network provider deductible*	$0
Individual *non-network provider deductible*	$5,000
Family *non- network provider deductible*	$10,000

SCHEDULE OF BENEFITS (continued)

Out-of-pocket limit

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

Any amount *you* pay exceeding the *maximum allowable fee* is not applied to the *out-of-pocket limits.*

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

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

Once the individual or family *non-network provider out-of-pocket limit* is met, *you* will continue to be responsible any amount exceeding the *maximum allowable fee*.

Any expense incurred by *you* for *covered expenses* provided by a *network provider* is applied to the *network provider out-of-pocket limit.* Any expense incurred by *you* for *covered expenses* provided by a *non-network provider* is applied to the *non-network provider out-of-pocket limit.*

If any *copayment, deductible* or *coinsurance* amount applied to *your* claim is waived by *your* health care provider, *you* are required to inform *us.* Any amount, thus waived and not paid by *you,* is not applied to any *out-of-pocket limit.*

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

SCHEDULE OF BENEFITS (continued)

Out-of-pocket limit	**Out-of-pocket limit amount**
Individual *network provider out-of-pocket limit*	$6,500
Family *network provider out-of-pocket limit*	$13,000
Individual *non-network provider out-of-pocket limit*	$26,000
Family *non-network provider out-of-pocket limit*	$52,000

SCHEDULE OF BENEFITS (continued)

Preventive services

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

Network provider	Covered in full
Non-network provider	50% *coinsurance* after *non-network provider deductible*

Health care practitioner office services

Health care practitioner office visit

Primary care physician	$40 *copayment* per visit
Specialty care physician	$80 *copayment* per visit
Non-network health care practitioner	50% *coinsurance* after *non-network provider deductible*

SCHEDULE OF BENEFITS (continued)

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

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

Primary care physician	Covered in full
Specialty care physician	Covered in full
Non-network health care practitioner	50% *coinsurance* after *non-network provider deductible*

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

Primary care physician	$500 *copayment* per visit
Specialty care physician	$500 *copayment* per visit
Non-network health care practitioner	50% *coinsurance* after *non-network provider deductible*

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

Primary care physician	Covered in full
Specialty care physician	Covered in full
Non-network health care practitioner	50% *coinsurance* after *non-network provider deductible*

SCHEDULE OF BENEFITS (continued)

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

Primary care physician	Covered in full
Specialty care physician	Covered in full
Non-network health care practitioner	50% *coinsurance* after *non-network provider deductible*

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

Primary care physician	Covered in full
Specialty care physician	Covered in full
Non-network health care practitioner	50% *coinsurance* after *non-network provider deductible*

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

Primary care physician	Covered in full
Specialty care physician	Covered in full
Non-network health care practitioner	50% *coinsurance* after *non-network provider deductible*

SCHEDULE OF BENEFITS (continued)

Virtual visit services

Network provider designated by *us* as a preferred provider for a *virtual visit*	Covered in full
Network provider	Same as any other *sickness* based upon location of services and the type of provider
Non-network provider	Same as any other *sickness* based upon location of services and the type of provider

Health care practitioner services at a retail clinic

Health care practitioner office visit in a retail clinic

Primary care physician	$20 *copayment* per visit
Non-network health care practitioner	50% *coinsurance* after *non-network provider deductible*

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

Primary care physician	Covered in full
Non-network health care practitioner	50% *coinsurance* after *non-network provider deductible*

Injections other than allergy when received in a retail clinic

Primary care physician	Covered in full
Non-network health care practitioner	50% *coinsurance* after *non-network provider deductible*

Hospital services

Hospital inpatient services

Network hospital	$1,250 *copayment* per day for the first 3 days per *admission*
Non-network hospital	50% *coinsurance* after *non-network provider deductible*

Health care practitioner inpatient services when provided in a hospital

Primary care physician	Covered in full
Specialty care physician	Covered in full
Non-network health care practitioner	50% *coinsurance* after *non-network provider deductible*

SCHEDULE OF BENEFITS (continued)

Hospital outpatient surgical services

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

Network hospital	$1,000 *copayment* per visit
Non-network hospital	50% *coinsurance* after *non-network provider deductible*

Health care practitioner outpatient services when provided in a hospital

Includes *outpatient surgery.*

Primary care physician	Covered in full
Specialty care physician	Covered in full
Non-network health care practitioner	50% *coinsurance* after *non-network provider deductible*

Hospital outpatient non-surgical services

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

Network hospital	$1,000 *copayment* per visit
Non-network hospital	50% *coinsurance* after *non-network provider deductible*

Hospital outpatient diagnostic radiology and laboratory

Network hospital	Covered in full
Non-network hospital	50% *coinsurance* after *non-network provider deductible*

Hospital outpatient advanced imaging

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

Network hospital	$500 *copayment* per visit
Non-network hospital	50% *coinsurance* after *non-network provider deductible*

Pregnancy and newborn benefit

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

Emergency services

Must be for an *emergency medical condition* as defined in the "Glossary" section.

Hospital emergency room services

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

Network hospital	$500 *copayment* per visit. *Copayment* waived if admitted.
Non-network hospital	$500 *copayment* per visit. *Copayment* waived if admitted.

Hospital emergency room advanced imaging

Network hospital	$500 *copayment* per visit
Non-network hospital	$500 *copayment* per visit

Hospital emergency room health care practitioner services

Network health care practitioner	Covered in full
Non-network health care practitioner	Covered in full

Ambulance services

Network provider	$500 *copayment* per transport
Non-network provider	$500 *copayment* per transport

Ambulatory surgical center services

Ambulatory surgical center for outpatient surgery

Network provider	$1,000 *copayment* per visit
Non-network provider	50% *coinsurance* after *non-network provider deductible*

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

Includes *outpatient surgery.*

Primary care physician	Covered in full
Specialty care physician	Covered in full
Non-network health care practitioner	50% *coinsurance* after *non-network provider deductible*

Durable medical equipment and diabetes equipment

Network provider	Covered in full
Non-network provider	50% *coinsurance* after *non-network provider deductible*

Hearing aids and related services

One hearing aid, per hearing impaired ear, every 36 months.

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

Free-standing facility services

Free-standing facility diagnostic laboratory and radiology services

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

Network provider	Covered in full
Non-network provider	50% *coinsurance* after *non-network provider deductible*

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

Primary care physician	Covered in full
Specialty care physician	Covered in full
Non-network health care practitioner	50% *coinsurance* after *non-network provider deductible*

Free-standing facility advanced imaging

Network provider	$500 *copayment* per visit
Non-network provider	50% *coinsurance* after *non-network provider deductible*

Home health care services

Limited to a maximum of 100 visits per *year*.

Network provider	$80 *copayment* per visit
Non-network provider	50% *coinsurance* after *non-network provider deductible*

Private duty nursing

Limited to a maximum of 250 visits per *year*.

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

Hospice services

Network provider	Covered in full
Non-network provider	Covered in full

Jaw joint benefit

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

Physical medicine and rehabilitative services

Physical therapy

Limited to a maximum of 25 visits per *year*.

Network provider	$40 *copayment* per visit
Non-network provider	50% *coinsurance* after *non-network provider deductible*

Occupational therapy

Limited to a maximum of 25 visits per *year*.

Network provider	$40 *copayment* per visit
Non-network provider	50% *coinsurance* after *non-network provider deductible*

Speech therapy

Limited to a maximum of 25 visits per *year*.

Network provider	$40 *copayment* per visit
Non-network provider	50% *coinsurance* after *non-network provider deductible*

Audiology services

Includes post cochlear aural therapy.

Limited to a maximum of 30 visits per *year*.

Network provider	$40 *copayment* per visit
Non-network provider	50% *coinsurance* after *non-network provider deductible*

Cognitive rehabilitation services

Limited to a maximum of 20 visits per *year*.

Network provider	$40 *copayment* per visit
Non-network provider	50% *coinsurance* after *non-network provider deductible*

SCHEDULE OF BENEFITS (continued)

Respiratory or pulmonary rehabilitation services

Network provider	Covered in full
Non-network provider	50% *coinsurance* after *non-network provider deductible*

Cardiac rehabilitation services

Network provider	Covered in full
Non-network provider	50% *coinsurance* after *non-network provider deductible*

Other therapy

Includes radiation therapy and chemotherapy.

Network provider	Covered in full
Non-network provider	50% *coinsurance* after *non-network provider deductible*

Habilitative services

Physical therapy

Limited to a maximum of 25 visits per *year*.

Network provider	$40 *copayment* per visit
Non-network provider	50% *coinsurance* after *non-network provider deductible*

Occupational therapy

Limited to a maximum of 25 visits per *year*.

Network provider	$40 *copayment* per visit
Non-network provider	50% *coinsurance* after *non-network provider deductible*

Speech therapy

Limited to a maximum of 25 visits per *year*.

Network provider	$40 *copayment* per visit
Non-network provider	50% *coinsurance* after *non-network provider deductible*

Audiology services

Includes post cochlear aural therapy.

Limited to a maximum of 30 visits per *year*.

Network provider	$40 *copayment* per visit
Non-network provider	50% *coinsurance* after *non-network provider deductible*

Spinal manipulations/adjustments

Limited to a maximum of 20 visits per *year*.

Network provider	$40 *copayment* per visit
Non-network provider	50% *coinsurance* after *non-network provider deductible*

Skilled nursing facility services

Limited to a maximum of 100 days per *year*.

Network provider	$80 *copayment* per day
Non-network provider	50% *coinsurance* after *non-network provider deductible*

Health care practitioner services when provided in a skilled nursing facility

Network health care practitioner	Covered in full
Non-network health care practitioner	50% *coinsurance* after *non-network provider deductible*

Specialty drugs in a medical place of service

Specialty drugs administered in a health care practitioner's office, free-standing facility and urgent care center

Network provider	$50 *copayment* per visit
Non-network provider	50% *coinsurance* after *non-network provider deductible*

Specialty drugs administered in home health care

Network provider designated by *us* as a preferred provider of *specialty drugs*	Covered in full
Network provider	$50 *copayment* per visit
Non-network provider	50% *coinsurance* after *non-network provider deductible*

Specialty drugs administered in a hospital, skilled nursing facility, ambulance or emergency room

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

SCHEDULE OF BENEFITS (continued)

Transplant services and immune effector cell therapy

Network provider designated by *us* as an approved transplant or *immune effector cell therapy* facility	Same as any other *sickness* based upon location of services and the type of provider
Non-network provider	Same as any other *sickness* based upon location of services and the type of provider

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

Network provider designated by *us* as an approved transplant or *immune effector cell therapy* facility	Covered in full

Urgent care services

Network provider	$100 *copayment* per visit
Non-network provider	50% *coinsurance* after *non-network provider deductible*

Additional covered expenses

Network provider	Same as any other *sickness* based upon location of services and the type of provider
Non-network provider	Same as any other *sickness* based upon location of services and the type of provider

Cochlear implants

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

Diabetes self-management training

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

Orthoptic Training (eye exercises)

Orthoptic training (eye exercises) is limited to a *covered person* up to age 22.

Network provider	$40 *copayment* per visit
Non-network provider	50% *coinsurance* after *non-network provider deductible*

SCHEDULE OF BENEFITS - PEDIATRIC DENTAL

Reading this "Schedule of Benefits – Pediatric Dental" section will help *you* understand the level of benefits *we* generally pay for the *pediatric dental services* under the *master group contract.*

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

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

Pediatric dental services benefit

Class I services

Network provider	Covered in full
Non-network provider	50% *coinsurance* after *non-network provider deductible*

Class II services

Network provider	50% *coinsurance*
Non-network provider	50% *coinsurance* after *non-network provider deductible*

Class III services

Network provider	50% *coinsurance*
Non-network provider	50% *coinsurance* after *non-network provider deductible*

SCHEDULE OF BENEFITS - PEDIATRIC DENTAL (continued)

Class IV services

Network provider	50% *coinsurance*
Non-network provider	50% *coinsurance* after *non-network provider deductible*

SCHEDULE OF BENEFITS - PEDIATRIC VISION CARE

Reading this "Schedule of Benefits – Pediatric Vision Care" section will help *you* understand the level of benefits *we* generally pay for *pediatric vision care* covered under the *master group contract.*

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

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

Comprehensive eye exam

Limited to one exam per *year*.

Network provider	$10 *copayment* per visit
Non-network provider	50% *coinsurance* after *non-network provider deductible*

Prescription lenses

Single vision lenses, bifocal vision lenses, trifocal vision lenses, and lenticular lenses are limited to two pairs of covered prescription lenses per *year*.

Network provider	50% *coinsurance*
Non-network provider	50% *coinsurance* after *non-network provider deductible*

SCHEDULE OF BENEFITS - PEDIATRIC VISION CARE (continued)

Standard lens options

Polycarbonate, scratch coating, ultraviolet-coating, blended lenses, intermediate lenses, progressive lenses, photochromatic lenses, polarized lenses, fashion & gradient tinting, oversized lenses, glass-grey prescription sunglass lenses, anti-reflective coating, and hi-index lenses must be selected at the same time covered prescription lenses are selected.

Network provider	50% *coinsurance*
Non-network provider	50% *coinsurance* after *non-network provider deductible*

Frames

Limited to two covered new frames per *year*.

Network provider	50% *coinsurance*
Non-network provider	50% *coinsurance* after *non-network provider deductible*

Elective contact lenses

(Benefits are in lieu of all other benefits for frames and lenses.)

Limited to a single purchase of a 12-month supply of daily disposables, or a 12-month supply of non-daily disposables per *year*.

Network provider	50% *coinsurance*
Non-network provider	50% *coinsurance* after *non-network provider deductible*

SCHEDULE OF BENEFITS - PEDIATRIC VISION CARE (continued)

Medically necessary contact lenses

Network provider	50% *coinsurance*
Non-network provider	50% *coinsurance* after *non-network provider deductible*

Contact lens fitting and follow-up exam

Network provider	50% *coinsurance*
Non-network provider	50% *coinsurance* after *non-network provider deductible*

Low vision

Limited to one comprehensive low vision testing and evaluation per *year*.

Network provider	50% *coinsurance*
Non-network provider	50% *coinsurance* after *non-network provider deductible*

SCHEDULE OF BENEFITS - PEDIATRIC VISION CARE (continued)

Low vision supplementary testing

Limited to 5 diagnostic evaluations beyond the *comprehensive eye exam* in 5 *years*.

Network provider	50% *coinsurance*
Non-network provider	50% *coinsurance* after *non-network provider deductible*

Low vision aids

Network provider	50% *coinsurance*
Non-network provider	50% *coinsurance* after *non-network provider deductible*

SCHEDULE OF BENEFITS - BEHAVIORAL HEALTH

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

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

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

Acute inpatient services

Network hospital	$1,250 *copayment* per day for the first 3 days per *admission*
Non-network hospital	50% *coinsurance* after *non-network provider deductible*

Acute inpatient health care practitioner services

Includes *inpatient virtual visit* services.

Network health care practitioner	Covered in full
Non-network health care practitioner	50% *coinsurance* after *non-network provider deductible*

SCHEDULE OF BENEFITS - BEHAVIORAL HEALTH (continued)

Urgent care services

Network provider	$40 *copayment* per visit
Non-network provider	50% *coinsurance* after *non-network provider deductible*

Outpatient services

Health care practitioner office visit

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

Primary care physician	$40 *copayment* per visit
Specialty care physician	$40 *copayment* per visit
Non-network health care practitioner	50% *coinsurance* after *non-network provider deductible*

SCHEDULE OF BENEFITS - BEHAVIORAL HEALTH (continued)

Virtual visit services

Does not include *inpatient virtual visit* services. Refer to "Acute inpatient health care practitioner services" in this "Schedule of Benefits – Behavioral Health" section.

Network provider designated by *us* as a preferred provider for a *virtual visit*	Covered in full
Primary care physician *Specialty care physician*	$40 *copayment* per visit
Any other *network provider*	Same as any other *sickness* based upon location of services and the type of provider
Non-network provider	Same as any other *sickness* based upon location of services and the type of provider

Health care practitioner office visit in a retail clinic

Network health care practitioner	$40 *copayment* per visit
Non-network health care practitioner	50% *coinsurance* after *non-network provider deductible*

SCHEDULE OF BENEFITS - BEHAVIORAL HEALTH (continued)

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

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

Network health care practitioner	Covered in full
Non-network health care practitioner	50% *coinsurance* after *non-network provider deductible*

Therapy

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

Network provider	$40 *copayment* per visit
Non-network provider	50% *coinsurance* after *non-network provider deductible*

Nutritional counseling

Network provider	Covered in full
Non-network provider	50% *coinsurance* after *non-network provider deductible*

SCHEDULE OF BENEFITS - BEHAVIORAL HEALTH (continued)

Intensive outpatient program

Network provider	Covered in full
Non-network provider	50% *coinsurance* after *non-network provider deductible*

Partial hospitalization services

Network hospital	Covered in full
Non-network hospital	50% *coinsurance* after *non-network provider deductible*

Outpatient hospital non-surgical services

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

Does not include *advanced imaging.* Refer to the *advanced imaging* benefits in the "Schedule of Benefits" section.

Network hospital	Covered in full
Non-network hospital	50% *coinsurance* after *non-network provider deductible*

SCHEDULE OF BENEFITS - BEHAVIORAL HEALTH (continued)

Skilled nursing facility services

Network provider	Covered in full
Non-network provider	50% *coinsurance* after *non-network provider deductible*

Home health care services

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

Network provider	Covered in full
Non-network provider	50% *coinsurance* after *non-network provider deductible*

Applied behavioral analysis therapy during a home health care visit

Network provider	$40 *copayment* per visit
Non-network provider	50% *coinsurance* after *non-network provider deductible*

SCHEDULE OF BENEFITS - BEHAVIORAL HEALTH (continued)

Specialty drugs in a medical place of services

Specialty drugs administered in a health care practitioner's office, free-standing facility and urgent care center

Network provider	Covered in full
Non-network provider	50% *coinsurance* after *non-network provider deductible*

Specialty drugs administered in home health care

Network provider designated by *us* as a preferred provider of *specialty drugs*	Covered in full
Network provider	Covered in full
Non-network provider	50% *coinsurance* after *non-network provider deductible*

Residential treatment facility services

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

Autism spectrum disorders

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

SCHEDULE OF BENEFITS - PHARMACY SERVICES

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

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

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

Covered expenses for *prescription* drugs and *specialty drugs* obtained from a *network pharmacy* under provisions of this benefit apply toward *your out-of-pocket limit.*

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

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

Prior authorization and step therapy requirements

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

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

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

Preventive medication coverage

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

SCHEDULE OF BENEFITS - PHARMACY SERVICES (continued)

Prescription drug cost sharing

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

Prescription synchronization

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

SCHEDULE OF BENEFITS - PHARMACY SERVICES (continued)

Retail pharmacy — Coverage for up to a 30-day supply

Does not include *level 5 drugs*. Refer to the "Specialty pharmacy / Retail pharmacy" provision in this "Schedule of Benefits - Pharmacy Services" section.

Network pharmacy level 1 drugs	$5 *copayment* per *prescription* fill or refill
Non-network pharmacy level 1 drugs	30% *coinsurance* of the *default rate* after $5 *copayment* per *prescription* fill or refill
Network pharmacy level 2 drugs	$15 *copayment* per *prescription* fill or refill
Non-network pharmacy level 2 drugs	30% *coinsurance* of the *default rate* after $15 *copayment* per *prescription* fill or refill
Network pharmacy level 3 drugs	$75 *copayment* per *prescription* fill or refill
Non-network pharmacy level 3 drugs	30% *coinsurance* of the *default rate* after $75 *copayment* per *prescription* fill or refill
Network pharmacy level 4 drugs	$150 *copayment* per *prescription* fill or refill
Non-network pharmacy level 4 drugs	30% *coinsurance* of the *default rate* after $150 *copayment* per *prescription* fill or refill

SCHEDULE OF BENEFITS - PHARMACY SERVICES (continued)

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

Network pharmacy designated by *us* as a preferred provider of *level 5 drugs*	$800 *copayment* per *prescription* fill or refill
Network pharmacy provider of *level 5 drugs*	$1,200 *copayment* per *prescription* fill or refill
Non-network pharmacy level 5 drugs	30% *coinsurance* of the *default rate* after $1,200 *copayment* per *prescription* fill or refill

90-day Retail pharmacy

Some retail *pharmacies* participate in *our* program, which allows *you* to receive a 90-day supply of a *prescription* fill or refill. *Your* cost is 3 times the applicable *copayment* outlined above, or the applicable *coinsurance* amount, if any, as specified above. *Specialty drugs* are limited to a 30-day supply from a *specialty pharmacy* or a retail *pharmacy*, unless otherwise determined by *us*.

Mail order pharmacy 90-day supply

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

Network pharmacy level 1 drugs, level 2 drugs, level 3 drugs, level 4 drugs and *level 5 drugs*	2.5 times the applicable *copayment* per *prescription* fill or refill, as outlined above under "Retail pharmacy" and "Specialty pharmacy / Retail pharmacy"
Non-network pharmacy level 1 drugs, level 2 drugs, level 3 drugs, level 4 drugs and *level 5 drugs*	30% *coinsurance* of the *default rate* after 2.5 times the applicable *copayment* per *prescription* fill or refill, as outlined above under "Retail pharmacy" and "Specialty pharmacy / Retail pharmacy"

SCHEDULE OF BENEFITS - PHARMACY SERVICES (continued)

Prescribed cancer treatment medications

Your cost share for covered self-administered cancer medications will not exceed $100 per *prescription* fill or refill.

Dispense as written

If *you* request a *brand-name drug* when a *generic drug* is available, *your cost share* is greater. *You* are responsible for the applicable *brand-name drug copayment* or *coinsurance* and 100% of the difference between the amount *we* would have paid the dispensing *pharmacy* for the *brand-name drug* and the amount *we* would have paid the dispensing *pharmacy* for the *generic drug.* If the prescribing *health care practitioner* determines that the *brand-name drug* is *medically necessary*, *you* are only responsible for the applicable *copayment* or *coinsurance* of the *brand-name drug*.

Non-network pharmacy claims

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

COVERED EXPENSES

This "Covered Expenses" section describes the services that will be considered *covered expenses* under the *master group contract*. Benefits will be paid for covered medical services for a *bodily injury* or *sickness*, or for specified *preventive services*, on a *maximum allowable fee* basis and as shown on the "Schedules of Benefits," subject to any applicable:

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

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

Preventive services

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

- Services with an A or B rating in the current recommendations of the U.S. Preventive Services Task Force (USPSTF). Coverage includes individual, group and telephonic tobacco cessation counseling and all U.S. Food and Drug Administration approved tobacco cessation medications.

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

- Preventive care for infants, children and adolescents provided in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA).

- Colorectal cancer screening examinations and laboratory tests administered at frequencies specified in current American Cancer Society guidelines for colorectal cancer screening.

- Preventive care for women provided in the comprehensive guidelines supported by HRSA which includes, but is not limited to sterilization and bone density screening beginning at age 35.

- Genetic screening for cancer risk that is recommended by a *health care practitioner* or genetic counselor if that recommendation is consistent with the most recent version of genetic testing guidelines published by the National Comprehensive Cancer Network (NCCN).

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

Health care practitioner office services

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

Health care practitioner office visit

Covered expenses include:

- Office visits for the diagnosis and treatment of a *sickness* or *bodily injury*.
- Office visits for prenatal care.
- Office visits for *diabetes self-management training*.
- Diagnostic laboratory and radiology.
- Allergy testing.
- Allergy serum.
- Allergy injections.
- Injections other than allergy.
- *Surgery*, including anesthesia.
- Second surgical opinions.

Virtual visit services

We will pay benefits for *covered expenses* incurred by *you* for *virtual visits* for the diagnosis and treatment of a *sickness* or *bodily injury*. *Virtual visits* must be for services provided by a *health care practitioner* at a *distant site* and a *covered person* at an *originating site* that would otherwise be a *covered expense* if provided during a face-to-face consultation between a *covered person* and a *health care practitioner.*

Health care practitioner services at a retail clinic

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

Hospital services

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

For *emergency medical condition* benefits provided in a *hospital*, refer to the "Emergency services" provision of this section.

COVERED EXPENSES (continued)

Hospital inpatient services

Covered expenses include:

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

Health care practitioner inpatient services when provided in a hospital

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

Covered expenses include:

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

Hospital outpatient services

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

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

Hospital outpatient surgical services

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

Health care practitioner outpatient services when provided in a hospital

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

Covered expenses include:

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

Hospital outpatient non-surgical services

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

Hospital outpatient advanced imaging

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

Pregnancy and newborn benefit

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

Covered expenses include:

- A minimum stay of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated cesarean section. If an earlier discharge is consistent with the most current protocols and guidelines of the American College of Obstetricians and Gynecologists or the American Academy of Pediatrics and is consented to by the mother and the attending *health care practitioner*, a post-discharge office visit to the *health care practitioner* or a home health care visit within the first 48 hours after discharge is also covered, subject to the terms of this *certificate.*

- For a newborn, *hospital confinement* during the first 48 hours or 96 hours following birth, as applicable and listed above for:

  - *Hospital* charges for *routine nursery care*;
  - The *health care practitioner's* charges for circumcision of the newborn child; and
  - The *health care practitioner's* charges for routine examination of the newborn before release from the *hospital*.

- If the covered newborn must remain in the *hospital* past the mother's *confinement,* services and supplies received for:

  - A *bodily injury* or *sickness*;
  - Care and treatment for premature birth; and
  - Medically diagnosed birth defects and abnormalities.

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

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

The covered newborn will not be required to satisfy a separate *deductible* for any *covered expenses* or *copayments* for *hospital* facility charges for the *confinement* period for the first 31 days following the newborn's date of birth. A *deductible* and/or *copayment,* if applicable, will be required for any *covered expenses* after the first 31 days of the newborn's date of birth. Please see the "Eligibility and Effective Dates" section of this *certificate* for an explanation of the enrollment requirements and the *effective date* for a newborn *dependent* child.

Emergency services

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

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

Covered expenses also include *health care practitioner* services for an *emergency medical condition,* including the treatment and stabilization of an *emergency medical condition,* provided in a *hospital* emergency facility. These services are subject to the terms, conditions, limitations, and exclusions of the *master group contract*.

Benefits under this "Emergency services" provision are not available if the services provided do not meet the definition of *emergency medical condition*.

Ambulance services

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

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

Ambulatory surgical center services

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

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

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

Covered expenses include:

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

Durable medical equipment and diabetes equipment

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

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

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

- Manufacturer's warranty is expired; and
- Repair or maintenance is not a result of misuse or abuse; and
- Repair cost is less than replacement cost.

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

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

Hearing aids and related services

Hearing aid and related services, any wearable, non-disposable instrument or device designed to aid or compensate for impaired hearing, including any parts, attachments, or accessories (excluding batteries and cords). Services to access, select, and adjust/fit the hearing aid to ensure optimal performance, as prescribed by a licensed audiologist and dispensed by a licensed audiologist or hearing instrument specialist. One hearing aid, per hearing impaired ear, every 36 months.

Free-standing facility services

Free-standing facility diagnostic laboratory and radiology services

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

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

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

Free-standing facility advanced imaging

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

Home health care services

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

The "Schedule of Benefits" shows the maximum number of visits allowed by a representative of a *home health care agency*, if any. A visit by any representative of a *home health care agency* will be considered one visit, except that at least four hours of home health aide service will be counted as one visit. Each additional two hours or less visit by any representative will be considered one additional visit except for a visit by a home health aide service where each additional four hours will be counted as one visit.

Home health care *covered expenses* are limited to:

- Care provided by a *nurse*;
- Physical, occupational, respiratory or speech therapy;
- Medical social work and nutrition services;
- Medical supplies, except for *durable medical equipment*;
- Laboratory services; and
- Private duty nursing.

Home health care *covered expenses* do not include:

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

Hospice services

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

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

Covered expenses for hospice services are payable as shown on the "Schedule of Benefits" for the following hospice services include:

- *Room and board* at a hospice, when it is for management of acute pain or for an acute phase of chronic symptom management;
- Part-time nursing care provided by or supervised by a registered nurse (R.N.) for the hours approved in the *hospice care program*;
- Counseling for the terminally ill *covered person* and his/her immediate covered *family members* by a licensed:

- Clinical social worker; or
- Pastoral counselor.

- Medical social services provided to the terminally ill *covered person* or his/her immediate covered *family members* under the direction of a *health care practitioner*, including:

  - Assessment of social, emotional and medical needs, and the home and family situation; and
  - Identification of the community resources available.

- Psychological and dietary counseling;
- Physical therapy;
- Home health care;
- Part-time home health aide services for the hours approved in the *hospice care program*; and
- Medical supplies, drugs, and medicines for *palliative care*.

Hospice care *covered expenses* do not include:

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

Jaw joint benefit

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

The following are *covered expenses*:

- A single examination including a history, physical examination, muscle testing, range of motion measurements, and psychological evaluation;

- Diagnostic x-rays;

- Physical therapy of necessary frequency and duration, limited to a multiple modality benefit when more than one therapeutic treatment is rendered on the same date of service;

- Therapeutic injections;

- Appliance therapy utilizing an appliance that does not permanently alter tooth position, jaw position or bite. Benefits for reversible appliance therapy will be based on the *maximum allowable fee* for use of a single appliance, regardless of the number of appliances used in treatment. The benefit for the appliance therapy will include an allowance for all jaw relation and position diagnostic services, office visits, adjustments, training, repair, and replacement of the appliance; and

- Surgical procedures.

Covered expenses do not include charges for:

- Computed Tomography (CT) scans or magnetic resonance imaging except in conjunction with surgical management;
- Electronic diagnostic modalities;
- Occlusal analysis; or
- Any irreversible procedure, including: orthodontics, occlusal adjustment, crowns, onlays, fixed or removable partial dentures, and full dentures.

Physical medicine and rehabilitative services

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

- Physical therapy services;
- Occupational therapy services;
- Speech therapy or speech pathology services;
- Audiology services, including post cochlear aural therapy;
- Cognitive rehabilitation services;
- Respiratory or pulmonary rehabilitation services;
- Cardiac rehabilitation services; and
- Orthoptic training (eye exercises) up to the age of 22.

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

Habilitative services

We will pay benefits for *covered expenses* incurred by *you* for the following *habilitative services* ordered and performed by a *health care practitioner* for a *covered person* with a *congenital anomaly*, developmental delay or defect:

- Physical therapy services;
- Occupational therapy services;
- Speech therapy or speech pathology services; and
- Audiology services, including post cochlear aural therapy.

The "Schedule of Benefits" shows the maximum number of visits for *habilitative services*, if any.

Spinal manipulations/adjustments

We will pay benefits for *covered expenses* incurred by *you* for spinal manipulations/adjustments performed by a *health care practitioner*.

The "Schedule of Benefits" shows the maximum number of visits for spinal manipulations/adjustments, if any.

Skilled nursing facility services

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

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

Health care practitioner services when provided in a skilled nursing facility

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

Covered expenses include:

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

Specialty drugs in a medical place of service

We will pay benefits for *covered expenses* incurred by *you* for *specialty drugs* that are administered in the following medical places of service:

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

Benefits for *specialty drugs* may be subject to *preauthorization* requirements, if any. Please refer to the "Schedule of Benefits" in this *certificate* for *preauthorization* requirements and contact *us* prior to receiving *specialty drugs.*

Benefits for *specialty drugs* do not include the charge for the actual administration of the *specialty drug*. Payment for the administration of *specialty drugs* is addressed in the "Schedule of Benefits" section of this *certificate.*

Transplant services and immune effector cell therapy

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

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

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

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

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

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

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

- *Hospital* and *health care practitioner* services.

- Acquisition of cell therapy products for *immune effector cell therapy*, acquisition of *stem cells* or solid organs for transplants and associated donor costs, including pre-transplant or *immune effector cell therapy* services, the acquisition procedure, and any complications resulting from the harvest and/or acquisition. Donor costs for post-discharge services and treatment of complications will not exceed the treatment period of 365 days from the date of discharge following harvest and/or acquisition.

- Non-medical travel and lodging costs for:

  - The *covered person* receiving the transplant or *immune effector cell therapy*, if the *covered person* lives more than 100 miles from the transplant or *immune effector cell therapy* facility designated by *us*; and

  - One caregiver or support person (two, when the *covered person* receiving the transplant or *immune effector cell therapy* is under 18 years of age), if the caregiver or support person lives more than 100 miles from the transplant or *immune effector cell therapy* facility designated by *us*.

  Non-medical travel and lodging costs include:

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

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

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

Urgent care services

We will pay benefits for *covered expenses* incurred by *you* for charges made by an *urgent care center* for *urgent care* services. *Covered expense* also includes *health care practitioner* services for *urgent care* provided at and billed by an *urgent care center*.

Additional covered expenses

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

- Blood and blood plasma, which is not replaced by donation; administration of the blood and blood products including blood extracts or derivatives.

- Oxygen and rental of equipment for its administration.

- Prosthetic devices and supplies, including limbs and eyes. Coverage will be provided for prosthetic devices to:

  - Restore the previous level of function lost as a result of a *bodily injury* or *sickness*; or
  - Improve function caused by a *congenital anomaly*.

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

  - A change in the *covered person's* physical condition causing the device to become non-functional; or
  - Normal wear and tear.

- Cochlear implants when provided to a *covered person* diagnosed with profound hearing impairment.

  Replacement or upgrade of a cochlear implant and its external components may be a *covered expense* if:

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

- Hearing examinations.

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

  Covered expense does not include:

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

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

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

COVERED EXPENSES (continued)

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

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

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

- Certain oral surgical operations as follows:

  - Excision of partially or completely impacted teeth;

  - Surgical preparation of soft tissues and excision of bone or bone tissue performed with or without extraction or excision of erupted, partially erupted or completely un-erupted teeth;

  - Excisions of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth, and related biopsy of bone, tooth, or related tissues when such conditions require pathological examinations;

  - Surgical procedures related to repositioning of teeth, tooth transplantation or re-implantation;

  - Services required to correct accidental injuries of the jaws, cheeks, lips, tongue, roof and floor of the mouth;

  - Reduction of fractures and dislocation of the jaw;

  - External incision and drainage of cellulitis and abscess;

  - Incision and closure of accessory sinuses, salivary glands or ducts;

  - Frenectomy (the cutting of the tissue in the midline of the tongue); and

  - Orthognathic *surgery* for a *congenital anomaly, bodily injury* or *sickness* causing a *functional impairment*.

- Orthodontic treatment for a *congenital anomaly* related to or developed as a result of cleft palate, with or without cleft lip.

- Reconstructive services required to correct certain deformities caused by disease, trauma, *congenital anomalies*, or previous therapeutic process are eligible for coverage. Reconstructive services required due to prior therapeutic process would be covered if the original procedure would have been a covered expense. *Covered expenses* are limited to the following:

- Hemangiomas and port wine stains of the head and neck areas for children through age 17;
- Limb deformities such as club hand, club foot, syndactyly (webbed digits) polydactyly (supermenary digits), macrodactylia;
- Otoplasty when performed to improve hearing by directing sound in the ear canal, when ear or ears are absent or deformed from trauma, surgery, disease or congenital defect;
- Tongue release for diagnosis of tongue-tied;
- Congenital disorders that cause skull deformity such as Crouzon's disease;
- Cleft lip; and
- Cleft palate.

- For a *covered person,* who is receiving benefits in connection with a mastectomy, service for:

  - Reconstructive *surgery* of the breast on which the mastectomy has been performed;
  - *Surgery* and reconstruction on the non-diseased breast to achieve symmetrical appearance; and
  - Prostheses and treatment of physical complications for all stages of mastectomy, including lymphedemas.

- Reconstructive *surgery* resulting from:

  - A *bodily injury,* infection or other disease of the involved part, when a *functional impairment* is present; or
  - A *congenital anomaly* that resulted in a *functional impairment*.

  Expenses for reconstructive *surgery* due to a psychological condition are <u>not</u> considered a *covered expense,* unless the condition(s) described above are also met.

- For a *covered person* who has been diagnosed with breast disease, mammograms are a *covered expense* regardless of age, upon referral by a *health care practitioner*.

- Therapeutic food and low-protein modified food products for a *covered person* when prescribed or ordered by a *health care practitioner* and are for the treatment of inborn metabolic errors or genetic conditions, e.g. phenylketonuria (PKU).

- Human milk fortifiers or 100% human milk-based diet, when prescribed for prevention of necrotizing enterocolitis and administered under the direction of a *health care practitioner*.

- Coverage for general anesthesia and *hospital* or facility services performed in a *hospital* or ambulatory surgical facility, in connection with dental procedures when certified by a *health care practitioner* for:

  - A *dependent* under the age of nine;
  - A *covered person* with a *serious mental condition* or a significant behavioral problem;
  - A *covered person* with a *serious physical condition*; or
  - A *covered person* age 9 or older who is determined by a licensed dentist or physician to require such services in order to prevent significant medical risk.

- *Palliative care*.

- Routine costs for a *covered person* participating in an approved Phase I, II, III or IV clinical trial.

  Routine costs include health care services that are otherwise a *covered expense* if the *covered person* were not participating in a clinical trial.

  Routine costs do not include services or items that are:

  - *Experimental, investigational* or *for research purposes*;
  - Provided only for data collection and analysis that is not directly related to the clinical management of the *covered person*; or
  - Inconsistent with widely accepted and established standards of care for a diagnosis.

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

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

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

  - Federally funded or approved by the appropriate federal agency;
  - The study or investigation is conducted under an investigational new drug application reviewed by the Federal Food and Drug Administration; or
  - The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

- *Covered expenses* for routine patient costs associated with a clinical trial for the treatment of cancer. The clinical trial must be approved by:

  - The National Institutes of Health (NIH) or any institutional review board recognized by the NIH;
  - Federal Drug Administration (FDA);
  - Department of Defense (DOD); and
  - Department of Veterans Affairs (VA).

  The clinical trial must do one of the following:

  - Test how to administer a service, item, or drug for the treatment of cancer;
  - Test responses to a service, item or drug for the treatment of cancer;
  - Compare the effectiveness of a service, item, or drug for the treatment of cancer with that of other services, items, or drugs for the treatment of cancer; or
  - Study new uses of services, items, or drugs for the treatment of cancer.

Coverage for routine patient costs does not include:

- The service, item or *experimental* or *investigational* drug that is the subject of the clinical trial;
- Any treatment modality outside the usual and customary standard of care required to administer or support the service, item or *experimental* or *investigational* drug that is the subject of the clinical trial;
- Any service, item or drug provided solely for data collection and analysis needs that are not used in the direct clinical management of the patient;
- Any drug or device that is *experimental* or *investigational* or *for research purposes*;
- Transportation, lodging, food or other expenses for the patient, *family member* or companion associated with the travel to or from the facility providing the clinical trial;
- Services, items or drugs provided for free for any new patient by the clinical trial sponsor; and
- Services, items or drugs that are eligible for reimbursement by a person other than the insurer, including the clinical trial sponsor.

- For a *covered person*, who is receiving benefits in connection with cancer treatment, the first wig following cancer treatment.
- Covered expenses for the diagnosis and treatment of endometriosis and endometritis.

COVERED EXPENSES - PEDIATRIC DENTAL

This "Covered Expenses – Pediatric Dental" section describes the services that will be considered *covered expenses* for *pediatric dental services* under the *master group contract.* Benefits for *pediatric dental services* will be paid on a *reimbursement limit* basis and as shown in the "Schedule of Benefits – Pediatric Dental," subject to any applicable:

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

Notwithstanding any other provisions of the *master group contract,* expenses covered under this benefit section are not covered under any other provision of the *master group contract.* Any amount in excess of the maximum amount provided under this benefit, if any, is not covered under any other provision in the *master group contract.*

All terms used in this benefit have the same meaning given to them in this *certificate,* unless otherwise specifically defined in this benefit. Refer to the "Limitations and exclusions" provision in this section and the "Limitations and Exclusions" section of this *certificate* for *pediatric dental services* not covered by the *master group contract.* All other terms and provisions of the *master group contract* are applicable to expenses covered for *pediatric dental services.*

Definitions

Accidental dental injury means damage to the mouth, teeth and supporting tissue due directly to an *accident.* It does not include damage to the teeth, appliances or prosthetic devices that results from chewing or biting food or other substances, unless the biting or chewing injury is a result of an act of domestic violence or a medical condition (including both physical and mental health conditions).

Clinical review means the review of required/submitted documentation by a *dentist* for the determination of *pediatric dental services.*

Cosmetic means services that are primarily for the purpose of improving appearance, including but not limited to:

- Facings on crowns or pontics (the portion of a fixed bridge between the abutments) posterior to the second bicuspid; or
- Characterizations and personalization of prosthetic devices.

Covered person under this "Covered Expenses – Pediatric Dental" and the "Schedule of Benefits – Pediatric Dental" sections means a person who is eligible and enrolled for benefits provided under the *master group contract* up to the end of the month following the date he or she attains age 21.

COVERED EXPENSES - PEDIATRIC DENTAL (continued)

Dental emergency means a sudden, serious dental condition caused by an *accident* or dental disease that, if not treated immediately, would result in serious harm to the dental health of the *covered person.*

Expense incurred date means the date on which:

- The teeth are prepared for fixed bridges, crowns, inlays, or onlays;
- The final impression is made for dentures or partials;
- The pulp chamber of a tooth is opened for root canal therapy;
- A periodontal surgical procedure is performed; or
- The service is performed for services not listed above.

Palliative dental care means treatment used in a *dental emergency* or *accidental dental injury* to relieve, ease or alleviate the acute severity of dental pain, swelling or bleeding. *Palliative dental care* treatment usually is performed for, but is not limited to, the following acute conditions:

- Toothache;
- Localized infection;
- Muscular pain; or
- Sensitivity and irritations of the soft tissue.

Services are not considered *palliative dental care* when used in association with any other *pediatric dental services,* except x-rays and/or exams.

Reimbursement limit means the maximum fee allowed for *pediatric dental services.* It is the lesser of:

- The actual cost for services;
- The fee most often charged in the geographical area where the service was performed;
- The fee most often charged by the provider;
- The fee determined by comparing charges for similar services to a national database adjusted to the geographical area where the services or procedures were performed;
- At *our* choice, the fee determined by using a national Relative Value Scale. Relative Value Scale means a methodology that values procedures and services relative to each other that includes, but is not limited to, a scale in terms of difficulty, work, risk, as well as the material and outside costs of providing the service, as adjusted to the geographic area where the services or procedures were performed;
- In the case of services rendered by providers with whom *we* have agreements, the fee that *we* have negotiated with that provider;

- The fee based on rates negotiated with one or more *network providers* in the geographic area for the same or similar services;
- The fee based on the provider's costs for providing the same or similar services as reported by the provider in the most recent, publicly available *Medicare* cost report submitted annually to the Centers for Medicare and Medicaid Services; or
- The fee based on a percentage of the fee *Medicare* allows for the same or similar services provided in the same geographic area.

The bill *you* receive for services provided by *non-network providers* may be significantly higher than the *reimbursement limit.* In addition to the *deductible, copayments* and *coinsurance, you* are responsible for the difference between the *reimbursement limit* and the amount the provider bills *you* for the services. Any amount *you* pay to the provider in excess of the *reimbursement limit* will not apply to *your deductible* or *out-of-pocket limit.*

Treatment plan means a written report on a form satisfactory to *us* and completed by the *dentist* that includes:

- A list of the services to be performed, using the American Dental Association terminology and codes;
- *Your dentist's* written description of the proposed treatment;
- Pretreatment x-rays supporting the services to be performed;
- Itemized cost of the proposed treatment; and
- Any other appropriate diagnostic materials (may include x-rays, chart notes, treatment records, etc.) as requested by *us.*

Pediatric dental services benefit

We will pay benefits for *covered expenses* incurred by a *covered person* for *pediatric dental services. Pediatric dental services* include the following as categorized below. Coverage for a *dental emergency* is limited to *palliative dental care* only:

Class I services

- Periodic and comprehensive oral evaluations. Limited to 2 per *year*.
- Limited, problem focused oral evaluations. Limited to 2 per *year*.
- Periodontal evaluations. Limited to 2 per *year*. Benefit allowed only for a *covered person* showing signs or symptoms of periodontal disease and for patients with risk factors such as smoking, diabetes or related health issues. No benefit is payable when performed with a cleaning (prophylaxis). Benefits are not available when a comprehensive oral evaluation is performed.
- Cleaning (prophylaxis), including all scaling and polishing procedures. Limited to 2 per *year*.
- Intra-oral complete series x-rays (at least 14 films, including bitewings). Limited to 2 per *year*. If the total cost of periapical and bitewing x-rays exceeds the cost of a complete series of x-rays, *we* will consider these as a complete series.

- Panoramic x-rays for *covered persons.* Limited to one per *year*.
- Cephalometric radiographic image for *covered persons*.
- Bitewing x-rays. Limited to 2 sets per *year*.
- Other x-rays, including intra-oral periapical and occlusal and extra-oral x-rays. Limited to x-rays necessary to diagnose a specific treatment.
- Topical fluoride treatment. Limited to two per *year*.
- Application of sealants to the occlusal surface of permanent molars that are free of decay and restorations. Limited to one per tooth every 3 *years*.
- Installation of space maintainers for retaining space when a primary tooth is prematurely lost. *Pediatric dental services* do not include separate adjustment expenses.
- Recementation of space maintainers.
- Removal of fixed space maintainers.
- Distal shoe space maintainer – fixed – unilateral.

Class II services

- Restorative services as follows:
  - Amalgam restorations (fillings). Multiple restorations on one surface are considered one restoration.
  - Composite restorations (fillings) on anterior teeth. Composite restorations on molar and bicuspid teeth are considered an alternate service and will be payable as a comparable amalgam filling. *You* will be responsible for the remaining expense incurred. Multiple restorations on one surface are considered one restoration.
  - Pin retention per tooth in addition to restoration that is not in conjunction with core build-up.
  - Non-cast pre-fabricated stainless steel, esthetic stainless steel, and resin crowns on primary teeth that cannot be adequately restored with amalgam or composite restorations. Esthetic stainless steel and resin crowns are considered an alternate service and will be payable as a comparable non-case pre-fabricated stainless steel crown. The *covered person* will be responsible for the remaining *expense incurred.*
- Miscellaneous services as follows:
  - *Palliative dental care* for a *dental emergency* for the treatment of pain or an *accidental dental injury* to the teeth and supporting structures. *We* will consider the service a separate benefit only if no other service, except for x-rays and problem focused oral evaluation is provided during the same visit.

- Re-cementing inlays, onlays and crowns.

Class III services

- Restorative services as follows:

  - Initial placement of laboratory-fabricated restorations, for a permanent tooth, when the tooth, as a result of extensive decay or a traumatic injury, cannot be restored with a direct placement filling material. *Pediatric dental services* include inlays, onlays, crowns, veneers, core build-ups and posts, implant supported crowns, and abutments. Limited to 1 per tooth every 5 *years.* Inlays are considered an alternate service and will be payable as a comparable amalgam filling.

  - Replacement of inlays, onlays, crowns or other laboratory-fabricated restorations for permanent teeth. *Pediatric dental services* include the replacement of the existing major restoration if:

    - It has been 5 *years* since the prior insertion and is not, and cannot be made serviceable;
    - It is damaged beyond repair as a result of an *accidental dental injury* while in the oral cavity; or
    - Extraction of functioning teeth, excluding third molars or teeth not fully in occlusion with an opposing tooth or prostheses requires the replacement of the prosthesis.

- Periodontic services as follows:

  - Periodontal scaling and root planing. Limited to 1 per quadrant every *year*.

  - Scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation. Limited to 1 per *year*. This service will reduce the number of cleanings available so that the total number of cleanings does not exceed 2 per *year*.

  - Full mouth debridement to enable comprehensive evaluation and diagnosis. Limited to one per pregnancy one per lifetime. If one per lifetime has been fulfilled, then one per pregnancy is still available.

  - Periodontal maintenance, (at least 30 days following periodontal therapy), unless a cleaning (prophylaxis) is performed on the same day. Limited to 4 every *year*.

  - Periodontal and osseous surgical procedures, including bone replacement, tissue regeneration, gingivectomy, and gingivoplasty. Limited to 1 per quadrant, per *year*.

  - Occlusal adjustments when performed in conjunction with a periodontal surgical procedure. Limited to 1 per quadrant, per *year*.

  - Clinical crown lengthening – hard tissue.

  - Tissue graft procedures, including: pedicle soft tissue graft procedure, free soft tissue graft procedure (including donor site surgery); and subepithelial connective tissue graft procedures (including donor site surgery).

Separate fees for pre- and post-operative care and re-evaluation within 3 months are not considered *pediatric dental services.*

- Endodontic procedures as follows:

  - Root canal therapy, including root canal treatments and root canal fillings for permanent teeth and primary teeth. Any test, intraoperative, x-rays, laboratory or any other follow-up care is considered integral to root canal therapy.

  - Root canal retreatment, including root canal treatments and root canal fillings for permanent and primary teeth. Any test, intraoperative x-rays, exam, laboratory or any other follow-up care is considered integral to root canal therapy.

  - Periradicular surgical procedures for permanent teeth, including apicoectomy, root amputation, tooth reimplementation, bone graft, and surgical isolation.

  - Partial pulpotomy for apexogenesis for permanent teeth.

  - Vital pulpotomy for primary teeth.

  - Pulp debridement, pulpal therapy (resorbable) for permanent and primary teeth.

  - Apexification/recalcification for permanent and primary teeth.

- Prosthodontics services as follows:

  - Denture adjustments when done by a *dentist* other than the one providing the denture, or adjustments performed more than six months after initial installation.

  - Initial placement of bridges, complete dentures and partial dentures. Limited to 1 every *year*. *Pediatric dental services* include pontics, inlays, onlays and crowns. Limited to 1 per tooth every 5 *years.*

  - Replacement of bridges, complete dentures, and partial dentures. *Pediatric dental services* include the replacement of the existing prosthesis if:

    - It has been 5 *years* since the prior insertion and is not, and cannot be made serviceable;
    - It is damaged beyond repair as a result of an *accidental dental injury* while in the oral cavity; or
    - Extraction of functioning teeth, excluding third molars or teeth not fully in occlusion with an opposing tooth or prostheses requires the replacement of the prosthesis.

  - Tissue conditioning.

  - Denture relines or rebases. Limited to 1 every *year* after 6 months of installation.

  - Post and core build-up in addition to partial denture retainers with or without core build-up. Limited to 1 per tooth every 5 *years*.

- The following simple oral surgical services as follows:

  - Extraction of coronal remnants of a primary tooth.
  - Extraction of an erupted tooth or exposed root for permanent and primary teeth.

- Implant services, subject to *clinical review*. Dental implants and related services, including implant supported bridges and provisional implant crown. Limited to 1 per tooth every 5 *years*. *Pediatric dental services* do not include an implant if it is determined a standard prosthesis or restoration will satisfy the dental need.

  Implant supported removable denture for:

  - Edentulous arch – maxillary. Limited to 1 per tooth every 5 *years*.
  - Edentulous arch – mandibular. Limited to 1 per tooth every 5 *years*.
  - Partially edentulous arch – maxillary. Limited to 1 per tooth every 5 *years*.
  - Partially edentulous arch – mandibular. Limited to 1 per tooth every 5 *years*.

- Miscellaneous services as follows:

  - Recementing of bridges and implants.
  - Repairs of bridges, complete dentures, immediate dentures, partial dentures, and crowns.

- General anesthesia or conscious sedation subject to *clinical review* and administered by a *dentist* in conjunction with covered oral surgical procedures, periodontal and osseous surgical procedures, and periradicular surgical procedures, for *pediatric dental services*. General anesthesia is not considered a *pediatric dental service* if administered for, including but not limited to, the following:

  - Pain control, unless the *covered person* has a documented allergy to local anesthetic.
  - Anxiety.
  - Fear of pain.
  - Pain management.
  - Emotional inability to undergo a surgical procedure.

Class IV services

Orthodontic treatment, not as a result of a *congenital anomaly*, when *medically necessary*. Orthodontic treatment that is a result of a congenital anomaly and when medically necessary, is covered under the "Covered Expenses" section in this *certificate*.

Covered expenses for orthodontic treatment, not as a result of a *congenital anomaly*, include those that are:

- For the treatment of and appliances for tooth guidance, interception and correction.
- Related to covered orthodontic treatment, including:

  - X-rays.
  - Exams.
  - Space retainers.
  - Study models.

Covered expenses do not include services to alter vertical dimensions, restore or maintain the occlusion. Such procedures include equilibration, periodontal splinting, full mouth rehabilitation, and restoration for misalignment of teeth.

- Orthodontic treatments are limited to Medically Necessary Dental Treatment, subject to clinical review. Services include treatment of, and appliance for, tooth guidance, interception, and correction as well as X-rays, exams, and follow-up care.

Integral service

Integral services are additional charges related to materials or equipment used in the delivery of dental care. The following services are considered integral to the dental service and will not be paid separately:

- Local anesthetics.
- Bases.
- Pulp testing.
- Pulp caps.
- Study models/diagnostic casts.
- *Treatment plans.*
- Occlusal (biting or grinding surfaces of molar and bicuspid teeth) adjustments.
- Nitrous oxide.
- Irrigation.
- Tissue preparation associated with impression or placement of a restoration.

Pretreatment plan

We suggest that if dental treatment is expected to exceed $300, *you* or *your dentist* should submit a *treatment plan* to *us* for review before *your* treatment. The *treatment plan* should include:

- A list of services to be performed using the American Dental Association terminology and codes;
- *Your dentist's* written description of the proposed treatment;
- Pretreatment x-rays supporting the services to be performed;
- Itemized cost of the proposed treatment; and
- Any other appropriate diagnostic materials that *we* may request.

We will provide *you* and *your dentist* with an estimate for benefits payable based on the submitted *treatment plan.* This estimate is not a guarantee of what *we* will pay. It tells *you* and *your dentist* in advance about the benefits payable for the *pediatric dental services* in the *treatment plan*.

An estimate for services is not necessary for a *dental emergency*.

Pretreatment plan process and timing

An estimate for services is valid for 90 days after the date *we* notify *you* and *your dentist* of the benefits payable for the proposed *treatment plan* (subject to *your* eligibility of coverage). If treatment will not begin for more than 90 days after the date *we* notify *you* and *your dentist, we* recommend that *you* submit a new *treatment plan*.

COVERED EXPENSES - PEDIATRIC DENTAL (continued)

Alternate services

If two or more services are acceptable to correct a dental condition, *we* will base the benefits payable on the least expensive *pediatric dental service* that produces a professionally satisfactory result, as determined by *us*. *We* will pay up to the *reimbursement limit* for the least costly *pediatric dental service* and subject to any applicable *deductible* and *coinsurance*. *You* will be responsible for any amount exceeding the *reimbursement limit.*

If *you* or *your dentist* decides on a more costly service, payment will be limited to the *reimbursement limit* for the least costly service and will be subject to any *deductible* and *coinsurance*. *You* will be responsible for any amount exceeding the *reimbursement limit.*

Limitations and exclusions

Refer to the "Limitations and Exclusions" section of this *certificate* for additional exclusions. Unless specifically stated otherwise, no benefit will be provided for, or on account of, the following items:

- Any expense arising from the completion of forms.
- Any expense due to *your* failure to keep an appointment.
- Any expense for a service *we* consider *cosmetic*, unless it is due to an *accidental dental injury*.
- Expenses incurred for:
  - Precision or semi-precision attachments;
  - Overdentures and any endodontic treatment associated with overdentures;
  - Other customized attachments;
  - Any services for 3D imaging (cone beam images);
  - Temporary and interim dental services; or
  - Additional charges related to materials or equipment used in the delivery of dental care.
- Charges for services rendered:
  - In a dental facility or *health care treatment facility* sponsored or maintained by the *employer* under this plan or an employer of any *covered person* covered by the *master group contract*; or
  - By an employee of any *covered person* covered by the *master group contract.*

  For the purposes of this exclusion, *covered person* means the *employee* and the *employee's dependents* enrolled for benefits under the *master group contract* and as defined in the "Glossary" section.

COVERED EXPENSES - PEDIATRIC DENTAL (continued)

- Any service related to:

  - Altering vertical dimension of teeth or changing the spacing or shape of the teeth;
  - Restoration or maintenance of occlusion;
  - Splinting teeth, including multiple abutments, or any service to stabilize periodontally weakened teeth;
  - Replacing tooth structures lost as a result of abrasion, attrition, erosion, or abfraction; or
  - Bite registration or bite analysis.

- Infection control, including sterilization techniques.

- Expenses incurred for services performed by someone other than a *dentist*, except for scaling and teeth cleaning and the topical application of fluoride, which can be performed by a licensed dental hygienist. The treatment must be rendered under the supervision and guidance of the *dentist* in accordance with generally accepted dental standards;

- Any *hospital*, surgical or treatment facility, or for services of an anesthesiologist or anesthetist;

- *Prescription* drugs or pre-medications, whether dispensed or prescribed.

- Any service that:

  - Is not eligible for benefits based on the *clinical review*;
  - Does not offer a favorable prognosis;
  - Does not have uniform professional acceptance; or
  - Is deemed to be experimental or investigational in nature.

- Preventive control programs including oral hygiene instructions, plaque control, take-home items, prescriptions and dietary planning.

- Replacement of any lost, stolen, damaged, misplaced or duplicate major restoration, prosthesis or appliance.

- Any caries susceptibility testing, laboratory tests, saliva samples, anaerobic cultures, sensitivity testing or charges for oral pathology procedures.

- The following services when performed at the same time as a root canal:

  - Partial pulpotomy for apexogensis;
  - Vital pulpotomy; or
  - Pulp debridment or pulpal therapy.

COVERED EXPENSES - PEDIATRIC VISION CARE

This "Covered Expenses – Pediatric Vision Care" section describes the services that will be considered *covered expenses* for *pediatric vision care* under the *master group contract.* Benefits for *pediatric vision care* will be paid on a *reimbursement limit* basis and as shown in the "Schedule of Benefits – Pediatric Vision Care," subject to any applicable:

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

All terms used in this benefit have the same meaning given to them in this *certificate,* unless otherwise specifically defined in this benefit. Refer to the "Limitations and exclusions" provision in this section and the "Limitations and Exclusions" section of this *certificate* for *pediatric vision care* expenses not covered by the *master group contract.* All terms and provisions of the *master group contract* apply.

Definitions

Comprehensive eye exam means an exam of the complete visual system which includes: case history; monocular and binocular visual acuity, with or without present corrective lenses; neurological integrity (pupil response); biomicroscopy (external exam); visual field testing (confrontation); ophthalmoscopy (internal exam); tonometry (intraocular pressure); refraction (with recorded visual acuity); extraocular muscle balance assessment; dilation as required; present prescription analysis; specific recommendation; assessment plan; and provider signature.

Contact lens fitting and follow-up means an exam which includes: keratometry; diagnostic lens testing; instruction for insertion and removal of contact lenses; and additional biomicroscopy with and without lens.

Covered person under this "Covered Expenses – Pediatric Vision Care" section and the "Schedule of Benefits – Pediatric Vision Care" section means a person who is eligible and enrolled for benefits provided under the *master group contract* up to the end of the month following the date he or she attains age 21.

Low vision means *severe vision problems* as diagnosed by an Ophthalmologist or Optometrist that cannot be corrected with regular prescription lenses or contact lenses and reduces a person's ability to function at certain or all tasks.

Reimbursement limit means the maximum fee allowed for *pediatric vision care*. *Reimbursement limit* for *pediatric vision care* is the lesser of:

- The actual cost for services or *materials*;
- The fee most often charged in the geographical area where the service was performed or *materials* provided;
- The fee most often charged by the provider;

- The fee determined by comparing charges for similar services or *materials* to a national database adjusted to the geographical area where the services or procedures were performed or *materials* provided;

- At *our* choice, the fee determined by using a national Relative Value Scale. Relative Value Scale means a methodology that values procedures and services relative to each other that includes, but is not limited to, a scale in terms of difficulty, work, risk, as well as the material and outside costs of providing the service, as adjusted to the geographic area where the services or procedures were performed or *materials* provided;

- In the case of services rendered by or *materials* obtained from providers with whom *we* have agreements, the fee that *we* have negotiated with that provider;

- The fee based on rates negotiated with one or more *network providers* for the same or similar services or *materials*;

- The fee based on the provider's costs for providing the same or similar services or *materials* as reported by the provider in the most recent, publicly available *Medicare* cost report submitted annually to the Centers for Medicare & Medicaid Services; or

- The fee based on a percentage of the fee *Medicare* allows for the same or similar services or *materials* provided in the same geographic area.

The bill *you* receive for services provided by, or *materials* obtained from, *non-network providers* may be significantly higher than the *reimbursement limit.* In addition to *deductibles, copayments* and *coinsurance*, *you* are responsible for the difference between the *reimbursement limit* and the amount the provider bills *you* for the services or *materials.* Any amount *you* pay to the provider in excess of the *reimbursement limit* will not apply to *your deductible* or *out-of-pocket limit.*

Severe vision problems mean the best-corrected acuity is:

- 20/200 or less in the better eye with best conventional spectacle or contact lens prescription;
- A demonstrated constriction of the peripheral fields in the better eye to 10 degrees or less from the fixation point; or
- The widest diameter subtends an angle less than 20 degrees in the better eye.

Pediatric vision care benefit

We will pay benefits for *covered expenses* incurred by a *covered person* for *pediatric vision care*. *Covered expenses* for *pediatric vision care* are:

- *Comprehensive eye exam.*

COVERED EXPENSES - PEDIATRIC VISION CARE (continued)

- Prescription lenses and standard lens options, including polycarbonate, scratch coating, ultraviolet-coating, blended lenses intermediate lenses, progressive lenses, photochromatic lenses, polarized lenses, fashion and gradient tinting, oversized lenses, glass grey prescription sunglass lenses, anti-reflective coating, and hi-index lenses. If a *covered person* sees a *network provider*, the *network provider* of *materials* will show the *covered person* the selection of lens options covered by the *master group contract.* If a *covered person* selects a lens option that is not included in the lens option selection the *master group contract* covers, the *covered person* is responsible for the difference in cost between the *network provider* of *materials* reimbursement amount for covered lens options and the retail price of the lens options selected.

- Frames available from a selection of covered frames. If a *covered person* sees a *network provider*, the *network provider* of *materials* will show the *covered person* the selection of frames covered by the *master group contract.* If a *covered person* selects a frame that is not included in the frame selection the *master group contract* covers, the *covered person* is responsible for the difference in cost between the *network provider* of *materials* reimbursement amount for covered frames and the retail price of the frame selected.

- Elective contact lenses available from a selection of covered contact lenses and *contact lens fitting and follow-up*. If a *covered person* sees a *network provider*, the *network provider* of *materials* will inform the *covered person* of the contact lens selection covered by the *master group contract.* If a *covered person* selects a contact lens that is not part of the contact lens selection the *master group contract* covers, the *covered person* is responsible for the difference in cost between the lowest cost contact lens available from the contact lens selection covered by the *master group contract* and the cost of the contact lens selected.

- *Medically necessary* contact lenses under the following circumstances:

  - Visual acuity cannot be corrected to 20/70 in the better eye, except by use of contact lenses;
  - Anisometropia;
  - Keratoconus;
  - Aphakia;
  - High ametropia of either +10D or -10D in any meridian;
  - Pathological myopia;
  - Aniseikonia;
  - Aniridia;
  - Corneal disorders;
  - Post-traumatic disorders; or
  - Irregular astigmatism.

- *Low vision* services include the following:

  - Comprehensive *low vision* testing and evaluation;
  - *Low vision* supplementary testing; and
  - *Low vision* aids include the following:

    - Spectacle-mounted magnifiers;
    - Hand-held and stand magnifiers;
    - Hand-held or spectacle-mounted telescopes; and
    - Video magnification.

COVERED EXPENSES - PEDIATRIC VISION CARE (continued)

Limitations and exclusions

In addition to the "Limitations and Exclusions" section of this *certificate* and any limitations specified in the "Schedule of Benefits – Pediatric Vision Care," benefits for *pediatric vision care* are limited as follows:

- In no event will benefits exceed the lesser of the limits of the *master group contract*, shown in the "Schedule of Benefits – Pediatric Vision Care" or in the "Schedule of Benefits" of this *certificate.*
- *Materials* covered by the *master group contract* that are lost, stolen, broken or damaged will only be replaced at normal intervals as specified in the "Schedule of Benefits – Pediatric Vision Care."

Refer to the "Limitations and Exclusions" section of this *certificate* for additional exclusions. Unless specifically stated otherwise, no benefits for *pediatric vision care* will be provided for, or on account of, the following items:

- Orthoptic or vision training and any associated supplemental testing.
- Two or more pair of glasses, in lieu of bifocals or trifocals.
- Medical or surgical treatment of the eye, eyes or supporting structures.
- Any services and/or *materials* required by an *employer* as a condition of employment.
- Safety lenses and frames.
- Contact lenses, when benefits for frames and lenses are received.
- Cosmetic items.
- Any services or *materials* not listed in this benefit section as a covered benefit or in the "Schedule of Benefits – Pediatric Vision Care."
- Expenses for missed appointments.
- Any charge from a provider's office to complete and submit claim forms.
- Treatment relating to or caused by disease.
- Non-prescription *materials* or vision devices.
- Costs associated with securing *materials.*
- Pre- and post-operative services.
- Orthokeratology.
- Maintenance of *materials.*
- Refitting or change in lens design after initial fitting.
- Artistically painted lenses.

COVERED EXPENSES - BEHAVIORAL HEALTH

This "Covered Expenses – Behavioral Health" section describes the services that will be considered *covered expenses* for *mental health services* and *chemical dependency* services under the *master group contract.* Benefits for *mental health services* and *chemical dependency* services will be paid on a *maximum allowable fee* basis and as shown in the "Schedule of Benefits – Behavioral Health." Refer to the "Schedule of Benefits" for any service not specifically listed in the "Schedule of Benefits – Behavioral Health." Benefits are subject to any applicable:

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

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

Acute inpatient services

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

Acute inpatient health care practitioner services

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

Emergency services

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

Emergency care provided by a *non-network hospital* or a *non-network health care practitioner* will be covered at the *network provider* benefit as specified in the "Emergency services" benefit in the "Schedule of Benefits" or "Schedule of Benefits – Behavioral Health" sections of this *certificate,* subject to the *maximum allowable fee. Non-network providers* have not agreed to accept discounted or negotiated fees, and may bill *you* for charges in excess of the *maximum allowable fee. You* may be required to pay any amount not paid by *us.*

Covered expenses also include *health care practitioner* services for emergency care, including the treatment and stabilization of an *emergency medical condition,* provided in a *hospital* emergency facility. These services are subject to the terms, conditions, limitations, and exclusions of the *master group contract.*

Benefits under this "Emergency services" provision are not available if the services provided do not meet the definition of *emergency medical condition*.

Urgent care services

We will pay benefits for *covered expenses* incurred by *you* in an *urgent care center* for *mental health services* and *chemical dependency* services. *Covered expenses* also include *health care practitioner* services for *urgent care* provided at and billed by an *urgent care center*.

Outpatient services

We will pay benefits for *covered expenses* incurred by *you* for *mental health services* and *chemical dependency* services, including services in a *health care practitioner* office or *retail clinic*, *outpatient* therapy, *outpatient* services provided as part of an *intensive outpatient program, partial hospitalization,* and other *outpatient* services, while not *confined* in a *hospital*, *residential treatment facility* or *health care treatment facility.*

Skilled nursing facility services

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

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

Home health care services

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

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

Home health care *covered expenses* do not include:

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

Specialty drugs in a medical place of service

We will pay benefits for *covered expenses* incurred by *you* for *behavioral health specialty drugs* that are administered in the following medical places of service:

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

Benefits for *specialty drugs* may be subject to *preauthorization* requirements, if any. Please refer to the "Schedule of Benefits" in this *certificate* for *preauthorization* requirements and contact *us* prior to receiving *specialty drugs.*

Benefits for *specialty drugs* do not include the charge for the actual administration of the *specialty drug*. Payment for the administration of *specialty drugs* is addressed in the "Schedule of Benefits" or "Schedule of Benefits – Behavioral Health" sections of this *certificate.*

Residential treatment facility services

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

Autism spectrum disorders

We will pay benefits for *covered expenses* incurred by *you,* for *health care practitioner* services to treat *autism spectrum disorders.*

Covered expenses include:

- Medical care;
- Habilitative or rehabilitative care;
- Pharmacy care, if covered by plan;
- Psychiatric care;
- Psychological care;
- Therapeutic care;
- Applied behavior analysis prescribed or ordered by a licensed health or allied health professional.

Refer to the "Schedule of Benefits – Behavioral Health" section for benefits payable for *autism spectrum disorders.*

COVERED EXPENSES - PHARMACY SERVICES

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

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

Coverage description

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

Covered *prescription* drugs are:

- Drugs, medicines or medications and *specialty drugs* that under federal or state law may be dispensed only by *prescription* from a *health care practitioner*.
- Drugs, medicines or medications and *specialty drugs* included on *our drug list.*
- Insulin and *diabetes supplies*.
- *Self-administered injectable drugs* approved by *us.*
- Hypodermic needles, syringes or other methods of delivery when prescribed by a *health care practitioner* for use with insulin or *self-administered injectable drugs*. (Hypodermic needles, syringes or other methods of delivery used in conjunction with covered drugs may be available at no cost to *you*).
- Enteral formulas and nutritional supplements for the treatment of phenylketonuria (PKU) or other inherited metabolic disease, or as otherwise determined by *us.*
- Human milk fortifiers when prescribed for prevention of necrotizing enterocolitis and administered under the direction of a *health care practitioner.*
- Eye drops, as identified on the *drug list,* including one additional bottle every three months when the initial prescription includes the request for the additional bottle and states it is needed for use in a day care center or school.
- Spacers and/or peak flow meters for the treatment of asthma.
- Drugs, medicines or medications on the Preventive Medication Coverage *drug list* with a *prescription* from a *health care practitioner*.

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

Restrictions on choice of providers

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

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

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

About our drug list

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

Access to medically necessary contraceptives

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

Access to non-formulary drugs

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

Non-formulary drug standard exception request

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

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

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

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

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

Non-formulary drug expedited exception request

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

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

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

- Statement that an exigent circumstance exists and explain the harm that could reasonably be expected to the *covered person* if the requested non-formulary drug is not provided within the timeframes of the standard exception request; and

- Justification supporting the need for the prescribed non-formulary drug to treat the *covered person's* condition, including a statement that all covered drugs on the *drug list* on any tier:

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

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

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

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

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

Non-formulary drug exception request external review

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

The final external review decision by the independent review organization to either uphold the denied exception request or grant the exception request will be provided orally or in writing to *you*, *your* appointed representative, or the prescribing *health care practitioner* no later than:

- 24 hours after receipt of an external review request if the original exception request was expedited.
- 72 hours after receipt of an external review request if the original exception request was standard.

If the independent review organization grants the exception request, *we* will cover the prescribed, clinically appropriate non-formulary drug for *you* for:

- The duration of the *prescription*, including refills, when the original request was a standard exception request.
- The duration of the exigent circumstance when the original request was an expedited exception request.

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

Step therapy exception request

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

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

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

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

- The *prescription* drug requiring *step therapy* has been ineffective in the treatment of *your* disease or medical condition; or

- Based on sound clinical evidence or medical and scientific evidence, the *prescription* drug requiring *step therapy*:

    - Is expected or likely to be ineffective based on *your* known relevant clinical characteristics and the known characteristics of the *prescription* drug regimen; or
    - Will cause or will likely cause an adverse reaction or physical harm to *you.*

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

- The reason for the denial;
- An alternative covered medication; and
- The right to appeal *our* decision as described in the "Internal Appeal and External Review" section of this *certificate.*

LIMITATIONS AND EXCLUSIONS

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

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

- Treatments, services, supplies or *surgeries* that are not *medically necessary*, except *preventive services*.
- A *sickness* or *bodily injury* arising out of, or in the course of, any employment for wage, gain or profit. This exclusion does not apply to an *employee* that is sole proprietor, partner, or corporate officer if the sole proprietor, partner or corporate officer is not eligible to receive Workers' Compensation benefits.
- Care and treatment while confined in a jail, holdover or regional jail when facilitated by a unit of local government or a regional jail authority for a *covered person* convicted of a felony.
- Care and treatment given in a *hospital* owned, or run, by any government entity, unless *you* are legally required to pay for such care and treatment. However, care and treatment provided by military *hospitals* to *covered persons* who are armed services retirees and their *dependents* are not excluded.
- Any service furnished while *you* are *confined* in a *hospital* or institution owned or operated by the United States government or any of its agencies for any military service-connected *sickness* or *bodily injury*.
- Services, or any portion of a service, for which no charge is made.
- Services, or any portion of a service, *you* would not be required to pay for, or would not have been charged for, in the absence of this coverage.
- Any portion of the amount *we* determine *you* owe for a services that the provider waives, rebates or discounts, including *your copayment, deductible* or *coinsurance*.
- *Sickness* or *bodily injury* for which *you* are in any way paid or entitled to payment or care and treatment by or through a government program.
- Any service not ordered by a *health care practitioner*.
- Services rendered by a standby physician, *surgical assistant* or *assistant surgeon* unless *medically necessary*.
- Any service not rendered by the billing provider.

LIMITATIONS AND EXCLUSIONS (continued)

- Any service not substantiated in the medical records of the billing provider.
- Education, or training, except for *diabetes self-management training* and *habilitative services*.
- Educational or vocational, therapy, testing, services or schools, including therapeutic boarding schools and other therapeutic environments. Educational or vocational videos, tapes, books and similar materials are also excluded.
- Services provided by a *covered person's family member*.
- *Ambulance* services for routine transportation to, from or between medical facilities and/or a *health care practitioner's* office.
- Any drug, biological product, device, medical treatment, or procedure which is *experimental, investigational* or *for research purposes*.
- Vitamins, except for *preventive services* with a *prescription* from a *health care practitioner*, dietary supplements and dietary formulas, except:
    - Dietary formulas and supplements necessary for the treatment of inborn metabolic errors or genetic conditions, e.g. phenylketonuria (PKU), which are covered by the "Covered Expenses – Pharmacy Services" section in this *certificate.*
    - Human milk fortifiers or 100% human-based diet, when prescribed for prevention of necrotizing enterocolitis and administered under the direction of a *health care practitioner*.
- Over-the-counter, non-prescription medications, unless for drugs, medicines or medications or supplies on the Preventive Medication Coverage *drug list* with a *prescription* from a *health care practitioner*.
- Over-the-counter medical items or supplies that can be provided or prescribed by a *health care practitioner* but are also available without a written order or *prescription*, except for *preventive services*.
- Immunizations required for foreign travel for a *covered person* of any age.
- Growth hormones, except as otherwise specified in the pharmacy services sections of this *certificate.*
- *Prescription* drugs and *self-administered injectable* drugs, except as specified in the "Covered Expenses – Pharmacy Services" section in this *certificate* or unless administered to *you*:
    - While an *inpatient* in a *hospital, skilled nursing facility, health care treatment facility* or *residential treatment facility*;
    - By the following, when deemed appropriate by *us*:
        - A *health care practitioner*:
            - During an office visit; or
            - While an *outpatient*; or

- A *home health care agency* as part of a covered *home health care plan.*

- Hearing aids, the fitting of hearing aids or advice on their care, except as otherwise provided within the "Covered Expenses" section of this *certificate*.

- Implantable hearing devices, except for cochlear implants when provided to a *covered person* diagnosed with profound hearing impairment, and as otherwise provided within the "Additional covered expenses" of the "Covered Expenses" section of this *certificate.*

- Services received in an emergency room, unless required because of an *emergency medical condition.*

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

- *Hospital inpatient* services when *you* are in *observation status.*

- *Infertility services*; or reversal of elective sterilization.

- In vitro fertilization regardless of the reason for treatment.

- Services for or in connection with a transplant or *immune effector cell therapy* if:

  - The expense relates to storage of cord blood and stem cells, unless it is an integral part of a transplant approved by *us.*

  - Not approved by *us,* based on *our* established criteria.

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

  - The expense relates to the transplantation of any non-human organ or tissue, unless otherwise stated in the *master group contract.*

  - The expense relates to the donation or acquisition of an organ or tissue for a recipient who is not covered by *us.*

  - The expense relates to a transplant or *immune effector cell therapy* performed outside of the United States and any care resulting from that transplant or *immune effector cell therapy*. This exclusion applies even if the *employee* and *dependents* live outside the United States and the *employee* is in *active status* with the *employer* sponsoring the *master group contract.*

- Services provided for:

  - Immunotherapy for recurrent abortion;
  - Chemonucleolysis;
  - Sleep therapy;

- Light treatments for Seasonal Affective Disorder (S.A.D.);
- Immunotherapy for food allergy;
- Prolotherapy; or
- Sensory integration therapy.

- *Cosmetic surgery* and cosmetic services or devices:

- Hair prosthesis, hair transplants or implants.

- Wigs, unless otherwise stated in the "Covered Expenses" section of this *certificate.*

- Dental services, appliances or supplies for treatment of the teeth, gums, jaws or alveolar processes, including any *oral surgery, endodontic services* or *periodontics,* implants and related procedures, orthodontic procedures, and any dental services related to a *bodily injury* or *sickness* unless otherwise stated in this *certificate.*

- The following types of care of the feet:

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

- *Custodial care* and *maintenance care*.

- Any loss contributed to, caused by:

  - War or any act of war, whether declared or not;
  - Insurrection; or
  - Any conflict involving armed forces of any authority.

- Services relating to a *sickness* or *bodily injury* as a result of:

  - Engagement in an illegal profession or occupation; or
  - Commission of or an attempt to commit a criminal act.

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

- Expenses for any membership fees or program fees, including health clubs, health spas, strength conditioning, work-hardening programs, and weight loss or surgical programs, and any materials or products related to these programs.

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

LIMITATIONS AND EXCLUSIONS (continued)

- Expenses for services that are primarily and customarily used for environmental control or enhancement (whether or not prescribed by a *health care practitioner*) and certain medical devices including:

  - Common household items including air conditioners, air purifiers, water purifiers, vacuum cleaners, waterbeds, hypoallergenic mattresses or pillows or exercise equipment;
  - Motorized transportation equipment (e.g. scooters), escalators, elevators, ramps or modifications or additions to living/working quarters or transportation vehicles;
  - Personal hygiene equipment including bath/shower chairs, transfer equipment or supplies or bed side commodes;
  - Personal comfort items including cervical pillows, gravity lumbar reduction chairs, swimming pools, whirlpools, spas or saunas;
  - Medical equipment including:

    - Blood pressure monitoring devices, unless prescribed by a *health care practitioner* for *preventive services* and ambulatory blood pressure monitoring is not available to confirm diagnosis of hypertension;

    - PUVA lights; and

    - Stethoscopes;

  - Communication systems, telephone, television or computer systems and related equipment or similar items or equipment;
  - Communication devices, except after surgical removal of the larynx or a diagnosis of permanent lack of function of the larynx.

- Duplicate or similar rentals or purchases of *durable medical equipment* or *diabetes equipment.*

- Therapy and testing for treatment of allergies including, services related to clinical ecology, environmental allergy and allergic immune system dysregulation and sublingual antigen(s), extracts, neutralization tests and/or treatment unless such therapy or testing is approved by:

  - The American Academy of Allergy and Immunology; or
  - The Department of Health and Human Services or any of its offices or agencies.

- Lodging accommodations or transportation, except as otherwise provided within this *certificate*.

- Communications or travel time.

- Bariatric *surgery,* any services or complications related to bariatric *surgery,* and other weight loss products or services.

- Elective medical or surgical abortion unless the abortion would preserve the life of the female upon whom it is performed.

- *Alternative medicine*.

LIMITATIONS AND EXCLUSIONS (continued)

- Acupuncture, unless:
  - The treatment is *medically necessary*, appropriate and is provided within the scope of the acupuncturist's license; and
  - *You* are directed to the acupuncturist for treatment by a licensed physician.
- Services rendered in a premenstrual syndrome clinic or holistic medicine clinic.
- Services of a midwife, unless the midwife holds a permit, as required by state law, and works in collaboration with a *health care practitioner*.
- Vision examinations or testing for the purposes of prescribing corrective lenses, except *comprehensive eye exams* provided under the "Covered Expenses – Pediatric Vision Care" section in this *certificate.*
- Orthoptic/vision training (eye exercises) except as specified in the "Covered Expenses" section of this certificate.
- Radial keratotomy, refractive keratoplasty or any other *surgery* or procedure to correct myopia, hyperopia or stigmatic error.
- The purchase or fitting of eyeglasses or contact lenses, except as:
  - The result of an *accident* or following cataract *surgery* as stated in this *certificate*.
  - Otherwise specified in the "Covered Expenses – Pediatric Vision Care" section in this *certificate.*
- Services and supplies which are:
  - Rendered in connection with mental illnesses not classified in the International Classification of Diseases of the U.S. Department of Health and Human Services; or
  - Extended beyond the period necessary for evaluation and diagnosis of learning and behavioral disabilities or for mental retardation.
- Marriage counseling.
- Expenses for employment, school, sport or camp physical examinations or for the purposes of obtaining insurance.
- Expenses for care and treatment of non-covered procedures or services.
- Expenses for treatment of complications of non-covered procedures or services.
- Expenses incurred for services prior to the *effective date* or after the termination date of *your* coverage under the *master group contract*. Coverage will be extended as described in the "Extension of Benefits" section, as required by state law.
- Any expense incurred for services received outside of the United States while *you* are residing outside of the United States for more than six months in a *year* except as required by law for an *emergency medical condition.*
- *Pre-surgical/procedural testing* duplicated during a *hospital confinement.*

LIMITATIONS AND EXCLUSIONS - PHARMACY SERVICES

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

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

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

- *Legend drugs,* which are not deemed *medically necessary* by *us.*
- *Prescription* drugs not included on the *drug list.*
- Any amount exceeding the *default rate.*
- *Specialty drugs* for which coverage is not approved by *us.*
- Drugs not approved by the FDA.
- Any drug prescribed for intended use other than for:
  - Indications approved by the FDA; or
  - Off-label indications recognized through peer-reviewed medical literature.
- Any drug prescribed for a *sickness* or *bodily injury* not covered under the *master group contract.*
- Any drug, medicine or medication that is either:
  - Labeled "Caution-limited by federal law to investigational use;" or
  - *Experimental, investigational* or *for research purposes,*

  even though a charge is made to you.
- Allergen extracts.
- Therapeutic devices or appliances:
  - Hypodermic needles and syringes (except when prescribed by a *health care practitioner* for use with insulin and *self-administered injectable drugs*, whose coverage is approved by *us*);
  - Support garments;
  - Test reagents;
  - Mechanical pumps for delivery of medications; and
  - Other non-medical substances.

LIMITATIONS AND EXCLUSIONS - PHARMACY SERVICES (continued)

- Dietary supplements and nutritional products, except enteral formulas and nutritional supplements for the treatment of phenylketonuria (PKU) or other inherited metabolic disease. Refer to the "Covered Expenses" section of the *certificate* for coverage of low protein modified foods.

- Non-prescription, over-the-counter minerals, except as specified on the Preventive Medication Coverage *drug list* when obtained from a *network pharmacy* with a *prescription* from a *health care practitioner*.

- Growth hormones for idiopathic short stature or any other condition, unless there is a laboratory confirmed diagnosis of growth hormone deficiency, or as otherwise determined by *us*.

- Herbs and vitamins, except prenatal (including greater than one milligram of folic acid), pediatric multi-vitamins with fluoride and vitamins on the Preventive Medication Coverage *drug list* when obtained from a *network pharmacy* with a *prescription* from a *health care practitioner*.

- Any drug used for the purpose of weight loss.

- Any drug used for cosmetic purposes:

  - Dermatologicals or hair growth stimulants; or
  - Pigmenting or de-pigmenting agents.

- Any drug or medicine that is lawfully obtainable without a *prescription* (over-the-counter drugs), except:

  - Insulin; and
  - Drugs, medicines or medications and supplies on the Preventive Medication Coverage *drug list* when obtained from a *network pharmacy* with a *prescription* from a *health care practitioner*.

- Compounded drugs that:

  - Are prescribed for a use or route of administration that is not FDA approved or compendia supported;
  - Are prescribed without a documented medical need for specialized dosing or administration;
  - Only contain ingredients that are available over-the-counter;
  - Only contain non-commercially available ingredients; or
  - Contain ingredients that are not FDA approved, including bulk compounding powders.

- Abortifacients (drugs used to induce abortions).

- *Infertility services* including medications.

- Any drug prescribed for impotence and/or sexual dysfunction.

LIMITATIONS AND EXCLUSIONS - PHARMACY SERVICES (continued)

- Any drug, medicine or medication that is consumed or injected at the place where the *prescription* is given, or dispensed by the *health care practitioner*.

- The administration of covered medication(s).

- *Prescriptions* that are to be taken by or administered to *you*, in whole or in part, while *you* are a patient in a facility where drugs are ordinarily provided on an *inpatient* basis by the facility. *Inpatient* facilities include:

  - *Hospital*;
  - *Skilled nursing facility*; or
  - Hospice facility.

- Injectable drugs, including:

  - Immunizing agents, unless for *preventive services* determined by *us* to be dispensed by or administered in a *pharmacy*;
  - Biological sera;
  - Blood;
  - Blood plasma; or
  - *Self-administered injectable drugs* or *specialty drugs* for which *prior authorization* or *step therapy* is not obtained from *us*.

- *Prescription* fills or refills:

  - In excess of the number specified by the *health care practitioner*; or
  - Dispensed more than one year from the date of the original order.

- Any portion of a *prescription* fill or refill that exceeds a 90-day supply when received from a *mail order pharmacy* or a retail *pharmacy* that participates in *our* program, which allows *you* to receive a 90-day supply of a *prescription* fill or refill.

- Any portion of a *prescription* fill or refill that exceeds a 30-day supply when received from a retail *pharmacy* that does not participate in *our* program, which allows *you* to receive a 90-day supply of a *prescription* fill or refill.

- Any portion of a *specialty drug prescription* fill or refill that exceeds a 30-day supply, unless otherwise determined by *us*.

- Any portion of a *prescription* fill or refill that:

  - Exceeds *our* drug-specific *dispensing limit*;
  - Is dispensed to a *covered person*, whose age is outside the drug-specific age limits defined by *us*;
  - Is refilled early, as defined by *us*; or
  - Exceeds the duration-specific *dispensing limit*.

LIMITATIONS AND EXCLUSIONS - PHARMACY SERVICES (continued)

- Any drug for which *we* require *prior authorization* or *step therapy* and it is not obtained.
- Any drug for which a charge is customarily not made.
- Any drug, medicine or medication received by *you*:
  - Before becoming covered; or
  - After the date *your* coverage has ended.
- Any costs related to the mailing, sending or delivery of *prescription* drugs.
- Any intentional misuse of this benefit, including *prescriptions* purchased for consumption by someone other than *you.*
- Any *prescription* fill or refill for drugs, medicines or medications that are lost, stolen, spilled, spoiled, or damaged.
- Drug delivery implants and other implant systems or devices except as specified under Durable Medical Equipment in the "Covered Expenses" section of this *certificate.*
- Any amount *you* paid for a *prescription* that has been filled, regardless of whether the *prescription* is revoked or changed due to adverse reaction or change in dosage or *prescription*.

ELIGIBILITY AND EFFECTIVE DATES

Eligibility date

Employee eligibility date

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

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

Dependent eligibility date

Each *dependent* is eligible for coverage on:

- The date the *employee* is eligible for coverage, if he or she has *dependents* who may be covered on that date;
- The date of the *employee's* marriage for any *dependents* (spouse or child) acquired on that date;
- The date of birth of the *employee's* natural-born child;
- The date of placement of the child for the purpose of adoption by the *employee*; or
- The date specified in a Qualified Medical Child Support Order (QMCSO), or National Medical Support Notice (NMSN) for a child, or a child for whom you are the court appointed legal guardian, or a valid court or administrative order for a spouse, which requires the *employee* to provide coverage for a child or spouse as specified in such orders.

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

Enrollment

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

Employee enrollment

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

ELIGIBILITY AND EFFECTIVE DATES (continued)

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

Health status will not be used to determine premium rates. *We* will not use *health status-related factors* to decline coverage to an eligible *employee* and *we* will administer this provision in a non-discriminatory manner.

Dependent enrollment

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

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

Health status will not be used to determine premium rates. *We* will not use *health status-related factors* to decline coverage to an eligible *dependent* and *we* will administer this provision in a non-discriminatory manner.

Newborn and adopted dependent enrollment

A newborn *dependent* will be automatically covered from the date of birth to 31 days of age. An adopted *dependent* will be automatically covered from the date of adoption or placement of the child with the *employee* for the purpose of adoption, whichever occurs first, for 31 days.

If additional premium is not required to add additional *dependents* and if *dependent* child coverage is in force as of the newborn's date of birth in the case of newborn *dependents* or the earlier of the date of adoption or placement of the child with the *employee* for purposes of adoption in case of adopted *dependents*, coverage will continue beyond the initial 31 days. *You* must notify *us* to make sure *we* have accurate records to administer benefits.

If premium is required to add *dependents you* must enroll the *dependent* child and pay the additional premium within 31 days:

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

ELIGIBILITY AND EFFECTIVE DATES (continued)

If enrollment is requested more than 31 days after the date of birth, date of adoption or placement with the *employee* for the purpose of adoption, and additional premium is required, the *dependent* is a *late applicant.* A *late applicant* must wait to enroll for coverage during the *open enrollment period*, unless the *late applicant* becomes eligible for special enrollment as specified in the "Special enrollment" provision.

Special enrollment

Special enrollment is available if the following apply:

- *You* have a change in family status due to:

  - Marriage;
  - Divorce;
  - A Qualified Medical Child Support Order (QMCSO);
  - A National Medical Support Notice (NMSN);
  - The birth of a natural born child; or
  - The adoption of a child or placement of a child with the *employee* for the purpose of adoption, or any child for which the insured is a court appointed guardian; and
  - You enroll within 31 days after the *special enrollment date*; or

- You are an *employee* or *dependent* eligible for coverage under the *master group contract,* and:

  - You previously declined enrollment stating you were covered under another group health plan or other *health insurance coverage*; and
  - Loss of eligibility of such other coverage occurs, regardless of whether you are eligible for, or elect COBRA; and
  - You enroll within 31 days after the *special enrollment date*.

  Loss of eligibility of other coverage includes:

  - Termination of employment or eligibility;
  - Reduction in number of hours of employment;
  - Divorce, legal separation or death of a spouse;
  - Loss of dependent eligibility, such as attainment of the limiting age;
  - Termination of your employer's contribution for the coverage;
  - Loss of individual HMO coverage because you no longer reside, live or work in the service area;
  - Loss of group HMO coverage because you no longer reside, live or work in the service area, and no other benefit package is available; or
  - The plan no longer offers benefits to a class of similarly situated individuals; or

- You had COBRA continuation coverage under another plan at the time of eligibility, and:

  - Such coverage has since been exhausted; and
  - You stated at the time of the initial enrollment that coverage under COBRA was your reason for declining enrollment; and
  - You enroll within 31 days after the *special enrollment date*; or

- You were covered under an alternate plan provided by the *employer* that terminates, and:

  - You are replacing coverage with the *master group contract*; and
  - You enroll within 31 days after the *special enrollment date*; or

- You are an *employee* or *dependent* eligible for coverage under the *master group contract,* and:

  - Your *Medicaid* coverage or your Children's Health Insurance Program (CHIP) coverage terminated as a result of loss of eligibility; and
  - You enroll within 60 days after the *special enrollment date*; or

- You are an *employee* or *dependent* eligible for coverage under the *master group contract,* and:

  - You become eligible for a premium assistance subsidy under *Medicaid* or CHIP; and
  - You enroll within 60 days after the *special enrollment date*.

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

Dependent special enrollment

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

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

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

Open enrollment

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

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

ELIGIBILITY AND EFFECTIVE DATES (continued)

Effective date

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

Employee effective date

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

Dependent effective date

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

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

Newborn and adopted dependent effective date

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

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

Premium is due within 31 days after the date of birth in order to have coverage continued beyond the first 31 days. Additional premium may not be required when *dependent* coverage is already in force.

Open enrollment effective date

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

Retired employee coverage

Retired employee eligibility date

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

Retired employee enrollment

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

Retired employee effective date

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

REPLACEMENT OF COVERAGE

Applicability

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

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

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

Deductible credit

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

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

Waiting period credit

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

Out-of-pocket limit

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

TERMINATION PROVISIONS

Termination of coverage

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

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

When *we* receive notification of a change in eligibility status in advance of the effective date of the change, coverage will terminate on the actual date specified by the *employer* or *employee* or at the end of that month, as selected by *your employer* on the EGA. In the event of cancellation, *we* will promptly return the unearned portion of premium paid.

When *we* receive the *employer's* request to terminate coverage retroactively, the *employer's* termination request is their representation to *us* that *you* did not pay any premium or make contribution for coverage past the requested termination date. We will not keep any premium for which coverage or benefits are not provided. Unearned premium received for coverage after the date *we* make the change effective, will be promptly returned.

Otherwise, coverage terminates on the earliest of the following:

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

- The date *your dependent* no longer qualifies as a *dependent*;
- For any benefit, the date the benefit is deleted from the *master group contract*; or
- The date fraud or an intentional misrepresentation of a material fact has been committed by *you.* For more information on fraud and intentional misrepresentation, refer to the "Fraud" provision in the "Miscellaneous Provisions" section of this *certificate. We* will give a 30 day advance written notice of cancellation.

Any dissatisfaction may be expressed to *us* through the established appeals process set out in the "Internal Appeal and External Review" section of this *certificate.*

Termination for cause

We will give a 30 day advance written notice if *we* terminate *your* coverage for cause under the following circumstances:

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

EXTENSION OF BENEFITS

Extension of coverage for total disability

We extend limited coverage if:

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

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

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

Extension of coverage for hospital confinement

We extend limited coverage if the *master group contract* terminates while *you* are *hospital confined* due to a *bodily injury* or *sickness* that occurs while the *master group contract* is in effect.

Benefits are payable only for those expenses incurred for the same *sickness* or *bodily injury* which caused *you* to be *hospital confined.* Coverage during the *hospital confinement* continues without premium payment, but not beyond the earliest of the following dates:

- The date *you* are discharged from the *hospital confinement*;
- The date any maximum benefit is reached; or
- The last day of a 12 consecutive month period following the date the *master group contract* terminated.

CONTINUATION

Continuation options in the event of termination

If coverage terminates:

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

A complete description of the "State continuation of coverage" and "Continuation of coverage for dependents" provisions follow.

State continuation of coverage

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

An *employee* may elect to continue his or her coverage.

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

In order to be eligible for this option:

- The *employee* must have been continuously covered under the *master group contract,* or any group coverage it replaced, for at least three consecutive months prior to termination;
- The *group plan sponsor* must notify *us* that the *covered person* has terminated membership under the *master group contract*;
- Written application and payment of premium is received from the *covered person* within 31 days after receiving notification from *us* of his or her right to continuation.

We must give the *covered person* written notice of the right to continue coverage under the *master group contract* upon notice from the *group plan sponsor* that the *covered person* has terminated coverage under the *master group contract. We* will mail or deliver written notice to the last known address of the *covered person,* which shall constitute the giving of notice as required.

Written application and payment of the first premium for continuation must be made within 31 days after the *covered person* has been given the required notice by *us.* No evidence of insurability is required to obtain continuation.

If *we* fail to provide written notice as soon as practicable after being notified of *our* failure to provide written notice, *you* will have an additional 60 days after written notice is received.

There is no right to continuation if:

- The *covered person* is, or could be, covered by *Medicare*;
- The *covered person* is, or could be, covered by similar benefits under another group coverage, either on an insured or uninsured basis; or
- Similar benefits are provided for, or available to, the *covered person* under any state or federal law.

If this state continuation option is selected, continuation will be permitted for a maximum of 18 months. Continuation shall terminate on the earliest of:

- The date 18 months after the date on which the *group* coverage would have otherwise terminated because of termination of employment or membership in the *group*;
- The date timely premium payments are not made on *your* behalf; or
- The date the *master group contract* terminates in its entirety and is not replaced by another group coverage within 31 days.

If the *master group contract* terminates in its entirety before the end of the continuation period and is replaced by another group coverage, the *covered person's* coverage will continue until the time otherwise specified.

Continuation of coverage for dependents

Continuation of coverage is available for *dependents* that are no longer eligible for the coverage provided by the *master group contract* because of:

- The death of the covered *employee*;
- The retirement of the covered *employee*; or
- The severance of the family relationship.

Continuation of coverage is also available to a covered *dependent* child who is no longer eligible for coverage under the *master group contract* due to attaining the limiting age of the *master group contract.*

Each *dependent* may choose to continue these benefits for up to 18 months after the date the coverage would have normally terminated.

In order to be eligible for this option:

- The *dependent* must have been continuously covered under the *master group contract*, or any group coverage it replaced, for at least three consecutive months prior to termination, except in the case of an infant under one year of age; and

CONTINUATION (continued)

- The covered *employee* or *dependent* must give the *group plan sponsor* written notice within 31days of the death or retirement of the *employee,* severance of the family relationship or the attainment of the limiting age by a covered *dependent* child that might activate this continuation option; and

- The *group plan sponsor* must notify *us* of the death or retirement of the *employee,* severance of the family relationship or the attainment of the limiting age by a covered *dependent* child;

- Written application and payment of premium is received from the *dependent* within 31 days after receiving notification from *us* of his or her right to continuation.

We must give the *dependent* written notice of the right to continue coverage under the *master group contract* upon notice from the *group plan sponsor* that the *dependent's* coverage terminated, or may terminate, under the *master group contract* as a result of the death or retirement of the *employee,* severance of the family relationship or the attainment of the limiting age by a covered *dependent* child. *We* will mail or deliver written notice to the last known address of the *dependent,* which shall constitute the giving of notice as required.

Written application and payment of the first premium for continuation must be made within 31 days after the *dependent* has been given the required notice by *us.* No evidence of insurability is required to obtain continuation.

If *we* fail to provide written notice as soon as practicable after being notified of *our* failure to provide written notice, *you* will have an additional 60 days after written notice is received.

The option to continue coverage is <u>not</u> available if:

- The termination of coverage occurred because the *dependent* failed to pay the required premium contribution within 31 days after being notified by *us* of his or her right to continuation coverage;

- The *master group contract* terminates in its entirety and is not replaced by another group coverage within 31 days;

- A *dependent* is, or could be, covered by *Medicare*;

- A *dependent* is, or could be, covered for similar benefits under another group coverage, either on an insured or self-insured basis;

- The *dependent* was not continuously covered by the *master group contract,* or any group coverage it replaced, for at least three months prior to the date coverage terminates, except in the case of an infant under 1 year of age; or

- The *dependent* elects to continue his or her coverage under the terms and conditions described in (COBRA).

CONTINUATION (continued)

Continued coverage terminates on the earliest of the following dates:

- The last day of the 18 month period following the date the *dependent* was no longer eligible for coverage;
- The date timely premium payments are not made on *your* behalf; or
- The date the *master group contract* terminates and is not replaced by another group coverage within 31 days.

The *covered person* is responsible for sending *us* written application and the premium payments for those individuals who choose to continue their coverage. Premiums must be paid each month in advance for coverage to continue. If the *covered person* fails to make proper payment of the premiums to *us*, *we* are relieved of all liability for any coverage that was continued.

MEDICAL CONVERSION PRIVILEGE

Eligibility

Subject to the terms below, if *your* medical coverage under the *master group contract* terminates, a Medical Conversion Plan is available without medical examination. *You* must have been covered continuously under the *master group contract* or any group health plan it replaced for at least 90 days and:

- *Your* coverage ends because the *employee's* employment terminated;
- *You* are a covered *dependent* whose coverage ends due to the *employee's* marriage ending via legal annulment, dissolution of marriage or divorce;
- *You* are the surviving covered *dependent*, in the event of the *employee's* death or at the end of any survivorship continuation as provided by the *master group contract*; or
- *You* have been a covered *dependent* child but no longer meet the definition of *dependent* under the *master group contract*; and
- *Your* coverage under the *master group contract* is not terminated because of fraud or material intentional misrepresentation.

Only persons covered under the *master group contract* on the date coverage terminates are eligible to be covered under the Medical Conversion Plan.

The Medical Conversion Plan may be issued covering each former *covered person* on a separate basis or it may be issued covering all former *covered persons* together. However, if conversion is due to dissolution of marriage by annulment or final divorce decree, only those persons who cease to be a *dependent* of the *employee* are eligible to exercise the medical conversion privilege.

The *group plan sponsor* must notify *us* that the *covered person* has terminated membership with the group plan. *We* will then give written notice of the right to conversion to any *covered person* entitled to conversion. Proper notice will be mailed or delivered to the last known address of the *covered person.*

Written application and payment of the first premium for conversion must be made to *us* within 31 days after the date coverage terminates or within 31 days after the *covered person* has been given the required notice. No evidence of insurability is required to obtain conversion.

If the *master group contract* terminates, *we* will notify each *covered person* of their right to continuation within 15 business days after the end of the grace period.

If *we* fail to provide written notice as soon as practicable after being notified of *our* failure to provide written notice, *you* will have an additional 60 days after written notice is received.

A medical Conversion Plan is not available when the *employer's* participation in the *master group contract* terminates and medical coverage is replaced within 31 days by another group coverage plan; or

- The covered person is or could be covered by *Medicare*; or
- The covered person has similar benefits under another group or individual plan whether insured or uninsured.

Please contact *us* for details regarding other coverage options that may be available to *you.*

MEDICAL CONVERSION PRIVILEGE (continued)

Overinsurance - duplication of coverage

We may refuse to issue a Medical Conversion Plan if *we* determine *you* would be overinsured. The Medical Conversion Plan will not be available if it would result in overinsurance or duplication of benefits. *We* will use *our* standards to determine overinsurance.

Medical conversion plan

The Medical Conversion Plan which *you* may apply for will be the Medical Conversion Plan customarily offered by *us* as a conversion from *group* coverage or as mandated by state law.

The Medical Conversion Plan is a new plan and not a continuation of *your* terminated coverage. The Conversion Master Group Contract benefits will differ from those provided under *your group* coverage. The benefits that may be available to *you* will be described in an Outline of Coverage provided to *you* when *you* request an application for conversion from *us*.

Effective date and premium

You have 31 days after the date *your* coverage terminates under the *master group contract* to apply and pay the required premiums for *your* Medical Conversion Plan. The premiums must be paid in advance. *You* may obtain application forms from *us.* The Medical Conversion Plan will be effective on the day after *your group* medical coverage ends, if *you* enroll and pay the first premiums within 31 days after the date *your* coverage ends.

The premiums for the Medical Conversion Plan will be the premiums charged by *us* as of the effective date based upon the Medical Conversion Plan form, classification of risk, age and benefit amounts selected. The premiums may change as provided in the Medical Conversion Plan.

COORDINATION OF BENEFITS

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

Definitions

The following definitions are used exclusively in this provision.

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

Plan includes:

- Group and nongroup insurance contracts, health maintenance organization (HMO) contracts, closed panel or other forms of group or group-type coverage (whether insured or uninsured);
- Medical care components of long-term care contracts, such as skilled nursing care; and
- *Medicare* or other governmental benefits, as permitted by law.

Plan does not include:

- Hospital indemnity benefits;
- School accident type coverage;
- Benefits for non-medical care components of group long-term care contracts;
- *Medicare* supplement policies;
- A state plan under *Medicaid*;
- Medical benefits under group, group-type, and individual automobile "No Fault" and traditional automobile "Fault" type contracts; and
- Coverage under other governmental plans, unless permitted by law.

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

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

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

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

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

- If a *covered person* is confined in a private *hospital* room, the difference between the cost of a semi-private room in the *hospital* and the private room, (unless the patient's stay in a private *hospital* room is medically necessary in terms of generally accepted medical practice, or one of the *plans* routinely provides coverage for *hospital* private rooms) is not an *allowable expense*.

- If a person is covered by two or more *plans* that compute their benefits payments on the basis of usual and customary fees, any amount in excess of the highest usual and customary fees for a specific benefit is not an *allowable expense.*

- If a person is covered by two or more *plans* that provide benefits or services on the basis of negotiated fees, any amount in excess of the highest of the fees is not an *allowable expense*.

- If a person is covered by one *plan* that calculates its benefits or services on the basis of usual and customary fees and another *plan* that provides its benefits or services on the basis of negotiated fees, the *primary plan's* payment arrangement shall be the *allowable expense* for all *plans*.

- The amount a benefit is reduced by the *primary plan* because a *covered person* does not comply with the *plan* provisions. Examples of these provisions are second surgical opinions, precertification of *admissions* and preferred provider arrangements.

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

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

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

Order of determination rules

General

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

- The *primary plan* pays or provides its benefits as if the *secondary plan* or *plans* did not exist.

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

- A *plan* may consider the benefits paid or provided by another *plan* in determining its benefits only when it is *secondary* to that other *plan*.

Rules

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

- **Non-dependent or *dependent*.** The *plan* that covers the person other than as a *dependent,* for example as an *employee,* member, subscriber or retiree is *primary* and the *plan* that covers the person as a *dependent* is *secondary*. However, if the person is a *Medicare* beneficiary and, as a result of federal law, *Medicare* is *secondary* to the *plan* covering the person as a *dependent*; and *primary* to the *plan* covering the person as other than a *dependent* (e.g. retired *employee*); then the order of benefits between the two *plans* is reversed so that the *plan* covering the person as an *employee,* member, subscriber or retiree is *secondary* and the other *plan* is *primary*.

- **Dependent child covered under more than one *plan***. The order of benefits when a child is covered by more than one *plan* is:

  - The *primary plan* is the *plan* of the parent whose birthday is earlier in the year if:

    - The parents are married;
    - The parents are not separated (whether or not they have been married); or
    - A court decree awards joint custody without specifying that one part has the responsibility to provide health care coverage.

  - If both the parents have the same birthday, the *plan* that covered either of the parents longer is *primary*.

  - If the specific terms of a court decree state that one parent is responsible for the child's health care expenses or health care coverage and the *plan* of that parent has actual knowledge of those terms, that *plan* is *primary*. This rule applies to *claim determination periods* or plan years commencing after the *plan* is given notice of the court decree.

  - If the parents are not married, or are separated (whether or not they ever have been married) or are divorced, the order of benefits is:

    - The *plan* of the *custodial parent*;
    - The *plan* of the spouse of the *custodial parent*;
    - The *plan* of the non-*custodial parent*; and then
    - The *plan* of the spouse of the non-*custodial parent.*

- **Active or inactive *employee***. The *plan* that covers a person as an *employee* who is neither laid off nor retired, is *primary*. The same would hold true if a person is a *dependent* of a person covered as a retiree and an *employee.* If the other *plan* does not have this rule, and if, as a result, the *plans* do not agree on the order of benefits, this rule is ignored.

- **Continuation coverage**. If a person whose coverage is provided under a right of continuation provided by federal or state law also is covered under another *plan,* the *plan* covering the person as an *employee,* member, subscriber or retiree (or as that person's *dependent*) is *primary*, and the continuation coverage is *secondary.* If the other *plan* does not have this rule, and if, as a result, the *plans* do not agree on the order of benefits, this rule is ignored.

- **Longer or shorter length of coverage**. The *plan* that covered the person as an *employee,* member, subscriber or retiree longer is *primary*.

  To determine the length of time a person has been covered under a *plan,* two plans shall be treated as one if the *covered person* was eligible under the second within twenty-four hours after the first ended;

  Changes during a coverage period that do not constitute the start of a new *plan* include:

  - A change in scope of a *plan's* benefits;
  - A change in the entity that pays, provides or administers the *plan's* benefits; or
  - A change from one type of *plan* to another.

  The person's length of time covered under a *plan* is measured from the person's first date of coverage under that *plan.* If that date is not readily available for a *group plan,* the date the person first became a member of the *group* shall be used as the date from which to determine the length of time the person's coverage under the present *plan* has been in force.

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

Effects on the benefits of this plan

When this *plan* is *secondary,* benefits may be reduced to the difference between the *allowable expense* (determined by the *primary plan*) and the benefits paid by any *primary plan* during the *claim determination period.* Payment from all *plans* will not exceed 100% of the total *allowable expense.*

The benefits of the *secondary plan* shall be reduced when the sum of the benefits payable that would be payable under the other *plans,* in the absence of a coordination of benefits provision, whether or not a claim is made, exceeds the *allowable expenses* in *claim determination period,* with a reduction of benefits as follow:

- The benefits of the *secondary plan* shall be reduced so that they and the benefits payable under the other *plans* do not total more than the *allowable expenses*; and
- Each benefit is reduced in proportion and charged against any applicable benefit limit of the *plan.*

COORDINATION OF BENEFITS (continued)

If a person is covered by more than one *secondary plan,* the order of benefit determination rules decide the order in which the *secondary plan* benefits are determined in relation to each other. Each *secondary plan* takes into consideration the benefits of the *primary plan* or *plans* and the benefits of any other *plan,* which has its benefits determined before those of that *secondary plan*.

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

Notice to covered persons

If *you* are covered by more than one health benefit plan, *you* should file all claims with each *plan*.

Miscellaneous provisions

A *secondary plan* that provides benefits in the form of services may recover the reasonable cash value of the services from the *primary plan,* to the extent that benefits for the services are covered by the *primary plan* and have not already been paid or provided by the *primary plan.*

A plan with order of benefit determination requirements that comply with this administrative regulation may coordinate its benefits with a plan that is "excess" or "always secondary" or that uses order of benefit determination requirements that do not comply with those contained in this administrative regulation on the following basis:

- If the complying plan is the primary plan, it shall pay or provide its benefits first;
- If the complying plan is the secondary plan, it shall pay or provide its benefits first; but the amount of the benefits payable shall be determined as if the complying plan were the secondary plan. In that situation, the payment shall be the limit of the complying plan's liability; and
- If the non-complying plan does not provide the information needed by the complying plan to determine its benefits within a reasonable time after it is requested to do so, the complying plan shall assume that the benefits of the non-complying plan are identical to its own, and shall pay its benefits accordingly. If, within two years of payment, the complying plan receives information as to the actual benefits of the non-complying plan, it shall adjust payments accordingly.

If the non-complying *plan* reduces its benefits so that the *covered person* receives less in benefits than he would have received had the complying *plan* paid or provided its benefits as the *secondary plan* and the non-complying *plan* paid or provided its benefits as the *primary plan,* and governing state law allows the right of subrogation set forth below, then the complying *plan* shall advance to or on behalf of the *covered person* an amount equal to the difference.

The complying *plan* shall not advance more than the complying *plan* would have paid had it been the *primary plan* less any amount it previously paid for the same expense or service, and:

- In consideration of the advance, the complying *plan* shall be subrogated to all rights of the *covered person* against the non-complying *plan*; and
- The advance by the complying *plan* shall also be without prejudice to any claim it may have against a non-complying *plan* in the absence of subrogation.

Coordination of benefits differs from subrogation. Provisions for one may be included in health care benefits contracts without compelling the inclusion or exclusion of the other.

If the *plans* cannot agree on the order of benefits within thirty calendar days after the *plans* have received all of the information needed to pay the claim, the *plans* shall immediately pay the claim in equal shares and determine their relative liabilities following payment, except that no *plan* shall be required to pay more than it would have paid had it been primary.

Severability

If any provision of this administrative regulation or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of this administrative regulation and the application of that provision to other person or circumstances shall not be affected thereby.

Right to receive and release needed information

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

Facility of payment

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

COORDINATION OF BENEFITS (continued)

Right of recovery

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

Cooperation required

The *covered person* shall cooperate by providing information and executing any documents to preserve *our* right and shall have the affirmative obligation of notifying *us* that claims are being made against responsible parties to recover for injuries for which *we* have paid. If the *covered person* enters into litigation or settlement negotiations regarding the obligations of the other party, the *covered person* must not prejudice, in any way, *our* rights to recover an amount equal to any benefits *we* have provided or paid for the *injury or sickness.* Failure of the *covered person* to provide *us* such notice or cooperation, or any action by the *covered person* resulting in prejudice to *our* rights will be a material breach of this *policy* and will result in the *covered person* being personally responsible to make repayment. In such an event, *we* may deduct from any pending or subsequent claim made under the *policy* any amounts the *covered person* owes *us* until such time as cooperation is provided and the prejudice ceases.

General coordination of benefits with Medicare

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

CLAIMS

Notice of claim

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

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

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

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

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

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

Proof of loss

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

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

Claims processing procedures

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

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

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

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

- *Medicare* laws, regulations, manuals and other related guidance;
- Federal and state laws, rules and regulations, including instructions published in the Federal Register;
- National Uniform Billing Committee (NUBC) guidance including the UB-04 Data Specifications Manual;
- American Medical Association's (AMA) Current Procedural Terminology (CPT®) and associated AMA publications and services;
- Centers for Medicare & Medicaid Services' (CMS) Healthcare Common Procedure Coding System (HCPCS) and associated CMS publications and services;
- International Classification of Diseases (ICD);
- American Hospital Association's Coding Clinic Guidelines;
- Uniform Billing Editor;
- American Psychiatric Association's (APA) Diagnostic and Statistical Manual of Mental Disorders (DSM) and associated APA publications and services;
- Food and Drug Administration guidance;

- Medical and surgical specialty societies and associations;
- Industry-standard utilization management criteria and/or care guidelines;
- *Our* medical and pharmacy coverage policies; and
- Generally accepted standards of medical, behavioral health and dental practice based on credible scientific evidence recognized in published peer reviewed literature.

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

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

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

Right to require medical examinations

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

To whom benefits are payable

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

All benefit payments for *covered expenses* rendered by a *non-network provider* are due and owing solely to the *covered person*. Assignment of benefits is prohibited. However, *you* may request that *we* direct a payment of selected medical benefits to the health care provider on whose charge the claim is based. If *we* consent to this request, *we* will pay the health care provider directly. Such payments will not constitute the assignment of any legal obligation to the *non-network provider*. If *we* decline this request, *we* will pay *you* directly, and *you* are then responsible for all payments to the n*on-network provider(s).*

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

CLAIMS (continued)

Time of payment of claims

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

Right to request overpayments

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

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

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

Right to collect needed information

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

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

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

Exhaustion of time limits

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

Recovery rights

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

Duty to cooperate in good faith

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

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

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

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

Duplication of benefits/other insurance

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

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

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

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

CLAIMS (continued)

Workers' compensation

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

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

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

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

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

Right of subrogation

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

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

We may enforce *our* subrogation rights by asserting a claim to any coverage to which *you* may be entitled. *We* shall have first priority to recover amounts *we* have paid and the reasonable value of services and benefits provided under a managed care agreement from any funds that are paid or payable as a result of any *sickness* or *bodily injury*, regardless of whether available funds are sufficient to fully compensate *you* for *your sickness* or *bodily injury.*

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

CLAIMS (continued)

Right of reimbursement

If benefits are paid under the *master group contract* and *you* recover from any legally responsible person, their insurer, or any uninsured motorist, underinsured motorist, medical payment/expense, Workers' Compensation, no-fault, or other similar coverage, *we* have the right to recover from *you* an amount equal to the amount *we* paid. and for the reasonable value of services and benefits provided under a managed care agreement.

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

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

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

Assignment of recovery rights

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

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

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

Cost of legal representation

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

INTERNAL APPEAL AND EXTERNAL REVIEW

Definitions

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

- A determination that an item or service is *experimental* or *investigational* or not *medically necessary;*
- A determination of *your* eligibility for group coverage under the *policy*;
- A determination that the benefit is not covered;
- Any rescission of coverage.

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

Commissioner means the Commissioner of the Kentucky Department of Insurance.

Final adverse benefit determination means an *adverse benefit determination* that has been upheld by *us* at the completion of the internal appeals process or in when the internal appeals process has been exhausted.

Independent Review Entity (IRE) means an entity assigned by the *commissioner* to conduct an independent *external review* of an *adverse benefit determination* and a *final adverse benefit determination.*

Urgent care means treatment or services with respect to which the application of the time periods for making non-urgent care determinations:

- Could seriously jeopardize the life or health of the *covered person,* including an unborn child of the *covered person* when pregnant, or the ability of the *covered person* to regain maximum function; or result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part; or

- Would, in the opinion of a physician with knowledge of the *covered person's* medical condition, subject the *covered person* to severe pain that cannot be adequately managed without the treatment or service that is the subject of the claim.

Urgent care includes all requests related to hospitalization or *outpatient surgery*.

Humana will make a determination of whether a claim involves *urgent care.* However, any claim a physician, with knowledge of a *covered person*'s medical condition, determines is a claim for *urgent care* will be treated as a "claim involving urgent care."

Contact information

You may contact the *commissioner* and the Kentucky Consumer Protection Division for assistance at any time using the contact information below:

Kentucky Department of Insurance
500 Mero Street, 2 SE 11
Frankfort, KY 40601

(Mailing address)
P.O. Box 517
Frankfort, KY 40602-0515

Phone number: 502-564-3630;
Toll Free (KY only): 800-595-6053;
TTY: 800-648-6056

Kentucky Consumer Protection Division
P.O. Box 517
Frankfort, KY 40602-0517

Filing a complaint

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

Internal appeals

You or *your authorized representative* must appeal an *adverse benefit determination* within 180 days after receiving written notice of the denial (or partial denial). An appeal of an *adverse benefit determination* may be made by *you* or *your authorized representative* by means of written application to Humana or by mail, postage prepaid to the address below:

Humana Insurance Company
ATTN: Grievance and Appeals Department
P.O. Box 14546
Lexington, KY 40512-4546

You or *your authorized representative* may request an expedited internal appeal of an adverse *urgent care* claim decision orally or in writing. In such case, all necessary documents, including the plan's benefit determination on review, will be transmitted between the plan and *you* or *your authorized representative* by telephone, FAX, or other available similarly expeditious method.

You or *your authorized representative* may request an expedited *external review* at the same time a request is made for an expedited internal appeal of an *adverse benefit determination* for a claim involving *urgent care* or when *you* are receiving an ongoing course of treatment.

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

INTERNAL APPEAL AND EXTERNAL REVIEW (continued)

You or *your authorized representative* may submit written comments, documents, records and other material relating to *adverse benefit determination* for consideration. *You* may also receive, upon request, reasonable access to, and copies of all documents, records and other relevant information considered during the appeal process.

If new or additional evidence is relied upon or if new or additional rationale is used during the internal appeal process, Humana will provide *you* or *your authorized representative*, free of charge, the evidence or rationale as soon as possible and in advance of the appeals decision in order to provide *you* or *your authorized representative* a reasonable opportunity to respond.

Time-periods for decisions on appeal

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

- As soon as possible but not later than 72 hours after *we* receive the appeal request for a claim involving *urgent care*;
- Within a reasonable period but not later than 30 days after *we* received the appeal request for a claim involving non-urgent care.

Exhaustion of remedies

You or *your authorized representative* will have exhausted the administrative remedies under the plan and my request an *external review*:

- When the internal appeals process under this section is complete;
- If *we* fail to make a timely determination or notification of an internal appeal;
- *You* or *your authorized representative* and Humana jointly agree to waive the internal appeal process; or
- If *we* fail to adhere to all requirements of the internal appeal process, except for failures that are based on de minimis violations.

After exhaustion of remedies, *you* or *your authorized representative* may pursue any other legal remedies available, which may include bringing civil action under ERISA section 502(a) for judicial review of the plan's determination. Additional information may be available from the local U.S. Department of Labor Office.

External review

Within 4 months after *you* or *your authorized representative* receives notice of a *final adverse benefit determination, you* or *your authorized representative* may request an *external review*. The request for *external review* must be made in writing to *us*. *You* or *your authorized representative* may be assessed a $25 filing fee that will be refunded if the *adverse benefit determination* is overturned. The fee will be waived if the payment of the fee would impose undue financial hardship. The annual limit on filing fees for each *covered person* within a single *year* will not exceed $75.

You or *your authorized representative* will be required to authorize release of any medical records that may be required to be reviewed for the purpose of reaching a decision on the external review. Please refer to the section titled "Expedited external review" if the *adverse benefit determination* involves a claim for *urgent care.*

If the request qualifies for an *external review, we* will notify *you* or *your authorized representative* in writing of the assignment of an *IRE* and the right to submit additional information. Additional information must be submitted within the first 5 business days of receipt of the letter. *You* or *your authorized representative* will be notified of the determination within 21 calendar days from receipt of all information required from *us.* An extension of up to 14 calendar days may be allowed if agreed by the *covered* person and *us.* This request for an *external review* will not exceed 45 days of the receipt of the request.

Expedited external review

You or *your authorized representative* may request an expedited *external review* in writing or orally:

- At the same time *you* request an expedited internal appeal of an *adverse benefit determination* for a claim involving *urgent care* or when *you* are receiving an ongoing course of treatment; or
- When *you* receive an *adverse benefit determination* or *final adverse benefit determination* of:

    - A claim involving *urgent care*;
    - An admission, availability of care, continued stay or health care service for which *you* received emergency services, but *you* have not been discharged from the facility; or
    - An *experimental* or *investigational* treatment if the treating physician certifies, in writing, that the recommended service would be significantly less effective if not promptly initiated.

An *adverse benefit determination* of any rescission of coverage is not available for *external review*.

If the request qualifies for an expedited *external review,* an *IRE* will be assigned. *We* will contact the *IRE* by telephone for acceptance of the assignment. *You* or *your authorized representative* will be notified within 24 hours of receiving the request. An extension of up to 24 hours may be allowed if agreed by the *covered person* or their *authorized representative* and *us.* This request for an expedited *external review* will not exceed 72 hours of the receipt of the request.

Legal actions and limitations

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

No legal action to recover on the *master group contract* may be brought after three years from the date written proof of loss is required to be given.

DISCLOSURE PROVISIONS

Employee assistance program

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

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

Discount programs

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

Wellness programs

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

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

"Health-contingent" wellness programs require *you* to attain certain wellness goals that are related to a health factor. Examples of health-contingent wellness programs may include completing a 5k event, lowering blood pressure or ceasing the use of tobacco.

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

The rewards may also include discounts or credits toward premium or a reduction in *copayments*, *deductibles* or *coinsurance*, as permitted under applicable state and federal laws. Such insurance premium or benefit rewards may be made available at the individual or *group* health plan level.

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

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

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

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

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

Shared savings program

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

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

DISCLOSURE PROVISIONS (continued)

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

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

MISCELLANEOUS PROVISIONS

Entire contract

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

Additional group plan sponsor responsibilities

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

- Collection of premium; and
- Distributing and providing *covered persons* access to:

    - Benefit plan documents and the Summary of Benefits and Coverage (SBC);
    - Renewal notices and *master group contract* modification information; and
    - Information regarding continuation rights.

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

Certificates

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

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

Incontestability

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

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

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

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

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

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

Fraud

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

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

Clerical error or misstatement

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

Modification of master group contract

The *master group contract* may be modified by *us,* upon renewal of the *master group contract,* as permitted by state and federal law. The *group plan sponsor* will be notified in writing or *electronically* at least 60 days prior to the effective date of the change. The *master group contract* may be modified by agreement between *us* and the *group plan sponsor* without the consent of any *covered person* or any beneficiary.

No modification will be valid unless approved by *our* President, Secretary or Vice-President. The approval must be endorsed on or attached to the *master group contract.* No agent has authority to modify the *master group contract,* or waive any of the *master group contract* provisions, to extend the time of premium payment, or bind *us* by making any promise or representation.

MISCELLANEOUS PROVISIONS (continued)

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

Discontinuation of coverage

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

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

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

Premium contributions

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

Premium rate change

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

Assignment

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

Conformity with statutes

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

GLOSSARY

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

A

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

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

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

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

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

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

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

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

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

Alternative medicine, for the purposes of this definition, includes: acupressure, aromatherapy, ayurveda, biofeedback, faith healing, guided mental imagery, herbal supplements and medicine, holistic medicine, homeopathy, hypnosis, macrobiotics, massage therapy, naturopathy, ozone therapy, reflexotherapy, relaxation response, rolfing, shiatsu, yoga, and chelation therapy.

Ambulance means a professionally operated 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 *health care practitioner*.

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

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

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

Autism spectrum disorders means a physical, mental, or cognitive illness or disorder which includes any of the pervasive developmental disorders as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders ("DSM"), published by the American Psychiatric Association, including Autistic disorder, Asperger's disorders, and Pervasive Developmental disorder not otherwise specified.

B

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

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

C

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

GLOSSARY (continued)

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

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

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

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

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

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

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

Covered expense means:

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

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

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

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

Custodial care means services given to *you* if:

- *You* need services including, assistance with dressing, bathing, preparation and feeding of special diets, walking, supervision of medication which is ordinarily self-administered, getting in and out of bed, and maintaining continence;

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

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

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

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

D

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

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

Dentist means an individual, who is duly licensed to practice dentistry or perform *oral surgery* and is acting within the lawful scope of his or her license.

GLOSSARY (continued)

Dependent means a covered *employee's*:

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

  The *domestic partner's* child cannot qualify as a *dependent* prior to the *employee's domestic partner* becoming a qualified *dependent.*

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

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

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

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

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

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

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

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

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

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

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

Domestic partner means an individual of the same or opposite gender, who resides with the covered *employee* in a long-term relationship of indefinite duration; and, there is an exclusive, mutual commitment in which the partners agree to be jointly responsible for each other's common welfare and share financial obligations. *We* will allow coverage for only one *domestic partner* of the covered *employee* at any one time. The *employee* and *domestic partner* must each be at a minimum 18 years of age, competent to contract, and not related by blood to a degree of closeness, which would prohibit legal marriage in the state in which the *employee* and *domestic partner* both legally reside. *We* reserve the right to require an affidavit from the *employee* and *domestic partner* attesting that the domestic partnership has existed for a minimum period of 6 months and, periodically thereafter, to require proof that the *domestic partner* relationship continues to exist.

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

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

E

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

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

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

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

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

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

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

With respect to a pregnant woman who is having contractions:

- A situation in which there is inadequate time to effect a safe transfer to another *hospital* before delivery; or
- A situation in which transfer may pose a threat to the health or safety of the woman or the unborn child.

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

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

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

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

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

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

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

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

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

- Cannot be lawfully marketed without the final approval of the United States Food and Drug Administration (FDA) and lacks such final FDA approval for the use or proposed use, unless (a) found to be accepted for that use in the most recently published edition of the United States Pharmacopeia-Drug Information for Healthcare Professional (USP-DI) or in the most recently published edition of the American Hospital Formulary Service (AHFS) Drug Information, (b) identified as safe, widely used and generally accepted as effective for that use as reported in nationally recognized peer reviewed medical literature published in the English language as of the date of service; or (c) is mandated by state law;

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

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

- Is the subject of a National Cancer Institute (NCI) Phase I, II or III trial or a treatment protocol comparable to a NCI Phase I, II or III trial, or any trial not recognized by NCI regardless of phase; or

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

F

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

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

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

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

G

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

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

H

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

Health care practitioner means a practitioner professionally licensed by the appropriate state agency to provide *preventive services* or diagnose or treat a *sickness* or *bodily injury* and who provides services within the scope of that license. Including, Chiropractors, Dentists, Nurse Practitioner, Registered Nurse First Assistant, Optometrists, Osteopaths, Physicians, Pharmacists, Podiatrists, Physical Therapist, Occupational Therapist, Physician's Assistant and Licensed Psychologist or Licensed Clinical Social Worker.

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

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

Health status-related factor means any of the following:

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

Hearing aid and related services means any wearable, non-disposable instrument or device designed to aid or compensate for impaired hearing, including any parts, attachments, or accessories (excluding batteries and cords). Services to assess, select, and adjust/fit the hearing aid to ensure optimal performance, as prescribed by a licensed audiologist and dispensed by a licensed audiologist or hearing instrument specialist.

GLOSSARY (continued)

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

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

Home health care plan means a plan of care and treatment for *you* to be provided in *your* home. To qualify, the *home health care plan* must be established and approved by a *health care practitioner*. The services to be provided by the plan must require the skills of a *nurse*, or another *health care practitioner* and must not be for *custodial care*.

Hospice care program means a coordinated, interdisciplinary program provided by a hospice that is designed to meet the special physical, psychological, spiritual and social needs of a terminally ill *covered person* and his or her immediate covered *family members*, by providing *palliative care* and supportive medical, nursing and other services through at-home or *inpatient* care. A hospice must be licensed by the laws of the jurisdiction where it is located and must be operated as a hospice as defined by those laws. It must provide a program of treatment for at least two unrelated individuals who have been medically diagnosed as having no reasonable prospect for cure for their *sickness* and, as estimated by their physicians, are expected to live 18 months or less as a result of that *sickness*.

Hospital means an institution that meets all of the following requirements:

- It must provide, for a fee, medical care and treatment of sick or injured patients on an *inpatient* basis;
- It must provide or operate, either on its premises or in facilities available to the *hospital* on a pre-arranged basis, medical, diagnostic and surgical facilities;
- Care and treatment must be given by and supervised by physicians. Nursing services must be provided on a 24-hour basis and must be given by or supervised by registered nurses;
- It must be licensed by the laws of the jurisdiction where it is located. It must be operated as a *hospital* as defined by those laws; and
- It must <u>not</u> be primarily a:
    - Convalescent, rest or nursing home; or
    - Facility providing custodial, educational or rehabilitative care.

The *hospital* must be accredited by one of the following:

- The Joint Commission on the Accreditation of Hospitals;
- The American Osteopathic Hospital Association; or
- The Commission on the Accreditation of Rehabilitative Facilities.

I

Immune effector cell therapy means immune cells or other blood products that are engineered outside of the body and infused into a patient. *Immune effector cell therapy* may include acquisition, integral chemotherapy components and engineered immune cell infusion.

Infertility services mean any treatment, supply, medication, or service provided to achieve pregnancy or to achieve or maintain ovulation. This includes:

- Artificial insemination;
- In vitro fertilization;
- Gamete Intrafallopian Transfer (GIFT);
- Zygote Intrafallopian Transfer (ZIFT);
- Tubal ovum transfer;
- Embryo freezing or transfer;
- Sperm storage or banking;
- Ovum storage or banking;
- Embryo or zygote banking; and
- Any other assisted reproductive techniques or cloning methods.

Inpatient means *you* are *confined* as a registered bed patient.

Intensive outpatient program means *outpatient* services providing:

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

Intensive outpatient program does not include services that are for:

- *Custodial care*; or
- Day care.

J

K

L

Late applicant means an *employee* or *dependent* who requests enrollment for coverage under the *master group contract* more than 31 days after his or her *eligibility date*, later than the time period specified in the "Special enrollment" provision, or after the *open enrollment period.*

GLOSSARY (continued)

M

Maintenance care means services and supplies furnished mainly to:

- Maintain, rather than improve, a level of physical or mental function; or
- Provide a protected environment free from exposure that can worsen the *covered person's* physical or mental condition.

Master group contract means the legal agreement between *us* and the *group plan sponsor* including the Employer Group Application and *certificate,* together with any riders, amendments and endorsements.

Materials means frames, lenses and lens options, or contact lenses and low vision aids.

Maximum allowable fee for a *covered expense,* other than *emergency medical condition* services provided by *non-network providers* in a *hospital's* emergency department, is the lesser of:

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

Maximum allowable fee for a *covered expense* for *emergency medical condition* services provided by *non-network providers* in a *hospital's* emergency department is an amount equal to the greatest of:

- The fee negotiated with *network providers*;
- The fee calculated using the same method to determine *maximum allowable fee* for a *covered expense,* other than *emergency care* services provided by *non-network providers*; or
- The fee paid by *Medicare* for the same services.

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

Medicaid means a state program of medical care for needy persons, as established under Title 19 of the Social Security Act of 1965, as amended.

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

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

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

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

Mental health services mean those diagnoses and treatments related to the care of a *covered person* who exhibits a mental, nervous or emotional condition classified in the Diagnostic and Statistical Manual of Mental Disorders.

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

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

N

Network health care practitioner means a *health care practitioner*, who has been designated as such or has signed an agreement with *us* as an independent contractor, or who has been designated by *us* to provide services to all *covered persons*. *Network health care practitioner* designation by *us* may be limited to specified services.

Network hospital means a *hospital* which has been designated as such or has signed an agreement with *us* as an independent contractor, or has been designated by *us* to provide services to all *covered persons*. *Network hospital* designation by *us* may be limited to specified services.

Network provider means a *hospital, health care treatment facility, health care practitioner*, or other health services provider who is designated as such or has signed an agreement with *us* as an independent contractor, or who has been designated by *us* to provide services to all *covered persons*. *Network provider* designation by *us* may be limited to specified services.

Non-network health care practitioner means a *health care practitioner* who has not been designated by *us* as a *network health care practitioner*.

Non-network hospital means a *hospital* which has not been designated by *us* as a *network hospital*.

Non-network provider means a *hospital, health care treatment facility, health care practitioner*, or other health services provider who has not been designated by us as a *network provider*.

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

O

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

Open enrollment period means no less than a 31 day period of time, occurring annually for the *group*, during which *employees* have an opportunity to enroll themselves and their eligible *dependents* for coverage under the *master group contract*.

Oral surgery means procedures to correct diseases, injuries and defects of the jaw and mouth structures. These procedures include the following:

- Surgical removal of full bony impactions;
- Mandibular or maxillary implant;
- Maxillary or mandibular frenectomy;
- Alveolectomy and alveoplasty;
- Orthognathic *surgery*;
- *Surgery* for treatment of temporomandibular joint syndrome/dysfunction; and
- Periodontal surgical procedures, including gingivectomies.

Originating site means the location of a *covered person* at the time a *telehealth* or *telemedicine* service is being furnished.

Out-of-pocket limit means the amount of any *copayments*, *deductibles* and *coinsurance* for *covered expenses* which *you* must pay, either individually or combined as a covered family, per *year* before a benefit percentage is increased. Any amount *you* pay exceeding the *maximum allowable fee* is not applied to the *out-of-pocket limits.*

Outpatient means *you* are not *confined* as a registered bed patient.

Outpatient surgery means *surgery* performed in a *health care practitioner's* office, *ambulatory surgical center*, or the *outpatient* department of a *hospital*.

P

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

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

- Has a comprehensive and intensive interdisciplinary psychiatric treatment for minimum of 5 hours a day, 5 days per week under the supervision of a psychiatrist for *mental health services* or a psychiatrist or addictionologist for *chemical dependency*, and patients are seen by a psychiatrist or addictionologist, as applicable, at least once a week;

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

- Has physicians and appropriately licensed behavioral health practitioners readily available for the emergent and urgent needs of the patients.

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

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

Partial hospitalization does not include services that are for:

- *Custodial care*; or
- Day care.

Pediatric dental services mean the following services:

- Ordered by a *dentist*; and
- Described in the "Pediatric dental" provision in the "Covered Expenses – Pediatric Dental" section.

Pediatric vision care means the services and *materials* specified in the "Pediatric vision care benefit" provision in the "Covered Expenses – Pediatric Vision Care" section.

Periodontics means the branch of dentistry concerned with the study, prevention, and treatment of diseases of the tissues and bones supporting the teeth. *Periodontics* includes the following dental procedures, related tests or treatment and follow-up care:

- Periodontal maintenance;
- Scaling and root planing;
- Gingivectomy;
- Gingivoplasty; or
- Osseous surgical procedures.

Pre-surgical/procedural testing means:

- Laboratory tests or radiological examinations done on an *outpatient* basis in a *hospital* or other facility accepted by the *hospital* before *hospital confinement* or *outpatient surgery* or procedure;
- The tests must be accepted by the *hospital* or *health care practitioner* in place of like tests made during *confinement*; and
- The tests must be for the same *bodily injury* or *sickness* causing *you* to be *hospital confined* or to have the *outpatient surgery* or procedure.

Preauthorization means approval by *us*, or *our* designee, of a service prior to it being provided. Certain services require medical review by *us* in order to determine eligibility for coverage.

Preauthorization is granted when such a review determines that a given service is a *covered expense* according to the terms and provisions of the *master group contract*.

Prescription means a direct order for the preparation and use of a drug, medicine or medication. The *prescription* must be written by a *health care practitioner* and provided to a *pharmacist* for *your* benefit and used for the treatment of a *sickness* or *bodily injury*, which is covered under this plan, or for drugs, medicines or medications on the Preventive Medication Coverage *drug list.* The drug, medicine or medication must be obtainable only by *prescription* or must be obtained by *prescription* for drugs, medicines or medications on the Preventive Medication Coverage *drug list.* The *prescription* may be given to the *pharmacist* verbally, *electronically* or in writing by the *health care practitioner*. The *prescription* must include at least:

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

Preventive services means services in the following recommendations appropriate for *you* during *your* plan *year*:

- Services with an A or B rating in the current recommendations of the U.S. Preventive Services Task Force (USPSTF). Coverage includes individual, group and telephonic tobacco cessation counseling and all U.S. Food and Drug Administration approved tobacco cessation medications.
- Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC).
- Preventive care for infants, children and adolescents provided in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA).
- Preventive care for women provided in the comprehensive guidelines supported by HRSA and bone density screenings beginning at age 35.
- Colorectal cancer screening examinations and laboratory tests administered at frequencies specified in current American Cancer Society guidelines for colorectal cancer screening.
- Genetic screening for cancer risk that is recommended by a *health care practitioner* or genetic counselor if that recommendation is consistent with the most recent version of genetic testing guidelines published by the National Comprehensive Cancer Network (NCCN).

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

Primary care physician means a *network health care practitioner* who provides initial and primary care services to *covered persons*, maintains the continuity of *covered persons*, medical care and helps direct *covered persons* to *specialty care physicians* and other providers.

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

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

Q

Qualified provider means a person, facility or any other health care provider:

- That is licensed by the appropriate state agency to:
  - Diagnose or treat a *sickness* or *bodily injury*;
  - Provide *preventive services*;
  - Provide *pediatric dental services*; or
  - Provide *pediatric vision care.*
- That provides services within the scope of their license; and
- Whose primary purpose is to provide health care services.

R

Registered nurse first assistant means a nurse who:

- Holds a current active registered nurse licensure;
- Is certified in perioperative nursing; and
- Has successfully completed and holds a degree or certificate from a recognized program, which shall consist of:
  - The Association of Operating Room Nurses, Inc.; Core curriculum for the registered nurse first assistant; and
  - One (1) year of post basic nursing study, which shall include at least forty-five hours of didactic instruction and one hundred twenty (120) hours of clinical internship or its equivalent of two college semesters
- A registered nurse who was certified prior to 1995 by the Certification Board of Perioperative Nursing shall not be required to fulfill the requirements of the third bulleted paragraph of this subsection.

Rehabilitation facility means any licensed public or private establishment which has permanent facilities that are equipped and operated primarily to render physical and occupational therapies, diagnostic services and other therapeutic services.

Rescission, rescind or ***rescinded*** means a cancellation or discontinuance of coverage that has a retroactive effect.

Residential treatment facility means an institution that:

- Is licensed as a 24-hour residential facility for *behavioral health* treatment, although not licensed as a *hospital*;
- Provides a multidisciplinary treatment plan in a controlled environment, under the supervision of a physician who is able to provide treatment on a daily basis;
- Provides supervision and treatment by a Ph.D. psychologist, licensed therapist, psychiatric nursing staff or registered nurse;
- Provides programs such as social, psychological, family counseling, and rehabilitative training, age appropriate for the special needs of the age group of patients, with focus on reintegration back into the community; and
- Provides structured activities throughout the day and evening, for a minimum of 6 hours a day.

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

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

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

Routine nursery care means the charges made by a *hospital* or licensed birthing center for the use of the nursery. It includes normal services and supplies given to well newborn children following birth. *Health care practitioner* visits are not considered *routine nursery care.* Treatment of a *bodily injury*, *sickness*, birth abnormality, or *congenital anomaly* following birth and care resulting from prematurity is not considered *routine nursery care*.

S

Self-administered injectable drugs means an FDA approved medication which a person may administer to himself or herself by means of intramuscular, intravenous, or subcutaneous injection, excluding insulin, and prescribed for use by *you.*

Serious mental condition or significant behavioral problem means in relation to general anesthesia for dental procedures a condition identified by a diagnostic code from the most recent edition of the:

- International Classification Of Disease-Clinical Modification (ICD-CM), coeds 290-299.9 and 300-319; or
- Diagnostic and Statistical Manual of Mental Disorders; and
- The person must also require dental care be performed in a *hospital* or *ambulatory surgical facility* because:

    - Their diagnosis reasonably infers they will be unable to cooperate; or
    - Airway, breathing, circulation of blood may be compromised.

Serious physical condition means a disease (or condition) requiring on-going medical care that may cause compromise of the airway, breathing or circulation of blood while receiving dental care unless performed in a hospital or ambulatory surgical facility.

Service area means the geographic area designated by *us*, or as otherwise agreed upon between the *group plan sponsor* and *us* and approved by the Department of Insurance of the state in which the *master group contract* is issued, if such approval is required. The *service area* is the geographic area where the *network provider* services are available to *you.* A description of the *service area* is provided in the provider directories.

Sickness means a disturbance in function or structure of the body which causes physical signs or physical symptoms and which, if left untreated, will result in a deterioration of the health state of the structure or system(s) of the body. The term also includes: (a) pregnancy; (b) any medical complications of pregnancy; and (c) *behavioral health.*

Skilled nursing facility means a licensed institution (other than a *hospital*, as defined) which meets all of the following requirements:

- It must provide permanent and full-time bed care facilities for resident patients;
- It must maintain, on the premises and under arrangements, all facilities necessary for medical care and treatment;
- It must provide such services under the supervision of physicians at all times;
- It must provide 24-hours-a-day nursing services by or under the supervision of a registered nurse; and
- It must maintain a daily record for each patient.

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

Small employer means an *employer* who employed an average of one but not more than 50 *employees* on business days during the preceding calendar year and who employs at least one *employee* on the first day of the *year*. All subsidiaries or affiliates of the *group plan sponsor* are considered one *employer* when the conditions specified in the "Subsidiaries or Affiliates" section of the *master group contract* are met.

Sound natural tooth means a tooth that:

- Is organic and formed by the natural development of the body (not manufactured, capped, crowned or bonded);
- Has not been extensively restored;
- Has not become extensively decayed or involved in periodontal disease; and
- Is not more susceptible to injury than a whole natural tooth, (for example a tooth that has not been previously broken, chipped, filled, cracked or fractured).

Special enrollment date means the date of:

- Change in family status after the *eligibility date*;
- Loss of other coverage under another group health plan or other *health insurance coverage*;
- COBRA exhaustion;
- Loss of coverage under *your employer's* alternate plan;
- Termination of your *Medicaid* coverage or your Children's Health Insurance Program (CHIP) coverage as a result of loss of eligibility; or
- Eligibility for a premium assistance subsidy under *Medicaid* or CHIP.

To be eligible for special enrollment, *you* must meet the requirements specified in the "Special enrollment" provision within the "Eligibility and Effective Dates" section of this *certificate.*

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

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

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

Stem cell means the transplant of human blood precursor cells. Such cells may be derived from bone marrow, circulating blood, or a combination of bone marrow and circulating blood obtained from the patient in an autologous transplant, from a matched related or unrelated donor, or cord blood. The *stem cell* transplant includes the harvesting, integral chemotherapy components and the *stem cell* infusion. A *stem cell* transplant is commonly referred to as a bone marrow transplant.

Surgery means procedures categorized as Surgery in either the:

- Current Procedural Terminology (CPT) manuals published by the American Medical Association; and
- Healthcare Common Procedure Coding System (HCPCS) Level II manual published by the Centers for Medicare & Medicaid Services (CMS).

The term *surgery* includes:

- Excision or incision of the skin or mucosal tissues;
- Insertion for exploratory purposes into a natural body opening;
- Insertion of instruments into any body opening, natural or otherwise, done for diagnostic or other therapeutic purposes;
- Treatment of fractures;
- Procedures to repair, remove or replace any body part or foreign object in or on the body; and
- Endoscopic procedures.

Surgical assistant means a *health care practitioner* who assists at *surgery* and is not a Doctor of Medicine (MD), Doctor of Osteopathic Medicine (DO) or Doctor of Podiatric Medicine (DPM), or where state law does not require that specific *health care practitioners* be treated and reimbursed the same as an MD, DO or DPM.

T

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

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

GLOSSARY (continued)

Total disability or ***totally disabled*** means *your* continuing inability, as a result of a *bodily injury* or *sickness*, to perform the material and substantial duties of any job for which *you* are or become qualified by reason of education, training or experience.

The term also means a *dependent's* inability to engage in the normal activities of a person of like age. If the *dependent* is employed, the *dependent* must be unable to perform his or her job.

U

Urgent care means those health care services that are appropriately provided for an unforeseen condition of a kind that usually requires attention without delay but that does not pose a threat to life, limb or permanent health of the *covered person.*

Urgent care center means any licensed public or private non-*hospital free-standing facility* which has permanent facilities equipped to provide *urgent care* services on an *outpatient* basis.

V

Virtual visit means *telehealth* or *telemedicine* services.

W

Waiting period means the period of time, elected by the *group plan sponsor*, that must pass before an *employee* is eligible for coverage under the *master group contract*.

We, ***us*** or ***our*** means the offering company as shown on the cover page of the *master group contract* and *certificate.*

X

Y

Year means the period of time which begins on any January 1st and ends on the following December 31st. When *you* first become covered by the *master group contract*, the first *year* begins for *you* on the *effective date* of *your* coverage and ends on the following December 31st.

You or ***your*** means any *covered person.*

Z

GLOSSARY – PHARMACY SERVICES

All terms used in the "Schedule of Benefits – Pharmacy Services," "Covered Expenses – Pharmacy Services" and "Limitations and Exclusions – Pharmacy Services" sections have the same meaning given to them in the "Glossary" section of this *certificate,* unless otherwise specifically defined below:

A

B

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

C

Coinsurance means the amount expressed as a percentage of the *covered expense* that *you* must pay toward the cost of each separate *prescription* fill or refill dispensed by a *pharmacy*.

Copayment means the specified dollar amount to be paid by *you* toward the cost of each separate *prescription* fill or refill dispensed by a *pharmacy*.

Cost share means any applicable *prescription drug deductible, copayment* and *coinsurance* that *you* must pay per *prescription* fill or refill.

D

Default rate means the fee based on rates negotiated by *us* or other payers with one or more *network providers* in a geographic area determined by *us* for the same or similar *prescription* fill or refill.

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

Drug list means a list of covered *prescription* drugs, medicines or medications and supplies specified by *us*.

E

F

G

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

H

I

J

K

L

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

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

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

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

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

Level 5 drugs mean a category of *prescription* drugs, medicines or medications within the *drug list* that are designated by *us* as level 5. The *prescription* drugs in this category are highest-cost/high technology drugs and *specialty drugs*.

GLOSSARY – PHARMACY SERVICES (continued)

M

Mail order pharmacy means a *pharmacy* that provides covered *mail order pharmacy* services, as defined by *us*, and delivers covered *prescription* drug, medicine or medication fills or refills through the mail to *covered persons.*

N

Network pharmacy means a *pharmacy* that has signed a direct agreement with *us* or has been designated by *us* to provide:

- Covered *pharmacy* services;
- Covered *specialty pharmacy* services; or
- Covered *mail order pharmacy* services,

as defined by *us*, to *covered persons,* including covered *prescription* fills or refills delivered to *your* home or health care provider.

Non-network pharmacy means a *pharmacy* that has not signed a direct agreement with *us* or has not been designated by *us* to provide:

- Covered *pharmacy* services;
- Covered *specialty pharmacy* services; or
- Covered *mail order pharmacy* services,

as defined by *us*, to *covered persons,* including covered *prescription* fills or refills delivered to *your* home or health care provider.

O

P

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

Pharmacy means a licensed establishment where *prescription* drugs, medicines or medications are dispensed by a *pharmacist.*

Prior authorization means the required prior approval from *us* for the coverage of certain *prescription* drugs, medicines or medications, including *specialty drugs*. The required prior approval from *us* for coverage includes the dosage, quantity and duration, as *medically necessary* for the *covered person.*

Q

R

S

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

Step therapy means a requirement for *you* to first try certain drugs, medicines or medications or *specialty drugs* to treat *your* medical condition before *we* will cover another *prescription* drug, medicine, medication or *specialty drug* for that condition.

T

U

V

W

X

Y

Z

Humana.

Toll Free:1 800-448-6262
500 West Main Street
Louisville, KY 40202

OFFERED BY
Humana Health Plan, Inc.

FEDERAL NOTICES

The following pages contain important information about certain federal laws. There may be differences between the Certificate of Insurance and this Notice packet. There may also be differences between this notice packet and state law. You are eligible for the rights more beneficial to you, unless preempted by state or federal law.

This section includes notices about:

Federal legislation

- **Women's health and cancer rights act**
- **Statement of rights under the newborns' and mothers' health Protection act**
- **Medical child support orders**
- **General notice of COBRA continuation of coverage rights**
- **Tax equity and fiscal responsibility act of 1982 (TEFRA)**
- **Family and medical leave act (FMLA)**
- **Uniformed services employment and reemployment rights act of 1994 (USERRA)**
- **Your rights under ERISA**
- **Patient protection act**

FEDERAL NOTICES (continued)

Federal legislation

Women's health and cancer rights act of 1998
Required coverage for reconstructive surgery following mastectomies

Under federal law, group health plans and health insurance issuers offering group health insurance providing medical and surgical benefits with respect to mastectomy shall provide, in a case of a participant or beneficiary who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with such mastectomy, coverage for:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce symmetrical appearance; and
- Prostheses and physical complications of all stages of mastectomy, including lymphedemas;

in a manner determined in consultation with the attending physician and the patient. Such coverage may be subject to annual deductibles and coinsurance provisions as may be deemed appropriate and as are consistent with those established for other benefits under the plan.

Statement of rights under the newborns' and mothers' health protection act (NMHPA)

If your plan covers normal pregnancy benefits, the following notice applies to you.

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, group health plans and health insurance issuers may not set the level of benefits or out-of-pocket costs so any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a group health plan or health insurance issuer may not, under federal law, require a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain pre-authorization. For information on pre-authorization, contact your plan administrator.

FEDERAL NOTICES (continued)

Medical child support orders

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

A QMCSO is a state-court order or judgment, including approval of a settlement agreement that:

- Provides for support of a covered employee's child;
- Provides for health care coverage for that child;
- Is made under state domestic relations law (including a community property law);
- Relates to benefits under the group health plan; and
- Is "qualified," i.e., it meets the technical requirements of ERISA or applicable state law.

QMCSO also means a state court order or judgment enforcing state Medicaid law regarding medical child support required by the Social Security Act §1908 (as added by Omnibus Budget Reconciliation Act of 1993).

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

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

General notice of COBRA continuation coverage rights

Introduction

You are getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

FEDERAL NOTICES (continued)

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary". You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you to lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced; or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you to lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a "dependent child".

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the employer, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

FEDERAL NOTICES (continued)

When is COBRA coverage available?

The plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- Commencement of a proceeding in bankruptcy with respect to the employer; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs.

How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

- ***Disability extension of 18-month period of continuation coverage*** - If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage;

- ***Second qualifying event extension of 18-month period of continuation coverage*** - If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

FEDERAL NOTICES (continued)

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period". Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting your group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep your plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information:

Humana
Billing/Enrollment Department
101 E Main Street
Louisville, KY 40201
1-800-872-7207

FEDERAL NOTICES (continued)

Important notice for individuals entitled to Medicare tax equity and fiscal responsibility act of 1982 (TEFRA) options

Where an employer employs more than 20 people, the Tax Equity And Fiscal Responsibility Act of 1982 (TEFRA) allows covered employees in active service who are age 65 or older and their covered spouses who are eligible for Medicare to choose one of the following options:

- ***Option 1*** - The benefits of their group health plan will be payable first and the benefits of Medicare will be payable second.
- ***Option 2*** - Medicare benefits only. The employee and his or her dependents, if any, will not be insured by the group health plan.

The employer must provide each covered employee and each covered spouse with the choice to elect one of these options at least one month before the covered employee or the insured spouse becomes age 65. All new covered employees and newly covered spouses age 65 or older must be offered these options. If Option 1 is chosen, its issue is subject to the same requirements as for an employee or dependent that is under age 65.

Under TEFRA regulations, there are two categories of persons eligible for Medicare. The calculation and payment of benefits by the group health plan differs for each category.

- ***Category 1*** Medicare eligibles are:
    - Covered employees in active service who are age 65 or older who choose Option 1;
    - Age 65 or older covered spouses; and
    - Age 65 or older covered spouses of employees in active service who are either under age 65 or age 70 or older;
- ***Category 2*** Medicare eligibles are any other covered persons entitled to Medicare, whether or not they enrolled. This category includes, but is not limited to:
    - Retired employees and their spouses; or
    - Covered dependents of a covered employee, other than his or her spouse.

Calculation and payment of benefits

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

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

FEDERAL NOTICES (continued)

Family and Medical Leave Act (FMLA)

If an employee is granted a leave of absence (Leave) by the employer as required by the Federal Family and Medical Leave Act, s/he may continue to be covered under the plan for the duration of the Leave under the same conditions as other employees who are currently employed and covered by the plan. If the employee chooses to terminate coverage during the Leave, or if coverage terminates as a result of nonpayment of any required contribution, coverage may be reinstated on the date the employee returns to work immediately following the end of the Leave. Charges incurred after the date of reinstatement will be paid as if the employee had been continuously covered.

Uniformed services employment and reemployment rights act of 1994 (USERRA)

Continuation of benefits

Effective October 13, 1994, federal law requires health plans offer to continue coverage for employees that are absent due to service in the uniformed services and/or dependents.

Eligibility

An employee is eligible for continuation under USERRA if he or she is absent from employment because of voluntary or involuntary performance of duty in the Armed Forces, Army National Guard, Air National Guard, or commissioned corps of the Public Health Service. Duty includes absence for active duty, active duty for training, initial active duty for training, inactive duty training and for the purpose of an examination to determine fitness for duty.

An employee's dependents that have coverage under the plan immediately prior to the date of the employee's covered absence are eligible to elect continuation under USERRA.

If continuation of Plan coverage is elected under USERRA, the employee or dependent is responsible for payment of the applicable cost of coverage. If the employee is absent for not longer than 31 days, the cost will be the amount the employee would otherwise pay for coverage. For absences exceeding 30 days, the cost may be up to 102% of the cost of coverage under the plan. This includes the employee's share and any portion previously paid by the employer.

Duration of coverage

If elected, continuation coverage under USERRA will continue until the earlier of:

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

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

Other information

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

Your rights under the Employee Retirement Income Security Act of 1974 (ERISA)

Under ERISA, all plan participants covered by ERISA are entitled to certain rights and protections, as described below. Notwithstanding anything in the group health plan or group insurance policy, following are a covered person's minimum rights under ERISA. ERISA requirements do not apply to plans maintained by governmental agencies or churches.

Information about the plan and benefits

Plan participants may:

- Examine, free of charge, all documents governing the plan. These documents are available in the plan administrator's office;

- Obtain, at a reasonable charge, copies of documents governing the plan, including a copy of any updated summary plan description and a copy of the latest annual report for the plan (Form 5500), if any, by writing to the plan administrator;

- Obtain, at a reasonable charge, a copy of the latest annual report (Form 5500) for the plan, if any, by writing to the plan administrator.

FEDERAL NOTICES (continued)

As a plan participant, you will receive a summary of any material changes made in the plan within 210 days after the end of the plan year in which the changes are made unless the change is a material reduction in covered services or benefits, in which case you will receive a summary of the material reduction within 60 days after the date of its adoption.

If the plan is required to file a summary annual financial report, you will receive a copy from the plan administrator.

Responsibilities of plan fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the plan. These people, called "fiduciaries" of the plan, have a duty to act prudently and in the interest of plan participants and beneficiaries.

No one, including an employer, may discharge or otherwise discriminate against a plan participant in any way to prevent the participant from obtaining a benefit to which the participant is otherwise entitled under the plan or from exercising ERISA rights.

Continue group health plan coverage

Participants may be eligible to continue health care coverage for themselves, their spouse or dependents if there is a loss of coverage under the group health plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review the COBRA notice in this document regarding the rules governing COBRA continuation coverage rights.

Claims determinations

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

Enforce your rights

Under ERISA, there are steps participants may take to enforce the above rights. For instance:

- If a participant requests a copy of plan documents and does not receive them within 30 days, the participant may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until the participant receives the materials, unless the materials were not sent because of reasons beyond the control of the plan administrator;

- If a claim for benefits is denied or disregarded, in whole or in part, the participant may file suit in a state or Federal court;

- If the participant disagrees with the plan's decision, or lack thereof, concerning the qualified status of a domestic relations order or a medical child support order, the participant may file suit in Federal court;

- If plan fiduciaries misuse the plan's money, or if participants are discriminated against for asserting their rights, they may seek assistance from the U.S. Department of Labor, or may file suit in a Federal court.

The court will decide who should pay court costs and legal fees. If the participant is successful, the court may order the person sued to pay costs and fees. If the participant loses, the court may order the participant to pay the costs and fees.

Assistance with questions

- Contact the group health plan human resources department or the plan administrator with questions about the plan;

- For questions about ERISA rights, contact the nearest area office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or:

The Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue N.W.
Washington, D.C. 20210;

- Call the publications hotline of the Employee Benefits Security Administration to obtain publications about ERISA rights.

FEDERAL NOTICES (continued)

Patient Protection Act

Humana generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For children, you may designate a pediatrician as the primary care provider. For information on how to select a primary care provider, and for a list of the participating primary care providers, visit our Website at www.humana.com or call the customer service telephone number on your identification card.

If your plan provides coverage for obstetric or gynecological care, you do not need prior authorization from us or from any other person (including a primary care provider) in order to obtain access to this care from a health care professional in our network who specialize in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, visit our Website at www.humana.com or call the customer service telephone number on your identification card.

Appeal and External Review Notice

The following pages contain important information about Humana's claims procedures, internal appeals and external review. There may be differences between the Certificate of Insurance and this Notice packet. There may also be differences between this notice packet and state law. You are eligible for the rights more beneficial to you, unless preempted by state or federal law.

Federal standards

The Employee Retirement Income Security Act of 1974 (ERISA) established minimum requirements for claims procedures. The Patient Protection and Affordable Care Act (PPACA) including all regulation enforcing PPACA established additional requirements for claims procedures, internal appeal and *external review* processes. Humana complies with these standards. In addition to the procedures below, you should also refer to your insurance benefit plan documents (e.g., the Certificate of Insurance or Evidence of Coverage).

Definitions

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

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

An *adverse benefit determination* also includes any rescission of coverage.

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

Clinical peer reviewer is:

- An expert in the treatment of your medical condition that is the subject of an *external review*;
- Knowledgeable about the recommended healthcare service or treatment through recent or current actual clinical experience treating patients with the same or similar to your medical condition;
- Holds a non-restricted license in a state of the United States and, for physicians, a current certification by a recognized American medical specialty board in the area or areas appropriate to the subject of the *external review*;
- Has no history of disciplinary actions or sanctions, including loss of staff privileges or participation restrictions, that have been taken or are pending by any hospital, governmental agency or unit, or regulatory body that raise a substantial question as to the *clinical peer reviewer's* physical, mental or professional competence or moral character; and

- Does not have a material professional, family or financial conflict of interest with the *claimant*, Humana and any of the following:

    - The healthcare provider, the healthcare provider's medical group or independent practice association recommending the healthcare service or treatment;
    - The facility at which the recommended healthcare service or treatment would be provided; or
    - The developer or manufacturer of the principal drug, device, procedure or other therapy being recommended.

Commissioner means the Commissioner of Insurance.

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

Evidence-based standard means the conscientious, explicit and judicious use of the current best evidence based on the overall systematic review of the research in making decisions about the care of individual patients.

External review means a review of an *adverse benefit determination* including a *final adverse benefit determination* conducted by an *Independent review organization (IRO).*

Final adverse benefit determination means an *adverse benefit determination* that has been upheld by us at the completion of the internal appeals process or when the internal appeals process has been exhausted.

Group health plan means an employee welfare benefit plan to the extent the plan provides medical care to employees or their dependents directly (self insured) or through insurance (including HMO plans), reimbursement or otherwise.

Health insurance issuer means the offering company listed on the face page of your Certificate of Insurance and referred to in this document as "Humana," "we," "us," or "our."

Independent review organization (IRO) means an entity that conducts independent *external reviews* of *adverse benefit determinations* and *final adverse benefit determinations.* All *IRO's* must be accredited by a nationally recognized private accrediting organization and have no conflicts of interest to influence its independence.

Medical or scientific evidence means evidence found in the following sources:

- Peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff;

- Peer-reviewed medical literature, including literature relating to therapies reviewed and approved by a qualified institutional review board, biomedical compendia and other medical literature that meet the criteria of the National Institutes of Health's Library of Medicine for indexing in Index Medicus (Medline) and Elsevier Science Ltd. for indexing in Excerpta Medicus (EMBASE);

- Medical journals recognized by the Secretary of Health and Human Services;

- The following standard reference compendia:

  - The American Hospital Formulary Service–Drug Information;
  - Drug Facts and Comparisons;
  - The American Dental Association Accepted Dental Therapeutics; and
  - The United States Pharmacopoeia–Drug Information;

- Findings, studies or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes, including:

  - The federal Agency for Healthcare Research and Quality;
  - The National Institutes of Health;
  - The National Cancer Institute;
  - The National Academy of Sciences;
  - The Centers for Medicare & Medicaid Services;
  - The federal Food and Drug Administration; and
  - Any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health care services; or

- Any other *medical or scientific evidence* that is comparable to the sources listed above.

Preliminary review means a review by Humana of an *external review* request to determination if:

- You are or were covered under the plan at the time a service was recommended, requested, or provided;

- The service is covered under the plan except when we determine the service is:

  - Not covered because it does not meet plan requirements for medical necessity, appropriateness, healthcare setting, level of care or effectiveness; or
  - Experimental or investigational for a particular medical condition and is not explicitly listed as an excluded benefit under the plan.

- In the case of experimental or investigational treatment:

  - Your treating physician has certified <u>one</u> of the following situations is applicable:

    - Standard services have not been effective in improving your condition;
    - Standard services are not medically appropriate for you; or
    - There is no available standard service covered by the plan that is more beneficial to you than the recommended or requested service.

- The treating physician certifies in writing:
    - The recommended service is likely to be more beneficial to you, in the physician's opinion, than any available standard services; or
    - Scientifically valid studies using accepted protocols demonstrate the service is likely to be more beneficial to you than any available standard services and the physician is a licensed, board certified or board eligible physician qualified to practice in the area of medicine appropriate to treat your condition.

- The internal appeals process has been exhausted as specified under the "Exhaustion of remedies" section;
- You have provided all information required to process an *external review*; including:
    - An *external review* request form provided with the *adverse benefit determination* or *final adverse benefit determination*; and
    - Release forms authorizing us to disclose protected health information that is pertinent to the *external review*.

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

Pre-service claim means a request for authorization of a benefit for which the plan conditions receipt of the benefit, in whole or in part, on advance approval.

Urgent-care claim means a claim for covered services to which the application of the time periods for making non-urgent care determinations:

- Could seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function; or
- In the opinion of a physician with knowledge of the covered person's medical condition, would subject the covered person to severe pain that cannot be adequately managed without the service that is the subject of the claim.

Humana will make a determination of whether a claim is an *urgent-care claim.* However, any claim a physician, with knowledge of a covered person's medical condition, determines is an "*urgent-care claim*" will be treated as a "claim involving urgent care."

Claim procedures

Discretionary authority

With respect to paying claims for benefits or determining eligibility for coverage under a policy issued by Humana, Humana as administrator for claims determinations and as ERISA claims review fiduciary, shall have full and exclusive discretionary authority to:

- Interpret plan provisions;
- Make decisions regarding eligibility for coverage and benefits; and
- Resolve factual questions relating to coverage and benefits.

Appeal and External Review Notice (continued)

Submitting a claim

This section describes how a *claimant* files a claim for plan benefits. A claim must be filed in writing and delivered by mail, postage prepaid, by FAX or e-mail. A request for pre-authorization may be filed by telephone. The claim or request for pre-authorization must be submitted to Humana or to Humana's designee at the address indicated in the covered person's benefit plan document or identification card. This is particularly important with respect to mental health coordinators and other providers to whom Humana has delegated responsibility for claims administration. Claims will be not be deemed submitted for purposes of these procedures unless and until received at the correct address.

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

Claims submissions must be timely. Claims must be filed as soon as reasonably possible after they are incurred, and in no event later than the period of time described in the benefit plan document.

Claims submissions must be complete and delivered to the designated address. At a minimum they must include:

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

Presentation of a prescription to a pharmacy does not constitute a claim for benefits under the plan. If a covered person is required to pay the cost of a covered prescription drug, he or she may submit a written claim for plan benefits to Humana.

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

Failure to provide necessary information

If a *pre-service claim* submission is not made in accordance with the plan's requirements, Humana will notify the *claimant* of the problem and how it may be remedied within five days (or as soon as possible but not more than 24 hours, in the case of an *urgent-care claim*). If a *post-service claim* is not made in accordance with the plan's requirements, it will be returned to the submitter.

Authorized representatives

A covered person may designate an authorized representative to act on his or her behalf in pursuing a benefit claim, an internal appeal or an *external review*. The designation must be in writing and must be made by the covered person on Humana's Appointment of Representation (AOR) Form or on a form approved in advance by Humana. An assignment of benefits does not constitute designation of an authorized representative.

Humana's AOR Form must be submitted to Humana at the time or prior to the date an authorized representative commences a course of action on behalf of the covered person. At the same time, the authorized representative should also provide notice of commencement of the action on behalf of the covered person to the covered person, which Humana may verify with the covered person prior to recognizing authorized representative status.

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

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

Claims decisions

After a determination on a claim is made, Humana will notify the *claimant* within a reasonable time, as follows:

- ***Pre-service claims*** - Humana will provide notice of a favorable or *adverse benefit determination* within a reasonable time appropriate to the medical circumstances but no later than 15 days after the plan receives the claim.

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

  If the reason for the extension is because Humana does not have enough information to decide the claim, the notice of extension will describe the required information, and the *claimant* will have at least 45 days from the date the notice is received to provide the necessary information.

- ***Urgent-care claims*** - Humana will determine whether a particular claim is an *urgent-care claim*. This determination will be based on information furnished by or on behalf of a covered person. Humana will exercise its judgment when making the determination with deference to the judgment of a physician with knowledge of the covered person's condition. Humana may require a *claimant* to clarify the medical urgency and circumstances supporting the *urgent-care claim* for expedited decision-making.

  Notice of a favorable or *adverse benefit determination* will be made by Humana as soon as possible, taking into account the medical urgency particular to the covered person's situation, but not later than 24 hours after receiving the *urgent-care claim*.

  If a claim does not provide sufficient information to determine whether, or to what extent, services are covered under the plan, Humana will notify the *claimant* as soon as possible, but not more than 24 hours after receiving the *urgent-care claim.* The notice will describe the specific information necessary to complete the claim. The *claimant* will have a reasonable amount of time, taking into account the covered person's circumstances, to provide the necessary information – but not less than 48 hours.

Humana will provide notice of the plan's *urgent-care claim* determination as soon as possible but no more than 48 hours after the earlier of:

- The plan receives the specified information; or
- The end of the period afforded the *claimant* to provide the specified additional information.

- ***Concurrent-care decisions*** - Humana will notify a *claimant* of a *concurrent-care decision* involving a reduction or termination of pre-authorized benefits sufficiently in advance of the reduction or termination to allow the *claimant* to appeal and obtain a determination.

  Humana will decide *urgent-care claims* involving an extension of a course of treatment as soon as possible taking into account medical circumstances. Humana will notify a *claimant* of the benefit determination, whether adverse or not, within 24 hours after the plan receives the claim, provided the claim is submitted to the plan 24 hours prior to the expiration of the prescribed period of time or number of treatments.

- ***Post-service claims*** - Humana will provide notice of a favorable or *adverse benefit determination* within a reasonable time appropriate to the medical circumstances but no later than 30 days after the plan receives the claim.

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

  If the reason for the extension is because Humana does not have enough information to decide the claim, the notice of extension will describe the required information, and the *claimant* will have at least 45 days from the date the notice is received to provide the specified information. Humana will make a decision on the earlier of the date on which the *claimant* responds or the expiration of the time allowed for submission of the requested information.

Initial denial notices

Notice of a claim denial (including a partial denial) will be provided to *claimants* by mail, postage prepaid, by FAX or by e-mail, as appropriate, within the time frames noted above. With respect to adverse decisions involving *urgent-care claims,* notice may be provided to *claimants* orally within the time frames noted above. If oral notice is given, written notification must be provided no later than three days after oral notification.

A claims denial notice will convey the specific reason for the *adverse benefit determination* and the specific plan provisions upon which the determination is based. The notice will also include a description of any additional information necessary to perfect the claim and an explanation of why such information is necessary. The notice will disclose if any internal plan rule, protocol or similar criterion was relied upon to deny the claim and a copy of the rule, protocol or similar criterion will be provided to *claimants,* free of charge. In addition to the information provided in the notice, a *claimant* has the right to request the diagnosis and treatment codes and descriptions upon which the determination is based.

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

Appeal and External Review Notice (continued)

If an *adverse benefit determination* is based on medical necessity, experimental treatment or similar exclusion or limitation, the notice will provide an explanation of the scientific or clinical basis for the determination, free of charge. The explanation will apply the terms of the plan to the covered person's medical circumstances.

In the case of an adverse decision of an *urgent-care claim*, the notice will provide a description of the plan's expedited review procedures.

Contact information

For questions about your rights, this notice, or assistance, you can contact: Humana, Inc. at www.humana.com or the Employee Benefits Security Administration at 1-866-444-EBSA (3272).

You may contact the *commissioner* for assistance at any time at the address and telephone number below:

Kentucky Department of Insurance
P.O. Box 517
Frankfort, KY 40602-0517

Phone: 502-564-3630 or 502-564-6034 or 1-800-595-6053 or
TTY: 800-648-6056

Email: DOI.ConsumerComplaints@ky.gov

You may also contact the state for consumer assistance with appeals, complaints or the external review process:

Kentucky Department of Insurance
Attn: Consumer Protection Division
P.O. Box 517
Frankfort, KY 40602-0517
1-800-595-6053

Appeal and External Review Notice (continued)

Internal appeals and external review of adverse benefit determinations

Internal appeals

A *claimant* must appeal an *adverse benefit determination* within 180 days after receiving written notice of the denial (or partial denial). An appeal may be made by a *claimant* by means of written application to Humana, in person, or by mail, postage prepaid.

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

A *claimant* may request an expedited *external review* at the same time a request is made for an expedited internal appeal of an *adverse benefit determination* for an *urgent-care claim* or when you are receiving an ongoing course of treatment.

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

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

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

If new or additional evidence is relied upon or if new or additional rational is used during the internal appeal process, Humana will provide the *claimant*, free of charge, the evidence or rational as soon as possible and in advance of the appeals decision in order to provide the *claimant* a reasonable opportunity to respond.

Appeal and External Review Notice (continued)

Time periods for decisions on appeal

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

- ***Urgent-care claims*** - As soon as possible but not later than 72 hours after Humana receives the appeal request;
- ***Pre-service claims*** - Within a reasonable period but not later than 30 days after Humana received the appeal request;
- ***Post-service claims*** - Within a reasonable period but not later than 60 days after Humana receives the appeal request;
- ***Concurrent-care decisions*** - Within the time periods specified above depending on the type of claim involved.

Appeals denial notices

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

A notice that a claim appeal has been denied will include:

- The specific reason or reasons for the *adverse benefit determination*;
- Reference to the specific plan provision upon which the determination is based;
- If any internal plan rule, protocol or similar criterion was relied upon to deny the claim. A copy of the rule, protocol or similar criterion will be provided to the *claimant*, free of charge;
- A statement of the *claimant's* right to *external review*, a description of the *external review* process, and the forms for submitting an *external review* request, including release forms authorizing Humana to disclose protected health information pertinent to the *external review*;
- A statement about the *claimant's* right to bring an action under §502(a) of ERISA;
- If an *adverse benefit determination* is based on medical necessity, experimental treatment or similar exclusion or limitation, the notice will provide an explanation of the scientific or clinical basis for the determination, free of charge. The explanation will apply the terms of the plan to the covered person's medical circumstances.

In addition to the information provided in the notice, a *claimant* has the right to request the diagnosis and treatment codes and descriptions upon which the determination is based.

Appeal and External Review Notice (continued)

Exhaustion of remedies

Upon completion of the internal appeals process under this section, a *claimant* will have exhausted his or her administrative remedies under the plan. If Humana fails to adhere to all requirements of the internal appeal process, except for failures that are based on a minimal error, the claim shall be deemed to have been denied and the *claimant* may request an *external review.*

After exhaustion of remedies, a *claimant* may pursue any other legal remedies available, which may include bringing civil action under ERISA section 502(a) for judicial review of the plan's determination. Additional information may be available from the local U.S. Department of Labor Office.

External review

Within four months after a *claimant* receives notice of an *adverse benefit determination* or *final adverse benefit determination* the *claimant* may request an *external review* if the determination concerns treatment that is *experimental, investigational* or not *medically necessary* or the determination concerns a rescission of coverage. The request for *external review* must be made in writing to the *commissioner.* Please refer to the section titled "Expedited external review" if the *adverse benefit determination* involves an *urgent-care claim* or an ongoing course of treatment.

Within one business day after the receipt of a request for *external review,* the *commissioner* will send a copy of the request to Humana. Within five business days, we will complete a *preliminary review* of the request.

Within one business day after we complete the *preliminary review,* we will notify the *claimant* and the *commissioner* in writing whether:

- The request is complete and is eligible for *external review*;
- The request is not complete and the information or materials needed to make the request complete; or
- The request is not eligible for *external review,* the reasons for ineligibility and the *claimant's* right to appeal to the *commissioner.* If appealed, the *commissioner* may determine that the request is eligible for *external review.*

Within one business day after the *commissioner* receives notice that the request is eligible for *external review,* the *commissioner* will:

- Impartially assign an *IRO* from a list compiled and maintained by the *commissioner* to conduct the *external review*;
- Provide Humana with the name of the *IRO*. Within five business days after the date of receipt of this notice, we will provide the *IRO* with all documents and information we considered in making the *adverse benefit determination* or *final adverse benefit determination*;

Appeal and External Review Notice (continued)

- Notify the *claimant* in writing of the following:

    - The eligibility of the request and acceptance for *external review*; and
    - The right to submit additional information in writing to the *IRO* and the time limits to submit the information.

Any information received by the *IRO* will be forwarded to Humana within one business day of receipt. Upon receipt of additional information, we may reconsider the *adverse benefit determination* or *final adverse benefit determination.* If we reverse the *adverse benefit determination* or *final adverse benefit determination,* the *external review* will be terminated and we will provide coverage for the service. We will immediately notify the *claimant,* the *IRO,* and the *commissioner* in writing of our decision.

The *IRO* will review all of the information received including, if available and considered appropriate the following:

- Your medical records;
- The attending healthcare professional's recommendation;
- Consulting reports from appropriate healthcare professionals and other documents submitted by Humana, the *claimant,* and treating provider;
- The terms of the coverage under the plan;
- The most appropriate practice guidelines, which will include applicable *evidence-based standards* and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards and associations;
- Any applicable clinical review criteria developed and used by Humana; and
- The opinion of the *IRO's clinical peer reviewer* or reviewers after considering the information and documents listed above.

If the *external review* involves experimental or investigational treatment, within one business day after the *IRO* receives notice of assignment to conduct the *external review,* the *IRO* will select one or more *clinical peer reviewers* to conduct the *external review.* The *clinical peer reviewer* will review all of the information and within 20 days after being selected, will provide a written opinion to the *IRO* on whether the service should be covered. The written opinion will include:

- A description of the medical condition;
- A description of the indicators relevant to determining whether there is sufficient evidence to demonstrate that the service is more likely than not to be beneficial to you than any available standard services;
- The adverse risks of the service would not be substantially increased over those of available standard services;
- A description and analysis of any *medical or scientific evidence,* or *evidence-based standard* considered in reaching the opinion;

- Information on whether the reviewer's rationale for the opinion is based on either:

  - The service has been approved by the federal Food and Drug Administration, if applicable, for the condition; or

  - *Medical or scientific evidence* or *evidence-based standards* demonstrate that the expected benefits of the service is more likely than not to be beneficial to you than any available standard health care service and the adverse risks of the service would not be substantially increased over those of available standard services.

The *IRO's* decision to either uphold or reverse the *adverse benefit determination* or *final adverse benefit determination* will be provided in writing to the *claimant,* the *commissioner* and Humana within:

- 20 days after receipt of each *clinical peer reviewer* opinion for an experimental or investigational treatment; or
- 45 days after receipt of the request for an *external review.*

In the case of experimental or investigational treatment, if a majority of *clinical peer reviewers* recommend the service should be covered, the *IRO* will make a decision to reverse the *adverse benefit determination* or *final adverse benefit determination.* If a majority of *clinical peer reviewers* recommend the service should not be covered, the *IRO* will make a decision to uphold the *adverse benefit determination* or *final adverse benefit determination.* If the *clinical peer reviewers* are evenly split, the *IRO* will obtain the opinion of an additional *clinical peer reviewer* in order for the *IRO* to make a decision.

The *IRO's* written notice of the decision will include:

- A general description of the reason for the request for *external review*;
- The date the *IRO* received the assignment from the *commissioner* to conduct the *external review*;
- The date the *external review* was conducted;
- The date of the *IRO's* decision;
- The principal reason for the decision, including applicable *evidence-based standards*, if any, used as a basis for the decision;
- The rationale for the decision;
- References to the evidence or documentation, including the *evidence-based standards,* considered in reaching the decision; and
- In the case of experimental or investigational treatment, the written opinion and rational for the recommendation of each *clinical peer reviewer.*

Immediately upon our receipt of the *IRO's* decision reversing the *adverse benefit determination* or *final adverse determination,* we will approve the service.

Expedited external review

You may request an expedited *external review* from the *commissioner*:

- At the same time you request an expedited internal appeal of an *adverse benefit determination* for an *urgent-care claim* or when you are receiving an ongoing course of treatment; or

Appeal and External Review Notice (continued)

- When you receive an *adverse benefit determination* or *final adverse benefit determination* of:

    - An *urgent-care claim*;
    - An admission, availability of care, continued stay or health care service for which you received emergency services, but you have not been discharged from the facility; or
    - An experimental or investigational treatment if the treating physician certifies, in writing, that the recommended service would be significantly less effective if not promptly initiated.

The *commissioner* will immediately send a copy of the request to Humana and upon receipt; we will immediately complete a *preliminary review* of the request. We will immediately notify the *claimant* and the *commissioner* of the *preliminary review* determination. If we determine the request is not eligible, the notice will advise you of your right to appeal to the *commissioner.* If appealed, the *commissioner* may determine that the request is eligible for *external review.*

Immediately after the commissioner receives notice that the request is eligible for *external review,* the *commissioner* will:

- Impartially assign an *IRO* to conduct the expedited *external review.*
- Provide Humana with the name of the *IRO* and we will immediately provide the *IRO* with all necessary documents and information.

The *IRO* will review all of the information received including, if available and considered appropriate, the following:

- Your medical records;
- The attending healthcare professional's recommendation;
- Consulting reports from appropriate healthcare professionals and other documents submitted by Humana, the *claimant* and treating provider;
- The terms of the coverage under the plan;
- The most appropriate practice guidelines, which will include *evidence-based standards* and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards and associations;
- Any applicable clinical review criteria developed and used by Humana; and
- The opinion of the *IRO's clinical peer reviewer* or reviewers after considering the information and documents listed above.

If the expedited *external review* request involves experimental or investigational treatment, within one business day after the *IRO* receives notice of assignment to conduct the *external review,* the *IRO* will select one or more *clinical peer reviewers* to conduct the *external review.* The *clinical peer reviewer* will:

- Review all of the information noted above including whether:

    - The recommended service has been approved by the federal Food and Drug Administration, if applicable, for the condition; or

- Medical or scientific evidence or *evidence-based standards* demonstrate that the expected benefits of the recommended service is more likely than not to be beneficial to you than any available standard service and the adverse risks of the recommended service would not be substantially increased over those of available standard services.

- Provide an opinion to the *IRO* as expeditiously as your condition or circumstances require, but in no event more than five calendar days after being selected.

The *IRO's* decision to either uphold or reverse the *adverse benefit determination* or *final adverse benefit determination* will be provided orally or in writing to the *claimant*, the *commissioner* and Humana within:

- 48 hours after receipt of each *clinical peer reviewer* opinion of an expedited *external review* for an experimental or investigational treatment; or
- 72 hours after the date of receipt of the request for an expedited *external review*.

In the case of experimental or investigational treatment, if a majority of *clinical peer reviewers* recommend the service should be covered, the *IRO* will make a decision to reverse the *adverse benefit determination* or *final adverse benefit determination.* If a majority of *clinical peer reviewers* recommend the service should not be covered, the *IRO* will make a decision to uphold the *adverse benefit determination* or *final adverse benefit determination.* If the *clinical peer reviewers* are evenly split, the *IRO* will obtain the opinion of an additional *clinical peer reviewer* in order for the *IRO* to make a decision.

The *IRO* will send written confirmation within 48 hours of an oral decision and will include:

- A general description of the reason for the request for an expedited *external review*;
- The date the *IRO* received the assignment from the *commissioner* to conduct the expedited *external review*;
- The date the expedited *external review* was conducted;
- The date of the *IRO's* decision;
- The principal reason for the decision, including applicable *evidence-based standards*, if any, used as a basis for the decision;
- The rationale for the decision;
- References to the evidence or documentation, including the *evidence-based standards,* considered in reaching the decision, except in the case of experimental or investigational treatment; and
- In the case of experimental or investigational treatment, the written opinion and rational for the recommendation of each *clinical peer reviewer*.

Immediately upon receipt of the *IRO's* decision reversing the *adverse benefit determination* or *final adverse benefit determination,* we will approve the service.

Legal actions and limitations

No lawsuit may be brought with respect to plan benefits until all remedies under the plan have been exhausted.

No lawsuit with respect to plan benefits may be brought after the expiration of the applicable limitations period stated in the benefit plan document. If no limitation is stated in the benefit plan document, then no such suit may be brought after the expiration of the applicable limitations under applicable law.

Humana.

Administrative Office:
500 West Main Street
Louisville, Kentucky 40202

Humana Health Plan, Inc.

Group Plan Sponsor: SAMPLE

Master Group Contract Number: SAMPLE

Effective Date of Master Group Contract: 01/01/2021 **Product Name:** KYNF0002

PLEASE READ THIS POLICY CAREFULLY

Terms printed in italic type in this *master group contract* have the meaning indicated in the "Glossary" sections of the Certificate of Coverage ("*certificate*").

This *master group contract* is a legal contract between the *group plan sponsor* and Humana Health Plan, Inc. and is delivered in and governed by the laws of: Kentucky.

Humana Health Plan, Inc. agrees, subject to all the terms and provisions of this *master group contract,* to pay benefits as described in the *certificate,* incorporated by reference herein, with respect to each *covered person* under this *master group contract.* Humana Health Plan, Inc. and the *group plan sponsor* have agreed to all of the terms of this *master group contract.*

This *master group contract* is issued in consideration of the Employer Group Application of the *group plan sponsor,* incorporated by reference herein, and such *group plan sponsor's* payment of premium as provided under this *master group contract.*

This *master group contract* and the coverage it provides become effective at 12:01 A.M. (Standard Time) of the effective date stated above. This *master group contract* and the coverage it provides terminate at 12:00 A.M. (Standard Time) of the date of termination. The provisions stated above and on the following pages are parts of this *master group contract.*

Bruce Broussard
President

SUBSIDIARIES OR AFFILIATES

Any *employer*, which is a subsidiary or affiliate of a *group plan sponsor*, is eligible for coverage under this *master group contract* if the following conditions are met:

- The subsidiary or affiliate is listed in the Employer Group Application of the *group plan sponsor*, or in any amendment thereto;
- The *group plan sponsor* and the subsidiary or affiliate are members of the same controlled group of corporations, trades or business under common control, as described for employee benefits taxation purposes in the Internal Revenue Code; and
- The subsidiary or affiliate has been approved for coverage under this *master group contract*, in writing or by *electronic mail*, by both the *group plan sponsor* and *us*.

For the purposes of this *master group contract*, an *employee* of such a subsidiary or affiliate of the *group plan sponsor* shall be considered to be an *employee* of the *group plan sponsor*.

A subsidiary or affiliate of a *group plan sponsor* shall cease to be eligible for coverage under this *master group contract* on the earliest of the following:

- The date the *group plan sponsor* and the subsidiary or affiliate are no longer members of the same controlled group of corporations, trades or business under common control, as described for employee benefits taxation purposes in the Internal Revenue Code;
- The date the subsidiary or affiliate has relocated outside of the *service area*;
- The date the *group plan sponsor's* written notice of its intent to terminate the participation of the subsidiary or affiliate is received by *us*, or on any later date as may be stated in such notice; or
- The date this *master group contract* terminates.

The coverage of any *employee* of a subsidiary or affiliate of a *group plan sponsor* and the coverage of such *employee's* covered *dependents* shall immediately terminate on the date the subsidiary or affiliate ceases participation under this *master group contract*.

REQUIREMENTS FOR COVERAGE

Eligibility

The *group plan sponsor* must indicate on the Employer Group Application the eligible classes of *employees* under this *master group contract*, if applicable, as defined below:

- An eligible class includes regular *full-time employees* in *active status*, if paid a salary or wage by the *employer* that meets state or federal minimum wage requirements.

  An eligible class may also include sole proprietors, partners, and corporate officers if:

  - The *employer* is a sole proprietorship, partnership or corporation;
  - The sole proprietorship or other entity (other than a partnership) has at least one common-law employee (other than the business owner and his or her spouse); and
  - The sole proprietor, partner or corporate officer is actively performing activities relating to the business, gains a livelihood from the sole proprietorship, partnership or corporation and meets the definition of *employee* as defined in the *certificate.*

- The *group* plan may also provide coverage for retired *employees* and their *dependents.* The retiree class will be eligible only if the *group plan sponsor* requests such coverage, and it is approved by *us.*

- Part-time *employees* and their *dependents* may be an eligible class only if the *group plan sponsor* makes specific reference that part-time *employees* are included, and it is approved by *us.*

- The spouse or a child of an *employee* may be included in an eligible class as a *dependent* of the *employee* only if the *employee* is covered under this *master group contract.*

Date eligible

Each *group* plan may provide one of the following as the *eligibility date* for *employees* and *dependents* as provided by this *master group contract.* The *group plan sponsor* must elect the *eligibility date* on the Employer Group Application. *Eligibility date* options include immediate eligibility or first of the month eligibility as outlined below.

Immediate eligibility

Each *employee* included in an eligible class on, or after, the date the *group plan sponsor* subscribes to the *master group contract* will be eligible under this *master group contract* on that date. The *employee* must have completed the required *waiting period*, if any, as indicated on the Employer Group Application.

First of the month eligibility

Each *employee* included in an eligible class after the date the *group plan sponsor* subscribes to the *master group contract* will be eligible under this *master group contract* on the first day of the next following calendar month, or on the first day of the next following calendar month after the completion of the required *waiting period*, if any, or as otherwise agreed to by the *group plan sponsor* and *us*.

Enrollment

Each *employee* must complete the enrollment process to enroll for coverage under this *master group contract* for himself or herself and their eligible *dependents*, if any, as outlined in the "Enrollment" provision within the "Eligibility and Effective Dates" section of the *certificate*.

Health status will not be used to determine premium rates. *We* will not use *health status-related factors* to decline medical coverage to an eligible *employee* or eligible *dependent*. *We* will administer this provision in a non-discriminatory manner.

Group plan sponsor responsibility for compliance with certain federal laws

If the *group plan sponsor* is contracting with *us* in connection with a health plan that is governed by the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), the following apply:

Group plan sponsor as plan administrator

The *group plan sponsor* shall serve as the "plan administrator" (as that term is defined by ERISA) and is solely responsible for administering its employee welfare plan (the "plan"). Those responsibilities include, but are not limited to:

- Complying with any federal, state or local law or regulation that may apply to the *group plan sponsor* as policyholder, plan sponsor or as plan administrator;
- Providing *covered persons* with all notices and documents required by such laws and regulations; and
- Applying the eligibility requirements described in this *master group contract.*

Summary plan description compliance

The *group plan sponsor* shall assure that each plan participant eligible to enroll for benefits under the *master group contract* is given, on a timely basis, a Summary Plan Description (SPD) and/or Notice of Material Modification to a previously delivered SPD, when and in the manner required by ERISA. The *group plan sponsor* warrants that each such SPD (and any Notice of Material Modification relating thereto) shall, to the extent required by ERISA (including any regulation adopted to implement ERISA), incorporate:

- As the plan's claims processing and review procedures, *our* claims processing and review procedures, including the review, appeal, grievance and external review procedures that *we* must provide under applicable law; and

- A statement clearly identifying circumstances which may result in disqualification, ineligibility, or denial, loss, forfeiture, suspension, offset, reduction, or recovery (e.g., by exercise of subrogation or reimbursement rights) of any benefits that a *covered person* might otherwise reasonably expect the plan to provide on the basis of the description of benefits required by ERISA.

The *group plan sponsor* acknowledges that there is no exception to ERISA's SPD and related disclosure requirements for *small employers.*

Humana has developed a Plan Overview Document to assist *employers* in complying with ERISA SPD requirements. This document and other enrollment materials are available at www.humana.com.

Cooperation

On request, the *group plan sponsor* shall promptly provide *us* with copies of its plan document, SPD, Notices of Material Modifications and/or verification of the plan's status as subject to ERISA as *we* may require:

- To verify compliance with this section;
- To assist *us* in connection with any actual or threatened denied benefit, subrogation or other litigation; or
- As otherwise required by *us* for regulatory compliance or other legitimate business purpose.

PARTICIPATION REQUIREMENTS

The *group plan sponsor* must maintain *our* minimum participation and contribution requirements, as specified in the underwriting requirements of the Employer Group Application.

We reserve the right to waive or modify the participation and contribution requirements. Modification or waiver of these requirements will be applied uniformly. Any modification of these requirements after the effective date of this *master group contract* will only be made upon renewal. The *group plan sponsor* will be notified in writing or *electronically* at least 60 days prior to the effective date of such changes.

Any such waiver shall not be construed as a waiver of any of the other requirements of this *master group contract* and shall not obligate *us* to provide any future waivers including any for participation or contribution requirements.

RENEWAL AND TERMINATION PRIVILEGE

Right to not renew or terminate this master group contract

The *group plan sponsor* may terminate this *master group contract* by giving written notice to *us* no later than 31 days prior to the desired termination date.

The *group plan sponsor* may terminate the coverage provided under any provision of this *master group contract,* with *our* consent, by giving written notice to *us* as of a date mutually agreeable to the *group plan sponsor* and *us.*

The *group plan sponsor* may terminate an eligible class of *covered persons,* if applicable, from the *group* plan, with *our* consent, as of a date mutually agreeable to the *group plan sponsor* and *us*. Termination will occur only with respect to *covered persons* included in the terminated class.

We may terminate this *master group contract,* as allowed by applicable law, by giving written notice to the *group plan sponsor*. Written notice will be mailed no later than 31 days prior to the termination date, except as otherwise outlined under this provision.

We may refuse to renew or *we* may terminate this *master group contract* if:

- The *group plan sponsor* fails to pay *us* any premium due, except coverage will continue during the grace period.
- The *group plan sponsor* has failed to comply with *our* minimum participation or contribution requirements, as specified in the Employer Group Application.
- The *group plan sponsor* is not an *employer*.
- The *group* has relocated outside of the *service area*.
- The *group plan sponsor* has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact. *We* may terminate this *master group contract* after giving 30 day advance written notice to the *group plan sponsor* for instances of fraud or intentional misrepresentation of a material fact.
- *We* decide to discontinue offering a particular group health plan:
    - Notice of such discontinuation will be provided at least 90 days prior to the date of discontinuation. The *group plan sponsor* is responsible for distributing and providing *covered persons* access to the notice; and
    - The *group plan sponsor* will be given the option to purchase all other group plans providing medical benefits that are being offered by *us* at such time.
- *We* cease to do business in the *small employer* group medical market, as applicable and as allowed by the state requirements. If *we* cease doing business in the *small employer* group market, notice for the *group plan sponsors, covered persons* and the Commissioner of Insurance will be provided at least 180 days prior to the date of discontinuation of such coverage.

RENEWAL AND TERMINATION PRIVILEGE (continued)

Effect of termination of this agreement

Upon termination of this *master group contract*, it is the *group plan sponsor's* obligation to notify all *employees* of such termination, except for the specific situations outlined in the "Right to not renew or terminate this master group contract" provision. If the *group plan sponsor* requires a contribution from the *employees* to offset a portion of the premium, it is the responsibility of the *group plan sponsor* to refund to those *employees* the portion of the contribution, if any, which the *group plan sponsor* may have collected for any period of time following the termination of this *master group contract*.

Our obligation to offer continuation coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA) to *covered persons* ends on the date this *master group contract* terminates. *Our* obligation to offer continuation coverage to *covered persons* under any other applicable law ends on the date this *master group contract* terminates or on such date as may be required under the applicable continuation of coverage law.

Termination of coverage

Unless otherwise agreed to by the *group plan sponsor* and *us*, termination of coverage will occur following any of the events listed below:

- The date this *master group contract* terminates in accordance with its terms and conditions;
- The termination date according to the "Right to not renew or terminate this master group contract" provision;
- The date the *group plan sponsor*, acting with *our* knowledge and consent, deletes an optional benefit under this *master group contract* (termination under this paragraph will occur only with respect to such deleted optional benefit coverage);
- The date the *group plan sponsor*, acting with *our* knowledge and consent, deletes an eligible class of *employees*, if applicable, from the *group plan sponsor's* plan (termination under this paragraph will occur only with respect to *covered persons* included in the terminated class); or
- The *group plan sponsor*, acting with *our* knowledge and written consent, terminates any provision of this *master group contract* (termination under this paragraph will occur on a date mutually agreeable to the *group plan sponsor* and *us*).

Rescission, reduction of coverage or increase past premium

We reserve the right to *rescind* this *master group contract* and any *certificate* issued due to fraud or an intentional misrepresentation of a material fact. *We* will provide a 30 calendar day advance written notice to the *group plan sponsor* and affected *employee*(*s*) before coverage is *rescinded* and it will include appeal rights as may be required by law.

We reserve the right to reduce coverage or increase past premium, unless prohibited by applicable law. *We* may apply this provision to one or all *covered persons* when such *covered person*(*s*), the *employer* or other person(s) provides or has provided incomplete, inaccurate or untimely information on any enrollment form, Employer Group Application or any other eligibility form, if such information materially affected the acceptance of the *group*, the *covered person* or the risk.

If no claims have been paid under this *master group contract* up to the date coverage is *rescinded* or reduced, *we* will return premiums paid for such coverage to the *group plan sponsor*.

If claims have been paid under this *master group contract* before the date coverage is *rescinded* or reduced, *we* reserve the right to deduct an amount equal to the amount of such claims paid from the premiums to be returned to the *group plan sponsor*. The c*overed person* is responsible for any amount of claims in excess of the premium paid.

Reinstatement

If this *master group contract* terminates, it may be reinstated at *our* option. Reinstatement requests must be submitted in writing by the *group plan sponsor*, are subject to *our* approval and are not guaranteed.

Any premium accepted in connection with a reinstatement will be applied to the period for which the premium was not previously paid.

PREMIUMS

Payment of premiums

Unless otherwise agreed to by *us*, the first premium is due on the *group plan sponsor's* effective date under this *master group contract* and subsequent premiums are due on the first of each calendar month thereafter.

Premiums should be sent to the designated location on the premium statement. Premiums will be recorded as paid on the date *we* receive the payment. If there are not sufficient funds in the designated bank account on the date that premiums are deducted, the *group plan sponsor* will be assessed an insufficient funds fee.

Premium statement

A premium statement will be prepared in accordance with the billing method *we* arrange with the *group plan sponsor.* This premium statement will show the premium due. It will also reflect any pro-rata premium charges and credits resulting from changes in the number of *covered persons* and changes in the amounts of coverage that took place during the period following the last premium statement. Please refer to the "Notice of covered person coverage terminations" provision in this section for information regarding premium and termination of coverage for a *covered person.*

Premium rate change

No change in rates will be made for the first 12 months, unless otherwise agreed to by the *group plan sponsor* and *us.*

Premium charges for benefit changes or a modification of a covered person's coverage

While this *master group contract* is in force, changes in premiums may be required due to a change in coverage as follows:

- If the premium rate change is effective on or before the 15th of the month, *we* will bill the current month based on the new rates.
- If the premium rate change is effective after the 15th of the month, *we* will bill the current month based on the old rates. The new rates will apply to the next month's billing.

Premium charges for individual changes

If coverage for a *covered person* is modified on a date other than a premium due date, the change in premium will become effective as specified on the Employer Group Application.

We must be notified of the change no more than 31 days following the date of the change. If *we* are not notified within 31 days of the date of the change, any change in premium will become effective on the date *we* receive written or *electronic* notification and approve the change.

Notice of covered person coverage terminations

The *group plan sponsor* is responsible to notify *us* of any *covered person's* coverage termination. Notice must be given to *us* within 31 days of the termination date. A *group plan sponsor's* request to *us* to terminate coverage retroactively is the *group plan sponsor's* representation that the *covered person* did not pay any premium or make contribution for coverage past the requested termination date, and the *group plan sponsor's* requested termination complies with applicable law.

Grace period

While this *master group contract* continues in force, a grace period of 31 days will be allowed to the *group plan sponsor* following the premium due date, for the payment of each required premium due. This *master group contract* will remain in force during the grace period. If the required premium is not paid by the end of the 31 day grace period, this *master group contract* will terminate effective as of the last day of the month for which the last premium was received.

Wellness Engagement Incentive Program Amendment

This "Wellness Engagement Incentive Program Amendment" (amendment) is made part of the *master group contract* to which it is attached.

Notwithstanding any other provisions of the *master group contract*, incentives or rewards provided under this amendment are not duplicated under any other provision of the *master group contract.* This amendment does not change any other terms or conditions of the *master group contract.*

All defined terms used in this amendment have the same meaning given to them in the *certificate* unless otherwise specifically defined in this amendment.

Payment of premium on or after the effective date of this amendment will be deemed to constitute the *group plan sponsor's* agreement to the terms of this amendment.

This amendment modifies the "Premium" section of the *master group contract* by adding the following:

Wellness engagement incentive program

Depending on the *group* size, *we* may credit to the *group plan sponsor's* premium statement, or issue separately to the *group plan sponsor* wellness engagement incentives for *employees* who:

- Participate in a wellness program made available with this *master group contract*; and
- Have achieved certain status levels, as defined by the wellness program.

The wellness engagement incentives will vary depending on the *employees'* status levels. An *employee's* status level will be determined on the last day of the preceding calendar month.

For *employees* covered under the *master group contract* as of the last day of the preceding calendar month, *we* will also consider the three preceding calendar months when the incentive is calculated to ensure *employees* that were not included in prior calculations due to certain delays in submitting information to *our* wellness program administrator are included if they attained the engaged status as defined in the wellness program.

The wellness engagement incentive is a reward provided under a nondiscriminatory wellness program and is subject to limits under state and federal law. It is the *employer's* responsibility to determine how the incentive will be used in accordance with applicable federal and state law, including but not limited to:

- The Federal Employee Retirement Income Security Act of 1974 (ERISA), as amended;
- The Patient Protection and Affordable Care Act (the Affordable Care Act), as amended;
- The Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended;
- The Civil Rights Act of 1964, as amended;
- The Americans with Disabilities Act of 1990 (ADA), as amended;
- The Age Discrimination in Employment Act of 1967 (ADEA), as amended; and
- The Genetic Information Nondiscrimination Act of 2008 (GINA), as amended.

Wellness Engagement Incentive Program Amendment (continued)

Employers should check with their tax and legal counsel to establish appropriate uses for the incentives. For example, if a *group* health plan is subject to ERISA, the *employer* or the administrator of the *group* health plan may have fiduciary responsibilities regarding use of the incentives. Some or all of the incentives may be considered funds attributable to plan assets, which generally must be used for the exclusive benefit of the *group* health plan participants. *We* are not liable for monetary penalties or fines, or other state or federal regulatory action taken against the *employer* for failure to comply with any applicable federal or state law.

No wellness engagement incentive will be earned:

- After the *master group contract* terminates; or
- During the last calendar month of coverage.

Humana Health Plan, Inc.
Administrative Office:
321 West Main Street
Louisville, Kentucky 40202

Bruce Broussard
President

Important!

At Humana, it is important you are treated fairly.

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

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

Auxiliary aids and services, free of charge, are available to you. Call the number on your ID card (TTY: 711)

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

Language assistance services, free of charge, are available to you. Call the number on your ID card (TTY: 711)

ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call the number on your ID card **(TTY: 711)**... ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al número que figura en su tarjeta de identificación **(TTY: 711)**... 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電會員卡上的電話號碼 **(TTY: 711)**... CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số điện thoại ghi trên thẻ ID của quý vị **(TTY: 711)**... 주의 : 한국어를 사용하시는 경우 , 언어 지원 서비스를 무료로 이용하실 수 있습니다 . ID 카드에 적혀 있는 번호로 전화해 주십시오 **(TTY: 711)**... PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tawagan ang numero na nasa iyong ID card **(TTY: 711)**... ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Наберите номер, указанный на вашей карточке-удостоверении **(телетайп: 711)**... ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele nimewo ki sou kat idantite manm ou **(TTY: 711)**... ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le numéro figurant sur votre carte de membre **(ATS: 711)**...UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Proszę zadzwonić pod numer podany na karcie identyfikacyjnej **(TTY: 711)**... ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para o número presente em seu cartão de identificação **(TTY: 711)**... ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero che appare sulla tessera identificativa **(TTY: 711)**... ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Wählen Sie die Nummer, die sich auf Ihrer Versicherungskarte befindet **(TTY: 711)**... 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。お手持ちの ID カードに記載されている電話番号までご連絡ください **(TTY: 711)**...

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با شماره تلفن روی کارت شناسایی تان تماس بگیرید **(TTY: 711)**...

Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, námboo ninaaltsoos yézhí, bee nééh ho'dólzin bikáá'ígíí bee hólne' **(TTY: 711)**...

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم الهاتف الموجود على بطاقة الهوية الخاصة بك **(TTY: 711)**.

Humana Health Plan, Inc.

500 West Main Street
Louisville, Kentucky 40202

READ YOUR CERTIFICATE CAREFULLY

This cover sheet is not the contract.

The provisions of the contract will control. The certificate, as part of the entire contract, sets forth, in detail the rights and obligations between you and us. The certificate provides information on eligibility, how to understand your coverage and describes what services are covered expenses, what portion of the costs you will be required to pay and what is not covered. Please refer to the Table of Contents within the certificate to locate additional information concerning the specific provisions of your coverage.

THEREFORE, IT IS IMPORTANT THAT YOU READ YOUR CERTIFICATE.

Humana.

Administrative Office:
500 West Main Street
Louisville, Kentucky 40202

Certificate of Coverage
Humana Health Plan, Inc.

Group Plan Sponsor: BULLOCK PEN WATER DIST

Group Plan Number: 794595

Effective Date: 01/01/2022

Product Name: KYNF0002 Simplicity

In accordance with the terms of the *master group contract* issued to the *group plan sponsor*, Humana Health Plan, Inc. certifies that a *covered person* has coverage for the benefits described in this *certificate.* This *certificate* becomes the Certificate of Coverage and replaces any and all certificates and certificate riders previously issued.

Bruce Broussard
President

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

TABLE OF CONTENTS

Understanding your coverage **7**

Schedule of benefits **13**

Schedule of benefits - pediatric dental **36**

Schedule of benefits - pediatric vision care **38**

Schedule of benefits - behavioral health **42**

Schedule of benefits - pharmacy services **49**

Covered expenses **54**

Covered expenses - pediatric dental **72**

Covered expenses - pediatric vision care **82**

Covered expenses - behavioral health **86**

Covered expenses - pharmacy services **89**

Limitations and exclusions **94**

Limitations and exclusions - pharmacy services **101**

Eligibility and effective dates **105**

Replacement of coverage **111**

TABLE OF CONTENTS (continued)

Termination provisions **112**

Extension of benefits **114**

Continuation **115**

Medical conversion privilege **119**

Coordination of benefits **121**

Claims **128**

Internal appeal and external review **136**

Disclosure provisions **140**

Miscellaneous provisions **143**

Glossary **146**

Glossary - pharmacy services **170**

UNDERSTANDING YOUR COVERAGE

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

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

Covered and non-covered expenses

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

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

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

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

How your master group contract works

We may apply a *copayment* or *deductible* before *we* pay for certain *covered expenses*. If a *deductible* applies, and it is met, *we* will pay *covered expenses* at the *coinsurance* amount. Refer to the "Schedule of Benefits" to see when a *copayment, deductible* and/or *coinsurance* may apply.

The service and diagnostic information submitted on the *qualified provider's* bill will be used to determine which provision of the "Schedule of Benefits" applies.

We will apply the *network provider* benefit level and *you* will only be responsible to pay the *network provider copayment, deductible* and/or *coinsurance* based on the *qualified payment amount* for *covered expenses* for *emergency care* and *air ambulance services* provided by a *non-network provider* or if *you* receive any of the following:

- *Ancillary services* from a *non-network provider* while *you* are at a *network health care treatment facility*;
- Services that are not considered *ancillary services* from a *non-network provider* while *you* are at a *network health care treatment facility,* and *you* did not consent to the *non-network provider* to obtain such services;
- Services from a *non-network provider* when a *network provider* is not available; or

- Additional services from a *non-network provider* related to *emergency care* after *you* are stabilized and *you* did not consent to the *non-network provider* to obtain such services.

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

For all other *covered expenses*, *we* will apply the applicable *network provider* or *non-network provider* benefit level to the total amount billed by the *qualified provider*, less any amounts such as:

- Those in excess of the negotiated amount by contract, directly or indirectly, between *us* and the *qualified provider*; or
- Those in excess of the *maximum allowable fee.*

For *covered expenses* other than those *you* pay based on the *qualified payment amount, you* will be responsible to pay the applicable *network provider* or *non-network provider copayment, deductible* and/or *coinsurance*.

We will also apply *our* claims processing procedures to all *covered expenses.* Refer to the Claims section of this *certificate* for more information on *our* claims processing procedures.

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

Preauthorization decisions

Certain services and supplies require *preauthorization* as described in the "Preauthorization requirements and penalty" provision on the "Schedule of Benefits." *Preauthorization* requests are submitted to *us* for review. *Our* decision on a *preauthorization* request will be provided to *you, your* appointed representative, or *your health care practitioner*.

- No later than 24 hours after obtaining all necessary information to make the *preauthorization* decision concerning urgent health care services; and
- Within five (5) days of obtaining all necessary information to make the preauthorization decision of non-urgent health care services.

For the purpose of *preauthorization,* urgent health care services means health care or treatment, including requests for *inpatient hospital* admission and *outpatient surgery*, to which the application of the time periods for making non-urgent health care service determinations:

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

- In the opinion of a *health care practitioner* with knowledge of the *covered person's* medical condition, would subject the *covered person* to severe pain that cannot be adequately managed without the care or treatment that is subject of *preauthorization.*

If *you* are not satisfied with *our* decision, additional rights may be available to *you* as described in the "Internal Appeal and External Review" section of this certificate.

Your choice of providers affects your benefits

We will pay a higher percentage most of the time if *you* see a *network provider*, so the amount *you* pay will be lower. *You* must pay any *copayment, deductible* or *coinsurance* to the *network provider*. Be sure to check if *your qualified provider* is a *network provider* before seeing them.

We may designate certain *network providers* as preferred providers for some services. If *you* do not see a *network provider* designated by *us* as a preferred provider for these services, *we* may pay less. Refer to the Schedule of Benefits sections for the benefits available when *you* see a *network provider* designated by *us* as a preferred provider. Refer to our Website at www.humana.com to determine the *network providers* designated by us as preferred providers for certain services. *You* may also contact *our* customer service department at the telephone number shown on *your* ID card.

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

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

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

- *Ancillary services* from a *non-network provider* when *you* are at a *network health care treatment facility*;
- Services that are not considered *ancillary services* from a *non-network provider,* when *you* are at a *network health care treatment facility,* and *you* did not consent to the *non-network provider* to obtain such services;
- Services from a *non-network provider* when a *network provider* is not available; or
- Additional services from a *non-network provider* related to *emergency care* after *you* are stabilized and *you* did not consent to the *non-network provider* to obtain such services.

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

You will be responsible to pay the *non-network provider copayment, deductible* and/or *coinsurance* and *you* may also be responsible to pay any amount over the *maximum allowable fee* for *covered expenses* if *you* consent to a *non-network provider* to receive the following:

- Services that are not considered *ancillary services* from a *non-network provider* when *you* are at a *network health care treatment facility*; or

- Additional services from a *non-network provider* related to *emergency care* after *you* are stabilized.

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

How to find a network provider

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

How to use your point of service (POS) plan

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

Continuity of care

You may be eligible to elect continuity of care if *you* are a continuing care patient as of the date any of the following events occur:

- *Your qualified provider* terminates as a *network provider*;
- The terms of a *network provider's* participation in the network changes in a manner that terminates a benefit for a service *you* are receiving as a continuing care patient; or
- The *policy* terminates.

You must be in a course of treatment with the *qualified provider* as a continuing care patient the day before you are eligible to elect continuity of care.

If *you* elect continuity of care, *we* will apply the *network provider* benefit level to *covered expenses* related to *your* treatment as a continuing care patient*. You* will be responsible for the *network provider copayment, deductible* and/or *coinsurance* during the transitional care until the earlier of:

- 90 days from the date *we* notify *you* the *qualified provider* is no longer a *network provider*;
- 90 days from the date *we* notify *you* the terms of a *network provider's* participation in the network changes in a manner that terminates a benefit for a service *you* are receiving as a continuing care patient; or
- 90 days from the date *we* notify you the *master group contract* terminates; or
- 9 months if *you* have a terminal illness; or
- The date *you* are no longer a continuing care patient.

For the purposes of this "Continuity of care" provision, continuing care patient means at the time continuity of care becomes available, *you* are undergoing treatment from the *network provider* for:

- An acute *sickness* or *bodily injury* that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm;
- A chronic *sickness* or *bodily injury* that is a life-threatening condition, degenerative, potentially disabling, or is a *congenital anomaly* and requires specialized medical care over a prolonged period of time;
- *Inpatient* care;
- A scheduled non-elective *surgery* and any related post-surgical care;
- A pregnancy;
- A disability; or
- A terminal illness.

For the purposes of this "Continuity of care" provision, a terminal illness means you have a medical prognosis with a life expectancy of 6 months or less.

Continuity of care is not available if:

- The *qualified provider's* participation in *our* network is terminated due to failure to meet applicable quality standards or fraud;
- *You* transition to another *qualified provider*;
- The services y*ou* receive services not related to *your* treatment as a continuing care patient;
- This "Continuity of Care" provision is exhausted; or
- *Your* coverage terminates, however the *master group contract* remains in effect.

All terms and provisions of the *master group contract* are applicable to this Continuity of Care provision.

Seeking emergency care

If you have an *emergency medical condition* go to the nearest emergency facility.

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

Seeking urgent care

If *you* need *urgent care, you* must go to the nearest network *urgent care center* for the *network provider* benefit *copayment, deductible* or *coinsurance* to apply. *You* must receive services from a *network provider* for any follow-up care for the *network provider copayment, deductible* or *coinsurance* to apply.

Our relationship with qualified providers

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

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

Our financial arrangements with network providers

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

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

The certificate

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

SCHEDULE OF BENEFITS

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

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

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

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

Network provider verification

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

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

Preauthorization requirements and penalty for services received from a non-network provider

Preauthorization by *us* is required for certain services and supplies. Visit *our* Website at www.humana.com or call the customer service telephone number on *your* ID card to obtain a list of services and supplies that require *preauthorization.* The list of services and supplies that require *preauthorization* is subject to change. Coverage provided in the past for services or supplies that did not receive or require *preauthorization,* is not a guarantee of future coverage of the same services or supplies.

You are responsible for informing *your health care practitioner* of the *preauthorization* requirements. *You* or *your health care practitioner* must contact *us* by telephone, *electronic mail,* or in writing to request the appropriate authorization. *Your* ID card will show the *health care practitioner* the telephone number to call to request authorization. Benefits are not paid at all for services or supplies that are not *covered expenses*.

If any required *preauthorization* of services or supplies is not obtained, the benefit payable for any *covered expenses* incurred for the services will be reduced to 50%, after any applicable *deductibles* or *copayments*. If the rendered services are not *covered expenses,* no benefits are payable. The out-of-pocket amounts incurred by *you* due to these benefit reductions may not be used to satisfy any *out-of-pocket limits.* This *preauthorization* penalty will apply if *you* received the services from a *non-network provider* when *preauthorization* is required and not obtained.

Annual deductible

An annual *deductible* is a specified dollar amount *you* must pay for *covered expenses*, except for any *deductible* met for *prescriptions* or *specialty drugs* from a *pharmacy* or *specialty pharmacy,* per *year* before any applicable *coinsurance* and most benefits are paid under the *master group contract.* There are individual and family *network provider* and *non-network provider deductibles.* The *deductible* amount(s) for each *covered person* and each covered family are as follows, and must be satisfied each *year*, either individually or combined as a covered family. *Covered expenses* that apply to the individual *deductible* also apply to the family *deductible.* Once a *covered person* meets the individual *deductible,* the *coinsurance* applies to applicable *covered expenses* for that *covered person.* Once the family *deductible* is met, any remaining individual *deductible* for a *covered person* in the family is waived for that *year*. The *coinsurance* then applies to applicable *covered expenses* for all *covered persons* in the family. *Copayments* do not apply toward the annual *deductible.*

Any amount *you* pay exceeding the *maximum allowable fee* is not applied to the individual or family *deductibles.*

SCHEDULE OF BENEFITS (continued)

Any *network provider deductible* paid by *you* for *covered expenses* is applied to the *network provider deductibles.* Any *non-network provider deductible* paid by *you* for *covered expenses* is applied to the *non-network provider deductibles.* The *deductible* paid by *you* for *covered expenses* provided by *non-network providers* for *ambulance* services, emergency care, and services subject to the *qualified payment amount,* as specified in the "How your master group contract works" provision in the "Understanding your coverage" section, is applied to the *network provider deductibles.*

Deductible	**Deductible amount**
Individual *network provider deductible*	$0
Family *network provider deductible*	$0
Individual *non-network provider deductible*	$5,000
Family *non- network provider deductible*	$10,000

Out-of-pocket limit

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

Any amount *you* pay exceeding the *maximum allowable fee* is not applied to the *out-of-pocket limits.*

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

SCHEDULE OF BENEFITS (continued)

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

Once the individual or family *non-network provider out-of-pocket limit* is met, *you* will continue to be responsible any amount exceeding the *maximum allowable fee*.

Any *network provider copayment, deductible* or *coinsurance* paid by *you* for *covered expenses* is applied to the *network provider out-of-pocket limit*. Any *non-network provider copayment, deductible* or *coinsurance* paid by *you* for *covered expenses* is applied to the *non-network provider out-of-pocket limit*. The *copayments*, *deductible* and *coinsurance* paid by *you* for *covered expenses* provided by *non-network providers* for *ambulance* services, emergency care, and services subject to the *qualified payment amount,* as specified in the "How your master group contract works" provision in the "Understanding Your Coverage" section, is applied to the *network provider out-of-pocket limit*.

If any *copayment, deductible* or *coinsurance* amount applied to *your* claim is waived by *your* health care provider, *you* are required to inform *us.* Any amount, thus waived and not paid by *you,* is not applied to any *out-of-pocket limit.*

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

Out-of-pocket limit	**Out-of-pocket limit amount**
Individual *network provider out-of-pocket limit*	$6,500
Family *network provider out-of-pocket limit*	$13,000
Individual *non-network provider out-of-pocket limit*	$26,000
Family *non-network provider out-of-pocket limit*	$52,000

Preventive services

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

Network provider	Covered in full
Non-network provider	50% *coinsurance* after *non-network provider deductible*

Health care practitioner office services

Health care practitioner office visit

Primary care physician	$40 *copayment* per visit
Specialty care physician	$80 *copayment* per visit
Non-network health care practitioner	50% *coinsurance* after *non-network provider deductible*

SCHEDULE OF BENEFITS (continued)

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

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

Primary care physician	Covered in full
Specialty care physician	Covered in full
Non-network health care practitioner	50% *coinsurance* after *non-network provider deductible*

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

Primary care physician	$500 *copayment* per visit
Specialty care physician	$500 *copayment* per visit
Non-network health care practitioner	50% *coinsurance* after *non-network provider deductible*

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

Primary care physician	Covered in full
Specialty care physician	Covered in full
Non-network health care practitioner	50% *coinsurance* after *non-network provider deductible*

SCHEDULE OF BENEFITS (continued)

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

Primary care physician	Covered in full
Specialty care physician	Covered in full
Non-network health care practitioner	50% *coinsurance* after *non-network provider deductible*

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

Primary care physician	Covered in full
Specialty care physician	Covered in full
Non-network health care practitioner	50% *coinsurance* after *non-network provider deductible*

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

Primary care physician	Covered in full
Specialty care physician	Covered in full
Non-network health care practitioner	50% *coinsurance* after *non-network provider deductible*

SCHEDULE OF BENEFITS (continued)

Virtual visit services

Network provider designated by *us* as a preferred provider for a *virtual visit*	Covered in full
Network provider	Same as any other *sickness* based upon location of services and the type of provider
Non-network provider	Same as any other *sickness* based upon location of services and the type of provider

Health care practitioner services at a retail clinic

Health care practitioner office visit in a retail clinic

Primary care physician	$20 *copayment* per visit
Non-network health care practitioner	50% *coinsurance* after *non-network provider deductible*

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

Primary care physician	Covered in full
Non-network health care practitioner	50% *coinsurance* after *non-network provider deductible*

Injections other than allergy when received in a retail clinic

Primary care physician	Covered in full
Non-network health care practitioner	50% *coinsurance* after *non-network provider deductible*

Hospital services

Hospital inpatient services

Network hospital	$1,250 *copayment* per day for the first 3 days per *admission*
Non-network hospital	50% *coinsurance* after *non-network provider deductible*

Health care practitioner inpatient services when provided in a hospital

Primary care physician	Covered in full
Specialty care physician	Covered in full
Non-network health care practitioner	50% *coinsurance* after *non-network provider deductible*

SCHEDULE OF BENEFITS (continued)

Hospital outpatient surgical services

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

Network hospital	$1,000 *copayment* per visit
Non-network hospital	50% *coinsurance* after *non-network provider deductible*

Health care practitioner outpatient services when provided in a hospital

Includes *outpatient surgery.*

Primary care physician	Covered in full
Specialty care physician	Covered in full
Non-network health care practitioner	50% *coinsurance* after *non-network provider deductible*

Hospital outpatient non-surgical services

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

Network hospital	$1,000 *copayment* per visit
Non-network hospital	50% *coinsurance* after *non-network provider deductible*

Hospital outpatient diagnostic radiology and laboratory

Network hospital	Covered in full
Non-network hospital	50% *coinsurance* after *non-network provider deductible*

Hospital outpatient advanced imaging

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

Network hospital	$500 *copayment* per visit
Non-network hospital	50% *coinsurance* after *non-network provider deductible*

Pregnancy and newborn benefit

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

Emergency services

Must be for an *emergency medical condition* as defined in the "Glossary" section.

Hospital emergency room services

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

Network hospital	$500 *copayment* per visit. *Copayment* waived if admitted.
Non-network hospital	$500 *copayment* per visit. *Copayment* waived if admitted.

Hospital emergency room advanced imaging

Network hospital	$500 *copayment* per visit
Non-network hospital	$500 *copayment* per visit

Hospital emergency room health care practitioner services

Network health care practitioner	Covered in full
Non-network health care practitioner	Covered in full

Ambulance services

Network provider	$500 *copayment* per transport
Non-network provider	$500 *copayment* per transport

Ambulatory surgical center services

Ambulatory surgical center for outpatient surgery

Network provider	$500 *copayment* per visit
Non-network provider	50% *coinsurance* after *non-network provider deductible*

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

Includes *outpatient surgery.*

Primary care physician	Covered in full
Specialty care physician	Covered in full
Non-network health care practitioner	50% *coinsurance* after *non-network provider deductible*

Durable medical equipment and diabetes equipment

Network provider	Covered in full
Non-network provider	50% *coinsurance* after *non-network provider deductible*

Hearing aids and related services

One hearing aid, per hearing impaired ear, every 36 months.

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

Free-standing facility services

Free-standing facility diagnostic laboratory and radiology services

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

Network provider	Covered in full
Non-network provider	50% *coinsurance* after *non-network provider deductible*

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

Primary care physician	Covered in full
Specialty care physician	Covered in full
Non-network health care practitioner	50% *coinsurance* after *non-network provider deductible*

Free-standing facility advanced imaging

Network provider	$500 *copayment* per visit
Non-network provider	50% *coinsurance* after *non-network provider deductible*

Home health care services

Limited to a maximum of 100 visits per *year*.

Network provider	$80 *copayment* per visit
Non-network provider	50% *coinsurance* after *non-network provider deductible*

Private duty nursing

Limited to a maximum of 250 visits per *year*.

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

Hospice services

Network provider	Covered in full
Non-network provider	Covered in full

Jaw joint benefit

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

Physical medicine and rehabilitative services

Physical therapy

Limited to a maximum of 25 visits per *year*.

Network provider	$40 *copayment* per visit
Non-network provider	50% *coinsurance* after *non-network provider deductible*

Occupational therapy

Limited to a maximum of 25 visits per *year*.

Network provider	$40 *copayment* per visit
Non-network provider	50% *coinsurance* after *non-network provider deductible*

SCHEDULE OF BENEFITS (continued)

Speech therapy

Limited to a maximum of 25 visits per *year*.

Network provider	$40 *copayment* per visit
Non-network provider	50% *coinsurance* after *non-network provider deductible*

Audiology services

Includes post cochlear aural therapy.

Limited to a maximum of 30 visits per *year*.

Network provider	$40 *copayment* per visit
Non-network provider	50% *coinsurance* after *non-network provider deductible*

Cognitive rehabilitation services

Limited to a maximum of 20 visits per *year*.

Network provider	$40 *copayment* per visit
Non-network provider	50% *coinsurance* after *non-network provider deductible*

Respiratory or pulmonary rehabilitation services

Network provider	Covered in full
Non-network provider	50% *coinsurance* after *non-network provider deductible*

Cardiac rehabilitation services

Network provider	Covered in full
Non-network provider	50% *coinsurance* after *non-network provider deductible*

Other therapy

Includes radiation therapy and chemotherapy.

Network provider	Covered in full
Non-network provider	50% *coinsurance* after *non-network provider deductible*

Habilitative services

Physical therapy

Limited to a maximum of 25 visits per *year*.

Network provider	$40 *copayment* per visit
Non-network provider	50% *coinsurance* after *non-network provider deductible*

Occupational therapy

Limited to a maximum of 25 visits per *year*.

Network provider	$40 *copayment* per visit
Non-network provider	50% *coinsurance* after *non-network provider deductible*

Speech therapy

Limited to a maximum of 25 visits per *year*.

Network provider	$40 *copayment* per visit
Non-network provider	50% *coinsurance* after *non-network provider deductible*

Audiology services

Includes post cochlear aural therapy.

Limited to a maximum of 30 visits per *year*.

Network provider	$40 *copayment* per visit
Non-network provider	50% *coinsurance* after *non-network provider deductible*

Spinal manipulations/adjustments

Limited to a maximum of 20 visits per *year*.

Network provider	$40 *copayment* per visit
Non-network provider	50% *coinsurance* after *non-network provider deductible*

Skilled nursing facility services

Limited to a maximum of 100 days per *year*.

Network provider	$80 *copayment* per day
Non-network provider	50% *coinsurance* after *non-network provider deductible*

Health care practitioner services when provided in a skilled nursing facility

Network health care practitioner	Covered in full
Non-network health care practitioner	50% *coinsurance* after *non-network provider deductible*

Specialty drug medical benefit

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

Network provider	$50 *copayment* per visit
Non-network provider	50% *coinsurance* after *non-network provider deductible*

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

Network provider designated by *us* as a preferred provider of *specialty drugs*	Covered in full
Network provider	$50 *copayment* per visit
Non-network provider	50% *coinsurance* after *non-network provider deductible*

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

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

SCHEDULE OF BENEFITS (continued)

Transplant services and immune effector cell therapy

Network provider designated by *us* as an approved transplant or *immune effector cell therapy* facility	Same as any other *sickness* based upon location of services and the type of provider
Non-network provider	Same as any other *sickness* based upon location of services and the type of provider

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

Network provider designated by *us* as an approved transplant or *immune effector cell therapy* facility	Covered in full

Urgent care services

Network provider	$100 *copayment* per visit
Non-network provider	50% *coinsurance* after *non-network provider deductible*

Additional covered expenses

Network provider	Same as any other *sickness* based upon location of services and the type of provider
Non-network provider	Same as any other *sickness* based upon location of services and the type of provider

Cochlear implants

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

Diabetes self-management training

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

Orthoptic Training (eye exercises)

Orthoptic training (eye exercises) is limited to a *covered person* up to age 22.

Network provider	$40 *copayment* per visit
Non-network provider	50% *coinsurance* after *non-network provider deductible*

SCHEDULE OF BENEFITS - PEDIATRIC DENTAL

Reading this "Schedule of Benefits – Pediatric Dental" section will help *you* understand the level of benefits *we* generally pay for the *pediatric dental services* under the *master group contract.*

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

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

Pediatric dental services benefit

Class I services

Network provider	Covered in full
Non-network provider	50% *coinsurance* after *non-network provider deductible*

Class II services

Network provider	50% *coinsurance*
Non-network provider	50% *coinsurance* after *non-network provider deductible*

Class III services

Network provider	50% *coinsurance*
Non-network provider	50% *coinsurance* after *non-network provider deductible*

SCHEDULE OF BENEFITS - PEDIATRIC DENTAL (continued)

Class IV services

Network provider	50% *coinsurance*
Non-network provider	50% *coinsurance* after *non-network provider deductible*

SCHEDULE OF BENEFITS - PEDIATRIC VISION CARE

Reading this "Schedule of Benefits – Pediatric Vision Care" section will help *you* understand the level of benefits *we* generally pay for *pediatric vision care* covered under the *master group contract.*

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

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

Comprehensive eye exam

Limited to one exam per *year*.

Network provider	$10 *copayment* per visit
Non-network provider	50% *coinsurance* after *non-network provider deductible*

Prescription lenses

Single vision lenses, bifocal vision lenses, trifocal vision lenses, and lenticular lenses are limited to two pairs of covered prescription lenses per *year*.

Network provider	50% *coinsurance*
Non-network provider	50% *coinsurance* after *non-network provider deductible*

SCHEDULE OF BENEFITS - PEDIATRIC VISION CARE (continued)

Standard lens options

Polycarbonate, scratch coating, ultraviolet-coating, blended lenses, intermediate lenses, progressive lenses, photochromatic lenses, polarized lenses, fashion & gradient tinting, oversized lenses, glass-grey prescription sunglass lenses, anti-reflective coating, and hi-index lenses must be selected at the same time covered prescription lenses are selected.

Network provider	50% *coinsurance*
Non-network provider	50% *coinsurance* after *non-network provider deductible*

Frames

Limited to two covered new frames per *year*.

Network provider	50% *coinsurance*
Non-network provider	50% *coinsurance* after *non-network provider deductible*

Elective contact lenses

(Benefits are in lieu of all other benefits for frames and lenses.)

Limited to a single purchase of a 12-month supply of daily disposables, or a 12-month supply of non-daily disposables per *year*.

Network provider	50% *coinsurance*
Non-network provider	50% *coinsurance* after *non-network provider deductible*

SCHEDULE OF BENEFITS - PEDIATRIC VISION CARE (continued)

Medically necessary contact lenses

Network provider	50% *coinsurance*
Non-network provider	50% *coinsurance* after *non-network provider deductible*

Contact lens fitting and follow-up exam

Network provider	50% *coinsurance*
Non-network provider	50% *coinsurance* after *non-network provider deductible*

Low vision

Limited to one comprehensive low vision testing and evaluation per *year*.

Network provider	50% *coinsurance*
Non-network provider	50% *coinsurance* after *non-network provider deductible*

SCHEDULE OF BENEFITS - PEDIATRIC VISION CARE (continued)

Low vision supplementary testing

Limited to 5 diagnostic evaluations beyond the *comprehensive eye exam* in 5 *years*.

Network provider	50% *coinsurance*
Non-network provider	50% *coinsurance* after *non-network provider deductible*

Low vision aids

Network provider	50% *coinsurance*
Non-network provider	50% *coinsurance* after *non-network provider deductible*

SCHEDULE OF BENEFITS - BEHAVIORAL HEALTH

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

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

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

Acute inpatient services

Network hospital	$1,250 *copayment* per day for the first 3 days per *admission*
Non-network hospital	50% *coinsurance* after *non-network provider deductible*

Acute inpatient health care practitioner services

Includes *inpatient virtual visit* services.

Network health care practitioner	Covered in full
Non-network health care practitioner	50% *coinsurance* after *non-network provider deductible*

SCHEDULE OF BENEFITS - BEHAVIORAL HEALTH (continued)

Urgent care services

Network provider	$40 *copayment* per visit
Non-network provider	50% *coinsurance* after *non-network provider deductible*

Outpatient services

Health care practitioner office visit

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

Primary care physician	$40 *copayment* per visit
Specialty care physician	$40 *copayment* per visit
Non-network health care practitioner	50% *coinsurance* after *non-network provider deductible*

SCHEDULE OF BENEFITS - BEHAVIORAL HEALTH (continued)

Virtual visit services

Does not include *inpatient virtual visit* services. Refer to "Acute inpatient health care practitioner services" in this "Schedule of Benefits – Behavioral Health" section.

Network provider designated by *us* as a preferred provider for a *virtual visit*	Covered in full
Primary care physician *Specialty care physician*	$40 *copayment* per visit
Any other *network provider*	Same as any other *sickness* based upon location of services and the type of provider
Non-network provider	Same as any other *sickness* based upon location of services and the type of provider

Health care practitioner office visit in a retail clinic

Network health care practitioner	$40 *copayment* per visit
Non-network health care practitioner	50% *coinsurance* after *non-network provider deductible*

SCHEDULE OF BENEFITS - BEHAVIORAL HEALTH (continued)

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

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

Network health care practitioner	Covered in full
Non-network health care practitioner	50% *coinsurance* after *non-network provider deductible*

Therapy

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

Network provider	$40 *copayment* per visit
Non-network provider	50% *coinsurance* after *non-network provider deductible*

Nutritional counseling

Network provider	Covered in full
Non-network provider	50% *coinsurance* after *non-network provider deductible*

SCHEDULE OF BENEFITS - BEHAVIORAL HEALTH (continued)

Intensive outpatient program

Network provider	Covered in full
Non-network provider	50% *coinsurance* after *non-network provider deductible*

Partial hospitalization services

Network hospital	Covered in full
Non-network hospital	50% *coinsurance* after *non-network provider deductible*

Outpatient hospital non-surgical services

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

Does not include *advanced imaging.* Refer to the *advanced imaging* benefits in the "Schedule of Benefits" section.

Network hospital	Covered in full
Non-network hospital	50% *coinsurance* after *non-network provider deductible*

SCHEDULE OF BENEFITS - BEHAVIORAL HEALTH (continued)

Skilled nursing facility services

Network provider	Covered in full
Non-network provider	50% *coinsurance* after *non-network provider deductible*

Home health care services

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

Network provider	Covered in full
Non-network provider	50% *coinsurance* after *non-network provider deductible*

Applied behavioral analysis therapy during a home health care visit

Network provider	$40 *copayment* per visit
Non-network provider	50% *coinsurance* after *non-network provider deductible*

SCHEDULE OF BENEFITS - BEHAVIORAL HEALTH (continued)

Specialty drug benefit

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

Network provider	Covered in full
Non-network provider	50% *coinsurance* after *non-network provider deductible*

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

Network provider designated by *us* as a preferred provider of *specialty drugs*	Covered in full
Network provider	Covered in full
Non-network provider	50% *coinsurance* after *non-network provider deductible*

Residential treatment facility services

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

Autism spectrum disorders

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

SCHEDULE OF BENEFITS - PHARMACY SERVICES

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

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

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

Covered expenses for *prescription* drugs and *specialty drugs* obtained from a *network pharmacy* under provisions of this benefit apply toward *your out-of-pocket limit.*

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

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

Prior authorization and step therapy requirements

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

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

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

Preventive medication coverage

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

SCHEDULE OF BENEFITS - PHARMACY SERVICES (continued)

Prescription drug cost sharing

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

Prescription synchronization

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

SCHEDULE OF BENEFITS - PHARMACY SERVICES (continued)

Retail pharmacy — Coverage for up to a 30-day supply

Does not include *level 5 drugs*. Refer to the "Specialty pharmacy / Retail pharmacy" provision in this "Schedule of Benefits - Pharmacy Services" section.

Network pharmacy level 1 drugs	$5 *copayment* per *prescription* fill or refill
Non-network pharmacy level 1 drugs	30% *coinsurance* of the *default rate* after $5 *copayment* per *prescription* fill or refill
Network pharmacy level 2 drugs	$15 *copayment* per *prescription* fill or refill
Non-network pharmacy level 2 drugs	30% *coinsurance* of the *default rate* after $15 *copayment* per *prescription* fill or refill
Network pharmacy level 3 drugs	$75 *copayment* per *prescription* fill or refill
Non-network pharmacy level 3 drugs	30% *coinsurance* of the *default rate* after $75 *copayment* per *prescription* fill or refill
Network pharmacy level 4 drugs	$150 *copayment* per *prescription* fill or refill
Non-network pharmacy level 4 drugs	30% *coinsurance* of the *default rate* after $150 *copayment* per *prescription* fill or refill

SCHEDULE OF BENEFITS - PHARMACY SERVICES (continued)

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

Network pharmacy designated by *us* as a preferred provider of *level 5 drugs*	$800 *copayment* per *prescription* fill or refill
Network pharmacy provider of *level 5 drugs*	$1,200 *copayment* per *prescription* fill or refill
Non-network pharmacy level 5 drugs	30% *coinsurance* of the *default rate* after $1,200 *copayment* per *prescription* fill or refill

90-day Retail pharmacy

Some retail *pharmacies* participate in *our* program, which allows *you* to receive a 90-day supply of a *prescription* fill or refill. *Your* cost is 3 times the applicable *copayment* outlined above, or the applicable *coinsurance* amount, if any, as specified above. *Specialty drugs* are limited to a 30-day supply from a *specialty pharmacy* or a retail *pharmacy*, unless otherwise determined by *us*.

Mail order pharmacy 90-day supply

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

Network pharmacy level 1 drugs, level 2 drugs, level 3 drugs, level 4 drugs and *level 5 drugs*	2.5 times the applicable *copayment* per *prescription* fill or refill, as outlined above under "Retail pharmacy" and "Specialty pharmacy / Retail pharmacy"
Non-network pharmacy level 1 drugs, level 2 drugs, level 3 drugs, level 4 drugs and *level 5 drugs*	30% *coinsurance* of the *default rate* after 2.5 times the applicable *copayment* per *prescription* fill or refill, as outlined above under "Retail pharmacy" and "Specialty pharmacy / Retail pharmacy"

SCHEDULE OF BENEFITS - PHARMACY SERVICES (continued)

Prescribed cancer treatment medications

Your cost share for covered self-administered cancer medications will not exceed $100 per *prescription* fill or refill.

Prescribed insulin medications

Your cost share for a 30-day supply of a covered *prescription* insulin medication obtained from a *network pharmacy* will not exceed $30 per *prescription* fill or refill.

Dispense as written

If *you* request a *brand-name drug* when a *generic drug* is available, *your cost share* is greater. *You* are responsible for the applicable *brand-name drug copayment* or *coinsurance* and 100% of the difference between the amount *we* would have paid the dispensing *pharmacy* for the *brand-name drug* and the amount *we* would have paid the dispensing *pharmacy* for the *generic drug.* If the prescribing *health care practitioner* determines that the *brand-name drug* is *medically necessary*, *you* are only responsible for the applicable *copayment* or *coinsurance* of the *brand-name drug*.

Non-network pharmacy claims

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

COVERED EXPENSES

This "Covered Expenses" section describes the services that will be considered *covered expenses* under the *master group contract*. Benefits will be paid for covered medical services for a *bodily injury* or *sickness*, or for specified *preventive services*, on a *maximum allowable fee* basis and as shown on the "Schedules of Benefits," subject to any applicable:

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

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

Preventive services

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

- Services with an A or B rating in the current recommendations of the U.S. Preventive Services Task Force (USPSTF). Coverage includes individual, group and telephonic tobacco cessation counseling and all U.S. Food and Drug Administration approved tobacco cessation medications.

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

- Preventive care for infants, children and adolescents provided in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA).

- Colorectal cancer screening examinations and laboratory tests administered at frequencies specified in current American Cancer Society guidelines for colorectal cancer screening.

- Preventive care for women provided in the comprehensive guidelines supported by HRSA which includes, but is not limited to sterilization and bone density screening beginning at age 35.

- Genetic screening for cancer risk that is recommended by a *health care practitioner* or genetic counselor if that recommendation is consistent with the most recent version of genetic testing guidelines published by the National Comprehensive Cancer Network (NCCN).

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

Health care practitioner office services

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

Health care practitioner office visit

Covered expenses include:

- Home and office visits for the diagnosis and treatment of a *sickness* or *bodily injury*.
- Home and office visits for prenatal care.
- Home and office visits for *diabetes self-management training*.
- Diagnostic laboratory and radiology.
- Allergy testing.
- Allergy serum.
- Allergy injections.
- Injections other than allergy.
- *Surgery*, including anesthesia.
- Second surgical opinions.

Virtual visit services

We will pay benefits for *covered expenses* incurred by *you* for *virtual visits* for the diagnosis and treatment of a *sickness* or *bodily injury*. *Virtual visits* must be for services that would otherwise be a *covered expense* if provided during a face-to-face consultation between a *covered person* and a *health care practitioner.*

Health care practitioner services at a retail clinic

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

Hospital services

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

For *emergency medical condition* benefits provided in a *hospital*, refer to the "Emergency services" provision of this section.

Hospital inpatient services

Covered expenses include:

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

- Services and supplies, other than *room and board*, provided by a *hospital* while *confined*.

Health care practitioner inpatient services when provided in a hospital

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

Covered expenses include:

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

Hospital outpatient services

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

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

Hospital outpatient surgical services

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

Health care practitioner outpatient services when provided in a hospital

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

Covered expenses include:

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

Hospital outpatient non-surgical services

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

Hospital outpatient advanced imaging

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

Pregnancy and newborn benefit

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

Covered expenses include:

- A minimum stay in a *hospital* for 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated cesarean section. If an earlier discharge is consistent with the most current protocols and guidelines of the American College of Obstetricians and Gynecologists or the American Academy of Pediatrics and is consented to by the mother and the attending *health care practitioner*, a post-discharge office visit to the *health care practitioner* or a home health care visit within the first 48 hours after discharge is also covered, subject to the terms of this *certificate.*

- For a newborn, *hospital confinement* during the first 48 hours or 96 hours following birth, as applicable and listed above for:

    - *Hospital* charges for *routine nursery care*;
    - The *health care practitioner's* charges for circumcision of the newborn child; and
    - The *health care practitioner's* charges for routine examination of the newborn before release from the *hospital*.

- If the covered newborn must remain in the *hospital* past the mother's *confinement,* services and supplies received for:

  - A *bodily injury* or *sickness*;
  - Care and treatment for premature birth; and
  - Medically diagnosed birth defects and abnormalities.

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

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

The covered newborn will not be required to satisfy a separate *deductible* for any *covered expenses* or *copayments* for *hospital* or *birthing center* facility charges for the *confinement* period for the first 31 days following the newborn's date of birth. A *deductible* and/or *copayment,* if applicable, will be required for any *covered expenses* after the first 31 days of the newborn's date of birth. Please see the "Eligibility and Effective Dates" section of this *certificate* for an explanation of the enrollment requirements and the *effective date* for a newborn *dependent* child.

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

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

Emergency services

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

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

Benefits under this "Emergency services" provision are not available if the services provided do not meet the definition of an *emergency medical condition.*

Ambulance services

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

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

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

- For *air ambulance* services, *you* will only be responsible to pay the *network provider copayment, deductible* and/or *coinsurance* based on the *qualified payment amount.*

Ambulatory surgical center services

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

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

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

Covered expenses include:

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

Durable medical equipment and diabetes equipment

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

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

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

- Manufacturer's warranty is expired; and
- Repair or maintenance is not a result of misuse or abuse; and
- Repair cost is less than replacement cost.

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

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

Hearing aids and related services

Hearing aid and related services, any wearable, non-disposable instrument or device designed to aid or compensate for impaired hearing, including any parts, attachments, or accessories (excluding batteries and cords). Services to access, select, and adjust/fit the hearing aid to ensure optimal performance, as prescribed by a licensed audiologist and dispensed by a licensed audiologist or hearing instrument specialist. One hearing aid, per hearing impaired ear, every 36 months.

Free-standing facility services

Free-standing facility diagnostic laboratory and radiology services

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

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

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

Free-standing facility advanced imaging

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

Home health care services

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

The "Schedule of Benefits" shows the maximum number of visits allowed by a representative of a *home health care agency*, if any. A visit by any representative of a *home health care agency* will be considered one visit, except that at least four hours of home health aide service will be counted as one visit. Each additional two hours or less visit by any representative will be considered one additional visit except for a visit by a home health aide service where each additional four hours will be counted as one visit.

Home health care *covered expenses* are limited to:

- Care provided by a *nurse*;
- Physical, occupational, respiratory or speech therapy;
- Medical social work and nutrition services;
- Medical supplies, except for *durable medical equipment*;
- Laboratory services; and
- Private duty nursing.

Home health care *covered expenses* do not include:

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

Hospice services

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

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

Covered expenses for hospice services are payable as shown on the "Schedule of Benefits" for the following hospice services include:

- *Room and board* at a hospice, when it is for management of acute pain or for an acute phase of chronic symptom management;
- Part-time nursing care provided by or supervised by a registered nurse (R.N.) for the hours approved in the *hospice care program*;
- Counseling for the terminally ill *covered person* and his/her immediate covered *family members* by a licensed:

- Clinical social worker; or
- Pastoral counselor.

- Medical social services provided to the terminally ill *covered person* or his/her immediate covered *family members* under the direction of a *health care practitioner*, including:

  - Assessment of social, emotional and medical needs, and the home and family situation; and
  - Identification of the community resources available.

- Psychological and dietary counseling;
- Physical therapy;
- Home health care;
- Part-time home health aide services for the hours approved in the *hospice care program*; and
- Medical supplies, drugs, and medicines for *palliative care*.

Hospice care *covered expenses* do not include:

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

Jaw joint benefit

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

The following are *covered expenses*:

- A single examination including a history, physical examination, muscle testing, range of motion measurements, and psychological evaluation;

- Diagnostic x-rays;

- Physical therapy of necessary frequency and duration, limited to a multiple modality benefit when more than one therapeutic treatment is rendered on the same date of service;

- Therapeutic injections;

- Appliance therapy utilizing an appliance that does not permanently alter tooth position, jaw position or bite. Benefits for reversible appliance therapy will be based on the *maximum allowable fee* for use of a single appliance, regardless of the number of appliances used in treatment. The benefit for the appliance therapy will include an allowance for all jaw relation and position diagnostic services, office visits, adjustments, training, repair, and replacement of the appliance; and

- Surgical procedures.

Covered expenses do not include charges for:

- Computed Tomography (CT) scans or magnetic resonance imaging except in conjunction with surgical management;
- Electronic diagnostic modalities;
- Occlusal analysis; or
- Any irreversible procedure, including: orthodontics, occlusal adjustment, crowns, onlays, fixed or removable partial dentures, and full dentures.

Physical medicine and rehabilitative services

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

- Physical therapy services;
- Occupational therapy services;
- Speech therapy or speech pathology services;
- Audiology services, including post cochlear aural therapy;
- Cognitive rehabilitation services;
- Respiratory or pulmonary rehabilitation services;
- Cardiac rehabilitation services; and
- Orthoptic training (eye exercises) up to the age of 22.

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

Habilitative services

We will pay benefits for *covered expenses* incurred by *you* for the following *habilitative services* ordered and performed by a *health care practitioner* for a *covered person* with a *congenital anomaly*, developmental delay or defect:

- Physical therapy services;
- Occupational therapy services;
- Speech therapy or speech pathology services; and
- Audiology services, including post cochlear aural therapy.

The "Schedule of Benefits" shows the maximum number of visits for *habilitative services*, if any.

Spinal manipulations/adjustments

We will pay benefits for *covered expenses* incurred by *you* for spinal manipulations/adjustments performed by a *health care practitioner*.

The "Schedule of Benefits" shows the maximum number of visits for spinal manipulations/adjustments, if any.

Skilled nursing facility services

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

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

Health care practitioner services when provided in a skilled nursing facility

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

Covered expenses include:

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

Specialty drug medical benefit

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

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

Specialty drugs may be subject to *preauthorization* requirements. Refer to the "Schedule of Benefits" in this *certificate* for *preauthorization* requirements and contact *us* prior to receiving *specialty drugs*.

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

Transplant services and immune effector cell therapy

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

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

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

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

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

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

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

- *Hospital* and *health care practitioner* services.

- Acquisition of cell therapy products for *immune effector cell therapy*, acquisition of *stem cells* or solid organs for transplants and associated donor costs, including pre-transplant or *immune effector cell therapy* services, the acquisition procedure, and any complications resulting from the harvest and/or acquisition. Donor costs for post-discharge services and treatment of complications will not exceed the treatment period of 365 days from the date of discharge following harvest and/or acquisition.

- Non-medical travel and lodging costs for:

  - The *covered person* receiving the transplant or *immune effector cell therapy*, if the *covered person* lives more than 100 miles from the transplant or *immune effector cell therapy* facility designated by *us*; and

  - One caregiver or support person (two, when the *covered person* receiving the transplant or *immune effector cell therapy* is under 18 years of age), if the caregiver or support person lives more than 100 miles from the transplant or *immune effector cell therapy* facility designated by *us*.

  Non-medical travel and lodging costs include:

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

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

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

Urgent care services

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

Additional covered expenses

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

- Blood and blood plasma, which is not replaced by donation; administration of the blood and blood products including blood extracts or derivatives.

- Oxygen and rental of equipment for its administration.

- Prosthetic devices and supplies, including limbs and eyes. Coverage will be provided for prosthetic devices to:

  - Restore the previous level of function lost as a result of a *bodily injury* or *sickness*; or

- Improve function caused by a *congenital anomaly*.

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

- A change in the *covered person's* physical condition causing the device to become non-functional; or
- Normal wear and tear.

- Cochlear implants when provided to a *covered person* diagnosed with profound hearing impairment.

  Replacement or upgrade of a cochlear implant and its external components may be a *covered expense* if:

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

- Hearing examinations.

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

  Covered expense does not include:

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

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

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

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

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

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

- Certain oral surgical operations as follows:

  - Excision of partially or completely impacted teeth;

- Surgical preparation of soft tissues and excision of bone or bone tissue performed with or without extraction or excision of erupted, partially erupted or completely un-erupted teeth;

- Excisions of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth, and related biopsy of bone, tooth, or related tissues when such conditions require pathological examinations;

- Surgical procedures related to repositioning of teeth, tooth transplantation or re-implantation;

- Services required to correct accidental injuries of the jaws, cheeks, lips, tongue, roof and floor of the mouth;

- Reduction of fractures and dislocation of the jaw;

- External incision and drainage of cellulitis and abscess;

- Incision and closure of accessory sinuses, salivary glands or ducts;

- Frenectomy (the cutting of the tissue in the midline of the tongue); and

- Orthognathic *surgery* for a *congenital anomaly*, *bodily injury* or *sickness* causing a *functional impairment*.

- Orthodontic treatment for a *congenital anomaly* related to or developed as a result of cleft palate, with or without cleft lip.

- Reconstructive services required to correct certain deformities caused by disease, trauma, *congenital anomalies*, or previous therapeutic process are eligible for coverage. Reconstructive services required due to prior therapeutic process would be covered if the original procedure would have been a covered expense. *Covered expenses* are limited to the following:

  - Hemangiomas and port wine stains of the head and neck areas for children through age 17;
  - Limb deformities such as club hand, club foot, syndactyly (webbed digits) polydactyly (supermenary digits), macrodactylia;
  - Otoplasty when performed to improve hearing by directing sound in the ear canal, when ear or ears are absent or deformed from trauma, surgery, disease or congenital defect;
  - Tongue release for diagnosis of tongue-tied;
  - Congenital disorders that cause skull deformity such as Crouzon's disease;
  - Cleft lip; and
  - Cleft palate.

- For a *covered person*, who is receiving benefits in connection with a mastectomy, service for:

  - Reconstructive *surgery* of the breast on which the mastectomy has been performed;
  - *Surgery* and reconstruction on the non-diseased breast to achieve symmetrical appearance; and
  - Prostheses and treatment of physical complications for all stages of mastectomy, including lymphedemas.

- Reconstructive *surgery* resulting from:

  - A *bodily injury*, infection or other disease of the involved part, when a *functional impairment* is present; or
  - A *congenital anomaly* that resulted in a *functional impairment*.

  Expenses for reconstructive *surgery* due to a psychological condition are not considered a *covered expense*, unless the condition(s) described above are also met.

- For a *covered person* who has been diagnosed with breast disease, mammograms are a *covered expense* regardless of age, upon referral by a *health care practitioner*.

- Therapeutic food and low-protein modified food products for a *covered person* when prescribed or ordered by a *health care practitioner* and are for the treatment of inborn metabolic errors or genetic conditions, e.g. phenylketonuria (PKU).

- Human milk fortifiers or 100% human milk-based diet, when prescribed for prevention of necrotizing enterocolitis and administered under the direction of a *health care practitioner*.

- Coverage for general anesthesia and *hospital* or facility services performed in a *hospital* or ambulatory surgical facility, in connection with dental procedures when certified by a *health care practitioner* for:

  - A *dependent* under the age of nine;
  - A *covered person* with a *serious mental condition* or a significant behavioral problem;
  - A *covered person* with a *serious physical condition*; or
  - A *covered person* age 9 or older who is determined by a licensed dentist or physician to require such services in order to prevent significant medical risk.

- *Palliative care*.

- Routine costs for a *covered person* participating in an approved Phase I, II, III or IV clinical trial.

  Routine costs include health care services that are otherwise a *covered expense* if the *covered person* were not participating in a clinical trial.

  Routine costs do not include services or items that are:

  - *Experimental, investigational or for research purposes*;
  - Provided only for data collection and analysis that is not directly related to the clinical management of the *covered person*; or
  - Inconsistent with widely accepted and established standards of care for a diagnosis.

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

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

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

- Federally funded or approved by the appropriate federal agency;
- The study or investigation is conducted under an investigational new drug application reviewed by the Federal Food and Drug Administration; or
- The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

- *Covered expenses* for routine patient costs associated with a clinical trial for the treatment of cancer. The clinical trial must be approved by:

  - The National Institutes of Health (NIH) or any institutional review board recognized by the NIH;
  - Federal Drug Administration (FDA);
  - Department of Defense (DOD); and
  - Department of Veterans Affairs (VA).

  The clinical trial must do one of the following:

  - Test how to administer a service, item, or drug for the treatment of cancer;
  - Test responses to a service, item or drug for the treatment of cancer;
  - Compare the effectiveness of a service, item, or drug for the treatment of cancer with that of other services, items, or drugs for the treatment of cancer; or
  - Study new uses of services, items, or drugs for the treatment of cancer.

- Coverage for routine patient costs does <u>not</u> include:

  - The service, item or *experimental* or *investigational* drug that is the subject of the clinical trial;

  - Any treatment modality outside the usual and customary standard of care required to administer or support the service, item or *experimental* or *investigational* drug that is the subject of the clinical trial;

  - Any service, item or drug provided solely for data collection and analysis needs that are not used in the direct clinical management of the patient;

  - Any drug or device that is *experimental* or *investigational* or *for research purposes*;

  - Transportation, lodging, food or other expenses for the patient, *family member* or companion associated with the travel to or from the facility providing the clinical trial;

  - Services, items or drugs provided for free for any new patient by the clinical trial sponsor; and

  - Services, items or drugs that are eligible for reimbursement by a person other than the insurer, including the clinical trial sponsor.

- For a *covered person,* who is receiving benefits in connection with cancer treatment, the first wig following cancer treatment.

- Covered expenses for the diagnosis and treatment of endometriosis and endometritis.

COVERED EXPENSES - PEDIATRIC DENTAL

This "Covered Expenses – Pediatric Dental" section describes the services that will be considered *covered expenses* for *pediatric dental services* under the *master group contract.* Benefits for *pediatric dental services* will be paid on a *reimbursement limit* basis and as shown in the "Schedule of Benefits – Pediatric Dental," subject to any applicable:

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

Notwithstanding any other provisions of the *master group contract,* expenses covered under this benefit section are not covered under any other provision of the *master group contract.* Any amount in excess of the maximum amount provided under this benefit, if any, is not covered under any other provision in the *master group contract.*

All terms used in this benefit have the same meaning given to them in this *certificate,* unless otherwise specifically defined in this benefit. Refer to the "Limitations and exclusions" provision in this section and the "Limitations and Exclusions" section of this *certificate* for *pediatric dental services* not covered by the *master group contract.* All other terms and provisions of the *master group contract* are applicable to expenses covered for *pediatric dental services.*

Definitions

Accidental dental injury means damage to the mouth, teeth and supporting tissue due directly to an *accident.* It does not include damage to the teeth, appliances or prosthetic devices that results from chewing or biting food or other substances, unless the biting or chewing injury is a result of an act of domestic violence or a medical condition (including both physical and mental health conditions).

Clinical review means the review of required/submitted documentation by a *dentist* for the determination of *pediatric dental services.*

Cosmetic means services that are primarily for the purpose of improving appearance, including but not limited to:

- Facings on crowns or pontics (the portion of a fixed bridge between the abutments) posterior to the second bicuspid; or
- Characterizations and personalization of prosthetic devices.

Covered person under this "Covered Expenses – Pediatric Dental" and the "Schedule of Benefits – Pediatric Dental" sections means a person who is eligible and enrolled for benefits provided under the *master group contract* up to the end of the month following the date he or she attains age 21.

COVERED EXPENSES - PEDIATRIC DENTAL (continued)

Dental emergency means a sudden, serious dental condition caused by an *accident* or dental disease that, if not treated immediately, would result in serious harm to the dental health of the *covered person.*

Expense incurred date means the date on which:

- The teeth are prepared for fixed bridges, crowns, inlays, or onlays;
- The final impression is made for dentures or partials;
- The pulp chamber of a tooth is opened for root canal therapy;
- A periodontal surgical procedure is performed; or
- The service is performed for services not listed above.

Palliative dental care means treatment used in a *dental emergency* or *accidental dental injury* to relieve, ease or alleviate the acute severity of dental pain, swelling or bleeding. *Palliative dental care* treatment usually is performed for, but is not limited to, the following acute conditions:

- Toothache;
- Localized infection;
- Muscular pain; or
- Sensitivity and irritations of the soft tissue.

Services are not considered *palliative dental care* when used in association with any other *pediatric dental services,* except x-rays and/or exams.

Reimbursement limit means the maximum fee allowed for *pediatric dental services.* It is the lesser of:

- The actual cost for services;
- The fee most often charged in the geographical area where the service was performed;
- The fee most often charged by the provider;
- The fee determined by comparing charges for similar services to a national database adjusted to the geographical area where the services or procedures were performed;
- At *our* choice, the fee determined by using a national Relative Value Scale. Relative Value Scale means a methodology that values procedures and services relative to each other that includes, but is not limited to, a scale in terms of difficulty, work, risk, as well as the material and outside costs of providing the service, as adjusted to the geographic area where the services or procedures were performed;
- In the case of services rendered by providers with whom *we* have agreements, the fee that *we* have negotiated with that provider;

- The fee based on rates negotiated with one or more *network providers* in the geographic area for the same or similar services;
- The fee based on the provider's costs for providing the same or similar services as reported by the provider in the most recent, publicly available *Medicare* cost report submitted annually to the Centers for Medicare and Medicaid Services; or
- The fee based on a percentage of the fee *Medicare* allows for the same or similar services provided in the same geographic area.

The bill *you* receive for services provided by *non-network providers* may be significantly higher than the *reimbursement limit.* In addition to the *deductible, copayments* and *coinsurance, you* are responsible for the difference between the *reimbursement limit* and the amount the provider bills *you* for the services. Any amount *you* pay to the provider in excess of the *reimbursement limit* will not apply to *your deductible* or *out-of-pocket limit.*

Treatment plan means a written report on a form satisfactory to *us* and completed by the *dentist* that includes:

- A list of the services to be performed, using the American Dental Association terminology and codes;
- *Your dentist's* written description of the proposed treatment;
- Pretreatment x-rays supporting the services to be performed;
- Itemized cost of the proposed treatment; and
- Any other appropriate diagnostic materials (may include x-rays, chart notes, treatment records, etc.) as requested by *us.*

Pediatric dental services benefit

We will pay benefits for *covered expenses* incurred by a *covered person* for *pediatric dental services. Pediatric dental services* include the following as categorized below. Coverage for a *dental emergency* is limited to *palliative dental care* only:

Class I services

- Periodic and comprehensive oral evaluations. Limited to 2 per *year*.
- Limited, problem focused oral evaluations. Limited to 2 per *year*.
- Periodontal evaluations. Limited to 2 per *year*. Benefit allowed only for a *covered person* showing signs or symptoms of periodontal disease and for patients with risk factors such as smoking, diabetes or related health issues. No benefit is payable when performed with a cleaning (prophylaxis). Benefits are not available when a comprehensive oral evaluation is performed.
- Cleaning (prophylaxis), including all scaling and polishing procedures. Limited to 2 per *year*.
- Intra-oral complete series x-rays (at least 14 films, including bitewings). Limited to 2 per *year*. If the total cost of periapical and bitewing x-rays exceeds the cost of a complete series of x-rays, *we* will consider these as a complete series.

- Panoramic x-rays for *covered persons.* Limited to one per *year*.
- Cephalometric radiographic image for *covered persons*.
- Bitewing x-rays. Limited to 2 sets per *year*.
- Other x-rays, including intra-oral periapical and occlusal and extra-oral x-rays. Limited to x-rays necessary to diagnose a specific treatment.
- Topical fluoride treatment. Limited to two per *year*.
- Application of sealants to the occlusal surface of permanent molars that are free of decay and restorations. Limited to one per tooth every 3 *years*.
- Installation of space maintainers for retaining space when a primary tooth is prematurely lost. *Pediatric dental services* do not include separate adjustment expenses.
- Recementation of space maintainers.
- Removal of fixed space maintainers.
- Distal shoe space maintainer – fixed – unilateral.

Class II services

- Restorative services as follows:
  - Amalgam restorations (fillings). Multiple restorations on one surface are considered one restoration.
  - Composite restorations (fillings) on anterior teeth. Composite restorations on molar and bicuspid teeth are considered an alternate service and will be payable as a comparable amalgam filling. *You* will be responsible for the remaining expense incurred. Multiple restorations on one surface are considered one restoration.
  - Pin retention per tooth in addition to restoration that is not in conjunction with core build-up.
  - Non-cast pre-fabricated stainless steel, esthetic stainless steel, and resin crowns on primary teeth that cannot be adequately restored with amalgam or composite restorations. Esthetic stainless steel and resin crowns are considered an alternate service and will be payable as a comparable non-case pre-fabricated stainless steel crown. The *covered person* will be responsible for the remaining *expense incurred.*
- Miscellaneous services as follows:
  - *Palliative dental care* for a *dental emergency* for the treatment of pain or an *accidental dental injury* to the teeth and supporting structures. *We* will consider the service a separate benefit only if no other service, except for x-rays and problem focused oral evaluation is provided during the same visit.

- Re-cementing inlays, onlays and crowns.

Class III services

- Restorative services as follows:

  - Initial placement of laboratory-fabricated restorations, for a permanent tooth, when the tooth, as a result of extensive decay or a traumatic injury, cannot be restored with a direct placement filling material. *Pediatric dental services* include inlays, onlays, crowns, veneers, core build-ups and posts, implant supported crowns, and abutments. Limited to 1 per tooth every 5 *years.* Inlays are considered an alternate service and will be payable as a comparable amalgam filling.

  - Replacement of inlays, onlays, crowns or other laboratory-fabricated restorations for permanent teeth. *Pediatric dental services* include the replacement of the existing major restoration if:

    - It has been 5 *years* since the prior insertion and is not, and cannot be made serviceable;
    - It is damaged beyond repair as a result of an *accidental dental injury* while in the oral cavity; or
    - Extraction of functioning teeth, excluding third molars or teeth not fully in occlusion with an opposing tooth or prostheses requires the replacement of the prosthesis.

- Periodontic services as follows:

  - Periodontal scaling and root planing. Limited to 1 per quadrant every *year*.

  - Scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation. Limited to 1 per *year*. This service will reduce the number of cleanings available so that the total number of cleanings does not exceed 2 per *year*.

  - Full mouth debridement to enable comprehensive evaluation and diagnosis. Limited to one per pregnancy one per lifetime. If one per lifetime has been fulfilled, then one per pregnancy is still available.

  - Periodontal maintenance, (at least 30 days following periodontal therapy), unless a cleaning (prophylaxis) is performed on the same day. Limited to 4 every *year*.

  - Periodontal and osseous surgical procedures, including bone replacement, tissue regeneration, gingivectomy, and gingivoplasty. Limited to 1 per quadrant, per *year*.

  - Occlusal adjustments when performed in conjunction with a periodontal surgical procedure. Limited to 1 per quadrant, per *year*.

  - Clinical crown lengthening – hard tissue.

  - Tissue graft procedures, including: pedicle soft tissue graft procedure, free soft tissue graft procedure (including donor site surgery); and subepithelial connective tissue graft procedures (including donor site surgery).

Separate fees for pre- and post-operative care and re-evaluation within 3 months are not considered *pediatric dental services.*

- Endodontic procedures as follows:

  - Root canal therapy, including root canal treatments and root canal fillings for permanent teeth and primary teeth. Any test, intraoperative, x-rays, laboratory or any other follow-up care is considered integral to root canal therapy.

  - Root canal retreatment, including root canal treatments and root canal fillings for permanent and primary teeth. Any test, intraoperative x-rays, exam, laboratory or any other follow-up care is considered integral to root canal therapy.

  - Periradicular surgical procedures for permanent teeth, including apicoectomy, root amputation, tooth reimplementation, bone graft, and surgical isolation.

  - Partial pulpotomy for apexogenesis for permanent teeth.

  - Vital pulpotomy for primary teeth.

  - Pulp debridement, pulpal therapy (resorbable) for permanent and primary teeth.

  - Apexification/recalcification for permanent and primary teeth.

- Prosthodontics services as follows:

  - Denture adjustments when done by a *dentist* other than the one providing the denture, or adjustments performed more than six months after initial installation.

  - Initial placement of bridges, complete dentures and partial dentures. Limited to 1 every *year*. *Pediatric dental services* include pontics, inlays, onlays and crowns. Limited to 1 per tooth every 5 *years.*

  - Replacement of bridges, complete dentures, and partial dentures. *Pediatric dental services* include the replacement of the existing prosthesis if:

    - It has been 5 *years* since the prior insertion and is not, and cannot be made serviceable;
    - It is damaged beyond repair as a result of an *accidental dental injury* while in the oral cavity; or
    - Extraction of functioning teeth, excluding third molars or teeth not fully in occlusion with an opposing tooth or prostheses requires the replacement of the prosthesis.

  - Tissue conditioning.

  - Denture relines or rebases. Limited to 1 every *year* after 6 months of installation.

  - Post and core build-up in addition to partial denture retainers with or without core build-up. Limited to 1 per tooth every 5 *years*.

- The following simple oral surgical services as follows:

  - Extraction of coronal remnants of a primary tooth.
  - Extraction of an erupted tooth or exposed root for permanent and primary teeth.

- Implant services, subject to *clinical review*. Dental implants and related services, including implant supported bridges and provisional implant crown. Limited to 1 per tooth every 5 *years*. *Pediatric dental services* do not include an implant if it is determined a standard prosthesis or restoration will satisfy the dental need.

  Implant supported removable denture for:

  - Edentulous arch – maxillary. Limited to 1 per tooth every 5 *years*.
  - Edentulous arch – mandibular. Limited to 1 per tooth every 5 *years*.
  - Partially edentulous arch – maxillary. Limited to 1 per tooth every 5 *years*.
  - Partially edentulous arch – mandibular. Limited to 1 per tooth every 5 *years*.

- Miscellaneous services as follows:

  - Recementing of bridges and implants.
  - Repairs of bridges, complete dentures, immediate dentures, partial dentures, and crowns.

- General anesthesia or conscious sedation subject to *clinical review* and administered by a *dentist* in conjunction with covered oral surgical procedures, periodontal and osseous surgical procedures, and periradicular surgical procedures, for *pediatric dental services*. General anesthesia is not considered a *pediatric dental service* if administered for, including but not limited to, the following:

  - Pain control, unless the *covered person* has a documented allergy to local anesthetic.
  - Anxiety.
  - Fear of pain.
  - Pain management.
  - Emotional inability to undergo a surgical procedure.

Class IV services

Orthodontic treatment, not as a result of a *congenital anomaly*, when *medically necessary*. Orthodontic treatment that is a result of a congenital anomaly and when medically necessary, is covered under the "Covered Expenses" section in this *certificate*.

Covered expenses for orthodontic treatment, not as a result of a *congenital anomaly*, include those that are:

- For the treatment of and appliances for tooth guidance, interception and correction.
- Related to covered orthodontic treatment, including:

  - X-rays.
  - Exams.
  - Space retainers.
  - Study models.

Covered expenses do not include services to alter vertical dimensions, restore or maintain the occlusion. Such procedures include equilibration, periodontal splinting, full mouth rehabilitation, and restoration for misalignment of teeth.

- Orthodontic treatments are limited to Medically Necessary Dental Treatment, subject to clinical review. Services include treatment of, and appliance for, tooth guidance, interception, and correction as well as X-rays, exams, and follow-up care.

Integral service

Integral services are additional charges related to materials or equipment used in the delivery of dental care. The following services are considered integral to the dental service and will not be paid separately:

- Local anesthetics.
- Bases.
- Pulp testing.
- Pulp caps.
- Study models/diagnostic casts.
- *Treatment plans.*
- Occlusal (biting or grinding surfaces of molar and bicuspid teeth) adjustments.
- Nitrous oxide.
- Irrigation.
- Tissue preparation associated with impression or placement of a restoration.

Pretreatment plan

We suggest that if dental treatment is expected to exceed $300, *you* or *your dentist* should submit a *treatment plan* to *us* for review before *your* treatment. The *treatment plan* should include:

- A list of services to be performed using the American Dental Association terminology and codes;
- *Your dentist's* written description of the proposed treatment;
- Pretreatment x-rays supporting the services to be performed;
- Itemized cost of the proposed treatment; and
- Any other appropriate diagnostic materials that *we* may request.

We will provide *you* and *your dentist* with an estimate for benefits payable based on the submitted *treatment plan.* This estimate is not a guarantee of what *we* will pay. It tells *you* and *your dentist* in advance about the benefits payable for the *pediatric dental services* in the *treatment plan*.

An estimate for services is not necessary for a *dental emergency*.

Pretreatment plan process and timing

An estimate for services is valid for 90 days after the date *we* notify *you* and *your dentist* of the benefits payable for the proposed *treatment plan* (subject to *your* eligibility of coverage). If treatment will not begin for more than 90 days after the date *we* notify *you* and *your dentist, we* recommend that *you* submit a new *treatment plan*.

COVERED EXPENSES - PEDIATRIC DENTAL (continued)

Alternate services

If two or more services are acceptable to correct a dental condition, *we* will base the benefits payable on the least expensive *pediatric dental service* that produces a professionally satisfactory result, as determined by *us*. *We* will pay up to the *reimbursement limit* for the least costly *pediatric dental service* and subject to any applicable *deductible* and *coinsurance*. *You* will be responsible for any amount exceeding the *reimbursement limit.*

If *you* or *your dentist* decides on a more costly service, payment will be limited to the *reimbursement limit* for the least costly service and will be subject to any *deductible* and *coinsurance*. *You* will be responsible for any amount exceeding the *reimbursement limit.*

Limitations and exclusions

Refer to the "Limitations and Exclusions" section of this *certificate* for additional exclusions. Unless specifically stated otherwise, no benefit will be provided for, or on account of, the following items:

- Any expense arising from the completion of forms.
- Any expense due to *your* failure to keep an appointment.
- Any expense for a service *we* consider *cosmetic*, unless it is due to an *accidental dental injury*.
- Expenses incurred for:
  - Precision or semi-precision attachments;
  - Overdentures and any endodontic treatment associated with overdentures;
  - Other customized attachments;
  - Any services for 3D imaging (cone beam images);
  - Temporary and interim dental services; or
  - Additional charges related to materials or equipment used in the delivery of dental care.
- Charges for services rendered:
  - In a dental facility or *health care treatment facility* sponsored or maintained by the *employer* under this plan or an employer of any *covered person* covered by the *master group contract*; or
  - By an employee of any *covered person* covered by the *master group contract.*

  For the purposes of this exclusion, *covered person* means the *employee* and the *employee's dependents* enrolled for benefits under the *master group contract* and as defined in the "Glossary" section.

COVERED EXPENSES - PEDIATRIC DENTAL (continued)

- Any service related to:

  - Altering vertical dimension of teeth or changing the spacing or shape of the teeth;
  - Restoration or maintenance of occlusion;
  - Splinting teeth, including multiple abutments, or any service to stabilize periodontally weakened teeth;
  - Replacing tooth structures lost as a result of abrasion, attrition, erosion, or abfraction; or
  - Bite registration or bite analysis.

- Infection control, including sterilization techniques.

- Expenses incurred for services performed by someone other than a *dentist*, except for scaling and teeth cleaning and the topical application of fluoride, which can be performed by a licensed dental hygienist. The treatment must be rendered under the supervision and guidance of the *dentist* in accordance with generally accepted dental standards;

- Any *hospital*, surgical or treatment facility, or for services of an anesthesiologist or anesthetist;

- *Prescription* drugs or pre-medications, whether dispensed or prescribed.

- Any service that:

  - Is not eligible for benefits based on the *clinical review*;
  - Does not offer a favorable prognosis;
  - Does not have uniform professional acceptance; or
  - Is deemed to be experimental or investigational in nature.

- Preventive control programs including oral hygiene instructions, plaque control, take-home items, prescriptions and dietary planning.

- Replacement of any lost, stolen, damaged, misplaced or duplicate major restoration, prosthesis or appliance.

- Any caries susceptibility testing, laboratory tests, saliva samples, anaerobic cultures, sensitivity testing or charges for oral pathology procedures.

- The following services when performed at the same time as a root canal:

  - Partial pulpotomy for apexogensis;
  - Vital pulpotomy; or
  - Pulp debridment or pulpal therapy.

COVERED EXPENSES - PEDIATRIC VISION CARE

This "Covered Expenses – Pediatric Vision Care" section describes the services that will be considered *covered expenses* for *pediatric vision care* under the *master group contract.* Benefits for *pediatric vision care* will be paid on a *reimbursement limit* basis and as shown in the "Schedule of Benefits – Pediatric Vision Care," subject to any applicable:

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

All terms used in this benefit have the same meaning given to them in this *certificate,* unless otherwise specifically defined in this benefit. Refer to the "Limitations and exclusions" provision in this section and the "Limitations and Exclusions" section of this *certificate* for *pediatric vision care* expenses not covered by the *master group contract.* All terms and provisions of the *master group contract* apply.

Definitions

Comprehensive eye exam means an exam of the complete visual system which includes: case history; monocular and binocular visual acuity, with or without present corrective lenses; neurological integrity (pupil response); biomicroscopy (external exam); visual field testing (confrontation); ophthalmoscopy (internal exam); tonometry (intraocular pressure); refraction (with recorded visual acuity); extraocular muscle balance assessment; dilation as required; present prescription analysis; specific recommendation; assessment plan; and provider signature.

Contact lens fitting and follow-up means an exam which includes: keratometry; diagnostic lens testing; instruction for insertion and removal of contact lenses; and additional biomicroscopy with and without lens.

Covered person under this "Covered Expenses – Pediatric Vision Care" section and the "Schedule of Benefits – Pediatric Vision Care" section means a person who is eligible and enrolled for benefits provided under the *master group contract* up to the end of the month following the date he or she attains age 21.

Low vision means *severe vision problems* as diagnosed by an Ophthalmologist or Optometrist that cannot be corrected with regular prescription lenses or contact lenses and reduces a person's ability to function at certain or all tasks.

Reimbursement limit means the maximum fee allowed for *pediatric vision care*. *Reimbursement limit* for *pediatric vision care* is the lesser of:

- The actual cost for services or *materials*;
- The fee most often charged in the geographical area where the service was performed or *materials* provided;
- The fee most often charged by the provider;

- The fee determined by comparing charges for similar services or *materials* to a national database adjusted to the geographical area where the services or procedures were performed or *materials* provided;

- At *our* choice, the fee determined by using a national Relative Value Scale. Relative Value Scale means a methodology that values procedures and services relative to each other that includes, but is not limited to, a scale in terms of difficulty, work, risk, as well as the material and outside costs of providing the service, as adjusted to the geographic area where the services or procedures were performed or *materials* provided;

- In the case of services rendered by or *materials* obtained from providers with whom *we* have agreements, the fee that *we* have negotiated with that provider;

- The fee based on rates negotiated with one or more *network providers* for the same or similar services or *materials*;

- The fee based on the provider's costs for providing the same or similar services or *materials* as reported by the provider in the most recent, publicly available *Medicare* cost report submitted annually to the Centers for Medicare & Medicaid Services; or

- The fee based on a percentage of the fee *Medicare* allows for the same or similar services or *materials* provided in the same geographic area.

The bill *you* receive for services provided by, or *materials* obtained from, *non-network providers* may be significantly higher than the *reimbursement limit.* In addition to *deductibles, copayments* and *coinsurance*, *you* are responsible for the difference between the *reimbursement limit* and the amount the provider bills *you* for the services or *materials.* Any amount *you* pay to the provider in excess of the *reimbursement limit* will not apply to *your deductible* or *out-of-pocket limit.*

Severe vision problems mean the best-corrected acuity is:

- 20/200 or less in the better eye with best conventional spectacle or contact lens prescription;
- A demonstrated constriction of the peripheral fields in the better eye to 10 degrees or less from the fixation point; or
- The widest diameter subtends an angle less than 20 degrees in the better eye.

Pediatric vision care benefit

We will pay benefits for *covered expenses* incurred by a *covered person* for *pediatric vision care*. *Covered expenses* for *pediatric vision care* are:

- *Comprehensive eye exam.*

COVERED EXPENSES - PEDIATRIC VISION CARE (continued)

- Prescription lenses and standard lens options, including polycarbonate, scratch coating, ultraviolet-coating, blended lenses intermediate lenses, progressive lenses, photochromatic lenses, polarized lenses, fashion and gradient tinting, oversized lenses, glass grey prescription sunglass lenses, anti-reflective coating, and hi-index lenses. If a *covered person* sees a *network provider*, the *network provider* of *materials* will show the *covered person* the selection of lens options covered by the *master group contract.* If a *covered person* selects a lens option that is not included in the lens option selection the *master group contract* covers, the *covered person* is responsible for the difference in cost between the *network provider* of *materials* reimbursement amount for covered lens options and the retail price of the lens options selected.

- Frames available from a selection of covered frames. If a *covered person* sees a *network provider*, the *network provider* of *materials* will show the *covered person* the selection of frames covered by the *master group contract.* If a *covered person* selects a frame that is not included in the frame selection the *master group contract* covers, the *covered person* is responsible for the difference in cost between the *network provider* of *materials* reimbursement amount for covered frames and the retail price of the frame selected.

- Elective contact lenses available from a selection of covered contact lenses and *contact lens fitting and follow-up*. If a *covered person* sees a *network provider*, the *network provider* of *materials* will inform the *covered person* of the contact lens selection covered by the *master group contract.* If a *covered person* selects a contact lens that is not part of the contact lens selection the *master group contract* covers, the *covered person* is responsible for the difference in cost between the lowest cost contact lens available from the contact lens selection covered by the *master group contract* and the cost of the contact lens selected.

- *Medically necessary* contact lenses under the following circumstances:

  - Visual acuity cannot be corrected to 20/70 in the better eye, except by use of contact lenses;
  - Anisometropia;
  - Keratoconus;
  - Aphakia;
  - High ametropia of either +10D or -10D in any meridian;
  - Pathological myopia;
  - Aniseikonia;
  - Aniridia;
  - Corneal disorders;
  - Post-traumatic disorders; or
  - Irregular astigmatism.

- *Low vision* services include the following:

  - Comprehensive *low vision* testing and evaluation;
  - *Low vision* supplementary testing; and
  - *Low vision* aids include the following:

    - Spectacle-mounted magnifiers;
    - Hand-held and stand magnifiers;
    - Hand-held or spectacle-mounted telescopes; and
    - Video magnification.

COVERED EXPENSES - PEDIATRIC VISION CARE (continued)

Limitations and exclusions

In addition to the "Limitations and Exclusions" section of this *certificate* and any limitations specified in the "Schedule of Benefits – Pediatric Vision Care," benefits for *pediatric vision care* are limited as follows:

- In no event will benefits exceed the lesser of the limits of the *master group contract*, shown in the "Schedule of Benefits – Pediatric Vision Care" or in the "Schedule of Benefits" of this *certificate.*
- *Materials* covered by the *master group contract* that are lost, stolen, broken or damaged will only be replaced at normal intervals as specified in the "Schedule of Benefits – Pediatric Vision Care."

Refer to the "Limitations and Exclusions" section of this *certificate* for additional exclusions. Unless specifically stated otherwise, no benefits for *pediatric vision care* will be provided for, or on account of, the following items:

- Orthoptic or vision training and any associated supplemental testing.
- Two or more pair of glasses, in lieu of bifocals or trifocals.
- Medical or surgical treatment of the eye, eyes or supporting structures.
- Any services and/or *materials* required by an *employer* as a condition of employment.
- Safety lenses and frames.
- Contact lenses, when benefits for frames and lenses are received.
- Cosmetic items.
- Any services or *materials* not listed in this benefit section as a covered benefit or in the "Schedule of Benefits – Pediatric Vision Care."
- Expenses for missed appointments.
- Any charge from a provider's office to complete and submit claim forms.
- Treatment relating to or caused by disease.
- Non-prescription *materials* or vision devices.
- Costs associated with securing *materials.*
- Pre- and post-operative services.
- Orthokeratology.
- Maintenance of *materials.*
- Refitting or change in lens design after initial fitting.
- Artistically painted lenses.

COVERED EXPENSES - BEHAVIORAL HEALTH

This "Covered Expenses – Behavioral Health" section describes the services that will be considered *covered expenses* for *mental health services* and *chemical dependency* services under the *master group contract.* Benefits for *mental health services* and *chemical dependency* services will be paid on a *maximum allowable fee* basis and as shown in the "Schedule of Benefits – Behavioral Health." Refer to the "Schedule of Benefits" for any service not specifically listed in the "Schedule of Benefits – Behavioral Health." Benefits are subject to any applicable:

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

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

Acute inpatient services

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

Acute inpatient health care practitioner services

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

Emergency services

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

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

Benefits under this "Emergency services" provision are not available if the services provided do not meet the definition of *emergency medical condition*.

COVERED EXPENSES - BEHAVIORAL HEALTH (continued)

Urgent care services

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

Outpatient services

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

Skilled nursing facility services

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

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

Home health care services

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

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

Home health care *covered expenses* do not include:

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

Specialty drug benefit

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

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

Specialty drugs may be subject to *preauthorization* requirements. Refer to the "Schedule of Benefits" in this *certificate* for *preauthorization* requirements and contact *us* prior to receiving *specialty drugs*.

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

Residential treatment facility services

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

Autism spectrum disorders

We will pay benefits for *covered expenses* incurred by *you,* for *health care practitioner* services to treat *autism spectrum disorders.*

Covered expenses include:

- Medical care;
- Habilitative or rehabilitative care;
- Pharmacy care, if covered by plan;
- Psychiatric care;
- Psychological care;
- Therapeutic care; and
- Applied behavior analysis prescribed or ordered by a licensed health or allied health professional.

Refer to the "Schedule of Benefits – Behavioral Health" section for benefits payable for *autism spectrum disorders.*

COVERED EXPENSES - PHARMACY SERVICES

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

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

Coverage description

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

Covered *prescription* drugs are:

- Drugs, medicines or medications and *specialty drugs* that under federal or state law may be dispensed only by *prescription* from a *health care practitioner*.
- Drugs, medicines or medications and *specialty drugs* included on *our drug list.*
- Insulin and *diabetes supplies*.
- *Self-administered injectable drugs* approved by *us.*
- Hypodermic needles, syringes or other methods of delivery when prescribed by a *health care practitioner* for use with insulin or *self-administered injectable drugs*. (Hypodermic needles, syringes or other methods of delivery used in conjunction with covered drugs may be available at no cost to *you*).
- Enteral formulas and nutritional supplements for the treatment of phenylketonuria (PKU) or other inherited metabolic disease, or as otherwise determined by *us.*
- Human milk fortifiers when prescribed for prevention of necrotizing enterocolitis and administered under the direction of a *health care practitioner.*
- Eye drops, as identified on the *drug list,* including one additional bottle every three months when the initial prescription includes the request for the additional bottle and states it is needed for use in a day care center or school.
- Spacers and/or peak flow meters for the treatment of asthma.
- Drugs, medicines or medications on the Preventive Medication Coverage *drug list* with a *prescription* from a *health care practitioner*.

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

Restrictions on choice of providers

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

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

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

About our drug list

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

Access to medically necessary contraceptives

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

Access to non-formulary drugs

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

Non-formulary drug standard exception request

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

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

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

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

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

Non-formulary drug expedited exception request

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

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

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

- Statement that an exigent circumstance exists and explain the harm that could reasonably be expected to the *covered person* if the requested non-formulary drug is not provided within the timeframes of the standard exception request; and

- Justification supporting the need for the prescribed non-formulary drug to treat the *covered person's* condition, including a statement that all covered drugs on the *drug list* on any tier:

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

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

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

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

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

Non-formulary drug exception request external review

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

The final external review decision by the independent review organization to either uphold the denied exception request or grant the exception request will be provided orally or in writing to *you, your* appointed representative, or the prescribing *health care practitioner* no later than:

- 24 hours after receipt of an external review request if the original exception request was expedited.
- 72 hours after receipt of an external review request if the original exception request was standard.

If the independent review organization grants the exception request, *we* will cover the prescribed, clinically appropriate non-formulary drug for *you* for:

- The duration of the *prescription*, including refills, when the original request was a standard exception request.
- The duration of the exigent circumstance when the original request was an expedited exception request.

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

Step therapy exception request

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

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

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

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

- The *prescription* drug requiring *step therapy* has been ineffective in the treatment of *your* disease or medical condition; or

- Based on sound clinical evidence or medical and scientific evidence, the *prescription* drug requiring *step therapy*:

    - Is expected or likely to be ineffective based on *your* known relevant clinical characteristics and the known characteristics of the *prescription* drug regimen; or
    - Will cause or will likely cause an adverse reaction or physical harm to *you.*

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

- The reason for the denial;
- An alternative covered medication; and
- The right to appeal *our* decision as described in the "Internal Appeal and External Review" section of this *certificate*.

LIMITATIONS AND EXCLUSIONS

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

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

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

LIMITATIONS AND EXCLUSIONS (continued)

- Any amount billed for a professional component of an automated:

  - Laboratory service; or
  - Pathology service.

- Education or training, except for *diabetes self-management training* and *habilitative services*.

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

- Services provided by a *covered person's family member*.

- *Ambulance* services for routine transportation to, from or between medical facilities and/or a *health care practitioner's* office.

- Any drug, biological product, device, medical treatment, or procedure which is *experimental, investigational or for research purposes.*

- Vitamins, except for *preventive services* with a *prescription* from a *health care practitioner,* dietary supplements and dietary formulas, except:

  - Dietary formulas and supplements necessary for the treatment of inborn metabolic errors or genetic conditions, e.g. phenylketonuria (PKU), which are covered by the "Covered Expenses – Pharmacy Services" section in this *certificate.*

  - Human milk fortifiers or 100% human-based diet, when prescribed for prevention of necrotizing enterocolitis and administered under the direction of a *health care practitioner*.

- Over-the-counter, non-prescription medications, unless for drugs, medicines or medications or supplies on the Preventive Medication Coverage *drug list* with a *prescription* from a *health care practitioner*.

- Over-the-counter medical items or supplies that can be provided or prescribed by a *health care practitioner* but are also available without a written order or *prescription,* except for *preventive services*.

- Immunizations required for foreign travel for a *covered person* of any age.

- Growth hormones, except as otherwise specified in the pharmacy services sections of this *certificate.*

- *Prescription* drugs and *self-administered injectable drugs,* except as specified in the "Covered Expenses – Pharmacy Services" section in this *certificate* or unless administered to *you*:

  - While an *inpatient* in a *hospital, skilled nursing facility, health care treatment facility* or *residential treatment facility*;

- By the following, when deemed appropriate by *us*:
  - A *health care practitioner*:
    - During an office visit; or
    - While an *outpatient*; or
  - A *home health care agency* as part of a covered *home health care plan.*

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

LIMITATIONS AND EXCLUSIONS (continued)

- Services provided for:

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

- *Cosmetic surgery* and cosmetic services or devices:

- Hair prosthesis, hair transplants or implants.

- Wigs, unless otherwise stated in the "Covered Expenses" section of this *certificate.*

- Dental services, appliances or supplies for treatment of the teeth, gums, jaws or alveolar processes, including any *oral surgery*, *endodontic services* or *periodontics*, implants and related procedures, orthodontic procedures, and any dental services related to a *bodily injury* or *sickness* unless otherwise stated in this *certificate.*

- The following types of care of the feet:

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

- *Custodial care* and *maintenance care*.

- Any loss contributed to, caused by:

  - War or any act of war, whether declared or not;
  - Insurrection; or
  - Any conflict involving armed forces of any authority.

- Services relating to a *sickness* or *bodily injury* as a result of:

  - Engagement in an illegal profession or occupation; or
  - Commission of or an attempt to commit a criminal act.

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

LIMITATIONS AND EXCLUSIONS (continued)

- Expenses for any membership fees or program fees, including health clubs, health spas, strength conditioning, work-hardening programs, and weight loss or surgical programs, and any materials or products related to these programs.

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

- Expenses for services that are primarily and customarily used for environmental control or enhancement (whether or not prescribed by a *health care practitioner*) and certain medical devices including:

  - Common household items including air conditioners, air purifiers, water purifiers, vacuum cleaners, waterbeds, hypoallergenic mattresses or pillows or exercise equipment;
  - Motorized transportation equipment (e.g. scooters), escalators, elevators, ramps or modifications or additions to living/working quarters or transportation vehicles;
  - Personal hygiene equipment including bath/shower chairs, transfer equipment or supplies or bed side commodes;
  - Personal comfort items including cervical pillows, gravity lumbar reduction chairs, swimming pools, whirlpools, spas or saunas;
  - Medical equipment including:

    - Blood pressure monitoring devices, unless prescribed by a *health care practitioner* for *preventive services* and ambulatory blood pressure monitoring is not available to confirm diagnosis of hypertension;

    - PUVA lights; and

    - Stethoscopes;

  - Communication systems telephone, television or computer systems and related equipment or similar items or equipment;
  - Communication devices, except after surgical removal of the larynx or a diagnosis of permanent lack of function of the larynx.

- Duplicate or similar rentals or purchases of *durable medical equipment* or *diabetes equipment.*

- Therapy and testing for treatment of allergies including, services related to clinical ecology, environmental allergy and allergic immune system dysregulation and sublingual antigen(s), extracts, neutralization tests and/or treatment unless such therapy or testing is approved by:

  - The American Academy of Allergy and Immunology; or
  - The Department of Health and Human Services or any of its offices or agencies.

- Lodging accommodations or transportation, except as otherwise provided within this *certificate*.

- Communications or travel time.

- Bariatric *surgery,* any services or complications related to bariatric *surgery,* and other weight loss products or services.

LIMITATIONS AND EXCLUSIONS (continued)

- Elective medical or surgical abortion unless the abortion would preserve the life of the female upon whom it is performed.

- *Alternative medicine*.

- Acupuncture, unless:

  - The treatment is *medically necessary*, appropriate and is provided within the scope of the acupuncturist's license; and
  - *You* are directed to the acupuncturist for treatment by a licensed physician.

- Services rendered in a premenstrual syndrome clinic or holistic medicine clinic.

- Services of a midwife, unless the midwife holds a permit, as required by state law, and works in collaboration with a *health care practitioner*.

- Vision examinations or testing for the purposes of prescribing corrective lenses, except *comprehensive eye exams* provided under the "Covered Expenses – Pediatric Vision Care" section in this *certificate.*

- Orthoptic/vision training (eye exercises), except as specified in the "Covered Expenses" section of this certificate.

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

- The purchase or fitting of eyeglasses or contact lenses, except as:

  - The result of an *accident* or following cataract *surgery* as stated in this *certificate*.
  - Otherwise specified in the "Covered Expenses – Pediatric Vision Care" section in this *certificate.*

- Services and supplies which are:

  - Rendered in connection with mental illnesses not classified in the International Classification of Diseases of the U.S. Department of Health and Human Services; or
  - Extended beyond the period necessary for evaluation and diagnosis of learning and behavioral disabilities or for mental retardation.

- Marriage counseling.

- Expenses for employment, school, sport or camp physical examinations or for the purposes of obtaining insurance.

- Expenses for care and treatment of non-covered procedures or services.

- Expenses for treatment of complications of non-covered procedures or services.

LIMITATIONS AND EXCLUSIONS (continued)

- Expenses incurred for services prior to the *effective date* or after the termination date of *your* coverage under the *master group contract*. Coverage will be extended as described in the "Extension of Benefits" section, as required by state law.

- Any expense incurred for services received outside of the United States while *you* are residing outside of the United States for more than six months in a *year* except as required by law for an *emergency medical condition* .

- *Pre-surgical/procedural testing* duplicated during a *hospital confinement.*

LIMITATIONS AND EXCLUSIONS - PHARMACY SERVICES

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

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

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

- *Legend drugs,* which are not deemed *medically necessary* by *us.*
- *Prescription* drugs not included on the *drug list.*
- Any amount exceeding the *default rate.*
- *Specialty drugs* for which coverage is not approved by *us.*
- Drugs not approved by the FDA.
- Any drug prescribed for intended use other than for:
  - Indications approved by the FDA; or
  - Off-label indications recognized through peer-reviewed medical literature.
- Any drug prescribed for a *sickness* or *bodily injury* not covered under the *master group contract.*
- Any drug, medicine or medication that is either:
  - Labeled "Caution-limited by federal law to investigational use;" or
  - *Experimental, investigational* or *for research purposes,*

  even though a charge is made to *you.*
- Allergen extracts.
- Therapeutic devices or appliances:
  - Hypodermic needles and syringes (except when prescribed by a *health care practitioner* for use with insulin and *self-administered injectable drugs,* whose coverage is approved by *us*);
  - Support garments;
  - Test reagents;
  - Mechanical pumps for delivery of medications; and
  - Other non-medical substances.

LIMITATIONS AND EXCLUSIONS - PHARMACY SERVICES (continued)

- Dietary supplements and nutritional products, except enteral formulas and nutritional supplements for the treatment of phenylketonuria (PKU) or other inherited metabolic disease. Refer to the "Covered Expenses" section of the *certificate* for coverage of low protein modified foods.

- Non-prescription, over-the-counter minerals, except as specified on the Preventive Medication Coverage *drug list* when obtained from a *network pharmacy* with a *prescription* from a *health care practitioner*.

- Growth hormones for idiopathic short stature or any other condition, unless there is a laboratory confirmed diagnosis of growth hormone deficiency, or as otherwise determined by *us*.

- Herbs and vitamins, except prenatal (including greater than one milligram of folic acid), pediatric multi-vitamins with fluoride and vitamins on the Preventive Medication Coverage *drug list* when obtained from a *network pharmacy* with a *prescription* from a *health care practitioner*.

- Any drug used for the purpose of weight loss.

- Any drug used for cosmetic purposes:

  - Dermatologicals or hair growth stimulants; or
  - Pigmenting or de-pigmenting agents.

- Any drug or medicine that is lawfully obtainable without a *prescription* (over-the-counter drugs), except:

  - Insulin; and
  - Drugs, medicines or medications and supplies on the Preventive Medication Coverage *drug list* when obtained from a *network pharmacy* with a *prescription* from a *health care practitioner*.

- Compounded drugs that:

  - Are prescribed for a use or route of administration that is not FDA approved or compendia supported;
  - Are prescribed without a documented medical need for specialized dosing or administration;
  - Only contain ingredients that are available over-the-counter;
  - Only contain non-commercially available ingredients; or
  - Contain ingredients that are not FDA approved, including bulk compounding powders.

- Abortifacients (drugs used to induce abortions).

- *Infertility services* including medications.

- Any drug prescribed for impotence and/or sexual dysfunction.

LIMITATIONS AND EXCLUSIONS - PHARMACY SERVICES (continued)

- Any drug, medicine or medication that is consumed or injected at the place where the *prescription* is given, or dispensed by the *health care practitioner*.

- The administration of covered medication(s).

- *Prescriptions* that are to be taken by or administered to *you,* in whole or in part, while *you* are a patient in a facility where drugs are ordinarily provided on an *inpatient* basis by the facility. *Inpatient* facilities include:

  - *Hospital*;
  - *Skilled nursing facility*; or
  - Hospice facility.

- Injectable drugs, including:

  - Immunizing agents, unless for *preventive services* determined by *us* to be dispensed by or administered in a *pharmacy*;
  - Biological sera;
  - Blood;
  - Blood plasma; or
  - *Self-administered injectable drugs* or *specialty drugs* for which *prior authorization* or *step therapy* is not obtained from *us.*

- *Prescription* fills or refills:

  - In excess of the number specified by the *health care practitioner*; or
  - Dispensed more than one year from the date of the original order.

- Any portion of a *prescription* fill or refill that exceeds a 90-day supply when received from a *mail order pharmacy* or a retail *pharmacy* that participates in *our* program, which allows *you* to receive a 90-day supply of a *prescription* fill or refill.

- Any portion of a *prescription* fill or refill that exceeds a 30-day supply when received from a retail *pharmacy* that does <u>not</u> participate in *our* program, which allows *you* to receive a 90-day supply of a *prescription* fill or refill.

- Any portion of a *specialty drug prescription* fill or refill that exceeds a 30-day supply, unless otherwise determined by *us*.

- Any portion of a *prescription* fill or refill that:

  - Exceeds *our* drug-specific *dispensing limit*;
  - Is dispensed to a *covered person,* whose age is outside the drug-specific age limits defined by *us*;
  - Is refilled early, as defined by *us*; or
  - Exceeds the duration-specific *dispensing limit*.

LIMITATIONS AND EXCLUSIONS - PHARMACY SERVICES (continued)

- Any drug for which *we* require *prior authorization* or *step therapy* and it is not obtained.
- Any drug for which a charge is customarily not made.
- Any drug, medicine or medication received by *you*:
  - Before becoming covered; or
  - After the date *your* coverage has ended.
- Any costs related to the mailing, sending or delivery of *prescription* drugs.
- Any intentional misuse of this benefit, including *prescriptions* purchased for consumption by someone other than *you.*
- Any *prescription* fill or refill for drugs, medicines or medications that are lost, stolen, spilled, spoiled, or damaged.
- Drug delivery implants and other implant systems or devices except as specified under Durable Medical Equipment in the "Covered Expenses" section of this *certificate.*
- Any amount *you* paid for a *prescription* that has been filled, regardless of whether the *prescription* is revoked or changed due to adverse reaction or change in dosage or *prescription*.

ELIGIBILITY AND EFFECTIVE DATES

Eligibility date

Employee eligibility date

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

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

Dependent eligibility date

Each *dependent* is eligible for coverage on:

- The date the *employee* is eligible for coverage, if he or she has *dependents* who may be covered on that date;
- The date of the *employee's* marriage for any *dependents* (spouse or child) acquired on that date;
- The date of birth of the *employee's* natural-born child;
- The date of placement of the child for the purpose of adoption by the *employee*; or
- The date specified in a Qualified Medical Child Support Order (QMCSO), or National Medical Support Notice (NMSN) for a child, or a child for whom you are the court appointed legal guardian, or a valid court or administrative order for a spouse, which requires the *employee* to provide coverage for a child or spouse as specified in such orders.

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

Enrollment

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

Employee enrollment

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

ELIGIBILITY AND EFFECTIVE DATES (continued)

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

Health status will not be used to determine premium rates. *We* will not use *health status-related factors* to decline coverage to an eligible *employee* and *we* will administer this provision in a non-discriminatory manner.

Dependent enrollment

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

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

Health status will not be used to determine premium rates. *We* will not use *health status-related factors* to decline coverage to an eligible *dependent* and *we* will administer this provision in a non-discriminatory manner.

Newborn and adopted dependent enrollment

A newborn *dependent* will be automatically covered from the date of birth to 31 days of age. An adopted *dependent* will be automatically covered from the date of adoption or placement of the child with the *employee* for the purpose of adoption, whichever occurs first, for 31 days.

If additional premium is not required to add additional *dependents* and if *dependent* child coverage is in force as of the newborn's date of birth in the case of newborn *dependents* or the earlier of the date of adoption or placement of the child with the *employee* for purposes of adoption in case of adopted *dependents*, coverage will continue beyond the initial 31 days. *You* must notify *us* to make sure *we* have accurate records to administer benefits.

If premium is required to add *dependents you* must enroll the *dependent* child and pay the additional premium within 31 days:

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

ELIGIBILITY AND EFFECTIVE DATES (continued)

If enrollment is requested more than 31 days after the date of birth, date of adoption or placement with the *employee* for the purpose of adoption, and additional premium is required, the *dependent* is a *late applicant.* A *late applicant* must wait to enroll for coverage during the *open enrollment period*, unless the *late applicant* becomes eligible for special enrollment as specified in the "Special enrollment" provision.

Special enrollment

Special enrollment is available if the following apply:

- *You* have a change in family status due to:

  - Marriage;
  - Divorce;
  - A Qualified Medical Child Support Order (QMCSO);
  - A National Medical Support Notice (NMSN);
  - The birth of a natural born child; or
  - The adoption of a child or placement of a child with the *employee* for the purpose of adoption, or any child for which the insured is a court appointed guardian; and
  - You enroll within 31 days after the *special enrollment date*; or

- You are an *employee* or *dependent* eligible for coverage under the *master group contract,* and:

  - You previously declined enrollment stating you were covered under another group health plan or other *health insurance coverage*; and
  - Loss of eligibility of such other coverage occurs, regardless of whether you are eligible for, or elect COBRA; and
  - You enroll within 31 days after the *special enrollment date*.

  Loss of eligibility of other coverage includes:

  - Termination of employment or eligibility;
  - Reduction in number of hours of employment;
  - Divorce, legal separation or death of a spouse;
  - Loss of dependent eligibility, such as attainment of the limiting age;
  - Termination of your employer's contribution for the coverage;
  - Loss of individual HMO coverage because you no longer reside, live or work in the service area;
  - Loss of group HMO coverage because you no longer reside, live or work in the service area, and no other benefit package is available; or
  - The plan no longer offers benefits to a class of similarly situated individuals; or

- You had COBRA continuation coverage under another plan at the time of eligibility, and:

  - Such coverage has since been exhausted; and
  - You stated at the time of the initial enrollment that coverage under COBRA was your reason for declining enrollment; and
  - You enroll within 31 days after the *special enrollment date*; or

- You were covered under an alternate plan provided by the *employer* that terminates, and:

  - You are replacing coverage with the *master group contract*; and
  - You enroll within 31 days after the *special enrollment date*; or

- You are an *employee* or *dependent* eligible for coverage under the *master group contract,* and:

  - Your *Medicaid* coverage or your Children's Health Insurance Program (CHIP) coverage terminated as a result of loss of eligibility; and
  - You enroll within 60 days after the *special enrollment date*; or

- You are an *employee* or *dependent* eligible for coverage under the *master group contract,* and:

  - You become eligible for a premium assistance subsidy under *Medicaid* or CHIP; and
  - You enroll within 60 days after the *special enrollment date*.

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

Dependent special enrollment

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

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

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

Open enrollment

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

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

Effective date

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

Employee effective date

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

Dependent effective date

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

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

Newborn and adopted dependent effective date

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

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

Premium is due within 31 days after the date of birth in order to have coverage continued beyond the first 31 days. Additional premium may not be required when *dependent* coverage is already in force.

Open enrollment effective date

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

Retired employee coverage

Retired employee eligibility date

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

Retired employee enrollment

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

Retired employee effective date

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

REPLACEMENT OF COVERAGE

Applicability

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

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

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

Deductible credit

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

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

Waiting period credit

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

Out-of-pocket limit

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

TERMINATION PROVISIONS

Termination of coverage

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

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

When *we* receive notification of a change in eligibility status in advance of the effective date of the change, coverage will terminate on the actual date specified by the *employer* or *employee* or at the end of that month, as selected by *your employer* on the EGA. In the event of cancellation, *we* will promptly return the unearned portion of premium paid.

When *we* receive the *employer's* request to terminate coverage retroactively, the *employer's* termination request is their representation to *us* that *you* did not pay any premium or make contribution for coverage past the requested termination date. We will not keep any premium for which coverage or benefits are not provided. Unearned premium received for coverage after the date *we* make the change effective, will be promptly returned.

Otherwise, coverage terminates on the earliest of the following:

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

- The date *your dependent* no longer qualifies as a *dependent*;
- For any benefit, the date the benefit is deleted from the *master group contract*; or
- The date fraud or an intentional misrepresentation of a material fact has been committed by *you.* For more information on fraud and intentional misrepresentation, refer to the "Fraud" provision in the "Miscellaneous Provisions" section of this *certificate. We* will give a 30 day advance written notice of cancellation.

Any dissatisfaction may be expressed to *us* through the established appeals process set out in the "Internal Appeal and External Review" section of this *certificate.*

Termination for cause

We will give a 30 day advance written notice if *we* terminate *your* coverage for cause under the following circumstances:

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

EXTENSION OF BENEFITS

Extension of coverage for total disability

We extend limited coverage if:

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

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

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

Extension of coverage for hospital confinement

We extend limited coverage if the *master group contract* terminates while *you* are *hospital confined* due to a *bodily injury* or *sickness* that occurs while the *master group contract* is in effect.

Benefits are payable only for those expenses incurred for the same *sickness* or *bodily injury* which caused *you* to be *hospital confined.* Coverage during the *hospital confinement* continues without premium payment, but not beyond the earliest of the following dates:

- The date *you* are discharged from the *hospital confinement*;
- The date any maximum benefit is reached; or
- The last day of a 12 consecutive month period following the date the *master group contract* terminated.

CONTINUATION

Continuation options in the event of termination

If coverage terminates:

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

A complete description of the "State continuation of coverage" and "Continuation of coverage for dependents" provisions follow.

State continuation of coverage

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

An *employee* may elect to continue his or her coverage.

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

In order to be eligible for this option:

- The *employee* must have been continuously covered under the *master group contract,* or any group coverage it replaced, for at least three consecutive months prior to termination;
- The *group plan sponsor* must notify *us* that the *covered person* has terminated membership under the *master group contract*;
- Written application and payment of premium is received from the *covered person* within 31 days after receiving notification from *us* of his or her right to continuation.

We must give the *covered person* written notice of the right to continue coverage under the *master group contract* upon notice from the *group plan sponsor* that the *covered person* has terminated coverage under the *master group contract. We* will mail or deliver written notice to the last known address of the *covered person,* which shall constitute the giving of notice as required.

Written application and payment of the first premium for continuation must be made within 31 days after the *covered person* has been given the required notice by *us.* No evidence of insurability is required to obtain continuation.

If *we* fail to provide written notice as soon as practicable after being notified of *our* failure to provide written notice, *you* will have an additional 60 days after written notice is received.

There is no right to continuation if:

- The *covered person* is, or could be, covered by *Medicare*;
- The *covered person* is, or could be, covered by similar benefits under another group coverage, either on an insured or uninsured basis; or
- Similar benefits are provided for, or available to, the *covered person* under any state or federal law.

If this state continuation option is selected, continuation will be permitted for a maximum of 18 months. Continuation shall terminate on the earliest of:

- The date 18 months after the date on which the *group* coverage would have otherwise terminated because of termination of employment or membership in the *group*;
- The date timely premium payments are not made on *your* behalf; or
- The date the *master group contract* terminates in its entirety and is not replaced by another group coverage within 31 days.

If the *master group contract* terminates in its entirety before the end of the continuation period and is replaced by another group coverage, the *covered person's* coverage will continue until the time otherwise specified.

Continuation of coverage for dependents

Continuation of coverage is available for *dependents* that are no longer eligible for the coverage provided by the *master group contract* because of:

- The death of the covered *employee*;
- The retirement of the covered *employee*; or
- The severance of the family relationship.

Continuation of coverage is also available to a covered *dependent* child who is no longer eligible for coverage under the *master group contract* due to attaining the limiting age of the *master group contract.*

Each *dependent* may choose to continue these benefits for up to 18 months after the date the coverage would have normally terminated.

In order to be eligible for this option:

- The *dependent* must have been continuously covered under the *master group contract*, or any group coverage it replaced, for at least three consecutive months prior to termination, except in the case of an infant under one year of age; and

CONTINUATION (continued)

- The covered *employee* or *dependent* must give the *group plan sponsor* written notice within 31days of the death or retirement of the *employee,* severance of the family relationship or the attainment of the limiting age by a covered *dependent* child that might activate this continuation option; and

- The *group plan sponsor* must notify *us* of the death or retirement of the *employee,* severance of the family relationship or the attainment of the limiting age by a covered *dependent* child;

- Written application and payment of premium is received from the *dependent* within 31 days after receiving notification from *us* of his or her right to continuation.

We must give the *dependent* written notice of the right to continue coverage under the *master group contract* upon notice from the *group plan sponsor* that the *dependent's* coverage terminated, or may terminate, under the *master group contract* as a result of the death or retirement of the *employee,* severance of the family relationship or the attainment of the limiting age by a covered *dependent* child. *We* will mail or deliver written notice to the last known address of the *dependent,* which shall constitute the giving of notice as required.

Written application and payment of the first premium for continuation must be made within 31 days after the *dependent* has been given the required notice by *us.* No evidence of insurability is required to obtain continuation.

If *we* fail to provide written notice as soon as practicable after being notified of *our* failure to provide written notice, *you* will have an additional 60 days after written notice is received.

The option to continue coverage is <u>not</u> available if:

- The termination of coverage occurred because the *dependent* failed to pay the required premium contribution within 31 days after being notified by *us* of his or her right to continuation coverage;

- The *master group contract* terminates in its entirety and is not replaced by another group coverage within 31 days;

- A *dependent* is, or could be, covered by *Medicare*;

- A *dependent* is, or could be, covered for similar benefits under another group coverage, either on an insured or self-insured basis;

- The *dependent* was not continuously covered by the *master group contract,* or any group coverage it replaced, for at least three months prior to the date coverage terminates, except in the case of an infant under 1 year of age; or

- The *dependent* elects to continue his or her coverage under the terms and conditions described in (COBRA).

CONTINUATION (continued)

Continued coverage terminates on the earliest of the following dates:

- The last day of the 18 month period following the date the *dependent* was no longer eligible for coverage;
- The date timely premium payments are not made on *your* behalf; or
- The date the *master group contract* terminates and is not replaced by another group coverage within 31 days.

The *covered person* is responsible for sending *us* written application and the premium payments for those individuals who choose to continue their coverage. Premiums must be paid each month in advance for coverage to continue. If the *covered person* fails to make proper payment of the premiums to *us*, *we* are relieved of all liability for any coverage that was continued.

MEDICAL CONVERSION PRIVILEGE

Eligibility

Subject to the terms below, if *your* medical coverage under the *master group contract* terminates, a Medical Conversion Policy is available without medical examination. *You* must have been covered continuously under the *master group contract* or any group health plan it replaced for at least 90 days and:

- *Your* coverage ends because the *employee's* employment terminated;
- *You* are a covered *dependent* whose coverage ends due to the *employee's* marriage ending via legal annulment, dissolution of marriage or divorce;
- *You* are the surviving covered *dependent*, in the event of the *employee's* death or at the end of any survivorship continuation as provided by the *master group contract*; or
- *You* have been a covered *dependent* child but no longer meet the definition of *dependent* under the *master group contract*; and
- *Your* coverage under the *master group contract* is not terminated because of fraud or material intentional misrepresentation.

Only persons covered under the *master group contract* on the date coverage terminates are eligible to be covered under the Medical Conversion Policy.

The Medical Conversion Policy may be issued covering each former *covered person* on a separate basis or it may be issued covering all former *covered persons* together. However, if conversion is due to dissolution of marriage by annulment or final divorce decree, only those persons who cease to be a *dependent* of the *employee* are eligible to exercise the medical conversion privilege.

The *group plan sponsor* must notify *us* that the *covered person* has terminated membership with the group plan. *We* will then give written notice of the right to conversion to any *covered person* entitled to conversion. Proper notice will be mailed or delivered to the last known address of the *covered person.*

Written application and payment of the first premium for conversion must be made to *us* within 31 days after the date coverage terminates or within 31 days after the *covered person* has been given the required notice. No evidence of insurability is required to obtain conversion.

If the *master group contract* terminates, *we* will notify each *covered person* of their right to continuation within 15 business days after the end of the grace period.

If *we* fail to provide written notice as soon as practicable after being notified of *our* failure to provide written notice, *you* will have an additional 60 days after written notice is received.

A Medical Conversion Policy is not available when:

- *You* are not a legal resident of Kentucky; or
- The *employer's* participation in the *master group contract* terminates and medical coverage is replaced within 31 days by another group coverage plan;
- The covered person is or could be covered by *Medicare*; or
- The covered person has similar benefits under another group or individual plan whether insured or uninsured.

Please contact *us* for details regarding other coverage options that may be available to *you.*

MEDICAL CONVERSION PRIVILEGE (continued)

Overinsurance - duplication of coverage

We may refuse to issue a Medical Conversion Policy if *we* determine *you* would be overinsured. The Medical Conversion Policy will not be available if it would result in overinsurance or duplication of benefits. *We* will use *our* standards to determine overinsurance.

Medical conversion policy

The Medical Conversion Policy which *you* may apply for will be the Medical Conversion Policy customarily offered by *us* as a conversion from *group* coverage or as mandated by state law.

The Medical Conversion Policy is a new plan and not a continuation of *your* terminated coverage. The Medical Conversion Policy benefits will differ from those provided under *your group* coverage. The benefits that may be available to *you* will be described in an Outline of Coverage provided to *you* when *you* request an application for conversion from *us.*

Effective date and premium

You have 31 days after the date *your* coverage terminates under the *master group contract* to apply and pay the required premiums for *your* Medical Conversion Policy. The premiums must be paid in advance. *You* may obtain application forms from *us.* The Medical Conversion Policy will be effective on the day after *your group* medical coverage ends, if *you* enroll and pay the first premiums within 31 days after the date *your* coverage ends.

The premiums for the Medical Conversion Policy will be the premiums charged by *us* as of the effective date based upon the Medical Conversion Policy form, classification of risk, age and benefit amounts selected. The premiums may change as provided in the Medical Conversion Policy.

COORDINATION OF BENEFITS

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

Definitions

The following definitions are used exclusively in this provision.

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

Plan includes:

- Group and nongroup insurance contracts, health maintenance organization (HMO) contracts, closed panel or other forms of group or group-type coverage (whether insured or uninsured);
- Medical care components of long-term care contracts, such as skilled nursing care; and
- *Medicare* or other governmental benefits, as permitted by law.

Plan does not include:

- Hospital indemnity benefits;
- School accident type coverage;
- Benefits for non-medical care components of group long-term care contracts;
- *Medicare* supplement policies;
- A state plan under *Medicaid*;
- Medical benefits under group, group-type, and individual automobile "No Fault" and traditional automobile "Fault" type contracts; and
- Coverage under other governmental plans, unless permitted by law.

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

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

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

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

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

- If a *covered person* is confined in a private *hospital* room, the difference between the cost of a semi-private room in the *hospital* and the private room, (unless the patient's stay in a private *hospital* room is medically necessary in terms of generally accepted medical practice, or one of the *plans* routinely provides coverage for *hospital* private rooms) is not an *allowable expense*.

- If a person is covered by two or more *plans* that compute their benefits payments on the basis of usual and customary fees, any amount in excess of the highest usual and customary fees for a specific benefit is not an *allowable expense.*

- If a person is covered by two or more *plans* that provide benefits or services on the basis of negotiated fees, any amount in excess of the highest of the fees is not an *allowable expense*.

- If a person is covered by one *plan* that calculates its benefits or services on the basis of usual and customary fees and another *plan* that provides its benefits or services on the basis of negotiated fees, the *primary plan's* payment arrangement shall be the *allowable expense* for all *plans*.

- The amount a benefit is reduced by the *primary plan* because a *covered person* does not comply with the *plan* provisions. Examples of these provisions are second surgical opinions, precertification of *admissions* and preferred provider arrangements.

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

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

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

Order of determination rules

General

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

- The *primary plan* pays or provides its benefits as if the *secondary plan* or *plans* did not exist.

COORDINATION OF BENEFITS (continued)

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

- A *plan* may consider the benefits paid or provided by another *plan* in determining its benefits only when it is *secondary* to that other *plan*.

Rules

The first of the following rules that describes which *plan* pays its benefits before another *plan* is the rule to use.

- **Non-dependent or *dependent*.** The *plan* that covers the person other than as a *dependent,* for example as an *employee,* member, subscriber or retiree is *primary* and the *plan* that covers the person as a *dependent* is *secondary*. However, if the person is a *Medicare* beneficiary and, as a result of federal law, *Medicare* is *secondary* to the *plan* covering the person as a *dependent*; and *primary* to the *plan* covering the person as other than a *dependent* (e.g. retired *employee*); then the order of benefits between the two *plans* is reversed so that the *plan* covering the person as an *employee,* member, subscriber or retiree is *secondary* and the other *plan* is *primary*.

- **Dependent child covered under more than one *plan***. The order of benefits when a child is covered by more than one *plan* is:

  - The *primary plan* is the *plan* of the parent whose birthday is earlier in the year if:

    - The parents are married;
    - The parents are not separated (whether or not they have been married); or
    - A court decree awards joint custody without specifying that one part has the responsibility to provide health care coverage.

  - If both the parents have the same birthday, the *plan* that covered either of the parents longer is *primary*.

  - If the specific terms of a court decree state that one parent is responsible for the child's health care expenses or health care coverage and the *plan* of that parent has actual knowledge of those terms, that *plan* is *primary*. This rule applies to *claim determination periods* or plan years commencing after the *plan* is given notice of the court decree.

  - If the parents are not married, or are separated (whether or not they ever have been married) or are divorced, the order of benefits is:

    - The *plan* of the *custodial parent*;
    - The *plan* of the spouse of the *custodial parent*;
    - The *plan* of the non-*custodial parent*; and then
    - The *plan* of the spouse of the non-*custodial parent.*

- **Active or inactive *employee***. The *plan* that covers a person as an *employee* who is neither laid off nor retired, is *primary*. The same would hold true if a person is a *dependent* of a person covered as a retiree and an *employee.* If the other *plan* does not have this rule, and if, as a result, the *plans* do not agree on the order of benefits, this rule is ignored.

- **Continuation coverage**. If a person whose coverage is provided under a right of continuation provided by federal or state law also is covered under another *plan,* the *plan* covering the person as an *employee,* member, subscriber or retiree (or as that person's *dependent*) is *primary*, and the continuation coverage is *secondary.* If the other *plan* does not have this rule, and if, as a result, the *plans* do not agree on the order of benefits, this rule is ignored.

- **Longer or shorter length of coverage**. The *plan* that covered the person as an *employee,* member, subscriber or retiree longer is *primary*.

  To determine the length of time a person has been covered under a *plan,* two plans shall be treated as one if the *covered person* was eligible under the second within twenty-four hours after the first ended;

  Changes during a coverage period that do not constitute the start of a new *plan* include:

  - A change in scope of a *plan's* benefits;
  - A change in the entity that pays, provides or administers the *plan's* benefits; or
  - A change from one type of *plan* to another.

  The person's length of time covered under a *plan* is measured from the person's first date of coverage under that *plan.* If that date is not readily available for a *group plan,* the date the person first became a member of the *group* shall be used as the date from which to determine the length of time the person's coverage under the present *plan* has been in force.

If the preceding rules do not determine the *primary plan,* the *allowable expenses* shall be shared equally between the *plans* meeting the definition of *plan* under this provision. In addition, this *plan* will not pay more that it would have had it been *primary*.

Effects on the benefits of this plan

When this *plan* is *secondary,* benefits may be reduced to the difference between the *allowable expense* (determined by the *primary plan*) and the benefits paid by any *primary plan* during the *claim determination period.* Payment from all *plans* will not exceed 100% of the total *allowable expense.*

The benefits of the *secondary plan* shall be reduced when the sum of the benefits payable that would be payable under the other *plans,* in the absence of a coordination of benefits provision, whether or not a claim is made, exceeds the *allowable expenses* in *claim determination period,* with a reduction of benefits as follow:

- The benefits of the *secondary plan* shall be reduced so that they and the benefits payable under the other *plans* do not total more than the *allowable expenses*; and
- Each benefit is reduced in proportion and charged against any applicable benefit limit of the *plan.*

COORDINATION OF BENEFITS (continued)

If a person is covered by more than one *secondary plan*, the order of benefit determination rules decide the order in which the *secondary plan* benefits are determined in relation to each other. Each *secondary plan* takes into consideration the benefits of the *primary plan* or *plans* and the benefits of any other *plan*, which has its benefits determined before those of that *secondary plan*.

If a *covered person* is enrolled in two or more *closed panel plans* and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one *closed panel plan*, COB shall not apply between that *plan* and the other *closed panel plan*.

Notice to covered persons

If *you* are covered by more than one health benefit plan, *you* should file all claims with each *plan*.

Miscellaneous provisions

A *secondary plan* that provides benefits in the form of services may recover the reasonable cash value of the services from the *primary plan*, to the extent that benefits for the services are covered by the *primary plan* and have not already been paid or provided by the *primary plan*.

A plan with order of benefit determination requirements that comply with this administrative regulation may coordinate its benefits with a plan that is "excess" or "always secondary" or that uses order of benefit determination requirements that do not comply with those contained in this administrative regulation on the following basis:

- If the complying plan is the primary plan, it shall pay or provide its benefits first;
- If the complying plan is the secondary plan, it shall pay or provide its benefits first; but the amount of the benefits payable shall be determined as if the complying plan were the secondary plan. In that situation, the payment shall be the limit of the complying plan's liability; and
- If the non-complying plan does not provide the information needed by the complying plan to determine its benefits within a reasonable time after it is requested to do so, the complying plan shall assume that the benefits of the non-complying plan are identical to its own, and shall pay its benefits accordingly. If, within two years of payment, the complying plan receives information as to the actual benefits of the non-complying plan, it shall adjust payments accordingly.

If the non-complying *plan* reduces its benefits so that the *covered person* receives less in benefits than he would have received had the complying *plan* paid or provided its benefits as the *secondary plan* and the non-complying *plan* paid or provided its benefits as the *primary plan*, and governing state law allows the right of subrogation set forth below, then the complying *plan* shall advance to or on behalf of the *covered person* an amount equal to the difference.

The complying *plan* shall not advance more than the complying *plan* would have paid had it been the *primary plan* less any amount it previously paid for the same expense or service, and:

- In consideration of the advance, the complying *plan* shall be subrogated to all rights of the *covered person* against the non-complying *plan*; and
- The advance by the complying *plan* shall also be without prejudice to any claim it may have against a non-complying *plan* in the absence of subrogation.

Coordination of benefits differs from subrogation. Provisions for one may be included in health care benefits contracts without compelling the inclusion or exclusion of the other.

If the *plans* cannot agree on the order of benefits within thirty calendar days after the *plans* have received all of the information needed to pay the claim, the *plans* shall immediately pay the claim in equal shares and determine their relative liabilities following payment, except that no *plan* shall be required to pay more than it would have paid had it been primary.

Severability

If any provision of this administrative regulation or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of this administrative regulation and the application of that provision to other person or circumstances shall not be affected thereby.

Right to receive and release needed information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this *plan* and other *plans*. *We* may get the facts *we* need from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under this *plan* and other *plans* covering the person claiming benefits. *We* need not tell, or get the consent of, any person to do this. Each person claiming benefits under this *plan* must give *us* any facts *we* need to apply those rules and determine benefits payable.

Facility of payment

A payment made under another *plan* may include an amount that should have been paid under this *plan*. If it does, *we* may pay that amount to the organization that made the payment. That amount will then be treated as though it were a benefit paid under this *plan*. *We* will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means a reasonable cash value of the benefits provided in the form of services.

COORDINATION OF BENEFITS (continued)

Right of recovery

If the amount of the payments made by *us* is more than *we* should have paid under this COB provision, *we* may recover the excess from one or more of the persons *we* have paid or for whom we have paid; or any other person or organization that may be responsible for the benefits or services provided for the *covered person.* The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

Cooperation required

The *covered person* shall cooperate by providing information and executing any documents to preserve *our* right and shall have the affirmative obligation of notifying *us* that claims are being made against responsible parties to recover for injuries for which *we* have paid. If the *covered person* enters into litigation or settlement negotiations regarding the obligations of the other party, the *covered person* must not prejudice, in any way, *our* rights to recover an amount equal to any benefits *we* have provided or paid for the *injury or sickness.* Failure of the *covered person* to provide *us* such notice or cooperation, or any action by the *covered person* resulting in prejudice to *our* rights will be a material breach of this *policy* and will result in the *covered person* being personally responsible to make repayment. In such an event, *we* may deduct from any pending or subsequent claim made under the *policy* any amounts the *covered person* owes *us* until such time as cooperation is provided and the prejudice ceases.

General coordination of benefits with Medicare

If *you* are covered under both *Medicare* and this *certificate,* federal law mandates that *Medicare* is the secondary plan in most situations. When permitted by law, this plan is the secondary plan. In all cases, coordination of benefits with *Medicare* will conform to federal statutes and regulations. If *you* are enrolled in *Medicare, your* benefits under this *certificate* will be coordinated to the extent benefits are payable under *Medicare,* as allowed by federal statutes and regulations.

CLAIMS

Notice of claim

Network providers will submit claims to *us* on *your* behalf. If *you* utilize a *non-network provider* for *covered expenses*, *you* must submit a notice of claim to *us*. Notice of claim must be given to *us* in writing or by *electronic mail* as required by *your* plan, or as soon as is reasonably possible thereafter. Notice must be sent to *us* at *our* mailing address shown on *your* ID card or at *our* Website at www.humana.com.

Claims must be complete. At a minimum a claim must contain:

- Name of the *covered person,* who incurred the *covered expenses*;
- Name and address of the provider;
- Diagnosis;
- Procedure or nature of the treatment;
- Place of service;
- Date of service; and
- Billed amount.

If *you* receive services outside the United States or from a foreign provider, *you* must also submit the following information along with *your* complete claim:

- *Your* proof of payment to the provider for the services received outside the United States or from a foreign provider;
- Complete medical information and medical records;
- *Your* proof of travel outside of the United States, such as airline tickets or passport stamps, if *you* traveled to receive the services; and
- The foreign provider's fee schedule if the provider uses a billing agency.

The forms necessary for filing proof of loss are available at www.humana.com. When requested by *you, we* will send *you* the forms for filing proof of loss. If the requested forms are not sent to *you* within 15 days, *you* will have met the proof of loss requirements by sending *us* a written or *electronic* statement of the nature and extent of the loss containing the above elements within the time limit stated in the "Proof of loss" provision.

Proof of loss

You must give written or *electronic* proof of loss within 90 days after the date *you* incur such loss. *Your* claims will not be reduced or denied if it was not reasonably possible to give such proof within that time period.

Your claims may be reduced or denied if written or *electronic* proof of loss is not provided to *us* within one year after the date proof of loss is required, unless *your* failure to timely provide that proof of loss is due to *your* legal incapacity as determined by an appropriate court of law.

Claims processing procedures

Qualified provider services are subject to *our* claims processing procedures. *We* use *our* claims processing procedures to determine payment of *covered expenses*. *Our* claims processing procedures include, but are not limited to, claims processing edits and claims payment policies, as determined by *us*. *Your qualified provider* may access *our* claim processing edits and claim payment policies on *our* website at www.humana.com by clicking on "For Providers" and "Claims Resources."

Claims processing procedures include the interaction of a number of factors. The amount determined to be payable for a *covered expense* may be different for each claim because the mix of factors may vary. Accordingly, it is not feasible to provide an exhaustive description of the claims processing procedures, but examples of the most commonly used factors are:

- The complexity of a service;
- Whether a service is one of multiple same-day services such that the cost of the service to the *qualified provider* is less than if the service had been provided on a different day. For example:
    - Two or more *surgeries* performed the same day;
    - Two or more endoscopic procedures performed during the same day; or
    - Two or more therapy services performed the same day;
- Whether a *co-surgeon*, *assistant surgeon*, *surgical assistant*, or any other *qualified provider*, who is billing independently is involved;
- When a charge includes more than one claim line, whether any service is part of or incidental to the primary service that was provided, or if these services cannot be performed together;
- Whether the service is reasonably expected to be provided for the diagnosis reported;
- Whether a service was performed specifically for *you*; or
- Whether services can be billed as a complete set of services under one billing code.

We develop *our* claims processing procedures in *our* sole discretion based on *our* review of correct coding initiatives, national benchmarks, industry standards, and industry sources such as the following, including any successors of the same:

- *Medicare* laws, regulations, manuals and other related guidance;
- Federal and state laws, rules and regulations, including instructions published in the Federal Register;
- National Uniform Billing Committee (NUBC) guidance including the UB-04 Data Specifications Manual;
- American Medical Association's (AMA) Current Procedural Terminology (CPT®) and associated AMA publications and services;
- Centers for Medicare & Medicaid Services' (CMS) Healthcare Common Procedure Coding System (HCPCS) and associated CMS publications and services;
- International Classification of Diseases (ICD);
- American Hospital Association's Coding Clinic Guidelines;
- Uniform Billing Editor;
- American Psychiatric Association's (APA) Diagnostic and Statistical Manual of Mental Disorders (DSM) and associated APA publications and services;
- Food and Drug Administration guidance;

- Medical and surgical specialty societies and associations;
- Industry-standard utilization management criteria and/or care guidelines;
- *Our* medical and pharmacy coverage policies; and
- Generally accepted standards of medical, behavioral health and dental practice based on credible scientific evidence recognized in published peer reviewed literature.

Changes to any one of the sources may or may not lead *us* to modify current or adopt new claims processing procedures.

Subject to applicable law, *qualified providers* who are *non-network providers* may bill *you* for any amount *we* do not pay even if such amount exceeds the allowed amount after *we* apply claims processing procedures. Any such amount paid by *you* will not apply to *your deductible* or any *out-of-pocket limit*. *You* will also be responsible for any applicable *deductible*, *copayment*, or *coinsurance*.

You should discuss *our* claims processing edits, claims payment policies and medical or pharmacy coverage policies and their availability with any *qualified provider* prior to receiving any services. *You* or *your qualified provider* may access *our* claims processing edits and claims payment policies on *our* website at www.humana.com by clicking on "For Providers" and "Coverage Policies." *Our* medical and pharmacy coverage policies may be accessed on *our* website at www.humana.com under "Medical Resources" by clicking "Coverage Policies." *You* or *your qualified provider* may also call *our* toll-free customer service number listed on *your* ID card to obtain a copy of a claims processing edit, claims payment policy or coverage policy.

Other programs and procedures

We may introduce new programs and procedures that apply to *your* coverage under this *master group contract*. *We* may also introduce limited pilot or test programs including, but not limited to, disease management, care management, expanded accessibility, or wellness initiatives.

We reserve the right to discontinue or modify a program or procedure at any time.

Right to require medical examinations

We have the right to require a medical examination on any *covered person* as often as *we* may reasonably require. If *we* require a medical examination, it will be performed at *our* expense. *We* also have a right to request an autopsy in the case of death, if state law so allows.

To whom benefits are payable

We will pay the *qualified provider* directly for *covered expenses* for services *you* receive from:

- A *network provider*; or
- A *non-network provider* when *you* are only responsible to pay the *network provider copayment, deductible* and/or *coinsurance* based on the *qualified payment amount.*

All other benefit payments for *covered expenses* rendered by a *non-network provider* are due and owing solely to the *covered person*. Assignment of benefits is prohibited. However, *you* may request that *we* direct a payment of selected medical benefits to the health care provider on whose charge the claim is based. If *we* consent to this request, *we* will pay the health care provider directly. Such payments will not constitute the assignment of any legal obligation to the *non-network provider*. If *we* decline this request, *we* will pay *you* directly, and *you* are then responsible to pay all charges to the *non-network provider(s)*.

If any *covered person* to whom benefits are payable is a minor or, in *our* opinion, not able to give a valid receipt for any payment due him or her, such payment will be made to his or her parent or legal guardian. However, if no request for payment has been made by the parent or legal guardian, *we* may, at *our* option, make payment to the person or institution appearing to have assumed his or her custody and support.

Time of payment of claims

Payments due under the *master group contract* will be paid no more than 30 days after receipt of written or *electronic* proof of loss.

Right to request overpayments

We reserve the right to recover any payments made by *us* that were:

- Made in error;
- Made to *you* or any party on *your* behalf, where *we* determine such payment made is greater than the amount payable under the *master group contract*;
- Made to *you* and/or any party on *your* behalf, based on fraudulent or misrepresented information; or
- Made to *you* and/or any party on *your* behalf for charges that were discounted, waived or rebated.

We reserve the right to adjust any amount applied in error to the *deductible* or *out-of-pocket limit* or *copayment limit*, if any.

Right to collect needed information

You must cooperate with *us* and when asked, assist *us* by:

- Authorizing the release of medical information including the names of all providers from whom *you* received medical attention;
- Obtaining medical information or records from any provider as requested by *us*;
- Providing information regarding the circumstances of *your sickness*, *bodily injury* or *accident*;
- Providing information about other insurance coverage and benefits, including information related to any *bodily injury* or *sickness* for which another party may be liable to pay compensation or benefits;
- Providing copies of claims and settlement demands submitted to third parties in relation to a *bodily injury* or *sickness*;

- Disclosing details of liability settlement agreements reached with third parties in relation to a *bodily injury* or *sickness*; and
- Providing information *we* request to administer the *master group contract.*

If *you* fail to cooperate or provide the necessary information, *we* may recover payments made by *us* and deny any pending or subsequent claims for which the information is requested.

Exhaustion of time limits

If *we* fail to complete a claim determination or appeal within the time limits set forth in the *master group contract,* the claim shall be deemed to have been denied and *you* may proceed to the next level in the review process outlined under the "Internal Appeal and External Review" section of this *certificate* or as required by law.

Recovery rights

You as well as *your dependents* agree to the following, as a condition of receiving benefits under the *master group contract.*

Duty to cooperate in good faith

You are obligated to cooperate with *us* and *our* agents in order to protect *our* recovery rights. Cooperation includes promptly notifying *us you* may have a claim, providing *us* relevant information, and signing and delivering such documents as *we* or *our* agents reasonably request to secure *our* recovery rights. *You* agree to obtain *our* consent before releasing any party from liability for payment of medical expenses. *You* agree to provide *us* with a copy of any summons, complaint or any other process served in any lawsuit in which *you* seek to recover compensation for *your* injury and its treatment.

You will do whatever is necessary to enable *us* to enforce *our* recovery rights and will do nothing after loss to prejudice *our* recovery rights.

You agree that *you* will not attempt to avoid *our* recovery rights by designating all (or any disproportionate part) of any recovery as exclusively for pain and suffering.

In the event that *you* fail to cooperate with *us, we* shall be entitled to recover from *you* any payments made by *us.*

Duplication of benefits/other insurance

We will not provide duplicate coverage for benefits under the *master group contract* when a person is covered by *us* and has, or is entitled to, benefits as a result of their injuries from any other coverage including, but not limited to, first party uninsured or underinsured motorist coverage, any no-fault insurance, medical payment coverage (auto, homeowners or otherwise), Workers' Compensation settlement or awards, other group coverage (including student plans), direct recoveries from liable parties, premises medical pay or any other insurer providing coverage that would apply to pay *your* medical expenses, except another "plan," as defined in the "Coordination of Benefits" section (e.g., group health coverage), in which case priority will be determined as described in the "Coordination of Benefits" section.

Where there is such coverage, *we* will not duplicate other coverage available to *you* and shall be considered secondary, except where specifically prohibited. Where double coverage exists, *we* shall have the right to be repaid from whomever has received the overpayment from *us* to the extent of the duplicate coverage.

We will not duplicate coverage under the *master group contract* whether or not *you* have made a claim under the other applicable coverage.

When applicable, *you* are required to provide *us* with authorization to obtain information about the other coverage available, and to cooperate in the recovery of overpayments from the other coverage, including executing any assignment of rights necessary to obtain payment directly from the other coverage available.

Workers' compensation

This *master group contract* excludes coverage for *sickness* or *bodily injury* for which Workers' Compensation or similar coverage is available.

If benefits are paid by *us* and *we* discover that a determination by the Workers Compensation Board for treatment of *bodily injury* or *sickness* arose from or was sustained in the course of, any occupation or employment for compensation, profit or gain, *we* have the right to recover as described below.

We shall have first priority to recover amounts *we* have paid and the reasonable value of services and benefits provided under a managed care agreement from any funds that are paid or payable by Workers' Compensation or similar coverage as a result of any *sickness* or *bodily injury,* and *we* shall not be required to contribute to attorney fees or recovery expenses under a Common Fund or similar doctrine.

Our right to recover from funds that are paid or payable by Workers' Compensation or similar coverage will apply.

As a condition to receiving benefits from *us, you* hereby agree, in consideration for the coverage provided by the *master group contract, you* will notify *us* of any Workers' Compensation claim *you* make, that *you* agree to reimburse *us* as described above. If *we* are precluded from exercising *our* recovery rights to recover from funds that are paid by Workers' Compensation or similar coverage *we* will exercise *our* right to recover against *you.*

Right of subrogation

As a condition to receiving benefits from *us, you* agree to transfer to *us* any rights *you* may have to make a claim, take legal action or recover any expenses paid under the *master group contract. We* will be subrogated to *your* rights to recover from any funds paid or payable as a result of a personal injury claim or any reimbursement of expenses by:

- Any legally liable person or their carrier, including self-insured entities;
- Any uninsured motorist or underinsured motorist coverage;
- Medical payments/expense coverage under any automobile, homeowners, premises or similar coverages;

- Workers' Compensation or other similar coverage; and
- No-fault or other similar coverage.

We may enforce *our* subrogation rights by asserting a claim to any coverage to which *you* may be entitled. *We* shall have first priority to recover amounts *we* have paid and the reasonable value of services and benefits provided under a managed care agreement from any funds that are paid or payable as a result of any *sickness* or *bodily injury*, regardless of whether available funds are sufficient to fully compensate *you* for *your sickness* or *bodily injury.*

If *we* are precluded from exercising *our* rights of subrogation, *we* may exercise *our* right of reimbursement.

Right of reimbursement

If benefits are paid under the *master group contract* and *you* recover from any legally responsible person, their insurer, or any uninsured motorist, underinsured motorist, medical payment/expense, Workers' Compensation, no-fault, or other similar coverage, *we* have the right to recover from *you* an amount equal to the amount *we* paid. and for the reasonable value of services and benefits provided under a managed care agreement.

You shall notify *us*, in writing or by *electronic mail*, within 31 days of any settlement, compromise or judgment. Any *covered person* who waives, abrogates or impairs *our* right of reimbursement or fails to comply with these obligations, relieves *us* from any obligation to pay past or future benefits or expenses until all outstanding lien(s) are resolved.

If, after the inception of coverage with *us, you* recover payment from and release any legally responsible person, their insurer, or any uninsured motorist, underinsured motorist, medical payment/expense, Workers' Compensation, no-fault, or other similar insurer from liability for future medical expenses relating to a *sickness* or *bodily injury, we* shall have a continuing right to reimbursement from *you* to the extent of the benefits *we* provided with respect to that *sickness* or *bodily injury.* This right, however, shall apply only to the extent of such payment.

The obligation to reimburse *us* in full exists, regardless of whether the settlement, compromise, or judgment designates the recovery as including or excluding medical expenses.

Assignment of recovery rights

The *master group contract* contains an exclusion for *sickness* or *bodily injury* for which there is medical payment/expenses coverage provided under any automobile, homeowner's, premises or other similar coverage.

If *your* claim against the other insurer is denied or partially paid, *we* will process *your* claim according to the terms and conditions of the *master group contract.* If payment is made by *us* on *your* behalf, *you* agree to assign to *us* the right *you* have against the other insurer for medical expenses *we* pay.

CLAIMS (continued)

If benefits are paid under the *master group contract* and *you* recover under any automobile, homeowner's, premises or similar coverage, *we* have the right to recover from *you*, or whomever *we* have paid, an amount equal to the amount *we* paid.

Cost of legal representation

The costs of *our* legal representation in matters related to *our* recovery rights shall be borne solely by *us*. The costs of legal representation incurred by *you* shall be borne solely by *you.* *We* shall not be responsible to contribute to the cost of legal fees or expenses incurred by *you* under any Common Fund or similar doctrine unless *we* were given timely notice of the claim and an opportunity to protect *our* own interests and *we* failed or declined to do so.

INTERNAL APPEAL AND EXTERNAL REVIEW

Definitions

Adverse benefit determination means a denial, reduction, or termination of, or a failure to provide or make a payment (in whole or in part) for a benefit, including a denial that is based on:

- A determination that an item or service is *experimental* or *investigational* or not *medically necessary;*
- A determination of *your* eligibility for group coverage under the *policy*;
- A determination that the benefit is not covered;
- Any rescission of coverage.

Authorized representative means someone *you* have appropriately authorized to act on *your* behalf, including *your* health care provider.

Commissioner means the Commissioner of the Kentucky Department of Insurance.

Final adverse benefit determination means an *adverse benefit determination* that has been upheld by *us* at the completion of the internal appeals process or in when the internal appeals process has been exhausted.

Independent Review Entity (IRE) means an entity assigned by the *commissioner* to conduct an independent *external review* of an *adverse benefit determination* and a *final adverse benefit determination.*

Urgent care means treatment or services with respect to which the application of the time periods for making non-urgent care determinations:

- Could seriously jeopardize the life or health of the *covered person,* including an unborn child of the *covered person* when pregnant, or the ability of the *covered person* to regain maximum function; or result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part; or

- Would, in the opinion of a physician with knowledge of the *covered person's* medical condition, subject the *covered person* to severe pain that cannot be adequately managed without the treatment or service that is the subject of the claim.

Urgent care includes all requests related to hospitalization or *outpatient surgery*.

Humana will make a determination of whether a claim involves *urgent care.* However, any claim a physician, with knowledge of a *covered person*'s medical condition, determines is a claim for *urgent care* will be treated as a "claim involving urgent care."

Contact information

You may contact the *commissioner* and the Kentucky Consumer Protection Division for assistance at any time using the contact information below:

Kentucky Department of Insurance
500 Mero Street, 2 SE 11
Frankfort, KY 40601

(Mailing address)
P.O. Box 517
Frankfort, KY 40602-0515

Phone number: 502-564-3630;
Toll Free (KY only): 800-595-6053;
TTY: 800-648-6056

Kentucky Consumer Protection Division
P.O. Box 517
Frankfort, KY 40602-0517

Filing a complaint

If *you* have a complaint about Humana or its *network providers*, please call *our* Customer Service Department as soon as possible. The toll-free number is identified on *your* identification card. Most problems may be resolved quickly in this manner.

Internal appeals

You or *your authorized representative* must appeal an *adverse benefit determination* within 180 days after receiving written notice of the denial (or partial denial). An appeal of an *adverse benefit determination* may be made by *you* or *your authorized representative* by means of written application to Humana or by mail, postage prepaid to the address below:

Humana Insurance Company
ATTN: Grievance and Appeals Department
P.O. Box 14546
Lexington, KY 40512-4546

You or *your authorized representative* may request an expedited internal appeal of an adverse *urgent care* claim decision orally or in writing. In such case, all necessary documents, including the plan's benefit determination on review, will be transmitted between the plan and *you* or *your authorized representative* by telephone, FAX, or other available similarly expeditious method.

You or *your authorized representative* may request an expedited *external review* at the same time a request is made for an expedited internal appeal of an *adverse benefit determination* for a claim involving *urgent care* or when *you* are receiving an ongoing course of treatment.

Determination of appeals of denied claims will be conducted promptly, will not defer to the initial determination and will not be made by the person who made the initial adverse claim determination or a subordinate of that person. The determination will take into account all comments, documents, records, and other information submitted by *you* or *your authorized representative* relating to the claim.

INTERNAL APPEAL AND EXTERNAL REVIEW (continued)

You or *your authorized representative* may submit written comments, documents, records and other material relating to *adverse benefit determination* for consideration. *You* may also receive, upon request, reasonable access to, and copies of all documents, records and other relevant information considered during the appeal process.

If new or additional evidence is relied upon or if new or additional rationale is used during the internal appeal process, Humana will provide *you* or *your authorized representative*, free of charge, the evidence or rationale as soon as possible and in advance of the appeals decision in order to provide *you* or *your authorized representative* a reasonable opportunity to respond.

Time-periods for decisions on appeal

Appeals of claims denials will be decided and notice of the decision provided as follows:

- As soon as possible but not later than 72 hours after *we* receive the appeal request for a claim involving *urgent care*;
- Within a reasonable period but not later than 30 days after *we* received the appeal request for a claim involving non-urgent care.

Exhaustion of remedies

You or *your authorized representative* will have exhausted the administrative remedies under the plan and my request an *external review*:

- When the internal appeals process under this section is complete;
- If *we* fail to make a timely determination or notification of an internal appeal;
- *You* or *your authorized representative* and Humana jointly agree to waive the internal appeal process; or
- If *we* fail to adhere to all requirements of the internal appeal process, except for failures that are based on de minimis violations.

After exhaustion of remedies, *you* or *your authorized representative* may pursue any other legal remedies available, which may include bringing civil action under ERISA section 502(a) for judicial review of the plan's determination. Additional information may be available from the local U.S. Department of Labor Office.

External review

Within 4 months after *you* or *your authorized representative* receives notice of a *final adverse benefit determination, you* or *your authorized representative* may request an *external review*. The request for *external review* must be made in writing to *us*. *You* or *your authorized representative* may be assessed a $25 filing fee that will be refunded if the *adverse benefit determination* is overturned. The fee will be waived if the payment of the fee would impose undue financial hardship. The annual limit on filing fees for each *covered person* within a single *year* will not exceed $75.

You or *your authorized representative* will be required to authorize release of any medical records that may be required to be reviewed for the purpose of reaching a decision on the external review. Please refer to the section titled "Expedited external review" if the *adverse benefit determination* involves a claim for *urgent care.*

If the request qualifies for an *external review, we* will notify *you* or *your authorized representative* in writing of the assignment of an *IRE* and the right to submit additional information. Additional information must be submitted within the first 5 business days of receipt of the letter. *You* or *your authorized representative* will be notified of the determination within 21 calendar days from receipt of all information required from *us.* An extension of up to 14 calendar days may be allowed if agreed by the *covered* person and *us.* This request for an *external review* will not exceed 45 days of the receipt of the request.

Expedited external review

You or *your authorized representative* may request an expedited *external review* in writing or orally:

- At the same time *you* request an expedited internal appeal of an *adverse benefit determination* for a claim involving *urgent care* or when *you* are receiving an ongoing course of treatment; or
- When *you* receive an *adverse benefit determination* or *final adverse benefit determination* of:

    - A claim involving *urgent care*;
    - An admission, availability of care, continued stay or health care service for which *you* received emergency services, but *you* have not been discharged from the facility; or
    - An *experimental* or *investigational* treatment if the treating physician certifies, in writing, that the recommended service would be significantly less effective if not promptly initiated.

An *adverse benefit determination* of any rescission of coverage is not available for *external review*.

If the request qualifies for an expedited *external review,* an *IRE* will be assigned. *We* will contact the *IRE* by telephone for acceptance of the assignment. *You* or *your authorized representative* will be notified within 24 hours of receiving the request. An extension of up to 24 hours may be allowed if agreed by the *covered person* or their *authorized representative* and *us.* This request for an expedited *external review* will not exceed 72 hours of the receipt of the request.

Legal actions and limitations

No legal action to recover on the *master group contract* may be brought until 60 days after written proof of loss has been given in accordance with the "Proof of loss" provision of the *master group contract.*

No legal action to recover on the *master group contract* may be brought after three years from the date written proof of loss is required to be given.

DISCLOSURE PROVISIONS

Employee assistance program

We may provide *you* access to an employee assistance program (EAP). The EAP may include confidential, telephonic consultations and work-life services. The EAP provides *you* with short-term, problem solving services for issues that may otherwise affect *your* work, personal life or health. The EAP is designed to provide *you* with information and assistance regarding *your* issue and may also assist *you* with finding a medical provider or local community resource.

The services provided by the EAP are not *covered expenses* under the *master group contract*, therefore the *copayments*, *deductible* or *coinsurance* do not apply. However, there may be additional costs to *you*, if *you* obtain services from a professional or organization the EAP has recommended or has referred *you* to. The EAP does not provide medical care. *You* are not required to participate in the EAP before using *your* benefits under the *master group contract*, and the EAP services are not coordinated with *covered expenses* under the *master group contract.* The decision to participate in the EAP is voluntary, and *you* may participate at any time during the *year*. Refer to the marketing literature for additional information.

Discount programs

From time to time, *we* may offer or provide access to discount programs to *you.* In addition, *we* may arrange for third party service providers such as pharmacies, optometrists, dentists and alternative medicine providers to provide discounts on goods and services to *you.* Some of these third party service providers may make payments to *us* when *covered persons* take advantage of these discount programs. These payments offset the cost to *us* of making these programs available and may help reduce the costs of *your* plan administration. Although *we* have arranged for third parties to offer discounts on these goods and services, these discount programs are not covered services under the *master group contract.* The third party service providers are solely responsible to *you* for the provision of any such goods and/or services. *We* are not responsible for any such goods and/or services, nor are *we* liable if vendors refuse to honor such discounts. Further, *we* are not liable to *covered persons* for the negligent provision of such goods and/or services by third party service providers. Discount programs may not be available to persons who "opt out" of marketing communications and where otherwise restricted by law.

Wellness programs

From time to time *we* may offer directly, or enter into agreements with third parties who administer, participatory or health-contingent wellness programs to *you*.

"Participatory" wellness programs do not require *you* to meet a standard related to a health factor. Examples of participatory wellness programs may include membership in a fitness center, certain preventive testing, or attending a no-cost health education seminar.

"Health-contingent" wellness programs require *you* to attain certain wellness goals that are related to a health factor. Examples of health-contingent wellness programs may include completing a 5k event, lowering blood pressure or ceasing the use of tobacco.

The rewards may include, payment for all or a portion of a participatory wellness program, merchandise, gift cards, debit cards, discounts or contributions to *your* health spending account. *We* are not responsible for any rewards provided by third parties that are non-insurance benefits or for *your* receipt of such reward(s).

The rewards may also include discounts or credits toward premium or a reduction in *copayments*, *deductibles* or *coinsurance*, as permitted under applicable state and federal laws. Such insurance premium or benefit rewards may be made available at the individual or *group* health plan level.

The rewards may be taxable income. *You* may consult a tax advisor for further guidance.

Our agreement with any third party does not eliminate any of *your* obligations under this *master group contract* or change any of the terms of this *master group contract.* *Our* agreement with the third parties and the program may be terminated at any time, although insurance benefits will be subject to applicable state and federal laws.

We are committed to helping *you* achieve *your* best health. Some wellness programs may be offered only to *covered persons* with particular health factors. If *you* think *you* might be unable to meet a standard for a reward under a health contingent wellness program, *you* might qualify for an opportunity to earn the same reward by different means. Contact *us* at the number listed on *your* ID card or in the marketing literature issued by the wellness program administrator for more information.

The wellness program administrator or *we* may require proof in writing from *your health care practitioner* that *your* medical condition prevents *you* from taking part in the available activities.

The decision to participate in wellness program activities is voluntary and if eligible, *you* may decide to participate anytime during the *year*. Refer to the marketing literature issued by the wellness program administrator for their program's eligibility, rules and limitations.

Shared savings program

As a *covered person* under the health benefit plan, *you* may obtain services from *network providers* who participate in the Point of Service network *or non-network providers* who do not participate in the Point of Service network. If *you* choose a *network provider*, *your* out-of-pocket expenses are normally lower than if *you* choose a *non-network provider*.

If *you* choose to obtain services from a *non-network provider*, the services may be eligible for a discount to *you* under the Shared Savings Program. It is not necessary for *you* to inquire in advance about services that may be discounted. When processing *your* claim, *we* will automatically determine if the services are subject to Shared Savings Program and calculate *your deductible* and *coinsurance* on the discounted amount. Whether the services are subject to the Shared Savings Program is at our discretion, and *we* apply the discounts in a non-discriminatory manner. *Your* Explanation of Benefits statement will reflect any savings with a remark code that the services have been discounted. *We* cannot guarantee that services rendered by *non-network providers* will be discounted. The *non-network provider* discounts in the Shared Savings Program may not be as favorable as *network provider* discounts.

DISCLOSURE PROVISIONS (continued)

If *you* would like to inquire in advance to determine if services rendered by a *non-network provider* may be subject to the Shared Savings Program, please contact *our* customer service department at the telephone number shown on *your* ID card. Provider arrangements in the Shared Savings Program are subject to change without notice. *We* cannot guarantee that the services *you* receive from a *non-network provider* are still subject to the Shared Savings Program at the time services are received. Discounts are dependent upon availability and cannot be guaranteed.

We reserve the right to modify, amend or discontinue the Shared Savings Program at any time.

MISCELLANEOUS PROVISIONS

Entire contract

The entire contract is made up of the *master group contract,* the Employer Group Application of the *group plan sponsor*, incorporated by reference herein, and the applications or enrollment forms, if any, of the *covered persons.* All statements made by the *group plan sponsor* or by a *covered person* are considered to be representations, not warranties. This means that the statements are made in good faith. No statement will void the *master group contract,* reduce the benefits it provides or be used in defense to a claim unless it is contained in a written or *electronic* application or enrollment form and a copy is furnished to the person making such statement or his or her beneficiary.

Additional group plan sponsor responsibilities

In addition to responsibilities outlined in the *master group contract,* the *group plan sponsor* is responsible for:

- Collection of premium; and
- Distributing and providing *covered persons* access to:

    - Benefit plan documents and the Summary of Benefits and Coverage (SBC);
    - Renewal notices and *master group contract* modification information; and
    - Information regarding continuation rights.

No *group plan sponsor* may change or waive any provision of the *master group contract.*

Certificates

A *certificate* setting forth the benefits available to the *employee* and the *employee's* covered *dependents* will be available at www.humana.com or in writing when requested. The *employer* is responsible for providing *employees* access to the *certificate.*

No document inconsistent with the *master group contract* shall take precedence over it. This is true, also, when this *certificate* is incorporated by reference into a summary description of plan benefits by the administrator of a group plan subject to ERISA. If the terms of a summary plan description differ with the terms of this *certificate,* the terms of this *certificate* will control.

Incontestability

No misstatement made by the *group plan sponsor*, except for fraud or an intentional misrepresentation of a material fact made in the application may be used to void the *master group contract.*

After *you* are covered without interruption for two years, *we* cannot contest the validity of *your* coverage except for:

- Nonpayment of premiums; or
- Any fraud or intentional misrepresentation of a material fact made by *you.*

At any time, *we* may assert defenses based upon provisions in the *master group contract* which relate to *your* eligibility for coverage under the *master group contract.*

No statement made by *you* can be contested unless it is in a written or *electronic* form signed by *you.* A copy of the form must be given to *you* or *your* beneficiary.

An independent incontestability period begins for each type of change in coverage or when a new application or enrollment form of the *covered person* is completed.

Fraud

Health insurance fraud is a criminal offense that can be prosecuted. Any person(s) who willingly and knowingly engages in an activity intended to defraud *us* by filing a claim or form that contains a false or deceptive statement may be guilty of insurance fraud.

If *you* commit fraud against *us* or *your employer* commits fraud pertaining to *you* against *us,* as determined by *us, we* reserve the right to *rescind your* coverage after *we* provide *you* a 30 calendar day advance written notice that coverage will be *rescinded. You* have the right to appeal the *rescission.*

Clerical error or misstatement

If it is determined that information about a *covered person* was omitted or misstated in error, an adjustment may be made in premiums and/or coverage in effect. This provision applies to *you* and to *us.*

Modification of master group contract

The *master group contract* may be modified by *us,* upon renewal of the *master group contract,* as permitted by state and federal law. The *group plan sponsor* will be notified in writing or *electronically* at least 60 days prior to the effective date of the change. The *master group contract* may be modified by agreement between *us* and the *group plan sponsor* without the consent of any *covered person* or any beneficiary.

No modification will be valid unless approved by *our* President, Secretary or Vice-President. The approval must be endorsed on or attached to the *master group contract.* No agent has authority to modify the *master group contract,* or waive any of the *master group contract* provisions, to extend the time of premium payment, or bind *us* by making any promise or representation.

MISCELLANEOUS PROVISIONS (continued)

Corrections due to clerical errors or clarifications that do not change benefits are not modifications of the *master group contract* and may be made by *us* at any time without prior consent of, or notice to, the *group plan sponsor*.

Discontinuation of coverage

If *we* decide to discontinue offering a particular group health plan:

- The *group plan sponsor* and the *employees* will be notified of such discontinuation at least 90 days prior to the date of discontinuation of such coverage; and
- The *group plan sponsor* will be given the option to purchase all other group plans providing medical benefits that are being offered by *us* at such time.

If *we* cease doing business in the *small employer* group market, the *group plan sponsors*, *covered persons*, and the Commissioner of Insurance will be notified of such discontinuation at least 180 days prior to the date of discontinuation of such coverage.

Premium contributions

Your employer must pay the required premium to *us* as they become due. *Your employer* may require *you* to contribute toward the cost of *your* coverage. Failure of *your employer* to pay any required premium to *us* when due may result in the termination of *your* coverage.

Premium rate change

We reserve the right to change any premium rates in accordance with applicable law upon notice to the *employer*. *We* will provide notice to the *employer* of any such premium changes. Questions regarding changes to premium rates should be addressed to the *employer*.

Assignment

The *master group contract* and its benefits may not be assigned by the *group plan sponsor*.

Conformity with statutes

Any provision of the *master group contract* which is not in conformity with applicable state law(s) or other applicable law(s) shall not be rendered invalid, but shall be construed and applied as if it were in full compliance with the applicable state law(s) and other applicable law(s).

GLOSSARY

Terms printed in italic type in this *certificate* have the meaning indicated below. Defined terms are printed in italic type wherever found in this *certificate.*

A

Accident means a sudden event that results in a *bodily injury* or *dental injury* and is exact as to time and place of occurrence.

Active status means the *employee* is performing all of his or her customary duties whether performed at the *employer's* business establishment, some other location which is usual for the *employee's* particular duties or another location, when required to travel on the job:

- On a regular *full-time* basis or for the number of hours per week determined by the *group plan sponsor*;
- For 48 weeks a year; and
- Is maintaining a bona fide *employer-employee* relationship with the *group plan sponsor* of the *master group contract* on a regular basis.

Each day of a regular vacation and any regular non-working holiday are deemed *active status*, if the *employee* was in *active status* on his or her last regular working day prior to the vacation or holiday. An *employee* is deemed to be in *active status* if an absence from work is due to a *sickness* or *bodily injury*, provided the individual otherwise meets the definition of *employee*.

Acute inpatient services mean care given in a *hospital* or *health care treatment facility* which:

- Maintains permanent full-time facilities for *room and board* of resident patients;
- Provides emergency, diagnostic and therapeutic services with a capability to provide life-saving medical and psychiatric interventions;
- Has physician services, appropriately licensed behavioral health practitioners and skilled nursing services available 24-hours a day;
- Provides direct daily involvement of the physician; and
- Is licensed and legally operated in the jurisdiction where located.

Acute inpatient services are utilized when there is an immediate risk to engage in actions which would result in death or harm to self or others or there is a deteriorating condition in which an alternative treatment setting is not appropriate.

Admission means entry into a facility as a registered bed patient according to the rules and regulations of that facility. An *admission* ends when *you* are discharged, or released, from the facility and are no longer registered as a bed patient.

Advanced imaging, for the purpose of this definition, includes Magnetic Resonance Imaging (MRI), Magnetic Resonance Angiography (MRA), Positron Emission Tomography (PET), Single Photon Emission Computed Tomography (SPECT), and Computed Tomography (CT) imaging.

Air ambulance means a professionally operated helicopter or airplane, provided by a licensed ambulance service, equipped for the transportation of a sick or injured person to or from the nearest medical facility qualified to treat the person's *sickness* or *bodily injury.* Use of the *air ambulance* must be *medically necessary* and ordered by a *health care practitioner*.

Alternative medicine, for the purposes of this definition, includes: acupressure, aromatherapy, ayurveda, biofeedback, faith healing, guided mental imagery, herbal supplements and medicine, holistic medicine, homeopathy, hypnosis, macrobiotics, massage therapy, naturopathy, ozone therapy, reflexotherapy, relaxation response, rolfing, shiatsu, yoga, and chelation therapy.

Ambulance means a professionally operated ground vehicle, provided by a licensed ambulance service, equipped for the transportation of a sick or injured person to or from the nearest medical facility qualified to treat the person's *sickness* or *bodily injury.* Use of the *ambulance* must be *medically necessary* and ordered by a *health care practitioner*.

Ambulatory surgical center means an institution which meets all of the following requirements:

- It must be staffed by physicians and a medical staff which includes registered nurses.
- It must have permanent facilities and equipment for the primary purpose of performing *surgery.*
- It must provide continuous physicians' services on an *outpatient* basis.
- It must admit and discharge patients from the facility within a 24-hour period.
- It must be licensed in accordance with the laws of the jurisdiction where it is located. It must be operated as an *ambulatory surgical center* as defined by those laws.
- It must not be used for the primary purpose of terminating pregnancies, or as an office or clinic for the private practice of any physician or dentist.

Ancillary services mean *covered expenses* that are:

- Items or services related to emergency medicine, anesthesiology, pathology; radiology; or neonatology;
- Provided by *assistant surgeons* or hospitalists intensivists; or
- Diagnostic laboratory or radiology services.

Assistant surgeon means a *health care practitioner* who assists at *surgery* and is a Doctor of Medicine (MD), Doctor of Osteopathic Medicine (DO), Doctor of Podiatric Medicine (DPM) or where state law requires a specific *health care practitioner* be treated and reimbursed the same as an MD, DO or DPM.

Autism spectrum disorders means a physical, mental, or cognitive illness or disorder which includes any of the pervasive developmental disorders as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders ("DSM"), published by the American Psychiatric Association, including Autistic disorder, Asperger's disorders, and Pervasive Developmental disorder not otherwise specified.

B

Behavioral health means *mental health services* and *chemical dependency* services.

Birthing center means a *free-standing facility* that is specifically licensed to perform uncomplicated pregnancy care, delivery and immediate care after delivery for a *covered person*.

Bodily injury means bodily damage other than a *sickness*, including all related conditions and recurrent symptoms. However, bodily damage resulting from infection or muscle strain due to athletic or physical activity is considered a *sickness* and not a *bodily injury*.

C

Certificate means this benefit plan document that describes the benefits, provisions and limitations of the *master group contract*. This *certificate* is part of the *master group contract* and is subject to the terms of the *master group contract.*

Chemical dependency means the abuse of, or psychological or physical dependence on, or addiction to alcohol or a controlled substance.

Coinsurance means the amount expressed as a percentage of the *covered expense* that *you* must pay.

Confinement or ***confined*** means *you* are a registered bed patient as the result of a *health care practitioner's* recommendation. It does not mean *you* are in *observation status*.

Congenital anomaly means an abnormality of the body that is present from the time of birth.

Copayment means the specified dollar amount *you* must pay to a provider for *covered expenses* regardless of any amounts that may be paid by *us*.

Cosmetic surgery means *surgery* performed to reshape normal structures of the body in order to improve or change *your* appearance or self-esteem.

Co-surgeon means one of two or more *health care practitioners* furnishing a single *surgery* which requires the skill of multiple surgeons each in a different specialty, performing parts of the same *surgery* simultaneously.

Covered expense means:

- *Medically necessary* services to treat a *sickness* or *bodily injury*, such as:
  - Procedures;
  - *Surgeries*;
  - Consultations;
  - Advice;
  - Diagnosis;
  - Referrals;
  - Treatment;
  - Supplies;
  - Drugs, including *prescription* and *specialty drugs*;
  - Devices; or
  - Technologies;

- *Preventive services*;
- *Pediatric dental services*; or
- *Pediatric vision care*.

To be considered a *covered expense*, services must be:

- Ordered by a *health care practitioner*;
- Authorized or prescribed by a *qualified provider*;
- Provided or furnished by a *qualified provider*;
- For the benefits described herein, subject to any maximum benefit and all other terms, provisions limitations, and exclusions of the *master group contract*; and
- Incurred when *you* are insured for that benefit under the *master group contract* on the date that the service is rendered.

Covered person means the *employee* or the *employee's dependents*, who are enrolled for benefits provided under the *master group contract*.

Custodial care means services given to *you* if:

- *You* need services including, assistance with dressing, bathing, preparation and feeding of special diets, walking, supervision of medication which is ordinarily self-administered, getting in and out of bed, and maintaining continence;

- The services *you* require are primarily to maintain, and not likely to improve, *your* condition; or

- The services involve the use of skills which can be taught to a layperson and do not require the technical skills of a *nurse*.

Services may still be considered *custodial care* by *us* even if:

- *You* are under the care of a *health care practitioner*;
- The *health care practitioner* prescribed services are to support or maintain *your* condition; or
- Services are being provided by a *nurse*.

D

Deductible means the amount of *covered expenses* that *you*, either individually or combined as a covered family, must pay per *year* before *we* pay benefits for certain specified *covered expenses*. Any amount *you* pay exceeding the *maximum allowable fee* is not applied to the individual or family *deductibles.*

Dental injury means an injury to a *sound natural tooth* caused by a sudden and external force that could not be predicted in advance and could not be avoided. It does not include biting or chewing injuries, unless the biting or chewing injury is a result of an act of domestic violence or a medical condition (including both physical and mental health conditions).

Dentist means an individual, who is duly licensed to practice dentistry or perform *oral surgery* and is acting within the lawful scope of his or her license.

GLOSSARY (continued)

Dependent means a covered *employee's*:

- Legally recognized spouse or *domestic partner*;
- Natural born child, step-child, legally adopted child, or child placed for adoption, whose age is less than the limiting age;
- Child whose age is less than the limiting age and for whom the *employee* has received a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN) to provide coverage, if the *employee* is eligible for family coverage until:
  - Such QMCSO or NMSN is no longer in effect; or
  - The child is enrolled for comparable health coverage, which is effective no later than the termination of the child's coverage under the *master group contract.*
- *Domestic partner's* natural born child, step-child, legally adopted child, or child placed for adoption whose age is less than the limiting age;

  The *domestic partner's* child cannot qualify as a *dependent* prior to the *employee's domestic partner* becoming a qualified *dependent.*

Under no circumstances shall *dependent* mean a grandchild, great grandchild or foster child, including where the grandchild, great grandchild or foster child meets all of the qualifications of a dependent as determined by the Internal Revenue Service.

The limiting age means the end of the month the *dependent* child attains age 26. Each *dependent* child is covered to the limiting age, regardless if the child is:

- Married;
- A tax dependent;
- A student;
- Employed;
- Residing with or receiving financial support from *you*;
- Eligible for other coverage through employment; or
- Residing or working outside of the *service area*.

A covered *dependent* child, who attains the limiting age while covered under the *master group contract*, remains eligible if the covered *dependent* child is:

- Mentally or physically handicapped; and
- Incapable of self-sustaining employment.

In order for the covered *dependent* child to remain eligible as specified above, *we* must receive notification within 31 days prior to the covered *dependent* child attaining the limiting age.

You must furnish satisfactory proof to *us*, upon *our* request, that the conditions, as defined in the bulleted items above, continuously exist on and after the date the limiting age is reached. After two years from the date the first proof was furnished, *we* may not request such proof more often than annually. If satisfactory proof is not submitted to *us*, the child's coverage will not continue beyond the last date of eligibility.

Diabetes equipment means blood glucose monitors, including monitors designed to be used by blind individuals; insulin pumps and associated accessories; insulin infusion devices; and podiatric appliances for the prevention of complications associated with diabetes.

Diabetes self-management training means the training provided to a *covered person* after the initial diagnosis of diabetes for care and management of the condition including nutritional counseling and use of *diabetes equipment* and supplies. It also includes training when changes are required to the self-management regime and when new techniques and treatments are developed.

Diabetes supplies means test strips for blood glucose monitors; visual reading and urine test strips; lancets and lancet devices; insulin and insulin analogs; injection aids; syringes; prescriptive agents for controlling blood sugar levels; prescriptive non-insulin injectable agents for controlling blood sugar levels; glucagon emergency kits; and alcohol swabs.

Distant site means the location of a *health care practitioner* at the time a *telehealth* or *telemedicine* service is provided.

Domestic partner means an individual of the same or opposite gender, who resides with the covered *employee* in a long-term relationship of indefinite duration; and, there is an exclusive, mutual commitment in which the partners agree to be jointly responsible for each other's common welfare and share financial obligations. *We* will allow coverage for only one *domestic partner* of the covered *employee* at any one time. The *employee* and *domestic partner* must each be at a minimum 18 years of age, competent to contract, and not related by blood to a degree of closeness which would prohibit legal marriage in the state in which the *employee* and *domestic partner* both legally reside. *We* reserve the right to require an affidavit from the *employee* and *domestic partner* attesting that the domestic partnership has existed for a minimum period of 6 months and, periodically thereafter, to require proof that the *domestic partner* relationship continues to exist.

Durable medical equipment means equipment that meets all of the following criteria:

- It is prescribed by a *health care practitioner*;
- It can withstand repeated use;
- It is primarily and customarily used for a medical purpose rather than being primarily for comfort or convenience;
- It is generally not useful to *you* in the absence of *sickness* or *bodily injury*;
- It is appropriate for home use or use at other locations as necessary for daily living;
- It is related to and meets the basic functional needs of *your* physical disorder;
- It is not typically furnished by a *hospital* or *skilled nursing facility*; and
- It is provided in the most cost effective manner required by *your* condition, including, at *our* discretion, rental or purchase.

E

Effective date means the date *your* coverage begins under the *master group contract*.

Electronic or ***electronically*** means relating to technology having electrical, digital, magnetic, wireless, optical, electromagnetic, or similar capabilities.

Electronic mail means a computerized system that allows a user of a network computer system and/or computer system to send and receive messages and documents among other users on the network and/or with a computer system.

Electronic signature means an electronic sound, symbol, or process attached to or logically associated with a record and executed or adopted by a person with the intent to sign the record.

Eligibility date means the date the *employee* or *dependent* is eligible to participate in the plan.

Emergency medical condition means services provided in an emergency facility for a *bodily injury* or *sickness* manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of that individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment of bodily functions; or
- Serious dysfunction of any bodily organ or part.

With respect to a pregnant woman who is having contractions:

- A situation in which there is inadequate time to effect a safe transfer to another *hospital* before delivery; or
- A situation in which transfer may pose a threat to the health or safety of the woman or the unborn child.

GLOSSARY (continued)

Employee means a person who is in *active status* for the *employer* on a *full-time* basis. The *employee* must be paid a salary or wage by the *employer* that meets the minimum wage requirements of *your* state or federal minimum wage law for work done at the *employer's* usual place of business or some other location, which is usual for the *employee's* particular duties.

Employee also includes a sole proprietor, partner or corporate officer, where:

- The *employer* is a sole proprietorship, partnership or corporation;
- The sole proprietorship or other entity (other than a partnership) has at least one common-law employee (other than the business owner and his or her spouse); and
- The sole proprietor, partner or corporate officer is actively performing activities relating to the business, gains their livelihood from the sole proprietorship, partnership or corporation and is in an *active status* at the *employer's* usual place of business or some other location, which is usual for the sole proprietor's, partner's or corporate officer's particular duties.

If specified on the Employer Group Application and approved by *us*, *employee* also includes retirees of the *employer*. A retired *employee* is not required to be in *active status* to be eligible for coverage under the *master group contract*.

Employer means the sponsor of this *group* plan or any subsidiary or affiliate described in the Employer Group Application. An *employer* must either employ at least one common-law employee or be a partnership with a bona fide partner who provides services on behalf of the partnership. A business owner and his or her spouse are not considered common-law employees for this purpose if the entity is considered to be wholly owned by one individual or one individual and his or her spouse.

Endodontic services mean the following dental procedures, related tests or treatment and follow-up care:

- Root canal therapy and root canal fillings;
- Periradicular *surgery*;
- Apicoectomy;
- Partial pulpotomy; or
- Vital pulpotomy.

Experimental, ***investigational*** or ***for research purposes*** means a drug, biological product, device, treatment or procedure that meets any one of the following criteria, as determined by *us*:

- Cannot be lawfully marketed without the final approval of the United States Food and Drug Administration (FDA) and lacks such final FDA approval for the use or proposed use, unless (a) found to be accepted for that use in the most recently published edition of the United States Pharmacopeia-Drug Information for Healthcare Professional (USP-DI) or in the most recently published edition of the American Hospital Formulary Service (AHFS) Drug Information, (b) identified as safe, widely used and generally accepted as effective for that use as reported in nationally recognized peer reviewed medical literature published in the English language as of the date of service; or (c) is mandated by state law;
- Is a device required to receive Premarket Approval (PMA) or 510K approval by the FDA but has not received a PMA or 510K approval;

- Is not identified as safe, widely used and generally accepted as effective for the proposed use as reported in nationally recognized peer reviewed medical literature published in the English language as of the date of service;

- Is the subject of a National Cancer Institute (NCI) Phase I, II or III trial or a treatment protocol comparable to a NCI Phase I, II or III trial, or any trial not recognized by NCI regardless of phase; or

- Is identified as not covered by the Centers for Medicare & Medicaid Services (CMS) Medicare Coverage Issues Manual, a CMS Operational Policy Letter or a CMS National Coverage Decision, except as required by state or federal law.

F

Family member means *you* or *your* spouse or *domestic partner.* It also means *your* or *your* spouse's or *domestic partner's* child, brother, sister, or parent.

Free-standing facility means any licensed public or private establishment other than a *hospital* which has permanent facilities equipped and operated to provide laboratory and diagnostic laboratory, *outpatient* radiology, *advanced imaging*, chemotherapy, inhalation therapy, radiation therapy, lithotripsy, physical, cardiac, speech and occupational therapy, or renal dialysis services. An appropriately licensed birthing center is also considered a *free-standing facility.*

Full-time, for an *employee*, means a work week of the number of hours determined by the *group plan sponsor*.

Functional impairment means a direct and measurable reduction in physical performance of an organ or body part.

G

Group means the persons for whom this health coverage has been arranged to be provided.

Group plan sponsor means the legal entity identified as the *group plan sponsor* on the face page of the *master group contract* or "Certificate of Coverage" who establishes, sponsors and endorses an employee benefit plan for health care coverage.

H

Habilitative services mean health care services and devices that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

GLOSSARY (continued)

Health care practitioner means a practitioner professionally licensed by the appropriate state agency to provide *preventive services* or diagnose or treat a *sickness* or *bodily injury* and who provides services within the scope of that license. Including, Chiropractors, Dentists, Nurse Practitioner, Registered Nurse First Assistant, Optometrists, Osteopaths, Physicians, Pharmacists, Podiatrists, Physical Therapist, Occupational Therapist, Physician's Assistant and Licensed Psychologist or Licensed Clinical Social Worker.

Health care treatment facility means a facility, institution or clinic, duly licensed by the appropriate state agency to provide medical services, *behavioral health* services, and is primarily established and operating within the scope of its license.

Health insurance coverage means medical coverage under any hospital or medical service policy or certificate, hospital or medical service plan contract or health maintenance organization (HMO) contract offered by a health insurance issuer. "Health insurance issuer" means an insurance company, insurance service or insurance organization (including an HMO) that is required to be licensed to engage in the business of insurance in a state and that is subject to the state law that regulates insurance.

Health status-related factor means any of the following:

- Health status or medical history;
- Medical condition, either physical or mental;
- Claims experience;
- Receipt of health care;
- Genetic information;
- Disability; or
- Evidence of insurability, including conditions arising out of acts of domestic violence.

Hearing aid and related services means any wearable, non-disposable instrument or device designed to aid or compensate for impaired hearing, including any parts, attachments, or accessories (excluding batteries and cords). Services to assess, select, and adjust/fit the hearing aid to ensure optimal performance, as prescribed by a licensed audiologist and dispensed by a licensed audiologist or hearing instrument specialist.

Home health care agency means a *home health care agency* or *hospital* which meets all of the following requirements:

- It must primarily provide skilled nursing services and other therapeutic services under the supervision of physicians or registered nurses;

- It must be operated according to established processes and procedures by a group of medical professionals, including *health care practitioners* and *nurses*;

- It must maintain clinical records on all patients; and

- It must be licensed by the jurisdiction where it is located, if licensure is required. It must be operated according to the laws of that jurisdiction which pertains to agencies providing home health care.

Home health care plan means a plan of care and treatment for *you* to be provided in *your* home. To qualify, the *home health care plan* must be established and approved by a *health care practitioner*. The services to be provided by the plan must require the skills of a *nurse*, or another *health care practitioner* and must not be for *custodial care*.

Hospice care program means a coordinated, interdisciplinary program provided by a hospice that is designed to meet the special physical, psychological, spiritual and social needs of a terminally ill *covered person* and his or her immediate covered *family members*, by providing *palliative care* and supportive medical, nursing and other services through at-home or *inpatient* care. A hospice must be licensed by the laws of the jurisdiction where it is located and must be operated as a hospice as defined by those laws. It must provide a program of treatment for at least two unrelated individuals who have been medically diagnosed as having no reasonable prospect for cure for their *sickness* and, as estimated by their physicians, are expected to live 18 months or less as a result of that *sickness*.

Hospital means an institution that meets all of the following requirements:

- It must provide, for a fee, medical care and treatment of sick or injured patients on an *inpatient* basis;
- It must provide or operate, either on its premises or in facilities available to the *hospital* on a pre-arranged basis, medical, diagnostic and surgical facilities;
- Care and treatment must be given by and supervised by physicians. Nursing services must be provided on a 24-hour basis and must be given by or supervised by registered nurses;
- It must be licensed by the laws of the jurisdiction where it is located. It must be operated as a *hospital* as defined by those laws; and
- It must <u>not</u> be primarily a:

    - Convalescent, rest or nursing home; or
    - Facility providing custodial, educational or rehabilitative care.

The *hospital* must be accredited by one of the following:

- The Joint Commission on the Accreditation of Hospitals;
- The American Osteopathic Hospital Association; or
- The Commission on the Accreditation of Rehabilitative Facilities.

I

Immune effector cell therapy means immune cells or other blood products that are engineered outside of the body and infused into a patient. *Immune effector cell therapy* may include acquisition, integral chemotherapy components and engineered immune cell infusion.

Infertility services mean any treatment, supply, medication, or service provided to achieve pregnancy or to achieve or maintain ovulation. This includes:

- Artificial insemination;
- In vitro fertilization;
- Gamete Intrafallopian Transfer (GIFT);
- Zygote Intrafallopian Transfer (ZIFT);

- Tubal ovum transfer;
- Embryo freezing or transfer;
- Sperm storage or banking;
- Ovum storage or banking;
- Embryo or zygote banking; and
- Any other assisted reproductive techniques or cloning methods.

Inpatient means *you* are *confined* as a registered bed patient.

Intensive outpatient program means *outpatient* services providing:

- Group therapeutic sessions greater than one hour a day, three days a week;
- *Behavioral health* therapeutic focus;
- Group sessions centered on cognitive behavioral constructs, social/occupational/educational skills development and family interaction;
- Additional emphasis on recovery strategies, monitoring of participation in 12-step programs and random drug screenings for the treatment of *chemical dependency*; and
- Physician availability for medical and medication management.

Intensive outpatient program does not include services that are for:

- *Custodial care*; or
- Day care.

J

K

L

Late applicant means an *employee* or *dependent* who requests enrollment for coverage under the *master group contract* more than 31 days after his or her *eligibility date*, later than the time period specified in the "Special enrollment" provision, or after the *open enrollment period.*

M

Maintenance care means services and supplies furnished mainly to:

- Maintain, rather than improve, a level of physical or mental function; or
- Provide a protected environment free from exposure that can worsen the *covered person's* physical or mental condition.

Master group contract means the legal agreement between *us* and the *group plan sponsor*, including the Employer Group Application and *certificate*, together with any riders, amendments and endorsements.

Materials means frames, lenses and lens options, or contact lenses and low vision aids.

Maximum allowable fee for a *covered expense* is the lesser of:

- The fee charged by the provider for the services;
- The fee that has been negotiated with the provider whether directly or through one or more intermediaries or shared savings contracts for the services;
- The fee established by *us* by comparing rates from one or more regional or national databases or schedules for the same or similar services from a geographical area determined by *us*;
- The fee based upon rates negotiated by *us* or other payors with one or more *network providers* in a geographic area determined by *us* for the same or similar services;
- The fee based upon the provider's cost for providing the same or similar services as reported by such provider in its most recent publicly available *Medicare* cost report submitted to the Centers for Medicare & Medicaid Services (CMS) annually; or
- The fee based on a percentage determined by *us* of the fee *Medicare* allows for the same or similar services provided in the same geographic area.

Medicaid means a state program of medical care for needy persons, as established under Title 19 of the Social Security Act of 1965, as amended.

Medically necessary means health care services that a *health care practitioner* exercising prudent clinical judgment would provide to his or her patient for the purpose of preventing, evaluating, diagnosing or treating a *sickness* or *bodily injury*, or its symptoms. Such health care service must be:

- In accordance with generally accepted standards of medical practice;
- Clinically appropriate in terms of type, frequency, extent, site and duration, and considered effective for the patient's *sickness* or *bodily injury*;
- Neither sourced from a location, nor provided primarily for the convenience of the patient, physician or other health care provider;
- More appropriate than an alternative source, service or sequence of services and at least as likely to produce equivalent therapeutic or diagnostic results; and
- Performed in the site, sourced from, or provided by the *qualified provider* that is deemed to be the most appropriate site, source or provider, when *preauthorization* is required.

For the purpose of *medically necessary*, generally accepted standards of medical practice means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations, the views of physicians practicing in relevant clinical areas and any other relevant factors.

Medicare means a program of medical insurance for the aged and disabled, as established under Title 18 of the Social Security Act of 1965, as amended.

Mental health services mean those diagnoses and treatments related to the care of a *covered person* who exhibits a mental, nervous or emotional condition classified in the Diagnostic and Statistical Manual of Mental Disorders.

Morbid obesity means a body mass index (BMI) as determined by a *health care practitioner* as of the date of service of:

- 40 kilograms or greater per meter squared (kg/m^2); or
- 35 kilograms or greater per meter squared (kg/m^2) with an associated comorbid condition such as hypertension, type II diabetes, life-threatening cardiopulmonary conditions; or joint disease that is treatable, if not for the obesity.

N

Network health care practitioner means a *health care practitioner*, who has been designated as such or has signed an agreement with *us* as an independent contractor, or who has been designated by *us* to provide services to all *covered persons*. *Network health care practitioner* designation by *us* may be limited to specified services.

Network health care treatment facility means a *health care treatment facility* that has been designated as such or has signed an agreement with *us* as an independent contractor, or who has been designated by *us* to provide services to all *covered persons*. *Network health care treatment facility* designation by *us* may be limited to specified services.

Network hospital means a *hospital* which has been designated as such or has signed an agreement with *us* as an independent contractor, or has been designated by *us* to provide services to all *covered persons*. *Network hospital* designation by *us* may be limited to specified services.

Network provider means a *hospital*, *health care treatment facility*, *health care practitioner*, or other health services provider who is designated as such or has signed an agreement with *us* as an independent contractor, or who has been designated by *us* to provide services to all *covered persons*. *Network provider* designation by *us* may be limited to specified services.

Non-network health care practitioner means a *health care practitioner* who has not been designated by *us* as a *network health care practitioner*.

Non-network hospital means a *hospital* which has not been designated by *us* as a *network hospital*.

Non-network provider means a *hospital*, *health care treatment facility*, *health care practitioner*, or other health services provider who has not been designated by us as a *network provider*.

Nurse means a registered nurse (R.N.), a licensed practical nurse (L.P.N.), or a licensed vocational nurse (L.V.N.).

O

Observation status means *hospital outpatient* services provided to *you* to help the *health care practitioner* decide if *you* need to be admitted as an *inpatient.*

Open enrollment period means no less than a 31-day period of time, occurring annually for the *group,* during which *employees* have an opportunity to enroll themselves and their eligible *dependents* for coverage under the *master group contract*.

Oral surgery means procedures to correct diseases, injuries and defects of the jaw and mouth structures. These procedures include the following:

- Surgical removal of full bony impactions;
- Mandibular or maxillary implant;
- Maxillary or mandibular frenectomy;
- Alveolectomy and alveoplasty;
- Orthognathic *surgery*;
- *Surgery* for treatment of temporomandibular joint syndrome/dysfunction; and
- Periodontal surgical procedures, including gingivectomies.

Originating site means the location of a *covered person* at the time a *telehealth* or *telemedicine* service is being furnished.

Out-of-pocket limit means the amount of any *copayments, deductibles* and *coinsurance* for *covered expenses* which *you* must pay, either individually or combined as a covered family, per *year* before a benefit percentage is increased. Any amount *you* pay exceeding the *maximum allowable fee* is not applied to the *out-of-pocket limits.*

Outpatient means *you* are not *confined* as a registered bed patient.

Outpatient surgery means *surgery* performed in a *health care practitioner's* office, *ambulatory surgical center,* or the *outpatient* department of a *hospital*.

P

Palliative care means care given to a *covered person* to relieve, ease, or alleviate, but not to cure, a *bodily injury* or *sickness*.

Partial hospitalization means *outpatient* services provided by a *hospital* or *health care treatment facility* in which patients do not reside for a full 24-hour period and:

- Has a comprehensive and intensive interdisciplinary psychiatric treatment for minimum of 5 hours a day, 5 days per week under the supervision of a psychiatrist for *mental health services* or a psychiatrist or addictionologist for *chemical dependency*, and patients are seen by a psychiatrist or addictionologist, as applicable, at least once a week;

- Provides for social, psychological and rehabilitative training programs with a focus on reintegration back into the community and admits children and adolescents who must have a treatment program designed to meet the special needs of that age range; and

- Has physicians and appropriately licensed behavioral health practitioners readily available for the emergent and urgent needs of the patients.

The *partial hospitalization* program must be accredited by the Joint Commission of the Accreditation of Hospitals or in compliance with an equivalent standard.

Licensed drug abuse rehabilitation programs and alcohol rehabilitation programs accredited by the Joint Commission on the Accreditation of Health Care Organizations or approved by the appropriate state agency are also considered *partial hospitalization* services.

Partial hospitalization does not include services that are for:

- *Custodial care*; or
- Day care.

Pediatric dental services mean the following services:

- Ordered by a *dentist*; and
- Described in the "Pediatric dental" provision in the "Covered Expenses – Pediatric Dental" section.

Pediatric vision care means the services and *materials* specified in the "Pediatric vision care benefit" provision in the "Covered Expenses – Pediatric Vision Care" section.

Periodontics means the branch of dentistry concerned with the study, prevention, and treatment of diseases of the tissues and bones supporting the teeth. *Periodontics* includes the following dental procedures, related tests or treatment and follow-up care:

- Periodontal maintenance;
- Scaling and root planing;
- Gingivectomy;
- Gingivoplasty; or
- Osseous surgical procedures.

Pre-surgical/procedural testing means:

- Laboratory tests or radiological examinations done on an *outpatient* basis in a *hospital* or other facility accepted by the *hospital* before *hospital confinement* or *outpatient surgery* or procedure;
- The tests must be accepted by the *hospital* or *health care practitioner* in place of like tests made during *confinement*; and
- The tests must be for the same *bodily injury* or *sickness* causing *you* to be *hospital confined* or to have the *outpatient surgery* or procedure.

Preauthorization means approval by *us*, or *our* designee, of a service prior to it being provided. Certain services require medical review by *us* in order to determine eligibility for coverage.

Preauthorization is granted when such a review determines that a given service is a *covered expense* according to the terms and provisions of the *master group contract*.

Prescription means a direct order for the preparation and use of a drug, medicine or medication. The *prescription* must be written by a *health care practitioner* and provided to a *pharmacist* for *your* benefit and used for the treatment of a *sickness* or *bodily injury*, which is covered under this plan, or for drugs, medicines or medications on the Preventive Medication Coverage *drug list.* The drug, medicine or medication must be obtainable only by *prescription* or must be obtained by *prescription* for drugs, medicines or medications on the Preventive Medication Coverage *drug list.* The *prescription* may be given to the *pharmacist* verbally, *electronically* or in writing by the *health care practitioner*. The *prescription* must include at least:

- *Your* name;
- The type and quantity of the drug, medicine or medication prescribed, and the directions for its use;
- The date the *prescription* was prescribed; and
- The name and address of the prescribing *health care practitioner*.

Preventive services means services in the following recommendations appropriate for *you* during *your* plan *year*:

- Services with an A or B rating in the current recommendations of the U.S. Preventive Services Task Force (USPSTF). Coverage includes individual, group and telephonic tobacco cessation counseling and all U.S. Food and Drug Administration approved tobacco cessation medications.

- Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC).

- Preventive care for infants, children and adolescents provided in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA).

- Preventive care for women provided in the comprehensive guidelines supported by HRSA and bone density screenings beginning at age 35.

- Colorectal cancer screening examinations and laboratory tests administered at frequencies specified in current American Cancer Society guidelines for colorectal cancer screening.

- Genetic screening for cancer risk that is recommended by a *health care practitioner* or genetic counselor if that recommendation is consistent with the most recent version of genetic testing guidelines published by the National Comprehensive Cancer Network (NCCN).

For the recommended *preventive services* that apply to *your* plan *year*, refer to the www.healthcare.gov website or call the customer service telephone number on *your* ID card.

Primary care physician means a *network health care practitioner* who provides initial and primary care services to *covered persons*, maintains the continuity of *covered persons*, medical care and helps direct *covered persons* to *specialty care physicians* and other providers.

A *primary care physician* is a *health care practitioner* in one of the following specialties:

- Family medicine/General practice;
- Internal medicine; and
- Pediatrics.

Q

Qualified payment amount means:

- The median of the contracted rates negotiated by *us* with one or more *network providers* in the same geographic area for the same or similar services; or

- If sufficient information is not available for *us* to calculate the median of the contracted rates, the rate established by *us* through use of any database that does not have any conflict of interest and has sufficient information reflecting allowed amounts paid to a *qualified provider* or *health care treatment facility* for relevant services furnished in the applicable geographic region.

The *qualified payment amount* applies to *covered expenses* for *emergency care* and *air ambulance* services provided by a *non-network provider* or if a *you* receive any of the following:

- *Ancillary services* from a *non-network provider* while *you* are at a *network health care treatment facility*;

- Services that are not considered *ancillary services* from a *non-network provider* while *you* are at a *network health care treatment facility,* and *you* did not consent to the *non-network provider* to obtain such services;

- Services from a *non-network provider* when a *network provider* is not available; or

- Services from a *non-network provider* related to an emergency medical condition after *you* are stabilized and *you* did not consent to the *non-network provider* to obtain such services.

Qualified provider means a person, facility or any other health care provider:

- That is licensed by the appropriate state agency to:

  - Diagnose or treat a *sickness* or *bodily injury*;
  - Provide *preventive services*;
  - Provide *pediatric dental services*; or
  - Provide *pediatric vision care.*

- That provides services within the scope of their license; and
- Whose primary purpose is to provide health care services.

R

Registered nurse first assistant means a nurse who:

- Holds a current active registered nurse licensure;
- Is certified in perioperative nursing; and
- Has successfully completed and holds a degree or certificate from a recognized program, which shall consist of:
    - The Association of Operating Room Nurses, Inc.; Core curriculum for the registered nurse first assistant; and
    - One (1) year of post basic nursing study, which shall include at least forty-five hours of didactic instruction and one hundred twenty (120) hours of clinical internship or its equivalent of two college semesters
- A registered nurse who was certified prior to 1995 by the Certification Board of Perioperative Nursing shall not be required to fulfill the requirements of the third bulleted paragraph of this subsection.

Rehabilitation facility means any licensed public or private establishment which has permanent facilities that are equipped and operated primarily to render physical and occupational therapies, diagnostic services and other therapeutic services.

Rescission, rescind or ***rescinded*** means a cancellation or discontinuance of coverage that has a retroactive effect.

Residential treatment facility means an institution that:

- Is licensed as a 24-hour residential facility for *behavioral health* treatment, although not licensed as a *hospital*;
- Provides a multidisciplinary treatment plan in a controlled environment, under the supervision of a physician who is able to provide treatment on a daily basis;
- Provides supervision and treatment by a Ph.D. psychologist, licensed therapist, psychiatric nursing staff or registered nurse;
- Provides programs such as social, psychological, family counseling, and rehabilitative training, age appropriate for the special needs of the age group of patients, with focus on reintegration back into the community; and
- Provides structured activities throughout the day and evening, for a minimum of 6 hours a day.

Residential treatment is utilized to provide structure, support and reinforcement of the treatment required to reverse the course of behavioral deterioration.

Retail clinic means a *health care treatment facility*, located in a retail store, that is often staffed by nurse practitioners and physician assistants who provide minor medical services on a "walk-in" basis (no appointment required).

Room and board means all charges made by a *hospital* or other *health care treatment facility* on its own behalf for room and meals and all general services and activities needed for the care of registered bed patients.

Routine nursery care means the charges made by a *hospital* or licensed birthing center for the use of the nursery. It includes normal services and supplies given to well newborn children following birth. *Health care practitioner* visits are not considered *routine nursery care*. Treatment of a *bodily injury*, *sickness*, birth abnormality, or *congenital anomaly* following birth and care resulting from prematurity is not considered *routine nursery care*.

S

Self-administered injectable drugs means an FDA approved medication which a person may administer to himself or herself by means of intramuscular, intravenous, or subcutaneous injection, excluding insulin, and prescribed for use by *you.*

Serious mental condition or significant behavioral problem means in relation to general anesthesia for dental procedures a condition identified by a diagnostic code from the most recent edition of the:

- International Classification Of Disease-Clinical Modification (ICD-CM), coeds 290-299.9 and 300-319; or
- Diagnostic and Statistical Manual of Mental Disorders; and
- The person must also require dental care be performed in a *hospital* or *ambulatory surgical facility* because:

    - Their diagnosis reasonably infers they will be unable to cooperate; or
    - Airway, breathing, circulation of blood may be compromised.

Serious physical condition means a disease (or condition) requiring on-going medical care that may cause compromise of the airway, breathing or circulation of blood while receiving dental care unless performed in a hospital or ambulatory surgical facility.

Service area means the geographic area designated by *us*, or as otherwise agreed upon between the *group plan sponsor* and *us* and approved by the Department of Insurance of the state in which the *master group contract* is issued, if such approval is required. The *service area* is the geographic area where the *network provider* services are available to *you.* A description of the *service area* is provided in the provider directories.

Sickness means a disturbance in function or structure of the body which causes physical signs or physical symptoms and which, if left untreated, will result in a deterioration of the health state of the structure or system(s) of the body. The term also includes: (a) pregnancy; (b) any medical complications of pregnancy; and (c) *behavioral health.*

Skilled nursing facility means a licensed institution (other than a *hospital*, as defined) which meets all of the following requirements:

- It must provide permanent and full-time bed care facilities for resident patients;
- It must maintain, on the premises and under arrangements, all facilities necessary for medical care and treatment;
- It must provide such services under the supervision of physicians at all times;
- It must provide 24-hours-a-day nursing services by or under the supervision of a registered nurse; and
- It must maintain a daily record for each patient.

A *skilled nursing facility* is not, except by incident, a rest home, a home for the care of the aged, or engaged in the care and treatment of *chemical dependency*.

Small employer means an *employer* who employed an average of one but not more than 50 *employees* on business days during the preceding calendar year and who employs at least one *employee* on the first day of the *year*. All subsidiaries or affiliates of the *group plan sponsor* are considered one *employer* when the conditions specified in the "Subsidiaries or Affiliates" section of the *master group contract* are met.

Sound natural tooth means a tooth that:

- Is organic and formed by the natural development of the body (not manufactured, capped, crowned or bonded);
- Has not been extensively restored;
- Has not become extensively decayed or involved in periodontal disease; and
- Is not more susceptible to injury than a whole natural tooth, (for example a tooth that has not been previously broken, chipped, filled, cracked or fractured).

Special enrollment date means the date of:

- Change in family status after the *eligibility date*;
- Loss of other coverage under another group health plan or other *health insurance coverage*;
- COBRA exhaustion;
- Loss of coverage under *your employer's* alternate plan;
- Termination of your *Medicaid* coverage or your Children's Health Insurance Program (CHIP) coverage as a result of loss of eligibility; or
- Eligibility for a premium assistance subsidy under *Medicaid* or CHIP.

To be eligible for special enrollment, *you* must meet the requirements specified in the "Special enrollment" provision within the "Eligibility and Effective Dates" section of this *certificate.*

Specialty care physician means a *health care practitioner* who has received training in a specific medical field other than the specialties listed as primary care.

Specialty drug means a drug, medicine, medication, or biological used as a specialized therapy developed for chronic, complex *sicknesses* or *bodily injuries*. *Specialty drugs* may:

- Be injected, infused or require close monitoring by a *health care practitioner* or clinically trained individual;
- Require nursing services or special programs to support patient compliance;
- Require disease-specific treatment programs;
- Have limited distribution requirements; or
- Have special handling, storage or shipping requirements.

Stem cell means the transplant of human blood precursor cells. Such cells may be derived from bone marrow, circulating blood, or a combination of bone marrow and circulating blood obtained from the patient in an autologous transplant, from a matched related or unrelated donor, or cord blood. The *stem cell* transplant includes the harvesting, integral chemotherapy components and the *stem cell* infusion. A *stem cell* transplant is commonly referred to as a bone marrow transplant.

Surgery means procedures categorized as Surgery in either the:

- Current Procedural Terminology (CPT) manuals published by the American Medical Association; or
- Healthcare Common Procedure Coding System (HCPCS) Level II manual published by the Centers for Medicare & Medicaid Services (CMS).

The term *surgery* includes:

- Excision or incision of the skin or mucosal tissues;
- Insertion for exploratory purposes into a natural body opening;
- Insertion of instruments into any body opening, natural or otherwise, done for diagnostic or other therapeutic purposes;
- Treatment of fractures;
- Procedures to repair, remove or replace any body part or foreign object in or on the body; and
- Endoscopic procedures.

Surgical assistant means a *health care practitioner* who assists at *surgery* and is not a Doctor of Medicine (MD), Doctor of Osteopathic Medicine (DO) or Doctor of Podiatric Medicine (DPM), or where state law does not require that specific *health care practitioners* be treated and reimbursed the same as an MD, DO or DPM.

T

Telehealth means delivery of health care services through telecommunication technologies. It includes synchronous and asynchronous technology, remote patient monitoring and audio-only encounters by a *qualified provider* to a *covered person* or to another *qualified provider* at a different location. *Telehealth* does not include:

- Services provided through the use of text, chat, facsimile, or *electronic mail,* unless a state agency authorized or required to enact regulations relating to *telehealth* determines the health care services can be delivered through these methods in ways that enhance a patient's health and well-being and meet all clinical and technology guidelines for the patient's safety and appropriate delivery of health care services; and

- Basic communication between a *qualified provider* and a patient, including but not limited to, appointment scheduling, appointment reminders, voicemails, or any other similar communication intended to assist in providing health care services either in-person or through *telehealth.*

Telemedicine means services other than *telehealth services* provided via telephonic or *electronic* communications.

Total disability or ***totally disabled*** means *your* continuing inability, as a result of a *bodily injury* or *sickness,* to perform the material and substantial duties of any job for which *you* are or become qualified by reason of education, training or experience.

The term also means a *dependent's* inability to engage in the normal activities of a person of like age. If the *dependent* is employed, the *dependent* must be unable to perform his or her job.

U

Urgent care means those health care services provided on an *outpatient* basis for an unforeseen condition that usually requires attention without delay but that does not pose a threat to life, limb or permanent health of the *covered person.*

Urgent care center means any licensed public or private non-*hospital free-standing facility* which has permanent facilities equipped to provide *urgent care* services.

V

Virtual visit means *telehealth* or *telemedicine* services.

W

Waiting period means the period of time, elected by the *group plan sponsor,* that must pass before an *employee* is eligible for coverage under the *master group contract*.

We, us or ***our*** means the offering company as shown on the cover page of the *master group contract* and *certificate.*

X

GLOSSARY (continued)

Y

Year means the period of time which begins on any January 1st and ends on the following December 31st. When *you* first become covered by the *master group contract*, the first *year* begins for *you* on the *effective date* of *your* coverage and ends on the following December 31st.

You or ***your*** means any *covered person.*

Z

GLOSSARY – PHARMACY SERVICES

All terms used in the "Schedule of Benefits – Pharmacy Services," "Covered Expenses – Pharmacy Services" and "Limitations and Exclusions – Pharmacy Services" sections have the same meaning given to them in the "Glossary" section of this *certificate,* unless otherwise specifically defined below:

A

B

Brand-name drug means a drug, medicine or medication that is manufactured and distributed by only one pharmaceutical manufacturer, or any drug product that has been designated as brand-name by an industry-recognized source used by *us.*

C

Coinsurance means the amount expressed as a percentage of the *covered expense* that *you* must pay toward the cost of each separate *prescription* fill or refill dispensed by a *pharmacy*.

Copayment means the specified dollar amount to be paid by *you* toward the cost of each separate *prescription* fill or refill dispensed by a *pharmacy*.

Cost share means any applicable *prescription drug deductible, copayment* and *coinsurance* that *you* must pay per *prescription* fill or refill.

D

Default rate means the fee based on rates negotiated by *us* or other payers with one or more *network providers* in a geographic area determined by *us* for the same or similar *prescription* fill or refill.

Dispensing limit means the monthly drug dosage limit and/or the number of months the drug usage is commonly prescribed to treat a particular condition, as determined by *us*.

Drug list means a list of covered *prescription* drugs, medicines or medications and supplies specified by *us*.

E

GLOSSARY – PHARMACY SERVICES (continued)

F

G

Generic drug means a drug, medicine or medication that is manufactured, distributed, and available from a pharmaceutical manufacturer and identified by the chemical name, or any drug product that has been designated as generic by an industry-recognized source used by *us*.

H

I

J

K

L

Legend drug means any medicinal substance, the label of which, under the Federal Food, Drug and Cosmetic Act, is required to bear the legend: "Caution: Federal Law Prohibits dispensing without prescription."

Level 1 drugs mean a category of *prescription* drugs, medicines or medications within the *drug list* that are designated by *us* as level 1.

Level 2 drugs mean a category of *prescription* drugs, medicines or medications within the *drug list* that are designated by *us* as level 2.

Level 3 drugs mean a category of *prescription* drugs, medicines or medications within the *drug list* that are designated by *us* as level 3.

Level 4 drugs mean a category of *prescription* drugs, medicines or medications within the *drug list* that are designated by *us* as level 4.

Level 5 drugs mean a category of *prescription* drugs, medicines or medications within the *drug list* that are designated by *us* as level 5. The *prescription* drugs in this category are highest-cost/high technology drugs and *specialty drugs*.

GLOSSARY – PHARMACY SERVICES (continued)

M

Mail order pharmacy means a *pharmacy* that provides covered *mail order pharmacy* services, as defined by *us*, and delivers covered *prescription* drug, medicine or medication fills or refills through the mail to *covered persons.*

N

Network pharmacy means a *pharmacy* that has signed a direct agreement with *us* or has been designated by *us* to provide:

- Covered *pharmacy* services;
- Covered *specialty pharmacy* services; or
- Covered *mail order pharmacy* services,

as defined by *us*, to *covered persons,* including covered *prescription* fills or refills delivered to *your* home or health care provider.

Non-network pharmacy means a *pharmacy* that has not signed a direct agreement with *us* or has not been designated by *us* to provide:

- Covered *pharmacy* services;
- Covered *specialty pharmacy* services; or
- Covered *mail order pharmacy* services,

as defined by *us*, to *covered persons,* including covered *prescription* fills or refills delivered to *your* home or health care provider.

O

P

Pharmacist means a person, who is licensed to prepare, compound and dispense medication, and who is practicing within the scope of his or her license.

Pharmacy means a licensed establishment where *prescription* drugs, medicines or medications are dispensed by a *pharmacist.*

GLOSSARY – PHARMACY SERVICES (continued)

Prior authorization means the required prior approval from *us* for the coverage of certain *prescription* drugs, medicines or medications, including *specialty drugs*. The required prior approval from *us* for coverage includes the dosage, quantity and duration, as *medically necessary* for the *covered person.*

Q

R

S

Specialty pharmacy means a *pharmacy* that provides covered *specialty pharmacy* services, as defined by *us,* to *covered persons.*

Step therapy means a requirement for *you* to first try certain drugs, medicines or medications or *specialty drugs* to treat *your* medical condition before *we* will cover another *prescription* drug, medicine, medication or *specialty drug* for that condition.

T

U

V

W

X

Y

Z

Humana.

Toll Free:1 800-448-6262
500 West Main Street
Louisville, KY 40202

OFFERED BY
Humana Health Plan, Inc.

FEDERAL NOTICES

The following pages contain important information about certain federal laws. There may be differences between the Certificate of Insurance and this Notice packet. There may also be differences between this notice packet and state law. You are eligible for the rights more beneficial to you, unless preempted by state or federal law.

This section includes notices about:

Federal legislation

- **Women's health and cancer rights act**
- **Statement of rights under the newborns' and mothers' health Protection act**
- **Medical child support orders**
- **General notice of COBRA continuation of coverage rights**
- **Tax equity and fiscal responsibility act of 1982 (TEFRA)**
- **Family and medical leave act (FMLA)**
- **Uniformed services employment and reemployment rights act of 1994 (USERRA)**
- **Your rights under ERISA**
- **Patient protection act**

FEDERAL NOTICES (continued)

Federal legislation

Women's health and cancer rights act of 1998
Required coverage for reconstructive surgery following mastectomies

Under federal law, group health plans and health insurance issuers offering group health insurance providing medical and surgical benefits with respect to mastectomy shall provide, in a case of a participant or beneficiary who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with such mastectomy, coverage for:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce symmetrical appearance; and
- Prostheses and physical complications of all stages of mastectomy, including lymphedemas;

in a manner determined in consultation with the attending physician and the patient. Such coverage may be subject to annual deductibles and coinsurance provisions as may be deemed appropriate and as are consistent with those established for other benefits under the plan.

Statement of rights under the newborns' and mothers' health protection act (NMHPA)

If your plan covers normal pregnancy benefits, the following notice applies to you.

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, group health plans and health insurance issuers may not set the level of benefits or out-of-pocket costs so any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a group health plan or health insurance issuer may not, under federal law, require a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain pre-authorization. For information on pre-authorization, contact your plan administrator.

FEDERAL NOTICES (continued)

Medical child support orders

An individual who is a child of a covered employee shall be enrolled for coverage under the group health plan in accordance with the direction of a Qualified Medical Child Support Order (QMCSO) or a National Medical Support Notice (NMSO).

A QMCSO is a state-court order or judgment, including approval of a settlement agreement that:

- Provides for support of a covered employee's child;
- Provides for health care coverage for that child;
- Is made under state domestic relations law (including a community property law);
- Relates to benefits under the group health plan; and
- Is "qualified," i.e., it meets the technical requirements of ERISA or applicable state law.

QMCSO also means a state court order or judgment enforcing state Medicaid law regarding medical child support required by the Social Security Act §1908 (as added by Omnibus Budget Reconciliation Act of 1993).

An NMSO is a notice issued by an appropriate agency of a state or local government that is similar to a QMCSO requiring coverage under the group health plan for a dependent child of a non-custodial parent who is (or will become) a covered person by a domestic relations order providing for health care coverage.

Procedures for determining the qualified status of medical child support orders are available at no cost upon request from the plan administrator.

General notice of COBRA continuation coverage rights

Introduction

You are getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

FEDERAL NOTICES (continued)

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary". You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you to lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced; or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you to lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a "dependent child".

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the employer, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

FEDERAL NOTICES (continued)

When is COBRA coverage available?

The plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- Commencement of a proceeding in bankruptcy with respect to the employer; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs.

How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

- ***Disability extension of 18-month period of continuation coverage*** - If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage;

- ***Second qualifying event extension of 18-month period of continuation coverage*** - If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

FEDERAL NOTICES (continued)

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period". Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting your group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep your plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information:

Humana
Billing/Enrollment Department
101 E Main Street
Louisville, KY 40201
1-800-872-7207

FEDERAL NOTICES (continued)

Important notice for individuals entitled to Medicare tax equity and fiscal responsibility act of 1982 (TEFRA) options

Where an employer employs more than 20 people, the Tax Equity And Fiscal Responsibility Act of 1982 (TEFRA) allows covered employees in active service who are age 65 or older and their covered spouses who are eligible for Medicare to choose one of the following options:

- ***Option 1*** - The benefits of their group health plan will be payable first and the benefits of Medicare will be payable second.
- ***Option 2*** - Medicare benefits only. The employee and his or her dependents, if any, will not be insured by the group health plan.

The employer must provide each covered employee and each covered spouse with the choice to elect one of these options at least one month before the covered employee or the insured spouse becomes age 65. All new covered employees and newly covered spouses age 65 or older must be offered these options. If Option 1 is chosen, its issue is subject to the same requirements as for an employee or dependent that is under age 65.

Under TEFRA regulations, there are two categories of persons eligible for Medicare. The calculation and payment of benefits by the group health plan differs for each category.

- ***Category 1*** Medicare eligibles are:
    - Covered employees in active service who are age 65 or older who choose Option 1;
    - Age 65 or older covered spouses; and
    - Age 65 or older covered spouses of employees in active service who are either under age 65 or age 70 or older;
- ***Category 2*** Medicare eligibles are any other covered persons entitled to Medicare, whether or not they enrolled. This category includes, but is not limited to:
    - Retired employees and their spouses; or
    - Covered dependents of a covered employee, other than his or her spouse.

Calculation and payment of benefits

For covered persons in Category 1, benefits are payable by the policy without regard to any benefits payable by Medicare. Medicare will then determine its benefits.

For covered persons in Category 2, Medicare benefits are payable before any benefits are payable by the policy. The benefits of the policy will then be reduced by the full amount of all Medicare benefits the covered person is entitled to receive, whether or not the eligible individual is actually enrolled for Medicare Benefits.

FEDERAL NOTICES (continued)

Family and Medical Leave Act (FMLA)

If an employee is granted a leave of absence (Leave) by the employer as required by the Federal Family and Medical Leave Act, s/he may continue to be covered under the plan for the duration of the Leave under the same conditions as other employees who are currently employed and covered by the plan. If the employee chooses to terminate coverage during the Leave, or if coverage terminates as a result of nonpayment of any required contribution, coverage may be reinstated on the date the employee returns to work immediately following the end of the Leave. Charges incurred after the date of reinstatement will be paid as if the employee had been continuously covered.

Uniformed services employment and reemployment rights act of 1994 (USERRA)

Continuation of benefits

Effective October 13, 1994, federal law requires health plans offer to continue coverage for employees that are absent due to service in the uniformed services and/or dependents.

Eligibility

An employee is eligible for continuation under USERRA if he or she is absent from employment because of voluntary or involuntary performance of duty in the Armed Forces, Army National Guard, Air National Guard, or commissioned corps of the Public Health Service. Duty includes absence for active duty, active duty for training, initial active duty for training, inactive duty training and for the purpose of an examination to determine fitness for duty.

An employee's dependents that have coverage under the plan immediately prior to the date of the employee's covered absence are eligible to elect continuation under USERRA.

If continuation of Plan coverage is elected under USERRA, the employee or dependent is responsible for payment of the applicable cost of coverage. If the employee is absent for not longer than 31 days, the cost will be the amount the employee would otherwise pay for coverage. For absences exceeding 30 days, the cost may be up to 102% of the cost of coverage under the plan. This includes the employee's share and any portion previously paid by the employer.

Duration of coverage

If elected, continuation coverage under USERRA will continue until the earlier of:

- 24 months beginning the first day of absence from employment due to service in the uniformed services; or
- The day after the employee fails to apply for a return to employment as required by USERRA, after the completion of a period of service.

Under federal law, the period coverage available under USERRA shall run concurrently with the COBRA period available to an employee and/or eligible dependent.

Other information

Employees should contact their employer with any questions regarding coverage normally available during a military leave of absence or continuation coverage and notify the employer of any changes in marital status, or change of address.

Your rights under the Employee Retirement Income Security Act of 1974 (ERISA)

Under ERISA, all plan participants covered by ERISA are entitled to certain rights and protections, as described below. Notwithstanding anything in the group health plan or group insurance policy, following are a covered person's minimum rights under ERISA. ERISA requirements do not apply to plans maintained by governmental agencies or churches.

Information about the plan and benefits

Plan participants may:

- Examine, free of charge, all documents governing the plan. These documents are available in the plan administrator's office;

- Obtain, at a reasonable charge, copies of documents governing the plan, including a copy of any updated summary plan description and a copy of the latest annual report for the plan (Form 5500), if any, by writing to the plan administrator;

- Obtain, at a reasonable charge, a copy of the latest annual report (Form 5500) for the plan, if any, by writing to the plan administrator.

FEDERAL NOTICES (continued)

As a plan participant, you will receive a summary of any material changes made in the plan within 210 days after the end of the plan year in which the changes are made unless the change is a material reduction in covered services or benefits, in which case you will receive a summary of the material reduction within 60 days after the date of its adoption.

If the plan is required to file a summary annual financial report, you will receive a copy from the plan administrator.

Responsibilities of plan fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the plan. These people, called "fiduciaries" of the plan, have a duty to act prudently and in the interest of plan participants and beneficiaries.

No one, including an employer, may discharge or otherwise discriminate against a plan participant in any way to prevent the participant from obtaining a benefit to which the participant is otherwise entitled under the plan or from exercising ERISA rights.

Continue group health plan coverage

Participants may be eligible to continue health care coverage for themselves, their spouse or dependents if there is a loss of coverage under the group health plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review the COBRA notice in this document regarding the rules governing COBRA continuation coverage rights.

Claims determinations

If a claim for a plan benefit is denied or disregarded, in whole or in part, participants have the right to know why this was done, to obtain copies of documents relating to the decision without charge and to appeal any denial within certain time schedules.

Enforce your rights

Under ERISA, there are steps participants may take to enforce the above rights. For instance:

- If a participant requests a copy of plan documents and does not receive them within 30 days, the participant may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until the participant receives the materials, unless the materials were not sent because of reasons beyond the control of the plan administrator;

- If a claim for benefits is denied or disregarded, in whole or in part, the participant may file suit in a state or Federal court;

- If the participant disagrees with the plan's decision, or lack thereof, concerning the qualified status of a domestic relations order or a medical child support order, the participant may file suit in Federal court;

- If plan fiduciaries misuse the plan's money, or if participants are discriminated against for asserting their rights, they may seek assistance from the U.S. Department of Labor, or may file suit in a Federal court.

The court will decide who should pay court costs and legal fees. If the participant is successful, the court may order the person sued to pay costs and fees. If the participant loses, the court may order the participant to pay the costs and fees.

Assistance with questions

- Contact the group health plan human resources department or the plan administrator with questions about the plan;

- For questions about ERISA rights, contact the nearest area office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or:

The Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue N.W.
Washington, D.C. 20210;

- Call the publications hotline of the Employee Benefits Security Administration to obtain publications about ERISA rights.

FEDERAL NOTICES (continued)

Patient Protection Act

Humana generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For children, you may designate a pediatrician as the primary care provider. For information on how to select a primary care provider, and for a list of the participating primary care providers, visit our Website at www.humana.com or call the customer service telephone number on your identification card.

If your plan provides coverage for obstetric or gynecological care, you do not need prior authorization from us or from any other person (including a primary care provider) in order to obtain access to this care from a health care professional in our network who specialize in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, visit our Website at www.humana.com or call the customer service telephone number on your identification card.

Appeal and External Review Notice

The following pages contain important information about Humana's claims procedures, internal appeals and external review. There may be differences between the Certificate of Insurance and this Notice packet. There may also be differences between this notice packet and state law. You are eligible for the rights more beneficial to you, unless preempted by state or federal law.

Federal standards

The Employee Retirement Income Security Act of 1974 (ERISA) established minimum requirements for claims procedures. The Patient Protection and Affordable Care Act (PPACA) including all regulation enforcing PPACA established additional requirements for claims procedures, internal appeal and *external review* processes. Humana complies with these standards. In addition to the procedures below, you should also refer to your insurance benefit plan documents (e.g., the Certificate of Insurance or Evidence of Coverage).

Definitions

Adverse benefit determination means a denial, reduction, or termination of, or a failure to provide or make a payment (in whole or in part) for a benefit based on:

- A determination of your eligibility to participate in the plan or health insurance coverage;
- A determination that the benefit is not covered;
- The imposition of a source-of-injury exclusion, network exclusion, or other limitation on otherwise covered benefits; or
- A determination that a benefit is experimental, investigational, or not medically necessary or appropriate.

An *adverse benefit determination* also includes any rescission of coverage.

Claimant means a covered person (or authorized representative) who files a claim.

Clinical peer reviewer is:

- An expert in the treatment of your medical condition that is the subject of an *external review*;
- Knowledgeable about the recommended healthcare service or treatment through recent or current actual clinical experience treating patients with the same or similar to your medical condition;
- Holds a non-restricted license in a state of the United States and, for physicians, a current certification by a recognized American medical specialty board in the area or areas appropriate to the subject of the *external review*;
- Has no history of disciplinary actions or sanctions, including loss of staff privileges or participation restrictions, that have been taken or are pending by any hospital, governmental agency or unit, or regulatory body that raise a substantial question as to the *clinical peer reviewer's* physical, mental or professional competence or moral character; and

- Does not have a material professional, family or financial conflict of interest with the *claimant*, Humana and any of the following:

    - The healthcare provider, the healthcare provider's medical group or independent practice association recommending the healthcare service or treatment;
    - The facility at which the recommended healthcare service or treatment would be provided; or
    - The developer or manufacturer of the principal drug, device, procedure or other therapy being recommended.

Commissioner means the Commissioner of Insurance.

Concurrent-care decision means a decision by the plan to reduce or terminate benefits otherwise payable for a course of treatment that has been approved by the plan (other than by plan amendment or termination) or a decision with respect to a request by a *claimant* to extend a course of treatment beyond the period of time or number of treatments that has been approved by the plan.

Evidence-based standard means the conscientious, explicit and judicious use of the current best evidence based on the overall systematic review of the research in making decisions about the care of individual patients.

External review means a review of an *adverse benefit determination* including a *final adverse benefit determination* conducted by an *Independent review organization (IRO).*

Final adverse benefit determination means an *adverse benefit determination* that has been upheld by us at the completion of the internal appeals process or when the internal appeals process has been exhausted.

Group health plan means an employee welfare benefit plan to the extent the plan provides medical care to employees or their dependents directly (self insured) or through insurance (including HMO plans), reimbursement or otherwise.

Health insurance issuer means the offering company listed on the face page of your Certificate of Insurance and referred to in this document as "Humana," "we," "us," or "our."

Independent review organization (IRO) means an entity that conducts independent *external reviews* of *adverse benefit determinations* and *final adverse benefit determinations.* All *IRO's* must be accredited by a nationally recognized private accrediting organization and have no conflicts of interest to influence its independence.

Medical or scientific evidence means evidence found in the following sources:

- Peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff;

- Peer-reviewed medical literature, including literature relating to therapies reviewed and approved by a qualified institutional review board, biomedical compendia and other medical literature that meet the criteria of the National Institutes of Health's Library of Medicine for indexing in Index Medicus (Medline) and Elsevier Science Ltd. for indexing in Excerpta Medicus (EMBASE);

- Medical journals recognized by the Secretary of Health and Human Services;

- The following standard reference compendia:

  - The American Hospital Formulary Service–Drug Information;
  - Drug Facts and Comparisons;
  - The American Dental Association Accepted Dental Therapeutics; and
  - The United States Pharmacopoeia–Drug Information;

- Findings, studies or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes, including:

  - The federal Agency for Healthcare Research and Quality;
  - The National Institutes of Health;
  - The National Cancer Institute;
  - The National Academy of Sciences;
  - The Centers for Medicare & Medicaid Services;
  - The federal Food and Drug Administration; and
  - Any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health care services; or

- Any other *medical or scientific evidence* that is comparable to the sources listed above.

Preliminary review means a review by Humana of an *external review* request to determination if:

- You are or were covered under the plan at the time a service was recommended, requested, or provided;

- The service is covered under the plan except when we determine the service is:

  - Not covered because it does not meet plan requirements for medical necessity, appropriateness, healthcare setting, level of care or effectiveness; or
  - Experimental or investigational for a particular medical condition and is not explicitly listed as an excluded benefit under the plan.

- In the case of experimental or investigational treatment:

  - Your treating physician has certified <u>one</u> of the following situations is applicable:

    - Standard services have not been effective in improving your condition;
    - Standard services are not medically appropriate for you; or
    - There is no available standard service covered by the plan that is more beneficial to you than the recommended or requested service.

- The treating physician certifies in writing:
    - The recommended service is likely to be more beneficial to you, in the physician's opinion, than any available standard services; or
    - Scientifically valid studies using accepted protocols demonstrate the service is likely to be more beneficial to you than any available standard services and the physician is a licensed, board certified or board eligible physician qualified to practice in the area of medicine appropriate to treat your condition.

- The internal appeals process has been exhausted as specified under the "Exhaustion of remedies" section;
- You have provided all information required to process an *external review*; including:
    - An *external review* request form provided with the *adverse benefit determination* or *final adverse benefit determination*; and
    - Release forms authorizing us to disclose protected health information that is pertinent to the *external review*.

Post-service claim means any claim for a benefit under a *group health plan* that is not a *pre-service claim.*

Pre-service claim means a request for authorization of a benefit for which the plan conditions receipt of the benefit, in whole or in part, on advance approval.

Urgent-care claim means a claim for covered services to which the application of the time periods for making non-urgent care determinations:

- Could seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function; or
- In the opinion of a physician with knowledge of the covered person's medical condition, would subject the covered person to severe pain that cannot be adequately managed without the service that is the subject of the claim.

Humana will make a determination of whether a claim is an *urgent-care claim.* However, any claim a physician, with knowledge of a covered person's medical condition, determines is an "*urgent-care claim*" will be treated as a "claim involving urgent care."

Claim procedures

Discretionary authority

With respect to paying claims for benefits or determining eligibility for coverage under a policy issued by Humana, Humana as administrator for claims determinations and as ERISA claims review fiduciary, shall have full and exclusive discretionary authority to:

- Interpret plan provisions;
- Make decisions regarding eligibility for coverage and benefits; and
- Resolve factual questions relating to coverage and benefits.

Appeal and External Review Notice (continued)

Submitting a claim

This section describes how a *claimant* files a claim for plan benefits. A claim must be filed in writing and delivered by mail, postage prepaid, by FAX or e-mail. A request for pre-authorization may be filed by telephone. The claim or request for pre-authorization must be submitted to Humana or to Humana's designee at the address indicated in the covered person's benefit plan document or identification card. This is particularly important with respect to mental health coordinators and other providers to whom Humana has delegated responsibility for claims administration. Claims will be not be deemed submitted for purposes of these procedures unless and until received at the correct address.

Claims submissions must be in a format acceptable to Humana and compliant with any legal requirements. Claims not submitted in accordance with the requirements of applicable federal law respecting privacy of protected health information and/or electronic claims standards will not be accepted by Humana.

Claims submissions must be timely. Claims must be filed as soon as reasonably possible after they are incurred, and in no event later than the period of time described in the benefit plan document.

Claims submissions must be complete and delivered to the designated address. At a minimum they must include:

- Name of the covered person who incurred the covered expense;
- Name and address of the provider;
- Diagnosis;
- Procedure or nature of the treatment;
- Place of service;
- Date of service; and
- Billed amount.

Presentation of a prescription to a pharmacy does not constitute a claim for benefits under the plan. If a covered person is required to pay the cost of a covered prescription drug, he or she may submit a written claim for plan benefits to Humana.

A general request for an interpretation of plan provisions will not be considered a claim. Requests of this type, such as a request for an interpretation of the eligibility provisions of the plan, should be directed to the plan administrator.

Failure to provide necessary information

If a *pre-service claim* submission is not made in accordance with the plan's requirements, Humana will notify the *claimant* of the problem and how it may be remedied within five days (or as soon as possible but not more than 24 hours, in the case of an *urgent-care claim*). If a *post-service claim* is not made in accordance with the plan's requirements, it will be returned to the submitter.

Authorized representatives

A covered person may designate an authorized representative to act on his or her behalf in pursuing a benefit claim, an internal appeal or an *external review*. The designation must be in writing and must be made by the covered person on Humana's Appointment of Representation (AOR) Form or on a form approved in advance by Humana. An assignment of benefits does not constitute designation of an authorized representative.

Humana's AOR Form must be submitted to Humana at the time or prior to the date an authorized representative commences a course of action on behalf of the covered person. At the same time, the authorized representative should also provide notice of commencement of the action on behalf of the covered person to the covered person, which Humana may verify with the covered person prior to recognizing authorized representative status.

In any event, a health care provider with knowledge of a covered person's medical condition acting in connection with an *urgent-care claim* will be recognized by the plan as the covered person's authorized representative.

Covered persons should carefully consider whether to designate an authorized representative. An authorized representative may make decisions independent of the covered person, such as whether and how to appeal a claim denial.

Claims decisions

After a determination on a claim is made, Humana will notify the *claimant* within a reasonable time, as follows:

- ***Pre-service claims*** - Humana will provide notice of a favorable or *adverse benefit determination* within a reasonable time appropriate to the medical circumstances but no later than 15 days after the plan receives the claim.

  This period may be extended by an additional 15 days, if Humana determines the extension is necessary due to matters beyond the control of the plan. Before the end of the initial 15-day period, Humana will notify the *claimant* of the circumstances requiring the extension and the date by which Humana expects to make a decision.

  If the reason for the extension is because Humana does not have enough information to decide the claim, the notice of extension will describe the required information, and the *claimant* will have at least 45 days from the date the notice is received to provide the necessary information.

- ***Urgent-care claims*** - Humana will determine whether a particular claim is an *urgent-care claim*. This determination will be based on information furnished by or on behalf of a covered person. Humana will exercise its judgment when making the determination with deference to the judgment of a physician with knowledge of the covered person's condition. Humana may require a *claimant* to clarify the medical urgency and circumstances supporting the *urgent-care claim* for expedited decision-making.

  Notice of a favorable or *adverse benefit determination* will be made by Humana as soon as possible, taking into account the medical urgency particular to the covered person's situation, but not later than 24 hours after receiving the *urgent-care claim*.

  If a claim does not provide sufficient information to determine whether, or to what extent, services are covered under the plan, Humana will notify the *claimant* as soon as possible, but not more than 24 hours after receiving the *urgent-care claim.* The notice will describe the specific information necessary to complete the claim. The *claimant* will have a reasonable amount of time, taking into account the covered person's circumstances, to provide the necessary information – but not less than 48 hours.

Humana will provide notice of the plan's *urgent-care claim* determination as soon as possible but no more than 48 hours after the earlier of:

- The plan receives the specified information; or
- The end of the period afforded the *claimant* to provide the specified additional information.

- ***Concurrent-care decisions*** - Humana will notify a *claimant* of a *concurrent-care decision* involving a reduction or termination of pre-authorized benefits sufficiently in advance of the reduction or termination to allow the *claimant* to appeal and obtain a determination.

  Humana will decide *urgent-care claims* involving an extension of a course of treatment as soon as possible taking into account medical circumstances. Humana will notify a *claimant* of the benefit determination, whether adverse or not, within 24 hours after the plan receives the claim, provided the claim is submitted to the plan 24 hours prior to the expiration of the prescribed period of time or number of treatments.

- ***Post-service claims*** - Humana will provide notice of a favorable or *adverse benefit determination* within a reasonable time appropriate to the medical circumstances but no later than 30 days after the plan receives the claim.

  This period may be extended an additional 15 days, if Humana determines the extension is necessary due to matters beyond the plan's control. Before the end of the initial 30-day period, Humana will notify the affected *claimant* of the extension, the circumstances requiring the extension and the date by which the plan expects to make a decision.

  If the reason for the extension is because Humana does not have enough information to decide the claim, the notice of extension will describe the required information, and the *claimant* will have at least 45 days from the date the notice is received to provide the specified information. Humana will make a decision on the earlier of the date on which the *claimant* responds or the expiration of the time allowed for submission of the requested information.

Initial denial notices

Notice of a claim denial (including a partial denial) will be provided to *claimants* by mail, postage prepaid, by FAX or by e-mail, as appropriate, within the time frames noted above. With respect to adverse decisions involving *urgent-care claims,* notice may be provided to *claimants* orally within the time frames noted above. If oral notice is given, written notification must be provided no later than three days after oral notification.

A claims denial notice will convey the specific reason for the *adverse benefit determination* and the specific plan provisions upon which the determination is based. The notice will also include a description of any additional information necessary to perfect the claim and an explanation of why such information is necessary. The notice will disclose if any internal plan rule, protocol or similar criterion was relied upon to deny the claim and a copy of the rule, protocol or similar criterion will be provided to *claimants,* free of charge. In addition to the information provided in the notice, a *claimant* has the right to request the diagnosis and treatment codes and descriptions upon which the determination is based.

The notice will describe the plan's review procedures and the time limits applicable to such procedures, including a statement of the *claimant's* right to bring a civil action under ERISA Section 502(a) following an *adverse benefit determination* on review.

Appeal and External Review Notice (continued)

If an *adverse benefit determination* is based on medical necessity, experimental treatment or similar exclusion or limitation, the notice will provide an explanation of the scientific or clinical basis for the determination, free of charge. The explanation will apply the terms of the plan to the covered person's medical circumstances.

In the case of an adverse decision of an *urgent-care claim*, the notice will provide a description of the plan's expedited review procedures.

Contact information

For questions about your rights, this notice, or assistance, you can contact: Humana, Inc. at www.humana.com or the Employee Benefits Security Administration at 1-866-444-EBSA (3272).

You may contact the *commissioner* for assistance at any time at the address and telephone number below:

Kentucky Department of Insurance
P.O. Box 517
Frankfort, KY 40602-0517

Phone: 502-564-3630 or 502-564-6034 or 1-800-595-6053 or
TTY: 800-648-6056

Email: DOI.ConsumerComplaints@ky.gov

You may also contact the state for consumer assistance with appeals, complaints or the external review process:

Kentucky Department of Insurance
Attn: Consumer Protection Division
P.O. Box 517
Frankfort, KY 40602-0517
1-800-595-6053

Appeal and External Review Notice (continued)

Internal appeals and external review of adverse benefit determinations

Internal appeals

A *claimant* must appeal an *adverse benefit determination* within 180 days after receiving written notice of the denial (or partial denial). An appeal may be made by a *claimant* by means of written application to Humana, in person, or by mail, postage prepaid.

A *claimant*, on appeal, may request an expedited internal appeal of an adverse *urgent-care claim* decision orally or in writing. In such case, all necessary information, including the plan's benefit determination on review, will be transmitted between the plan and the *claimant* by telephone, FAX, or other available similarly expeditious method, to the extent permitted by applicable law.

A *claimant* may request an expedited *external review* at the same time a request is made for an expedited internal appeal of an *adverse benefit determination* for an *urgent-care claim* or when you are receiving an ongoing course of treatment.

Determination of appeals of denied claims will be conducted promptly, will not defer to the initial determination and will not be made by the person who made the initial adverse claim determination or a subordinate of that person. The determination will take into account all comments, documents, records, and other information submitted by the *claimant* relating to the claim.

On appeal, a *claimant* may review relevant documents and may submit issues and comments in writing. A *claimant* on appeal may, upon request, discover the identity of medical or vocational experts whose advice was obtained on behalf of the plan in connection with the *adverse benefit determination* being appealed, as permitted under applicable law.

If the claims denial is based in whole, or in part, upon a medical judgment, including determinations as to whether a particular treatment, drug, or other service is experimental, investigational, or not medically necessary or appropriate, the person deciding the appeal will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The consulting health care professional will not be the same person who decided the initial appeal or a subordinate of that person.

If new or additional evidence is relied upon or if new or additional rational is used during the internal appeal process, Humana will provide the *claimant*, free of charge, the evidence or rational as soon as possible and in advance of the appeals decision in order to provide the *claimant* a reasonable opportunity to respond.

Appeal and External Review Notice (continued)

Time periods for decisions on appeal

Appeals of claims denials will be decided and notice of the decision provided as follows:

- ***Urgent-care claims*** - As soon as possible but not later than 72 hours after Humana receives the appeal request;
- ***Pre-service claims*** - Within a reasonable period but not later than 30 days after Humana received the appeal request;
- ***Post-service claims*** - Within a reasonable period but not later than 60 days after Humana receives the appeal request;
- ***Concurrent-care decisions*** - Within the time periods specified above depending on the type of claim involved.

Appeals denial notices

Notice of a claim denial (including a partial denial) will be provided to *claimants* by mail, postage prepaid, by FAX or by e-mail, as appropriate, within the time periods noted above.

A notice that a claim appeal has been denied will include:

- The specific reason or reasons for the *adverse benefit determination*;
- Reference to the specific plan provision upon which the determination is based;
- If any internal plan rule, protocol or similar criterion was relied upon to deny the claim. A copy of the rule, protocol or similar criterion will be provided to the *claimant*, free of charge;
- A statement of the *claimant's* right to *external review*, a description of the *external review* process, and the forms for submitting an *external review* request, including release forms authorizing Humana to disclose protected health information pertinent to the *external review*;
- A statement about the *claimant's* right to bring an action under §502(a) of ERISA;
- If an *adverse benefit determination* is based on medical necessity, experimental treatment or similar exclusion or limitation, the notice will provide an explanation of the scientific or clinical basis for the determination, free of charge. The explanation will apply the terms of the plan to the covered person's medical circumstances.

In addition to the information provided in the notice, a *claimant* has the right to request the diagnosis and treatment codes and descriptions upon which the determination is based.

Appeal and External Review Notice (continued)

Exhaustion of remedies

Upon completion of the internal appeals process under this section, a *claimant* will have exhausted his or her administrative remedies under the plan. If Humana fails to adhere to all requirements of the internal appeal process, except for failures that are based on a minimal error, the claim shall be deemed to have been denied and the *claimant* may request an *external review.*

After exhaustion of remedies, a *claimant* may pursue any other legal remedies available, which may include bringing civil action under ERISA section 502(a) for judicial review of the plan's determination. Additional information may be available from the local U.S. Department of Labor Office.

External review

Within four months after a *claimant* receives notice of an *adverse benefit determination* or *final adverse benefit determination* the *claimant* may request an *external review* if the determination concerns treatment that is *experimental, investigational* or not *medically necessary* or the determination concerns a rescission of coverage. The request for *external review* must be made in writing to the *commissioner.* Please refer to the section titled "Expedited external review" if the *adverse benefit determination* involves an *urgent-care claim* or an ongoing course of treatment.

Within one business day after the receipt of a request for *external review,* the *commissioner* will send a copy of the request to Humana. Within five business days, we will complete a *preliminary review* of the request.

Within one business day after we complete the *preliminary review,* we will notify the *claimant* and the *commissioner* in writing whether:

- The request is complete and is eligible for *external review*;
- The request is not complete and the information or materials needed to make the request complete; or
- The request is not eligible for *external review,* the reasons for ineligibility and the *claimant's* right to appeal to the *commissioner.* If appealed, the *commissioner* may determine that the request is eligible for *external review.*

Within one business day after the *commissioner* receives notice that the request is eligible for *external review,* the *commissioner* will:

- Impartially assign an *IRO* from a list compiled and maintained by the *commissioner* to conduct the *external review*;
- Provide Humana with the name of the *IRO*. Within five business days after the date of receipt of this notice, we will provide the *IRO* with all documents and information we considered in making the *adverse benefit determination* or *final adverse benefit determination*;

Appeal and External Review Notice (continued)

- Notify the *claimant* in writing of the following:

    - The eligibility of the request and acceptance for *external review*; and
    - The right to submit additional information in writing to the *IRO* and the time limits to submit the information.

Any information received by the *IRO* will be forwarded to Humana within one business day of receipt. Upon receipt of additional information, we may reconsider the *adverse benefit determination* or *final adverse benefit determination.* If we reverse the *adverse benefit determination* or *final adverse benefit determination,* the *external review* will be terminated and we will provide coverage for the service. We will immediately notify the *claimant,* the *IRO,* and the *commissioner* in writing of our decision.

The *IRO* will review all of the information received including, if available and considered appropriate the following:

- Your medical records;
- The attending healthcare professional's recommendation;
- Consulting reports from appropriate healthcare professionals and other documents submitted by Humana, the *claimant,* and treating provider;
- The terms of the coverage under the plan;
- The most appropriate practice guidelines, which will include applicable *evidence-based standards* and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards and associations;
- Any applicable clinical review criteria developed and used by Humana; and
- The opinion of the *IRO's clinical peer reviewer* or reviewers after considering the information and documents listed above.

If the *external review* involves experimental or investigational treatment, within one business day after the *IRO* receives notice of assignment to conduct the *external review,* the *IRO* will select one or more *clinical peer reviewers* to conduct the *external review.* The *clinical peer reviewer* will review all of the information and within 20 days after being selected, will provide a written opinion to the *IRO* on whether the service should be covered. The written opinion will include:

- A description of the medical condition;
- A description of the indicators relevant to determining whether there is sufficient evidence to demonstrate that the service is more likely than not to be beneficial to you than any available standard services;
- The adverse risks of the service would not be substantially increased over those of available standard services;
- A description and analysis of any *medical or scientific evidence,* or *evidence-based standard* considered in reaching the opinion;

- Information on whether the reviewer's rationale for the opinion is based on either:

  - The service has been approved by the federal Food and Drug Administration, if applicable, for the condition; or

  - *Medical or scientific evidence* or *evidence-based standards* demonstrate that the expected benefits of the service is more likely than not to be beneficial to you than any available standard health care service and the adverse risks of the service would not be substantially increased over those of available standard services.

The *IRO's* decision to either uphold or reverse the *adverse benefit determination* or *final adverse benefit determination* will be provided in writing to the *claimant,* the *commissioner* and Humana within:

- 20 days after receipt of each *clinical peer reviewer* opinion for an experimental or investigational treatment; or
- 45 days after receipt of the request for an *external review.*

In the case of experimental or investigational treatment, if a majority of *clinical peer reviewers* recommend the service should be covered, the *IRO* will make a decision to reverse the *adverse benefit determination* or *final adverse benefit determination.* If a majority of *clinical peer reviewers* recommend the service should not be covered, the *IRO* will make a decision to uphold the *adverse benefit determination* or *final adverse benefit determination.* If the *clinical peer reviewers* are evenly split, the *IRO* will obtain the opinion of an additional *clinical peer reviewer* in order for the *IRO* to make a decision.

The *IRO's* written notice of the decision will include:

- A general description of the reason for the request for *external review*;
- The date the *IRO* received the assignment from the *commissioner* to conduct the *external review*;
- The date the *external review* was conducted;
- The date of the *IRO's* decision;
- The principal reason for the decision, including applicable *evidence-based standards*, if any, used as a basis for the decision;
- The rationale for the decision;
- References to the evidence or documentation, including the *evidence-based standards,* considered in reaching the decision; and
- In the case of experimental or investigational treatment, the written opinion and rational for the recommendation of each *clinical peer reviewer.*

Immediately upon our receipt of the *IRO's* decision reversing the *adverse benefit determination* or *final adverse determination,* we will approve the service.

Expedited external review

You may request an expedited *external review* from the *commissioner*:

- At the same time you request an expedited internal appeal of an *adverse benefit determination* for an *urgent-care claim* or when you are receiving an ongoing course of treatment; or

Appeal and External Review Notice (continued)

- When you receive an *adverse benefit determination* or *final adverse benefit determination* of:

    - An *urgent-care claim*;
    - An admission, availability of care, continued stay or health care service for which you received emergency services, but you have not been discharged from the facility; or
    - An experimental or investigational treatment if the treating physician certifies, in writing, that the recommended service would be significantly less effective if not promptly initiated.

The *commissioner* will immediately send a copy of the request to Humana and upon receipt; we will immediately complete a *preliminary review* of the request. We will immediately notify the *claimant* and the *commissioner* of the *preliminary review* determination. If we determine the request is not eligible, the notice will advise you of your right to appeal to the *commissioner.* If appealed, the *commissioner* may determine that the request is eligible for *external review.*

Immediately after the commissioner receives notice that the request is eligible for *external review,* the *commissioner* will:

- Impartially assign an *IRO* to conduct the expedited *external review.*
- Provide Humana with the name of the *IRO* and we will immediately provide the *IRO* with all necessary documents and information.

The *IRO* will review all of the information received including, if available and considered appropriate, the following:

- Your medical records;
- The attending healthcare professional's recommendation;
- Consulting reports from appropriate healthcare professionals and other documents submitted by Humana, the *claimant* and treating provider;
- The terms of the coverage under the plan;
- The most appropriate practice guidelines, which will include *evidence-based standards* and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards and associations;
- Any applicable clinical review criteria developed and used by Humana; and
- The opinion of the *IRO's clinical peer reviewer* or reviewers after considering the information and documents listed above.

If the expedited *external review* request involves experimental or investigational treatment, within one business day after the *IRO* receives notice of assignment to conduct the *external review,* the *IRO* will select one or more *clinical peer reviewers* to conduct the *external review.* The *clinical peer reviewer* will:

- Review all of the information noted above including whether:

    - The recommended service has been approved by the federal Food and Drug Administration, if applicable, for the condition; or

- Medical or scientific evidence or *evidence-based standards* demonstrate that the expected benefits of the recommended service is more likely than not to be beneficial to you than any available standard service and the adverse risks of the recommended service would not be substantially increased over those of available standard services.

- Provide an opinion to the *IRO* as expeditiously as your condition or circumstances require, but in no event more than five calendar days after being selected.

The *IRO's* decision to either uphold or reverse the *adverse benefit determination* or *final adverse benefit determination* will be provided orally or in writing to the *claimant*, the *commissioner* and Humana within:

- 48 hours after receipt of each *clinical peer reviewer* opinion of an expedited *external review* for an experimental or investigational treatment; or
- 72 hours after the date of receipt of the request for an expedited *external review*.

In the case of experimental or investigational treatment, if a majority of *clinical peer reviewers* recommend the service should be covered, the *IRO* will make a decision to reverse the *adverse benefit determination* or *final adverse benefit determination.* If a majority of *clinical peer reviewers* recommend the service should not be covered, the *IRO* will make a decision to uphold the *adverse benefit determination* or *final adverse benefit determination.* If the *clinical peer reviewers* are evenly split, the *IRO* will obtain the opinion of an additional *clinical peer reviewer* in order for the *IRO* to make a decision.

The *IRO* will send written confirmation within 48 hours of an oral decision and will include:

- A general description of the reason for the request for an expedited *external review*;
- The date the *IRO* received the assignment from the *commissioner* to conduct the expedited *external review*;
- The date the expedited *external review* was conducted;
- The date of the *IRO's* decision;
- The principal reason for the decision, including applicable *evidence-based standards*, if any, used as a basis for the decision;
- The rationale for the decision;
- References to the evidence or documentation, including the *evidence-based standards,* considered in reaching the decision, except in the case of experimental or investigational treatment; and
- In the case of experimental or investigational treatment, the written opinion and rational for the recommendation of each *clinical peer reviewer*.

Immediately upon receipt of the *IRO's* decision reversing the *adverse benefit determination* or *final adverse benefit determination,* we will approve the service.

Legal actions and limitations

No lawsuit may be brought with respect to plan benefits until all remedies under the plan have been exhausted.

No lawsuit with respect to plan benefits may be brought after the expiration of the applicable limitations period stated in the benefit plan document. If no limitation is stated in the benefit plan document, then no such suit may be brought after the expiration of the applicable limitations under applicable law.

Humana.

Administrative Office:
500 West Main Street
Louisville, Kentucky 40202

Humana Health Plan, Inc.

Group Plan Sponsor: BULLOCK PEN WATER DIST

Master Group Contract Number: 794595

Effective Date of Master Group Contract: 01/01/2022 **Product Name:** KYNF0002

PLEASE READ THIS POLICY CAREFULLY

Terms printed in italic type in this *master group contract* have the meaning indicated in the "Glossary" sections of the Certificate of Coverage ("*certificate*").

This *master group contract* is a legal contract between the *group plan sponsor* and Humana Health Plan, Inc. and is delivered in and governed by the laws of: Kentucky.

Humana Health Plan, Inc. agrees, subject to all the terms and provisions of this *master group contract,* to pay benefits as described in the *certificate,* incorporated by reference herein, with respect to each *covered person* under this *master group contract.* Humana Health Plan, Inc. and the *group plan sponsor* have agreed to all of the terms of this *master group contract.*

This *master group contract* is issued in consideration of the Employer Group Application of the *group plan sponsor,* incorporated by reference herein, and such *group plan sponsor's* payment of premium as provided under this *master group contract.*

This *master group contract* and the coverage it provides become effective at 12:01 A.M. (Standard Time) of the effective date stated above. This *master group contract* and the coverage it provides terminate at 12:00 A.M. (Standard Time) of the date of termination. The provisions stated above and on the following pages are parts of this *master group contract.*

Bruce Broussard
President

SUBSIDIARIES OR AFFILIATES

Any *employer*, which is a subsidiary or affiliate of a *group plan sponsor*, is eligible for coverage under this *master group contract* if the following conditions are met:

- The subsidiary or affiliate is listed in the Employer Group Application of the *group plan sponsor*, or in any amendment thereto;
- The *group plan sponsor* and the subsidiary or affiliate are members of the same controlled group of corporations, trades or business under common control, as described for employee benefits taxation purposes in the Internal Revenue Code; and
- The subsidiary or affiliate has been approved for coverage under this *master group contract*, in writing or by *electronic mail*, by both the *group plan sponsor* and *us*.

For the purposes of this *master group contract*, an *employee* of such a subsidiary or affiliate of the *group plan sponsor* shall be considered to be an *employee* of the *group plan sponsor*.

A subsidiary or affiliate of a *group plan sponsor* shall cease to be eligible for coverage under this *master group contract* on the earliest of the following:

- The date the *group plan sponsor* and the subsidiary or affiliate are no longer members of the same controlled group of corporations, trades or business under common control, as described for employee benefits taxation purposes in the Internal Revenue Code;
- The date the subsidiary or affiliate has relocated outside of the *service area*;
- The date the *group plan sponsor's* written notice of its intent to terminate the participation of the subsidiary or affiliate is received by *us*, or on any later date as may be stated in such notice; or
- The date this *master group contract* terminates.

The coverage of any *employee* of a subsidiary or affiliate of a *group plan sponsor* and the coverage of such *employee's* covered *dependents* shall immediately terminate on the date the subsidiary or affiliate ceases participation under this *master group contract*.

REQUIREMENTS FOR COVERAGE

Eligibility

The *group plan sponsor* must indicate on the Employer Group Application the eligible classes of *employees* under this *master group contract*, if applicable, as defined below:

- An eligible class includes regular *full-time employees* in *active status*, if paid a salary or wage by the *employer* that meets state or federal minimum wage requirements.

  An eligible class may also include sole proprietors, partners, and corporate officers if:

  - The *employer* is a sole proprietorship, partnership or corporation;

  - The sole proprietorship or other entity (other than a partnership) has at least one common-law employee (other than the business owner and his or her spouse); and

  - The sole proprietor, partner or corporate officer is actively performing activities relating to the business, gains a livelihood from the sole proprietorship, partnership or corporation and meets the definition of *employee* as defined in the *certificate.*

- The *group* plan may also provide coverage for retired *employees* and their *dependents.* The retiree class will be eligible only if the *group plan sponsor* requests such coverage, and it is approved by *us.*

- Part-time *employees* and their *dependents* may be an eligible class only if the *group plan sponsor* makes specific reference that part-time *employees* are included, and it is approved by *us.*

- The spouse or a child of an *employee* may be included in an eligible class as a *dependent* of the *employee* only if the *employee* is covered under this *master group contract.*

Date eligible

Each *group* plan may provide one of the following as the *eligibility date* for *employees* and *dependents* as provided by this *master group contract.* The *group plan sponsor* must elect the *eligibility date* on the Employer Group Application. *Eligibility date* options include immediate eligibility or first of the month eligibility as outlined below.

Immediate eligibility

Each *employee* included in an eligible class on, or after, the date the *group plan sponsor* subscribes to the *master group contract* will be eligible under this *master group contract* on that date. The *employee* must have completed the required *waiting period*, if any, as indicated on the Employer Group Application.

First of the month eligibility

Each *employee* included in an eligible class after the date the *group plan sponsor* subscribes to the *master group contract* will be eligible under this *master group contract* on the first day of the next following calendar month, or on the first day of the next following calendar month after the completion of the required *waiting period,* if any, or as otherwise agreed to by the *group plan sponsor* and *us.*

Enrollment

Each *employee* must complete the enrollment process to enroll for coverage under this *master group contract* for himself or herself and their eligible *dependents,* if any, as outlined in the "Enrollment" provision within the "Eligibility and Effective Dates" section of the *certificate.*

Health status will not be used to determine premium rates. *We* will not use *health status-related factors* to decline medical coverage to an eligible *employee* or eligible *dependent. We* will administer this provision in a non-discriminatory manner.

Group plan sponsor responsibility for compliance with certain federal laws

If the *group plan sponsor* is contracting with *us* in connection with a health plan that is governed by the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), the following apply:

Group plan sponsor as plan administrator

The *group plan sponsor* shall serve as the "plan administrator" (as that term is defined by ERISA) and is solely responsible for administering its employee welfare plan (the "plan"). Those responsibilities include, but are not limited to:

- Complying with any federal, state or local law or regulation that may apply to the *group plan sponsor* as policyholder, plan sponsor or as plan administrator;
- Providing *covered persons* with all notices and documents required by such laws and regulations; and
- Applying the eligibility requirements described in this *master group contract.*

Summary plan description compliance

The *group plan sponsor* shall assure that each plan participant eligible to enroll for benefits under the *master group contract* is given, on a timely basis, a Summary Plan Description (SPD) and/or Notice of Material Modification to a previously delivered SPD, when and in the manner required by ERISA. The *group plan sponsor* warrants that each such SPD (and any Notice of Material Modification relating thereto) shall, to the extent required by ERISA (including any regulation adopted to implement ERISA), incorporate:

- As the plan's claims processing and review procedures, *our* claims processing and review procedures, including the review, appeal, grievance and external review procedures that *we* must provide under applicable law; and

- A statement clearly identifying circumstances which may result in disqualification, ineligibility, or denial, loss, forfeiture, suspension, offset, reduction, or recovery (e.g., by exercise of subrogation or reimbursement rights) of any benefits that a *covered person* might otherwise reasonably expect the plan to provide on the basis of the description of benefits required by ERISA.

The *group plan sponsor* acknowledges that there is no exception to ERISA's SPD and related disclosure requirements for *small employers.*

Humana has developed a Plan Overview Document to assist *employers* in complying with ERISA SPD requirements. This document and other enrollment materials are available at www.humana.com.

Cooperation

On request, the *group plan sponsor* shall promptly provide *us* with copies of its plan document, SPD, Notices of Material Modifications and/or verification of the plan's status as subject to ERISA as *we* may require:

- To verify compliance with this section;
- To assist *us* in connection with any actual or threatened denied benefit, subrogation or other litigation; or
- As otherwise required by *us* for regulatory compliance or other legitimate business purpose.

PARTICIPATION REQUIREMENTS

The *group plan sponsor* must maintain *our* minimum participation and contribution requirements, as specified in the underwriting requirements of the Employer Group Application.

We reserve the right to waive or modify the participation and contribution requirements. Modification or waiver of these requirements will be applied uniformly. Any modification of these requirements after the effective date of this *master group contract* will only be made upon renewal. The *group plan sponsor* will be notified in writing or *electronically* at least 60 days prior to the effective date of such changes.

Any such waiver shall not be construed as a waiver of any of the other requirements of this *master group contract* and shall not obligate *us* to provide any future waivers including any for participation or contribution requirements.

RENEWAL AND TERMINATION PRIVILEGE

Right to not renew or terminate this master group contract

The *group plan sponsor* may terminate this *master group contract* by giving written notice to *us* no later than 31 days prior to the desired termination date.

The *group plan sponsor* may terminate the coverage provided under any provision of this *master group contract,* with *our* consent, by giving written notice to *us* as of a date mutually agreeable to the *group plan sponsor* and *us.*

The *group plan sponsor* may terminate an eligible class of *covered persons,* if applicable, from the *group* plan, with *our* consent, as of a date mutually agreeable to the *group plan sponsor* and *us*. Termination will occur only with respect to *covered persons* included in the terminated class.

We may terminate this *master group contract,* as allowed by applicable law, by giving written notice to the *group plan sponsor*. Written notice will be mailed no later than 31 days prior to the termination date, except as otherwise outlined under this provision.

We may refuse to renew or *we* may terminate this *master group contract* if:

- The *group plan sponsor* fails to pay *us* any premium due, except coverage will continue during the grace period.
- The *group plan sponsor* has failed to comply with *our* minimum participation or contribution requirements, as specified in the Employer Group Application.
- The *group plan sponsor* is not an *employer*.
- The *group* has relocated outside of the *service area*.
- The *group plan sponsor* has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact. *We* may terminate this *master group contract* after giving 30 day advance written notice to the *group plan sponsor* for instances of fraud or intentional misrepresentation of a material fact.
- *We* decide to discontinue offering a particular group health plan:
    - Notice of such discontinuation will be provided at least 90 days prior to the date of discontinuation. The *group plan sponsor* is responsible for distributing and providing *covered persons* access to the notice; and
    - The *group plan sponsor* will be given the option to purchase all other group plans providing medical benefits that are being offered by *us* at such time.
- *We* cease to do business in the *small employer* group medical market, as applicable and as allowed by the state requirements. If *we* cease doing business in the *small employer* group market, notice for the *group plan sponsors, covered persons* and the Commissioner of Insurance will be provided at least 180 days prior to the date of discontinuation of such coverage.

RENEWAL AND TERMINATION PRIVILEGE (continued)

Effect of termination of this agreement

Upon termination of this *master group contract*, it is the *group plan sponsor's* obligation to notify all *employees* of such termination, except for the specific situations outlined in the "Right to not renew or terminate this master group contract" provision. If the *group plan sponsor* requires a contribution from the *employees* to offset a portion of the premium, it is the responsibility of the *group plan sponsor* to refund to those *employees* the portion of the contribution, if any, which the *group plan sponsor* may have collected for any period of time following the termination of this *master group contract*.

Our obligation to offer continuation coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA) to *covered persons* ends on the date this *master group contract* terminates. *Our* obligation to offer continuation coverage to *covered persons* under any other applicable law ends on the date this *master group contract* terminates or on such date as may be required under the applicable continuation of coverage law.

Termination of coverage

Unless otherwise agreed to by the *group plan sponsor* and *us*, termination of coverage will occur following any of the events listed below:

- The date this *master group contract* terminates in accordance with its terms and conditions;
- The termination date according to the "Right to not renew or terminate this master group contract" provision;
- The date the *group plan sponsor*, acting with *our* knowledge and consent, deletes an optional benefit under this *master group contract* (termination under this paragraph will occur only with respect to such deleted optional benefit coverage);
- The date the *group plan sponsor*, acting with *our* knowledge and consent, deletes an eligible class of *employees*, if applicable, from the *group plan sponsor's* plan (termination under this paragraph will occur only with respect to *covered persons* included in the terminated class); or
- The *group plan sponsor*, acting with *our* knowledge and written consent, terminates any provision of this *master group contract* (termination under this paragraph will occur on a date mutually agreeable to the *group plan sponsor* and *us*).

Rescission, reduction of coverage or increase past premium

We reserve the right to *rescind* this *master group contract* and any *certificate* issued due to fraud or an intentional misrepresentation of a material fact. *We* will provide a 30 calendar day advance written notice to the *group plan sponsor* and affected *employee*(*s*) before coverage is *rescinded* and it will include appeal rights as may be required by law.

RENEWAL AND TERMINATION PRIVILEGE (continued)

We reserve the right to reduce coverage or increase past premium, unless prohibited by applicable law. *We* may apply this provision to one or all *covered persons* when such *covered person*(*s*), the *employer* or other person(s) provides or has provided incomplete, inaccurate or untimely information on any enrollment form, Employer Group Application or any other eligibility form, if such information materially affected the acceptance of the *group*, the *covered person* or the risk.

If no claims have been paid under this *master group contract* up to the date coverage is *rescinded* or reduced, *we* will return premiums paid for such coverage to the *group plan sponsor*.

If claims have been paid under this *master group contract* before the date coverage is *rescinded* or reduced, *we* reserve the right to deduct an amount equal to the amount of such claims paid from the premiums to be returned to the *group plan sponsor*. The c*overed person* is responsible for any amount of claims in excess of the premium paid.

Reinstatement

If this *master group contract* terminates, it may be reinstated at *our* option. Reinstatement requests must be submitted in writing by the *group plan sponsor*, are subject to *our* approval and are <u>not</u> guaranteed.

Any premium accepted in connection with a reinstatement will be applied to the period for which the premium was not previously paid.

PREMIUMS

Payment of premiums

Unless otherwise agreed to by *us*, the first premium is due on the *group plan sponsor's* effective date under this *master group contract* and subsequent premiums are due on the first of each calendar month thereafter.

Premiums should be sent to the designated location on the premium statement. Premiums will be recorded as paid on the date *we* receive the payment. If there are not sufficient funds in the designated bank account on the date that premiums are deducted, the *group plan sponsor* will be assessed an insufficient funds fee.

Premium statement

A premium statement will be prepared in accordance with the billing method *we* arrange with the *group plan sponsor.* This premium statement will show the premium due. It will also reflect any pro-rata premium charges and credits resulting from changes in the number of *covered persons* and changes in the amounts of coverage that took place during the period following the last premium statement. Please refer to the "Notice of covered person coverage terminations" provision in this section for information regarding premium and termination of coverage for a *covered person.*

Premium rate change

No change in rates will be made for the first 12 months, unless otherwise agreed to by the *group plan sponsor* and *us.*

Premium charges for benefit changes or a modification of a covered person's coverage

While this *master group contract* is in force, changes in premiums may be required due to a change in coverage as follows:

- If the premium rate change is effective on or before the 15th of the month, *we* will bill the current month based on the new rates.
- If the premium rate change is effective after the 15th of the month, *we* will bill the current month based on the old rates. The new rates will apply to the next month's billing.

Premium charges for individual changes

If coverage for a *covered person* is modified on a date other than a premium due date, the change in premium will become effective as specified on the Employer Group Application.

We must be notified of the change no more than 31 days following the date of the change. If *we* are not notified within 31 days of the date of the change, any change in premium will become effective on the date *we* receive written or *electronic* notification and approve the change.

Notice of covered person coverage terminations

The *group plan sponsor* is responsible to notify *us* of any *covered person's* coverage termination. Notice must be given to *us* within 31 days of the termination date. A *group plan sponsor's* request to *us* to terminate coverage retroactively is the *group plan sponsor's* representation that the *covered person* did not pay any premium or make contribution for coverage past the requested termination date, and the *group plan sponsor's* requested termination complies with applicable law.

Grace period

While this *master group contract* continues in force, a grace period of 31 days will be allowed to the *group plan sponsor* following the premium due date, for the payment of each required premium due. This *master group contract* will remain in force during the grace period. If the required premium is not paid by the end of the 31 day grace period, this *master group contract* will terminate effective as of the last day of the month for which the last premium was received.

Wellness Engagement Incentive Program Amendment

This "Wellness Engagement Incentive Program Amendment" (amendment) is made part of the *master group contract* to which it is attached.

Notwithstanding any other provisions of the *master group contract,* incentives or rewards provided under this amendment are not duplicated under any other provision of the *master group contract.* This amendment does not change any other terms or conditions of the *master group contract.*

All defined terms used in this amendment have the same meaning given to them in the *certificate* unless otherwise specifically defined in this amendment.

Payment of premium on or after the effective date of this amendment will be deemed to constitute the *group plan sponsor's* agreement to the terms of this amendment.

This amendment modifies the "Premium" section of the *master group contract* by adding the following:

Wellness engagement incentive program

Depending on the *group* size, *we* may credit to the *group plan sponsor's* premium statement, or issue separately to the *group plan sponsor* wellness engagement incentives for *employees* who:

- Participate in a wellness program made available with this *master group contract*; and
- Have achieved certain status levels, as defined by the wellness program.

The wellness engagement incentives will vary depending on the *employees'* status levels. An *employee's* status level will be determined on the last day of the preceding calendar month.

For *employees* covered under the *master group contract* as of the last day of the preceding calendar month, *we* will also consider the three preceding calendar months when the incentive is calculated to ensure *employees* that were not included in prior calculations due to certain delays in submitting information to *our* wellness program administrator are included if they attained the engaged status as defined in the wellness program.

The wellness engagement incentive is a reward provided under a nondiscriminatory wellness program and is subject to limits under state and federal law. It is the *employer's* responsibility to determine how the incentive will be used in accordance with applicable federal and state law, including but not limited to:

- The Federal Employee Retirement Income Security Act of 1974 (ERISA), as amended;
- The Patient Protection and Affordable Care Act (the Affordable Care Act), as amended;
- The Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended;
- The Civil Rights Act of 1964, as amended;
- The Americans with Disabilities Act of 1990 (ADA), as amended;
- The Age Discrimination in Employment Act of 1967 (ADEA), as amended; and
- The Genetic Information Nondiscrimination Act of 2008 (GINA), as amended.

Wellness Engagement Incentive Program Amendment (continued)

Employers should check with their tax and legal counsel to establish appropriate uses for the incentives. For example, if a *group* health plan is subject to ERISA, the *employer* or the administrator of the *group* health plan may have fiduciary responsibilities regarding use of the incentives. Some or all of the incentives may be considered funds attributable to plan assets, which generally must be used for the exclusive benefit of the *group* health plan participants. *We* are not liable for monetary penalties or fines, or other state or federal regulatory action taken against the *employer* for failure to comply with any applicable federal or state law.

No wellness engagement incentive will be earned:

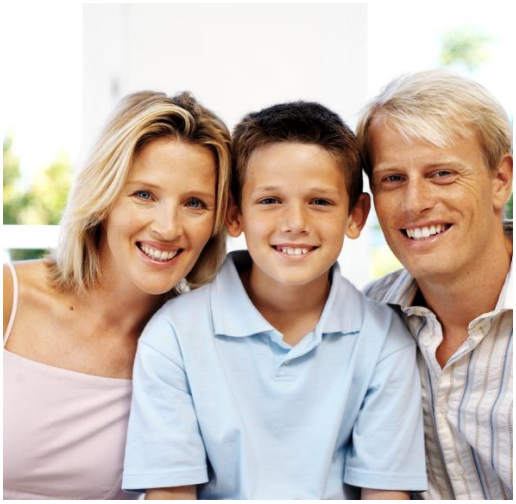
- After the *master group contract* terminates; or
- During the last calendar month of coverage.

Humana Health Plan, Inc.
Administrative Office:
321 West Main Street
Louisville, Kentucky 40202

Bruce Broussard
President

DELTA DENTAL®

Delta Dental PPO Plus Premier



Our national Preferred Provider Program

Welcome!

Your dental program is administered by Delta Dental of Kentucky, Inc., a Kentucky not-for-profit dental service corporation. Delta Dental of Kentucky is the Commonwealth's dental benefits specialist. Good oral health is a vital part of good general health, and your Delta Dental program is designed to promote regular dental visits. We encourage you to take advantage of this program by calling your Dentist today for an appointment.

This Certificate, along with your Summary of Dental Plan Benefits, describes the specific benefits of your Delta Dental program and how to use them. If you have any questions about this program, please call our Customer Service department at (800) 955-2030 or access our website at www.deltadentalky.com.

You can easily verify your own benefits, claims and eligibility information online 24 hours a day, seven days a week by visiting www.deltadentalky.com and selecting the Consumer Toolkit. The Consumer Toolkit will also allow you to print claim forms, ID cards, explanation of benefits (EOBs), review your claims status, choose to receive paperless EOBs, search our Dentist directories, read oral health tips and more.

We look forward to serving you!

TABLE OF CONTENTS

1. Certificate…….…… 2
2. Definitions.....2
3. Selecting a Dentist 5
4. Accessing Your Benefits 6
5. How Claim Payment is Made 7
6. Benefit Categories.....8
7. Exclusions and Limitations.....9
8. Coordination of Benefits.....13
9. Claims Appeal Procedure.....15
10. Termination of Coverage 16
11. Continuation of Coverage.....16
12. General Provisions 17

Note: Please read this Certificate with the Summary of Dental Plan Benefits. The Summary of Dental Plan Benefits lists the specific provisions of your group dental Plan. If a statement in the Summary conflicts with a statement in this Certificate, the statement in the Summary applies to this Plan and you should ignore the conflicting statement in this Certificate.

1. Delta Dental PPO Plus Premier Certificate

Delta Dental of Kentucky, Inc., issues this Certificate to you, the Subscriber. The Certificate is a summary of your dental benefits coverage. It reflects and is subject to a contract between Delta Dental and your employer or organization.

The Benefits provided under This Plan are subject to change as required by any state or federal law.

Delta Dental agrees to provide Benefits as described in this Certificate and the Summary of Dental Plan Benefits.

2. Definitions

This section defines terms having special meanings in the Certificate and Summary of Dental Plan Benefits. A word or phrase starting with a capital letter has a special meaning. It is defined either in this Definitions section or in the text itself.

Adverse Benefit Determination

Any denial, reduction or termination of the benefits for which you filed a claim; or any failure to make payment (in whole or in part) for the benefits you sought, including any determination based on eligibility.

Alternate Benefit

A Benefit provided in cases where alternative methods of treatment exist for the same Dental Service. In this case, Benefits are provided for the least costly, professionally acceptable treatment. This is a determination of Benefits under this Plan. It is not a recommendation of which service should be provided. The Dentist and patient should decide the course of treatment. If the dental procedure used is different from the procedure covered under this Certificate, the Dentist may bill the patient for the difference between the Maximum Approved Fee for the service provided and the amount paid by Delta Dental for the claim.

Benefit Year

The annual period of your coverage as shown in the Summary of Dental Plan Benefits. Your Benefit Year ends at the same time your coverage ends.

Benefits

Payment for the Covered Services under This Plan.

Certificate

This document is your Certificate of Coverage. Delta Dental will provide Benefits as described in this Certificate and the Summary of Dental Plan Benefits. Any changes in this Certificate will be based on changes to the contract between Delta Dental and your Group. The Certificate may also be referred to as This Plan.

Children or Child

Your natural children; stepchildren; adopted children; children by virtue of legal guardianship; or children who reside with you during the waiting period for adoption or legal guardianship.

Completion Dates

The date that treatment is complete. Some procedures may require more than one appointment before they can be completed. Treatment is complete:

- For dentures and partial dentures, on the delivery dates;
- For crowns and bridgework, on the permanent cementation date;
- For root canals and periodontal treatment, on the date of the final procedure that completes treatment.
- For appliances, on the date the appliance is placed.
- For implants, on the date the implant is placed.

Copayment

The percentage of the bill that you are responsible for after you have met your Deductible, if any. Please refer

to The Summary of Dental Benefits for percentages and Deductibles.

Cosmetic Dentistry

Any procedure that is for general appearance and is not caused by disease, prevention, diagnosis, injury, decay, fracture or orthodontic correction.

Covered Services

The Dental Services shown in your Summary of Dental Plan Benefits are the Covered Services that will be paid under This Plan. The Covered Services must be provided by or under the direction of a Dentist. Covered Services includes services that are not reimbursed because of a Deductible, Copayment, waiting period, Maximum Payment, frequency, or other limit.

Deductible

The amounts a person or a family as a whole must pay toward Covered Services before Delta Dental begins paying for those services. The Summary of Dental Plan Benefits lists the Deductibles, if any, that apply to you and your family. The individual Deductibles apply toward the family Deductible. No Eligible Person pays more than the individual Deductible for that person while the total of Deductibles for all Eligible Persons in the family cannot exceed the family Deductible.

Delta Dental

Delta Dental of Kentucky, Inc., a Kentucky not-for-profit dental service corporation that provides dental benefits to its Subscribers.

Delta Dental Plan

A Delta Dental company that is a member of the Delta Dental Plans Association, the nation's largest, most experienced system of dental health plans.

Delta Dental PPO

Delta Dental's national preferred provider organization program that can reduce your out-of-pocket expenses if you receive care from a Delta Dental PPO Dentist.

Delta Dental PPO Plus Premier

This program offers the Delta Dental PPO plan and also has back-up coverage through Delta Dental Premier that will pay at the Premier Dentist Schedule.

Delta Dental Premier

Delta Dental's national managed fee-for-service dental benefits program.

Dental Services

Any service, treatment or care you receive from a dental professional. Any dental procedure or materials related to the procedure. A Dental Service may or may not be a Covered Service.

Dentist

A person licensed to practice dentistry in the state in which dental services are performed.

- **Delta Dental PPO Dentist ("PPO Dentist")** is a Dentist who has signed an agreement in his or her state to participate in Delta Dental PPO. PPO Dentists agree to accept Delta Dental's payment, your Copayment and Deductible, if any, as payment in full for Covered Services.
- **Delta Dental Premier Dentist ("Premier Dentist")** is a Dentist who has signed an agreement in his or her state to participate in Delta Dental Premier. Premier Dentists agree to accept the Maximum Approved Fee as payment in full for Covered Services.
- **Non-participating Dentist** is a Dentist who has not signed an agreement with any Delta Dental Plan to participate in Delta Dental PPO or Delta Dental Premier.
- **Out-of-Country Dentist** is a Dentist whose office is located outside the United States and its territories. Out-of-Country Dentists are not eligible to sign participating agreements with Delta Dental.

PPO Dentists and Premier Dentists are sometimes collectively referred to as **"Participating Dentists."** Wherever a definition or provision of this Certificate differs from another state's Delta Dental Plan and its agreement with Participating Dentists, the agreement in that state with that Dentist will be controlling.

Non-participating Dentists, and Out-of-Country Dentists are sometimes collectively referred to as **"Non-participating Dentists."** Non-participating Dentists may bill you for the difference between the amount charged and the Maximum Approved Fee in addition to Deductibles, Copayments and charges for Non-Covered Services.

Eligible Dependent(s)

The Summary of Dental Plan Benefits has specific information about This Plan's rules for dependent eligibility, but generally, your Eligible Dependents are:

- Your legal spouse or domestic partner. Please check the Summary of Dental Plan Benefits for coverage;
- Your unmarried Children living with you. Please refer to your Summary of Dental Plan Benefits for specific age limits of This Plan;
- Any unmarried Children for whom you or your legal spouse are financially responsible for their medical or dental care under the terms of a court decree or who have been named as alternate recipients under a Qualified Medical Child Support Order (QMCSO);
- Your Children who have reached the age specified in your Summary of Dental Plan Benefits, but who are totally and permanently disabled by a physical and/or mental condition. You must submit medical reports confirming the Child's initial or continuing total disability;
- Your child, a post-secondary, full-time student who has taken a medically necessary leave of absence from the school due to a serious illness or injury. Coverage is extended up to one year during such leave of absence;

These definitions and age limits of Eligible Dependents may be superseded by any applicable state and/or federal laws.

Effective Date

The date on which your coverage under your Group contract begins.

Eligible Person

Any Subscriber or Eligible Dependent with coverage under This Plan.

Group

The employer, trust or other plan sponsor that has entered into a contract with Delta Dental.

Investigational

A device, treatment, procedure or service that is being studied to determine if it should be used for patient care. We reserve the sole right to determine what is Investigational. Approval by the Food and Drug Administration (FDA) does not mean that we approve the service. Devices and any services involved in clinical trials are Investigational.

Maximum Approved Fee

The maximum amount a Participating Dentist can charge the patient and Delta Dental combined for a Covered Service. The Maximum Approved Fee requirements are the lowest of:

- The Submitted Amount;
- The lowest fee regularly charged, offered or received by an individual Dentist for a dental service, regardless of the Dentist's contract with another dental benefits organization;
- The maximum fee that the local Delta Dental Plan approves for a given procedure in a given region or specialty, under normal circumstances, based upon applicable Participating Dentist schedules and internal procedures.

Participating Dentists are not allowed to charge Delta Dental patients more than the Maximum Approved Fee for a Covered Service. In all cases, Delta Dental will make the final determination regarding the Maximum Approved Fee for a Covered Service.

Maximum Payment

The maximum dollar amount Delta Dental will pay in any Benefit Year or lifetime for Covered Services. Maximum Payment amounts are described in the Summary of Dental Plan Benefits.

Nonparticipating Dentist Fee

The maximum fee allowed per procedure for services rendered by a Nonparticipating Dentist.

Non-Covered Service

A Non-Covered Service is any Dental Service that is not a Covered Service.

Open Enrollment Period

The period of time, as determined by your employer or organization, during which an eligible person may enroll or be enrolled for Benefits. Open Enrollment is held once in a 12-month period.

Out-of-Country Dentist Fee

The maximum fee allowed per procedure for services rendered by an Out-of-Country Dentist.

PPO Dentist Schedule

The maximum fee allowed per procedure for services rendered by a PPO Dentist as determined by that Dentist's local Delta Dental Plan.

Pre-Treatment Estimate

A process where Delta Dental issues a written estimate of dental benefits, which may be available under your coverage for proposed dental treatment. Your Dentist may submit a request for a Pre-Treatment Estimate in advance of providing the treatment.

A Pre-Treatment Estimate can be provided at your or your Dentist's request and is provided for informational purposes only. It is not required before you receive any dental care or for approval of future dental benefits payment. You will receive the same benefits under This Plan whether or not a Pre-Treatment Estimate is requested. The benefit provided on a Pre-Treatment Estimate notice is based on your coverage on the date the notice is issued. It is not a guarantee of future dental benefits or payment.

A Pre-Treatment Estimate is not a claim for Benefits, pre-authorization, pre-certification, or reservation of future Benefits.

Premier Dentist Schedule

The maximum fee allowed per procedure for services rendered by a Premier Dentist as determined by that Dentist's local Delta Dental Plan.

Processing Policies

Delta Dental's policies and guidelines used for Pre-Treatment Estimates and payment of claims. The Processing Policies may be amended from time to time.

Submitted Amount

The amount a Dentist bills for a specific treatment or service. A Participating Dentist cannot charge you or your Eligible Dependents for the difference between this amount and the Maximum Approved Fee for Covered Services.

Subscriber

You, when your employer or organization notifies Delta Dental that you are eligible to receive dental benefits under This Plan.

Summary of Dental Plan Benefits

A description of the specific provisions of your Group dental coverage. The Summary of Dental Plan Benefits is, and should be read as, a part of this Certificate, and supersedes any contrary provision of this Certificate.

This Plan

The dental coverage established for Eligible Persons pursuant to this Certificate including the Summary of Dental Plan Benefits.

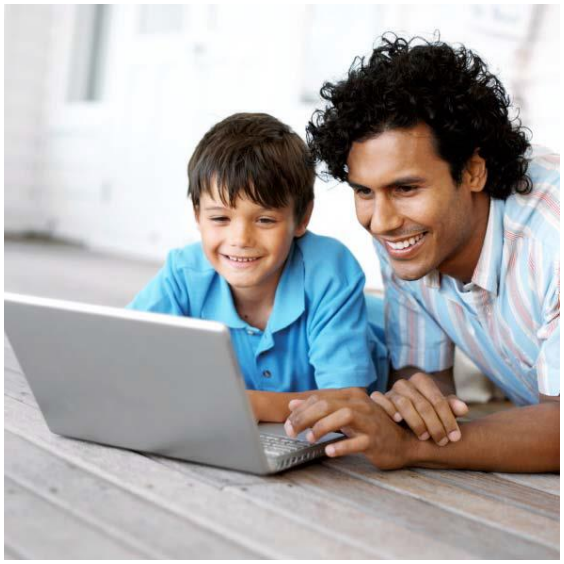
3. Selecting a Dentist

You may choose any Dentist. Your out-of-pocket costs are likely to be less if you go to a Delta Dental PPO Dentist.

- Delta Dental PPO Dentists agree to accept payment according to the PPO Dentist Schedule and, in most cases, this will result in a reduction of their fees. You are responsible for any Copayment and Deductible plus any balance not reimbursed under This Plan up to the PPO Dentist Schedule fee.

- Delta Dental Premier Dentists agree to accept payment according to the Premier Dentist Schedule. You are responsible for any Deductible and Copayment plus any balance not reimbursed under This Plan up to the PPO Dentist Schedule fee. Please check the Summary of Dental Plan Benefits as the Copayment and Deductible may be higher.

- If you choose a Dentist who does not participate in either program, you will be responsible for any difference between the Maximum Approved Fee and the Dentist's Submitted Fee, in addition to any Copayment or Deductible.



To verify that a Dentist is a Participating Dentist in This Plan, you can use Delta Dental's online Dentist Directory at www.deltadentalky.com or call (800) 955-2030.

4. Accessing Your Benefits

To utilize your coverage, follow these steps:

1. Please read this Certificate and the Summary of Dental Plan Benefits carefully so you are familiar with the Benefits, how claim payments are made and provisions of This Plan.
2. Make an appointment with your Dentist. Tell your Dentist that you have dental benefits coverage with Delta Dental of Kentucky PPO Plan. Your Dentist should call Delta Dental at (800) 955-2030 or go to www.deltadentalky.com with any questions about This Plan
3. After you receive your dental treatment, you or the dental office staff will file a claim form with:
   - The Subscriber's full name and address;
   - The Subscriber's Delta Dental ID number;
   - The name and date of birth of the person receiving dental care.

Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Insurance fraud significantly increases the cost of health care. If you are aware of any false information submitted to Delta Dental, please call our Customer Service at 1-800-955-2030.

Questions and Assistance

Questions about your coverage should go to your Human Resources department or to our Customer Service department by US mail, phone, or e-mail:

Delta Dental Customer Service
P.O Box 242810
Louisville, KY 40224-2810
(800) 955-2030
customerservice@deltadentalky.com.

Always include your name, your Group's name and number, the Subscriber's Delta Dental ID number and your daytime telephone number with any correspondence.

If you (a) need the assistance of the state agency that regulates insurance or (b) have a complaint you have been unable to resolve with your insurer, you may contact the Department of Insurance by mail, telephone, or e-mail.

Kentucky Department of Insurance
Consumer Protection Division
P.O. Box 517
Frankfort, Kentucky 40602
800-595-6053
http://insurance.ky.gov/

Claim Forms

Most Dentists will submit your dental claims for you. A Non-participating Dentist may require you to submit the claim yourself. You can access a claim form on our website at www.deltadentalky.com or by calling Customer Service at 1-800-955-2030. Mail the completed claim forms to:

Delta Dental
P.O. Box 242810
Louisville, KY 40224-2810.

All claims must be filed with Delta Dental within the 12 months following the date of service.

5. How Claim Payment is Made

If your Dentist is a Participating Dentist, Delta Dental will base payment on the lesser of the Submitted Amount or the Maximum Approved Fee for a Covered Service.

Delta Dental will send payment directly to a Participating Dentist and you will be responsible for any applicable Copayments or Deductibles and any amounts that exceed Maximum Payment amounts under your coverage. You will be responsible for the Dentist's Submitted Amount for any Non-Covered Service.

For Covered Services rendered by a Non-participating Dentist or Out-of-Country Dentist, Delta Dental will send payment to you, and you will be responsible for making full payment to the Dentist including any difference between Delta Dental's payment and the Dentist's Submitted Amount.

To be eligible for coverage under This Plan, a Dental service must be:

1. A Covered Service.
2. Performed by a Dentist or, as applicable, a registered dental hygienist or other dental professional as permitted by state law.
3. Consistent with the symptoms, diagnosis or treatment of the condition, disease or injury.
4. Payable under the Processing Policies of Delta Dental.
5. Not solely for the convenience of you or your Dentist.
6. The most appropriate level of service that can safely be provided to you.
7. Received after your Effective Date and completed before your coverage ends.

We will pay the claim within (30) days from the date we receive a properly completed claim form, as prescribed by applicable law, including all required information, to determine the amount payable under This Plan. You agree that any person or entity having medical information relating to the dental benefits claimed, may give us that information. We may provide such information to other persons in accordance with our published Notice of Privacy Practices under HIPAA.

After we process the claim, you and/or your Dentist will receive an Explanation of Benefits (EOB), unless you have no financial responsibility. The EOB is not a bill, but a statement to help you understand the coverage you are receiving. The EOB shows:

- Total amount charged by the Dentist for services received (Submitted Amount).
- The maximum amount that your Dentist will receive (Maximum Approved Fee).
- The amount for which you are responsible (patient payment).

Delta Dental will process and pay all submitted claims in accordance with this Certificate and applicable law. We cannot deny a claim or withhold payment upon your request.

In the event of death, any Benefits payable to a Covered Person will be paid to that person's estate.

If Delta Dental pays a claim in error we may recover the overage from you or, if applicable, the Dentist. As an alternative, Delta Dental reserves the right to deduct from any pending or future claim any amounts you or the Dentist may owe us. Payment of any claim in error does not mean that similar claims will be paid in the future.

6. Benefit Categories

This Plan covers only Covered Services listed in the Summary of Dental Plan Benefits. If there is any conflict between the Certificate and the Summary of Dental Plan Benefits, the Summary of Dental Plan Benefits will control. The following is a description of various Dental Services that can be selected for a dental program. Please review the Exclusions and Limitations section regarding the information listed below. **Your Benefits at the time of your treatment depend on several factors. These include your continued eligibility for benefits; your available annual or lifetime Maximum Payment; any coordination of benefits; the status of your coverage; your Dentist, This Plan's limitations, and any other provisions**.

Diagnostic and Preventive Services

Diagnostic and Preventive Services

Services and procedures to evaluate existing conditions and/or to prevent dental abnormalities or disease. These services include examinations, evaluations, prophylaxes (routine cleanings), space maintainers, and topical fluoride treatments.

Brush Biopsy

Oral brush biopsy procedure and laboratory analysis used to detect oral cancer. Using this diagnostic procedure, Dentists can identify and treat abnormal cells that could become cancerous, or they can detect the disease in its earliest and most treatable stage.

Radiographs

X-rays as required for routine care or as needed to diagnose the condition of your teeth.

Emergency Palliative Treatments

Emergency treatment to temporarily relieve pain.

Basic Services

Oral Surgery Services

Extractions and dental surgery, including pre-operative and post-operative care.

Endodontic Services

The treatment of teeth with diseased or damaged nerves (for example, root canals).

Periodontic Services

The treatment of diseases of the gums and supporting structures of the teeth, including periodontal maintenance following periodontal therapy (periodontal cleanings).

Relines and Repairs

Relines and repairs to partial dentures and complete dentures, and repairs to bridges.

Restorative Services

Services to rebuild and repair natural tooth structure damaged by disease, decay, fracture, or injury. Restorative services include:

- Minor restorative services, such as amalgam (silver) fillings and composite resin (white) fillings on anterior teeth.
- Major restorative services, such as crowns, when teeth cannot be restored with another filling material.

Major Services

Prosthodontic Services

Services and appliances that replace missing natural teeth (such as bridges, endosteal implants, partial dentures, and complete dentures).

Orthodontic Services

Services, treatment and procedures to correct malposed teeth (such as braces).

Other Benefits

Any additional Benefits specified in The Summary of Dental Plan Benefits.

7. Exclusions and Limitations

Exclusions

Delta Dental will make no payment for the following services, unless otherwise specified in the Summary of Dental Plan Benefits. All charges for the same will be your responsibility.

1. General anesthesia as relating to Periodontic, Prosthetic, Restorative, Endodontic or Orthodontic services or for the sole purpose of patient management.
2. Services for injuries or conditions payable under Workers' Compensation or employer's liability laws. Services that are received from any government agency, political subdivision, community agency, foundation, or similar entity. NOTE: This provision does not apply to any programs provided under Title XIX of the Social Security Act (Medicaid).
3. [Dental Services received from a dental or medical department maintained by or on behalf of the Group, a mutual benefit association, labor union, trustee, or similar person or group.]
4. Cosmetic surgery, bleaching or dentistry for aesthetic reasons, as determined by Delta Dental.
5. A complete occlusal adjustment.
6. Services rendered before the Effective Date or after the termination date of This Plan.
7. Charges for hospitalization, laboratory tests, and histopathological examinations.
8. Charges for failure to keep a scheduled visit with the Dentist.
9. Services as determined by Delta Dental, for which no valid dental need can be demonstrated or which are specialized techniques.
10. Services as determined by Delta Dental that are Investigational in nature, including services or supplies required to treat complications from Investigational procedures.
11. Services, as determined by Delta Dental, which are not rendered in accordance with generally accepted standards of dental practice.
12. Treatment by anyone other than a Dentist, except for services performed by a licensed dental hygienist or other dental professional as determined by Delta Dental under the scope of the professional's license as permitted by applicable state law.
13. Services for which no charge is made, for which the patient is not legally obligated to pay, or for which no charge would be made in the absence of Delta Dental coverage.
14. Replacement, repair or adjustments to space maintainers.
15. Services received as a result of dental disease, defect, or injury for any military-connected disability or condition or due to an act of war, declared or undeclared.
16. Services required while incarcerated in a penal institution or while in custody of law enforcement authorities, including work release programs.

17. Services for injuries sustained from participating in a civil disturbance or while committing an assault or felony.

18. Services that are covered under another group medical or dental plan. We will coordinate coverage where permissible under applicable laws.

19. Services that are not within the categories of Benefits that have been selected by your employer or organization and that are not covered under the terms of this Certificate.

20. Fluoride rinses, self-applied fluorides, or desensitizing medicaments.

21. Preventive control programs (including oral hygiene instruction, caries susceptibility tests, dietary control, tobacco counseling, home care medications, etc.).

22. Appliances, surgical procedures, and restorations for increasing vertical dimension; for altering, restoring, or maintaining occlusion; for replacing tooth structure loss resulting from attrition, abrasion, abfraction, or erosion; or for periodontal splinting.

23. Temporary root canal fillings on permanent teeth.

24. Chemical curettage.

25. Personalization/characterization of any service or appliance.

26. Separate claims for tooth preparation, temporary services, bases, impressions, local anesthesia or other services that are components of a complete procedure will be subject to the Maximum Approved Fee.

27. Appliances, restorations, or services for the diagnosis or treatment of disturbances of the temporomandibular joint (TMJ).

28. Mounted case analyses.

29. Consultations.

30. Subperiosteal implants and bone grafts.

31. Laser Assisted New Attachment Procedure, also known as LANAP, Wavelength-optimized Periodontal Therapy, Deep Pocket Therapy with New Attachment and similar laser periodontal treatment procedures are considered to be Investigational procedures and are not covered under the terms of this Certificate.

Delta Dental will make no payment for the following services. Participating Dentists <u>may not</u> charge you or your Eligible Dependents for these services. All charges from Non-participating Dentists for the following will be your responsibility:

1. The completion of forms or submission of claims.

2. Consultations, when performed in conjunction with examinations/evaluations.

3. Local anesthesia.

4. Acid etching, cement bases, cavity liners, and bases or temporary fillings.

5. Infection control.

6. Temporary crowns.

7. Gingivectomy as an aid to the placement of a restoration.

8. The correction of occlusion, when performed with prosthetics and restorations involving occlusal surfaces.

9. Diagnostic casts, when performed in conjunction with restorative or prosthodontic procedures.

10. Palliative treatment, when any other service is provided on the same date except X-rays and tests necessary to diagnose the emergency condition.

11. Post-operative X-rays, when done following any completed service or procedure.

12. Periodontal charting.

13. Pins and/or preformed posts, when done with core buildups for crowns, onlays, or inlays.

14. A pulp cap, when done with a sedative filling or any other restoration. A sedative or temporary filling, when done with pulpal debridement for the relief of acute pain prior to conventional root canal therapy or another endodontic procedure. The opening and drainage of a tooth or palliative treatment, when done by the same Dentist or dental office on the same day as completed root canal treatment.

15. A pulpotomy on a permanent tooth, except on a tooth with an open apex.

16. A therapeutic apical closure on a permanent tooth, except on a tooth where the root is not fully formed.
17. Retreatment of a root canal by the same Dentist or dental office within two years of the original root canal treatment.
18. A prophylaxis or full mouth debridement, when done on the same day as periodontal maintenance or scaling and root planing.
19. An occlusal adjustment, when performed on the same day as the delivery of an occlusal guard.
20. Reline, rebase, or any adjustment or repair within six months of the delivery of a partial denture.
21. Tissue conditioning, when performed on the same day as the delivery of a denture or the reline or rebase of a denture.

Limitations

The following benefits are limited as described in your Summary of Dental Plan Benefits:

- Oral examinations/evaluations.
- Routine teeth cleaning (prophylaxis).
- Bitewing X-rays.
- Full mouth or panographic X-rays (which include bitewing X-rays),
- Preventive fluoride treatments are payable once per Benefit Year to the age specified in your Summary of Dental Plan Benefits.

The benefits for the following services are limited as follows, unless otherwise specified in your Summary of Dental Plan Benefits. All charges for services that exceed these limitations will be your responsibility.

1. A separate benefit is not provided for **periapical or bitewing x-rays** when performed on the same date as a complete series or a panorex.
2. Benefits for a **problem-focused examination** are limited to two in a Benefit Year.
3. When the total amount charged for **individual periapical x-rays** equals or exceeds the Maximum Approved Fee for a complete series, Benefits are limited to the Maximum Approved Fee for a complete series. Benefits will also be subject to the limitations for a complete series.
4. **Space maintainers** are payable up to the age of 14 and are limited to one placement per location.
5. **Topical fluoride applications** are provided only for Eligible Persons up to the age of 19 and are limited to one application per Benefit Year.
6. **Sealants** are limited to topically applied acrylic plastic or composite material exclusively for the purpose of preventing tooth decay and are payable for people up to the age of 16. They must be placed on the occlusal surface of permanent molars that are free of decay and Benefits are limited to one application per tooth in a two-year period.
7. **Sealants repair or replacement** is covered only when performed after two years of the original placement or replacement. If performed within the two-year time limit, it will be considered part of a completed procedure and not a separate Benefit.
8. **Amalgam and resin restorations** are allowed once per tooth surface in a two-year period. **Composite resin or acrylic restorations** in posterior teeth are paid as an Alternate Benefit at amalgam Approved Fee unless specified otherwise in your Summary of Dental Plan Benefits.
9. Services are provided for one **restoration** in each tooth surface in an episode of treatment.
10. **Root canal treatment** includes periapical x-rays, cultures, follow-up care, treatments, pulpotomy or pulpectomy, and routine postoperative procedures. No separate charges will be paid for these procedures. Retreatment is payable after two years.
11. **Payments for pulpotomies are** limited to primary (baby) teeth.
12. **Stainless steel crowns** are limited to once per tooth in a two-year period on primary teeth only.
13. **Pulp capping** is a Covered Service for exposure of the pulp only and if performed on the same day as the final restoration is limited to the Maximum Approved Fee for the complete procedure.
14. **Remineralization** includes temporary restoration. Permanent restorations are not

payable within two months following the temporary placement.

15. **Payment for periodontal maintenance** is limited as listed in your Summary of Dental Plan Benefits provided the patient has completed active periodontal therapy.

16. **Periodontal scaling and root planing** is limited to once in a Benefit Year unless otherwise specified in your Summary of Dental Plan Benefits.

17. **Occlusal guards** are limited to one in a five-year period on permanent teeth. Occlusal guards for Children with primary or mixed primary and permanent teeth are not covered.

18. **Bone replacement grafts** are payable only when performed around natural teeth. (They are not covered in conjunction with implants, extractions for ridge augmentation or to replace bone lost in the area of an abscess).

19. **Osseous surgery** or osseous grafts are payable once per area within a three-year period.

20. Payment for **crowns, inlays, and onlays** is limited to one per tooth in a five-year period.

21. Services for any **optional gold restoration,** crown or jacket, are limited to the Maximum Approved Fee for an amalgam, synthetic or plastic restoration.

22. **Porcelain veneer** or cast crowns are payable when an Eligible Dependent is 12 years of age or over. For Eligible Dependents under the age of 12, an acrylic crown or preformed crown may be payable with approval.

23. **Denture reline or rebases** is payable once in a three-year period and at least six months after initial placement.

24. Benefits for **repair of a full or partial denture** are limited to 50% of the Maximum Approved Fee for a replacement denture.

25. **Oral Surgery** procedure includes routine postoperative procedures, dry socket treatments and sutures. These services are not payable as a separate benefit.

26. **General anesthesia** is limited to the following procedures when administered by a Dentist licensed to administer general anesthesia;

    a. Removal of impacted tooth – partially bony

    b. Removal of impacted tooth – completely bony

    c. Removal of impacted tooth – completely bony, with unusual surgical complications

    d. Surgical removal of residual root

    e. Oroantral fistula closure

    f. Vestibuloplasty – ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment, and management of hypertrophied and hyperplastic tissue)

    g. Five or more extractions performed on the same date of service.

    h. General anesthesia is not payable for the sole purpose of patient management.

27. **Tissue conditioning** is limited to three times in an episode of treatment.

28. **Denture or bridge replacement** is payable five years after the initial placement, however no replacement is payable for lost or stolen dentures or bridges.

29. **Fixed bridges** or removable cast partials are only payable for Eligible Dependents after the age of 16.

30. Benefits for **special techniques** or personalized restorations with a bridge or denture are limited to the Maximum Approved Fee for a standard procedure.

31. Benefits for an **overdenture**, including necessary crowns and root canal treatment, are limited to the Maximum Approved Fee for a full denture.

32. **Interim dentures** (stayplates) are payable only for Children under age 17 to replace extracted anterior permanent teeth during the healing period.

33. Payment for **implants** is limited to one implant per tooth in a five-year period.

34. When **implants** are not a Covered Service under this plan, Alternate Benefits may be payable for missing tooth replacement or partial denture payment.

35. In the event you **transfer from one Dentist** to another during your course of treatment, or more than one Dentist performs services for one procedure, Benefits are limited to the Maximum Approved Fee for the services of one Dentist.

Orthodontic Services

1. The diagnosis for Orthodontic Services must show that the handicapping malocclusion is abnormal and can be corrected. It is recommended that your Dentist submit a treatment plan to us to determine the Benefits available. One diagnosis and treatment plan is payable in a five-year period.

   We may review your dental records to determine if Benefits will be provided for the requested services.

2. All Orthodontic Services are considered to have been rendered on the date performed.
3. Orthodontic Services are subject to the total Maximum Payment per Eligible Person. Please refer to the Summary of Dental Benefits for your Maximum Payment.
4. Payment for orthodontic treatment, including appliances, will not exceed three years.
5. If the orthodontic treatment plan is terminated before completion of the case for any reason, Delta Dental's obligation for payment ends on the last day in which the patient was treated.
6. Replacement and/or repair of any appliance furnished under the orthodontic treatment plan are not covered.

Orthodontic Processing Policies

1. Benefits are paid as the services are rendered; therefore, lump sum payments cannot be made if full payment was made in advance.
2. Payments will be made for the following treatment;

   - Orthodontic records (if charged separately)
   - Down payment or initial fee (placement of appliances)
   - Monthly adjustments (paid each month as services are rendered.)
   - Retainers are paid as a one-time fee and monthly adjustments are included in this fee.

8. Coordination of Benefits

Coordination of Benefits ("COB") applies to This Plan when an Eligible Person has dental benefits under more than one plan. The objective of COB is to make sure the combined payments of the plans are no more than your actual dental bills. COB rules establish whether This Plan's Benefits are determined before or after another plan's benefits.

You must submit all your claims to each plan. The primary plan must pay its full benefits as if you had no other coverage. If the primary plan denies your claim or does not pay the full claim, the secondary plan will then calculate any additional payment under these rules.

Which Plan is Primary?

This Plan is a Secondary Plan unless:

- the other plan has rules coordinating its benefits with those of This Plan; and,
- both those rules and This Plan's rules make This Plan the Primary Plan.

The primary plan is determined by the first of the following rules that applies:

1. **Dependent or Non-dependent.**

The plan that covers the Eligible Person as other than a Dependent is always primary.

2. **Children (parents who are not divorced or separated) and the Birthday Rule.**

   The Plan of the parent with the first birthday in a calendar year is always primary for Children. If your birthday is in January and your spouse's birthday is in March, your plan will be primary for all of your Children. If both parents have the same birthday, the plan that covers the Children for the longer period will be primary.

3. **Children (Parents Divorced or Separated)**.

   If a court decree makes one parent responsible for health care expenses, that parent's plan is primary.

   If a court decree states that the parents will share custody without stating that one of the parents is responsible for the Child's health care expenses, Delta Dental follows the birthday rule (see #2 above).

   If neither of these rules applies, the order will be determined as follows:

   - First, the plan of the parent with custody of the Child.
   - Then, the plan of the spouse of the parent with custody of the Child.
   - Next, the plan of the parent without custody of the Child; and,
   - Last, the plan of the spouse of the parent without custody of the Child.

   If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of Benefits, this rule is ignored.

4. **Active or Inactive Employee.**

   The plan of the employee who is not laid off nor retired is Primary.

5. **COBRA Continuation of Coverage.**

   The plan of the Eligible Person that is not provided under a right of continuation pursuant to federal law (that is COBRA) or a similar state law is primary.

6. **Length of Coverage.**

   The plan that has covered the Eligible Person for the longer time is primary.

7. **None of the Above Applies.**

   If none of the rules above determines the order of Benefits, the allowable expense will be shared equally between plans.

How Delta Dental Pays as Primary Plan

When This Plan is Primary, it will pay Benefits under This Plan as if you had no other coverage.

How Delta Dental Pays as Secondary Plan

When This Plan is secondary, any difference between the amount we pay on a claim and the amount we would have paid if we had been Primary will be added to a Benefit Reserve under Kentucky law. At the end of a benefit year, we will reimburse the Covered Person for any non-reimbursed allowable expenses incurred during the previous year up to the total amount of your Benefit Reserve. At that time, your Benefit Reserve will be returned to zero and will start over for the next year. Examples of non-reimbursed expenses may include deductibles and copayments.

Right to Receive and Release Needed Information

Delta Dental needs certain facts to apply these COB rules, and it has the right to decide which facts it needs. We may get needed facts from, or give them to, any other organization or person. Delta Dental need not tell, or get the consent of, any person to do this. Each person claiming Benefits under This Plan must give Delta Dental any facts it needs to pay the claim.

Payment Made By Other Plans

A payment made under another plan may include an amount that should have been paid under This Plan. If it does, Delta Dental may pay that amount to the organization that made the payment.

That amount will then be treated as though it were a Benefit paid under This Plan, and Delta Dental will not have to pay that amount again. The term "payment made" includes providing Benefits in the form of

services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If Delta Dental pays more than it should have paid under this COB provision, it may recover the excess from one or more of the following:

- The people it has paid or for whom it has paid;
- Insurance companies; or
- Other organizations.

Payment includes the reasonable cash value of any Benefits provided in the form of services.

9. Claims Appeal Procedure

If you receive notice of an Adverse Benefit Determination that you think is incorrect, you or your Dentist should contact us at (800)955-2030 or customerservice@deltadentalky.com. Ask them to check the claim to make sure it was processed correctly. We provide this opportunity for you to describe the problem and why you think your claim was improperly denied. We will correct any errors quickly and without delay. This inquiry is not required and is not a formal appeal for review of your claim.

Whether or not you ask us informally to recheck the claim, you can submit your claim to a formal claims appeal procedure described below.

If you decide to appeal, you should seek a review as soon as possible. However, you must file an appeal within 180 days of the date you received your notice of an Adverse Benefit Determination. To appeal your claim, send your request by email to:

customerservice@deltadentalky.com

or in writing to:

Customer Service
Delta Dental of Kentucky
P O Box 242810
Louisville, Kentucky 40224

Your appeal should include your name, address, the Subscriber's Delta Dental ID and all information related to your appeal. This includes comments, documents, or records submitted by your Dentist and any other comments or information you wish to provide in support of your appeal. You are entitled to receive, upon request and free of charge, reasonable access to and copies of documents, or records and other information we have that are relevant to your appeal. If you would like a record of your request and proof that it was received by Delta Dental, you should mail it via certified mail, return receipt requested.

We will conduct your appeal by making a fresh determination of your claim based on a review of the information available. We will not defer to our original decision. The individuals who conduct the appeal will not be the persons who made the initial decision or those persons' subordinates. If your claim was denied for missing information, you or your Dentist may resubmit the claim with complete information. If the decision is based, in whole or in part, on a dental judgment (including determinations with respect to whether a particular treatment, or service is Investigational or not appropriate under your Certificate), the reviewer(s) will, as necessary, consult a dental health care professional with appropriate training and experience. The dental health care professional will not be the same individual, or that person's subordinate, consulted during the initial determination.

The reviewer(s) will make a determination within 30 days of receipt of your appeal. Delta Dental will send a written decision to you, your representative, and if applicable, your Dentist.

If we uphold any part or all of the initial Adverse Benefit Determination, you or your Dentist may contact the Department of Insurance, PO Box 517, Frankfort, Kentucky 40602, or online at http://insurance.ky.gov and request a review of our decision.

Notice. Your initial notice of an Adverse Benefit Determination will inform you of the following:

- specific reason(s) for the denial.
- the Plan provision(s) on which the denial is based.
- the review procedures for dental claims, including applicable time limits.
- that upon request, you are entitled to access, free of charge, all documents, records and other information relevant to your claim.

The notice will also contain or reference:

- a description of any additional materials necessary to complete your claim.

- an explanation of why such materials are necessary.
- a statement that you have the right to bring a civil action in court if you receive an Adverse Benefit Determination after your claim has been completely reviewed according to this claims appeal procedure.
- any internal rule, guideline, protocol, or similar document or criteria relied on in making the Adverse Benefit Determination.
- a statement that a copy of such rule, guideline or protocol may be obtained upon request, at no charge.

If the Adverse Benefit Determination is based on a matter of dental judgment or appropriateness under your coverage, the notice will also contain:

- an explanation of the scientific or clinical judgment on which the determination was based; or,
- a statement that a copy of the basis for the scientific or clinical judgment can be obtained upon request at no charge.

10. Termination of Coverage

Your Delta Dental coverage may automatically terminate:

- When your employer or organization advises Delta Dental to terminate your coverage.
- If we receive your premium more than 30 days late (or as specified in your Group contract). If so, the termination will occur on the date through which premiums are paid.
- For fraud or material misrepresentation in the submission of any claim or eligibility information.
- For any other reason stated in the Contract between Delta Dental and your Group.

Delta Dental will not continue eligibility for any Eligible Person under This Plan beyond the termination date given by your employer or organization. A person whose eligibility is terminated may not continue group coverage under this Certificate, except as required by the continuation coverage provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") or comparable, applicable state law.

11. Continuation of Coverage

Your Group may be required to comply with provisions under the Consolidated Omnibus Budget Reconciliation Act of 1986 ("COBRA"), the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), or the Uniformed Services Employment and Reemployment Rights Act of 1984 ("USERRA"). If your coverage would otherwise end, you and/or your Eligible Dependents may have the right, under certain circumstances, to continue coverage, at your expense, beyond the time coverage would normally end. You should check with your Group's benefit administrator to determine your eligibility for coverage continuation.

When is Plan Continuation Coverage Available?

Continuation coverage may be available if your coverage or a covered Dependent's coverage would otherwise end because of any of these reasons:

1. Your employment ends for any reason other than your gross misconduct.
2. Your hours of work are reduced so that you are no longer a full-time employee.
3. You are divorced or legally separated.
4. You die.
5. Your Child is no longer eligible to be a covered Dependent.
6. You become enrolled in Medicare (if applicable).
7. You are called to active duty in the armed forces of the United States.

If you believe you are entitled to continuation coverage, you should contact your Group's Benefit administrator to receive the appropriate documentation required under the Employee Retirement Income Security Act of 1974 (ERISA).

12. General Provisions

Family and Medical Leave Act of 1993 (FMLA)

Your Group determines whether or not you are eligible for FMLA. If you take FMLA leave, you will retain eligibility for coverage during this period. You and your Eligible Dependents will be considered eligible even if you are not actively working. If the Subscriber does not retain coverage during the leave period, any Eligible Person who was covered immediately prior to the leave may be reinstated upon return to work. In that event, there will be no new waiting period for pre-existing conditions.

Privacy of Your Health Information

Health Insurance Portability and Accountability Act (HIPAA)

Delta Dental is committed to protecting your health information. You may obtain a copy of our HIPAA Notice of Privacy Practices by contacting us at customerservice@deltadentalky.com.

Children's Health Insurance Program (CHIP)

You may have special enrollment rights under CHIP. You should ask your Group's benefit administrator if you are eligible. Under the law, you and your Eligible Dependents not enrolled in the plan have the right to request enrollment . This must be done within 60 days of when you or your Eligible Dependents are terminated from Medicaid or state CHIP coverage as a result of loss of eligibility or if you or your Eligible Dependents become eligible for a premium assistance subsidy under Medicaid or state CHIP. You should notify your Group's benefit administrator if you are eligible for this special enrollment.

Assignment

Services and payments to Eligible Persons are for the personal benefit of those persons. You cannot transfer or assign payments other than to allow us to make direct payments to Participating Dentists.

Subrogation and Right of Reimbursement

Subrogation happens when you or your Eligible Dependents are involved in an automobile accident or require Covered Services that may entitle you to recover damages from a third party.

Delta Dental may have the right to be paid any amount you recover up to the amount we paid under This Plan.

You agree that Delta Dental has first priority in any payment an Eligible Person receives from someone else or that person's insurance company. We may exercise our right to direct recovery against the Eligible Person. You or your legal representative must do whatever is necessary to enable us to exercise our rights. You also agree to do nothing that could harm our right to recover.

Obligation to Assist in Delta Dental's Reimbursement Activities

You and your Eligible Dependents are required to provide Delta Dental with:

- any information concerning other insurance coverage that may be available. (This includes automobile, home, and other liability insurance coverage, and coverage under another group health plan; and,
- the identity of any other person or entity, and his or her insurers (if known), that may be obligated to provide payments or benefits for the same Covered Services for which Delta Dental made payments.

You and your Eligible Dependents are required to:

- cooperate fully with us to exercise our right to subrogation and reimbursement.
- refrain from doing anything to prejudice those rights (such as settling a claim against another party without notifying Delta Dental, or not including Delta Dental as a co-payee of any settlement amount).
- sign any document deemed by Delta Dental to be relevant in protecting our subrogation and reimbursement rights.
- provide relevant information when requested.

The term "information" includes any documents, insurance policies, police or other investigative

reports, and any other facts that we may reasonably request. Failure by an Eligible Person to cooperate with Delta Dental in the exercise of these rights may result in a reduction of future benefit payments available to you under This Plan in an amount up to the total amount paid by us, but for which we were not reimbursed.

Dentist-Patient Relationship

You are free to choose any Dentist. However, you should keep in mind the differences in payment levels between Participating and Non-participating Providers. We do not recommend or warrant any Dentist and a Dentist may decline to provide care to you for any lawful reason. Each Dentist maintains the dentist-patient relationship with the patient and is solely responsible to the patient for dental advice and treatment and any resulting liability.

Delta Dental contracts with Participating Dentists in order to reduce dental care costs. We are not responsible or liable for the furnishing of Covered Services, but merely for the payment of them under the terms of This Plan. You will have no claim against us for acts or omissions of any Dentist from whom you receive services. We have no responsibility for any act or omission of any Dentist or the failure or refusal of any Dentist to provide services to you. This Plan does not give anyone any claim, right or cause of action based on what any Dentist or other dental professional does or does not do.

Loss of Eligibility During Treatment

If an Eligible Person loses eligibility while receiving dental treatment, Delta Dental will only pay for Covered Services received while that person was covered under This Plan.

Certain services begun before the loss of eligibility may be covered if they are completed within a 60-day period from the date of termination. In those cases, Delta Dental evaluates those services in progress to determine what portion may be paid by Delta Dental. The difference between Delta Dental's payment and the total fee for those services is your responsibility.

Governing Law

This Certificate will be governed by and interpreted under the laws of the Commonwealth of Kentucky.

Actions

No action on a legal claim arising out of or related to This Plan can be brought within 60 days after notice of the legal claim has been given to Delta Dental, unless prohibited by applicable state law. In addition, no action can be brought more than three years after the legal claim first arose or after expiration of the applicable statute of limitations, if longer. Any person seeking to do so will be deemed to have waived that person's right to bring suit on such legal claim. This provision does not preclude you from seeking a decision from a jury trial once all administrative appeals have been exhausted.

Change of Certificate or Contract

Delta Dental may amend your Certificate or Summary of Dental Plan Benefits or adjust the premiums from time to time. We will inform the Group in writing at least 30 days before any amendment goes into effect. No agent or other person has the authority to change any provisions in this Certificate, Summary of Dental Plan Benefits or the provisions of the contract on which it is based. No change in this Certificate or Summary of Dental Plan Benefits will be effective until approved, in writing, by an officer of Delta Dental.

Change of Status

You must notify Delta Dental, through your Group, of any event that changes the status of an Eligible Person. These events include, marriage, birth, death, divorce, and entrance into military service.

Right of Recovery Due to Fraud

We have the right to recover from any eligible Person any payment that we make because of fraud or

material misrepresentation. This includes any payment for:

- services that were sought or received under fraudulent, false, or misleading circumstances.
- a claim that contains false or misrepresented information.
- a claim that is determined to be fraudulent due to the acts of any Eligible Person.

We may recover any payments made to any Eligible Person that were based on false, fraudulent, misleading, or misrepresented information. We may deduct that amount from any payments properly due to an Eligible Person. We will provide an explanation of any payment being recovered at the time we make the deduction.

Legally Mandated Benefits

Any law that requires broader coverage or more favorable treatment for Eligible Persons than is provided by This Plan controls over This Plan.

Claims, Pre-Treatment Estimate, Inquiries or Review

P.O. Box 242810
Louisville, Kentucky 40224-2810

An Equal Opportunity Employer

DELTA DENTAL®

Delta Dental of Kentucky
Delta Dental PPO plus Premier™
Summary of Dental Plan Benefits

Group Name: BULLOCK PEN WATER DISTRICT

Group Number: 509640-0000

Benefit Year: January 1 through December 31

Covered Services –

	Delta Dental PPO™ Dentist	Delta Dental Premier® Dentist	Non-participating Dentist
	Plan Pays	**Plan Pays**	**Plan Pays***
Diagnostic & Preventive			
Diagnostic and Preventive Services – exams, cleanings, fluoride, and space maintainers	100%	100%	100%
Emergency Palliative Treatment – to temporarily relieve pain	100%	100%	100%
Sealants – to prevent decay of permanent teeth	100%	100%	100%
Brush Biopsy – to detect oral cancer	100%	100%	100%
Radiographs – X-rays	100%	100%	100%
Basic Services			
Minor Restorative Services – fillings and crown repair	80%	80%	80%
Endodontic Services – root canals	80%	80%	80%
Periodontic Services – to treat gum disease	80%	80%	80%
Oral Surgery Services – extractions and dental surgery	80%	80%	80%
Other Basic Services – misc. services	80%	80%	80%
Denture Repair – repairs to complete or partial dentures	80%	80%	80%
Major Services			
Major Restorative Services – crowns	50%	50%	50%
Fixed Prosthodontic Repair – to bridges	50%	50%	50%
Implant Repair – implant maintenance, repair, and removal	50%	50%	50%
Relines and Rebase – to dentures	50%	50%	50%
Adjustments to Dentures – adjustments to complete or partial dentures	50%	50%	50%
Prosthodontic Services – bridges, implants, and dentures	50%	50%	50%

* When you receive services from a Nonparticipating Dentist, the percentages in this column indicate the portion of Delta Dental's Nonparticipating Dentist Fee that will be paid for those services. The Nonparticipating Dentist Fee may be less than what the dentist charges and you are responsible for that difference.

- Oral exams (including evaluations by a specialist) are payable twice per calendar year. Limited oral evaluations for a specific problem or complaint are also payable twice in the same calendar year.
- Prophylaxes (cleanings) are payable twice per calendar year. Two additional periodontal maintenance procedures are payable per calendar year for individuals with a documented history of periodontal disease. Full mouth debridement is payable once in a lifetime.
- People with specific at-risk health conditions may be eligible for additional prophylaxes (cleanings) or fluoride treatment. The patient should talk with his or her Dentist about treatment.
- Fluoride treatments are payable once per calendar year for people age 18 and under.
- Space maintainers are payable once per area per lifetime for people age 13 and under.

- Bitewing X-rays are payable once per calendar year and full mouth X-rays (which include bitewing X-rays) or a panorex are payable once in any five-year period.
- Sealants are payable once per tooth per two-year period for first and second permanent molars for people age 15 and under. The surface must be free from decay and restorations.
- Payment for crowns, inlays, and onlays are payable once per tooth in any five-year period. Stainless steel crowns are payable once per tooth in any two-year period on primary teeth only.
- Composite resin (white) restorations are payable on posterior teeth.
- Root canal treatment is inclusive of periapical X-rays, cultures, follow-up care, treatments, pulpotomy or pulpectomy, and routine post-operative procedures. Separate charges are not Covered Services for these procedures. Retreatment is payable two years after the initial treatment.
- Denture and/or bridge replacement is payable five-years post initial place. Replacement is not a Covered Service for lost or stolen dentures and/or bridges. Interim dentures are payable only for people under age 17 to replace extracted anterior permanent teeth.
- Fixed bridges or removable cast partials are payable only for Eligible Dependents over age 16. Services and appliances that replace missing natural teeth (such as bridges, endosteal implants, implant crowns, partial dentures, and complete dentures) may be subject to an Alternate Benefit.
- Porcelain and resin facings on bridges are payable on posterior teeth.
- Implants are payable once per tooth in any five-year period. Implant related services are Covered Services.
- Crowns over implants are payable once per tooth in any five-year period. Services related to crowns over implants are Covered Services.

Deductible – None.

Maximum Payment – $1,000 per person total per Benefit Year on all services.

Dependent Age Limit – Dependents are covered up to age 26.

Eligible People – The subscriber (you) is eligible for dental benefits when your employer or organization notifies Delta Dental.

Also eligible at your option are your legal spouse and your children who meet the age requirements noted above. Enrollees and dependents choosing this plan are required to remain enrolled for a minimum of 12 months. Should an Enrollee or Dependent choose to drop coverage after that time, he or she may not re-enroll prior to the date on which 12 months have elapsed. Dependents may only enroll if the Enrollee is enrolled (except under COBRA) and must be enrolled in the same plan as the Enrollee. An election may be revoked or changed at any time if the change is the result of a qualifying event as defined under Internal Revenue Code Section 125.

If you and your spouse are both eligible under this Contract, you may be enrolled as both a Subscriber on your own application and as a dependent on your spouse's application. Your dependent children may be enrolled on both applications as well. Delta Dental will coordinate benefits.

Benefits will cease on the last day of the month in which your employment is terminated.

This Summary of Dental Plan Benefits should be read along with your Certificate. Your Certificate provides additional information about your Delta Dental plan, including information about plan exclusions and limitations. If a statement in this Summary conflict with a statement in the Certificate, the statement in this Summary applies to you and you should ignore the conflicting statement in the Certificate. The percentages above are applied to Delta Dental's allowance for each service and it may vary due to the dentist's network participation.*

BULLOCK PEN WATER DISTRICT

Your Group Life and Accidental Death
and Dismemberment Plan

Identification No. 600710 011

Underwritten by Unum Life Insurance Company of America

3/3/2014

CERTIFICATE OF COVERAGE

Unum Life Insurance Company of America (referred to as Unum) welcomes you as a client.

This is your certificate of coverage as long as you are eligible for coverage and you become insured. You will want to read it carefully and keep it in a safe place.

Unum has written your certificate of coverage in plain English. However, a few terms and provisions are written as required by insurance law. If you have any questions about any of the terms and provisions, please consult Unum's claims paying office. Unum will assist you in any way to help you understand your benefits.

If the terms and provisions of the certificate of coverage (issued to you) are different from the Summary of Benefits (issued to the Employer), the Summary of Benefits will govern. The Summary of Benefits may be changed in whole or in part. Only an officer or registrar of Unum can approve a change. The approval must be in writing and endorsed on or attached to the Summary of Benefits. Any other person, including an agent, may not change the Summary of Benefits or waive any part of it.

The Summary of Benefits is delivered in and is governed by the laws of the governing jurisdiction and to the extent applicable by the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments.

For purposes of effective dates and ending dates under the group Summary of Benefits, all days begin at 12:01 a.m. and end at 12:00 midnight at the Employer's address.

Unum Life Insurance Company of America
2211 Congress Street
Portland, Maine 04122

TABLE OF CONTENTS

BENEFITS AT A GLANCE.....B@G-LIFE-1

LIFE INSURANCE PLAN.....B@G-LIFE-1

BENEFITS AT A GLANCE.....B@G-AD&D-1

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE PLAN .....B@G-AD&D-1

CLAIM INFORMATION.....LIFE-CLM-1

LIFE INSURANCE.....LIFE-CLM-1

CLAIM INFORMATION.....AD&D-CLM-1

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE .....AD&D-CLM-1

GENERAL PROVISIONS EMPLOYEE-1

LIFE INSURANCE.....LIFE-BEN-1

BENEFIT INFORMATION.....LIFE-BEN-1

OTHER BENEFIT FEATURES LIFE-OTR-1

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE .....AD&D-BEN-1

BENEFIT INFORMATION.....AD&D-BEN-1

OTHER BENEFIT FEATURES .....AD&D-OTR-1

GLOSSARY GLOSSARY-1

BENEFITS AT A GLANCE

LIFE INSURANCE PLAN

This life insurance plan provides financial protection for your beneficiary(ies) by paying a benefit in the event of your death. The amount your beneficiary(ies) receive(s) is based on the amount of coverage in effect just prior to the date of your death according to the terms and provisions of the plan.

EMPLOYER'S ORIGINAL PLAN EFFECTIVE DATE: March 1, 2014

IDENTIFICATION NUMBER: 600710 011

ELIGIBLE GROUP(S):

All Employees in active employment in the United States with the Employer

MINIMUM HOURS REQUIREMENT:

Employees must be working at least 30 hours per week.

WAITING PERIOD:

For employees in an eligible group on or before March 1, 2014: None

For employees entering an eligible group after March 1, 2014: First of the month following the date you enter an eligible group

REHIRE:

If your employment ends and you are rehired within 1 year, your previous work while in an eligible group will apply toward the waiting period. All other Summary of Benefits' provisions apply.

WHO PAYS FOR THE COVERAGE:

Your Employer pays the cost of your coverage.

ELIMINATION PERIOD:

Premium Waiver: 9 months

Disability-based benefits begin the day after Unum approves your claim and the elimination period is completed.

LIFE INSURANCE BENEFIT:

AMOUNT OF LIFE INSURANCE FOR YOU

$15,000

AMOUNT OF LIFE INSURANCE AVAILABLE IF YOU BECOME INSURED AT CERTAIN AGES OR HAVE REACHED CERTAIN AGES WHILE INSURED

If you have reached age 70, your amount of life insurance will be:
- 50% of the amount of life insurance you had prior to age 70; or
- 50% of the amount of life insurance shown above if you become insured on or after age 70.

There will be no further increases in your amount of life insurance.

SOME LOSSES MAY NOT BE COVERED UNDER THIS PLAN.

OTHER FEATURES:

Accelerated Benefit

Conversion

Continuity of Coverage

Portability

The above items are only highlights of this plan. For a full description of your coverage, continue reading your certificate of coverage section. The plan includes enrollment, risk management and other support services related to your Employer's Benefit Program.

BENEFITS AT A GLANCE

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE PLAN

This accidental death and dismemberment insurance plan provides financial protection for your beneficiary(ies) by paying a benefit in the event of your death or for you in the event of any other covered loss. The amount you or your beneficiary(ies) receive(s) is based on the amount of coverage in effect just prior to the date of your death or any other covered loss according to the terms and provisions of the plan.

EMPLOYER'S ORIGINAL PLAN EFFECTIVE DATE: March 1, 2014

IDENTIFICATION NUMBER: 600710 011

ELIGIBLE GROUP(S):

All Employees in active employment in the United States with the Employer

MINIMUM HOURS REQUIREMENT:

Employees must be working at least 30 hours per week.

WAITING PERIOD:

For employees in an eligible group on or before March 1, 2014: None

For employees entering an eligible group after March 1, 2014: First of the month following the date you enter an eligible group

REHIRE:

If your employment ends and you are rehired within 1 year, your previous work while in an eligible group will apply toward the waiting period. All other Summary of Benefits' provisions apply.

WHO PAYS FOR THE COVERAGE:

Your Employer pays the cost of your coverage.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT:

AMOUNT OF ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) INSURANCE FOR YOU (FULL AMOUNT)

Amounts in $1,000 benefit units as applied for by you and approved by Unum.

$15,000

AMOUNT OF ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE AVAILABLE IF YOU BECOME INSURED AT CERTAIN AGES OR HAVE REACHED CERTAIN AGES WHILE INSURED

If you have reached age 70, your amount of AD&D insurance will be:
- 50% of the amount of AD&D insurance you had prior to age 70; or
- 50% of the amount of AD&D insurance shown above if you become insured on or after age 70.

There will be no further increases in your amount of AD&D insurance.

REPATRIATION BENEFIT FOR YOU

Maximum Benefit Amount:

Up to $5,000

The Repatriation Benefit is separate from any accidental death and dismemberment benefit which may be payable. To receive the Repatriation Benefit, your accidental death benefit must be paid first.

SEATBELT(S) AND AIR BAG BENEFIT FOR YOU

Benefit Amount:

Seatbelt(s): 10% of the Full Amount of your accidental death and dismemberment insurance benefit.

Air Bag: 5% of the Full Amount of your accidental death and dismemberment insurance benefit.

Maximum Benefit Payment:

Seatbelt(s): $25,000

Air bag: $5,000

The Seatbelt(s) and Air Bag Benefit is separate from any accidental death and dismemberment benefit which may be payable. To receive the Seatbelt(s) and Air Bag Benefit, your accidental death benefit must be paid first.

EDUCATION BENEFIT

Each Qualified Child

Benefit Amount per Academic Year for which a Qualified Child is enrolled:

6% of the Full Amount of the employee's accidental death and dismemberment insurance to a maximum of $6,000.

Maximum Benefit Payments:

4 per lifetime

Maximum Benefit Amount:

$24,000

Maximum Benefit Period:

6 years from the date the first benefit payment has been made.

The Education Benefit is separate from any accidental death and dismemberment benefit which may be payable. In order for your Qualified Child to receive the Education Benefit, your accidental death benefit must be paid first.

EXPOSURE AND DISAPPEARANCE BENEFIT FOR YOU

Maximum Benefit Amount: The Full Amount

SOME LOSSES MAY NOT BE COVERED UNDER THIS PLAN.

OTHER FEATURES:

Portability

Continuity of Coverage is available under this plan - refer to the **ACCIDENTAL DEATH AND DISMEMBERMENT OTHER BENEFIT FEATURES** for further details.

The above items are only highlights of this plan. For a full description of your coverage, continue reading your certificate of coverage section. The plan includes enrollment, risk management and other support services related to your Employer's Benefit Program.

CLAIM INFORMATION

LIFE INSURANCE

WHEN DO YOU OR YOUR AUTHORIZED REPRESENTATIVE NOTIFY UNUM OF A CLAIM?

We encourage you or your authorized representative to notify us as soon as possible, so that a claim decision can be made in a timely manner.

If a claim is based on your disability, written notice and proof of claim must be sent no later than 90 days after the end of the elimination period.

If a claim is based on death, written notice and proof of claim must be sent no later than 90 days after the date of death.

If it is not possible to give proof within these time limits, it must be given no later than 1 year after the proof is required as specified above. These time limits will not apply during any period you or your authorized representative lacks the legal capacity to give us proof of claim.

The claim form is available from your Employer, or you or your authorized representative can request a claim form from us. If you or your authorized representative does not receive the form from Unum within 15 days of the request, send Unum written proof of claim without waiting for the form.

If you have a disability, you must notify us immediately when you return to work in any capacity, regardless of whether you are working for your Employer.

HOW DO YOU FILE A CLAIM FOR A DISABILITY?

You or your authorized representative, and your Employer must fill out your own sections of the claim form and then give it to your attending physician. Your physician should fill out his or her section of the form and send it directly to Unum.

WHAT INFORMATION IS NEEDED AS PROOF OF YOUR CLAIM?

If your claim is based on your disability, your proof of claim, provided at your expense, must show:

- that you are under the **regular care** of a **physician**;
- the date your disability began;
- the cause of your disability;
- the extent of your disability, including restrictions and limitations preventing you from performing your regular occupation or any gainful occupation; and
- the name and address of any **hospital or institution** where you received treatment, including all attending physicians.

We may request that you send proof of continuing disability indicating that you are under the regular care of a physician. This proof, provided at your expense, must be received within 45 days of a request by us.

If claim is based on death, proof of claim, provided at your or your authorized representative's expense, must show the cause of death. Also a certified copy of the death certificate must be given to us.

In some cases, you will be required to give Unum authorization to obtain additional medical and non-medical information as part of your proof of claim or proof of continuing disability. Unum will deny your claim if the appropriate information is not submitted.

WHEN CAN UNUM REQUEST AN AUTOPSY?

In the case of death, Unum will have the right and opportunity to request an autopsy where not forbidden by law.

HOW DO YOU DESIGNATE OR CHANGE A BENEFICIARY? (Beneficiary Designation)

At the time you become insured, you should name a beneficiary on your enrollment form for your death benefits under your life insurance. You may change your beneficiary at any time by filing a form approved by Unum with your Employer. The new beneficiary designation will be effective as of the date you sign that form. However, if we have taken any action or made any payment before your Employer receives that form, that change will not go into effect.

It is important that you name a beneficiary and keep your designation current. If more than one beneficiary is named and you do not designate their order or share of payments, the beneficiaries will share equally. The share of a beneficiary who dies before you, or the share of a beneficiary who is disqualified, will pass to any surviving beneficiaries in the order you designated.

If you do not name a beneficiary, or if all named beneficiaries do not survive you, or if your named beneficiary is disqualified, your death benefit will be paid to your estate.

Instead of making a death payment to your estate, Unum has the right to make payment to the first surviving family members of the family members in the order listed below:

- spouse;
- child or children;
- mother or father; or
- sisters or brothers.

If we are to make payments to a beneficiary who lacks the legal capacity to give us a release, Unum may pay up to $2,000 to the person or institution that appears to have assumed the custody and main support of the beneficiary. This payment made in good faith satisfies Unum's legal duty to the extent of that payment and Unum will not have to make payment again.

Also, at Unum's option, we may pay up to $1,000 to the person or persons who, in our opinion, have incurred expenses for your last sickness and death.

HOW WILL UNUM MAKE PAYMENTS?

If your life claim is at least $10,000, Unum will make available to the beneficiary a **retained asset account** (the Unum Security Account).

Payment for the life claim may be accessed by writing a draft in a single sum or drafts in smaller sums. The funds for the draft or drafts are fully guaranteed by Unum.

If the life claim is less than $10,000, Unum will pay it in one lump sum to your beneficiary.

Also, your beneficiary may request the life claim to be paid according to one of Unum's other settlement options. This request must be in writing in order to be paid under Unum's other settlement options.

WHAT HAPPENS IF UNUM OVERPAYS YOUR CLAIM?

Unum has the right to recover any overpayments due to:

- fraud; and
- any error Unum makes in processing a claim.

You must reimburse us in full. We will determine the method by which the repayment is to be made.

Unum will not recover more money than the amount we paid you.

WHAT ARE YOUR ASSIGNABILITY RIGHTS FOR THE DEATH BENEFITS UNDER YOUR LIFE INSURANCE? (Assignability Rights)

The rights provided to you by the plan for life insurance are owned by you, unless:

- you have previously assigned these rights to someone else (known as an "assignee"); or
- you assign your rights under the plan(s) to an assignee.

We will recognize an assignee as the owner of the rights assigned only if:

- the assignment is in writing, signed by you, and acceptable to us in form; and
- a signed or certified copy of the written assignment has been received and registered by us at our home office.

We will not be responsible for the legal, tax or other effects of any assignment, or for any action taken under the plan(s') provisions before receiving and registering an assignment.

CLAIM INFORMATION

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

WHEN DO YOU OR YOUR AUTHORIZED REPRESENTATIVE NOTIFY UNUM OF A CLAIM?

We encourage you or your authorized representative to notify us as soon as possible, so that a claim decision can be made in a timely manner.

If a claim is based on death or other covered loss, written notice and proof of claim must be sent no later than 90 days after the date of death or the date of any other covered loss.

If a claim is based on the Education Benefit, written notice and proof of claim must be sent no later than 60 days after the date of your death.

If it is not possible to give proof within these time limits, it must be given no later than 1 year after the time proof is required as specified above. These time limits will not apply during any period you or your authorized representative lacks the legal capacity to give us proof of claim.

The claim form is available from your Employer, or you or your authorized representative can request a claim form from us. If you or your authorized representative does not receive the form from Unum within 15 days of your request, send Unum written proof of claim without waiting for the form.

HOW DO YOU FILE A CLAIM FOR A COVERED LOSS?

You or your authorized representative and your Employer must fill out your own sections of the claim form and then give it to your attending physician. Your physician should fill out his or her section of the form and send it directly to Unum.

WHAT INFORMATION IS NEEDED AS PROOF OF CLAIM?

If claim is based on death or other covered loss, proof of claim for death or covered loss, provided at your or your authorized representative's expense, must show:

- the cause of death or covered loss;
- the extent of the covered loss;
- the date of covered loss; and
- the name and address of any **hospital or institution** where treatment was received, including all attending **physicians**.

Also, in case of death, a certified copy of the death certificate must be given to us.

In some cases, you will be required to give Unum authorization to obtain additional medical and non-medical information as part of your proof of claim. Unum will deny your claim if the appropriate information is not submitted.

If a claim is based on the Education Benefit, proof of claim, provided at your authorized representative's expense, must show:

- the date of enrollment of your qualified child in an accredited post-secondary institution of higher learning;
- the name of the institution;
- a list of courses for the current academic term; and
- the number of credit hours for the current academic term.

WHEN CAN UNUM REQUEST AN AUTOPSY?

In the case of death, Unum will have the right and opportunity to request an autopsy where not forbidden by law.

HOW DO YOU DESIGNATE OR CHANGE A BENEFICIARY? (Beneficiary Designation)

At the time you become insured, you should name a beneficiary on your enrollment form for your death benefits under your accidental death and dismemberment insurance. You may change your beneficiary at any time by filing a form approved by Unum with your Employer. The new beneficiary designation will be effective as of the date you sign that form. However, if we have taken any action or made any payment before your Employer receives that form, that change will not go into effect.

It is important that you name a beneficiary and keep your designation current. If more than one beneficiary is named and you do not designate their order or share of payments, the beneficiaries will share equally. The share of a beneficiary who dies before you, or the share of a beneficiary who is disqualified, will pass to any surviving beneficiaries in the order you designated.

If you do not name a beneficiary, or if all named beneficiaries do not survive you, or if your named beneficiary is disqualified, your death benefit will be paid to your estate.

Instead of making a death payment to your estate, Unum has the right to make payment to the first surviving family members of the family members in the order listed below:

- spouse;
- child or children;
- mother or father; or
- sisters or brothers.

If we are to make payments to a beneficiary who lacks the legal capacity to give us a release, Unum may pay up to $2,000 to the person or institution that appears to have assumed the custody and main support of the beneficiary. This payment made in good faith satisfies Unum's legal duty to the extent of that payment and Unum will not have to make payment again.

Also, at Unum's option, we may pay up to $1,000 to the person or persons who, in our opinion, have incurred expenses for your last sickness and death.

HOW WILL UNUM MAKE PAYMENTS?

If your accidental death or dismemberment claim is at least $10,000 Unum will make available to you or your beneficiary a **retained asset account** (the Unum Security Account).

Payment for the accidental death or dismemberment claim may be accessed by writing a draft in a single sum or drafts in smaller sums. The funds for the draft or drafts are fully guaranteed by Unum.

If the accidental death or dismemberment claim is less than $10,000, Unum will pay it in one lump sum to you or your beneficiary.

Also, your beneficiary may request the accidental death claim to be paid according to one of Unum's other settlement options. This request must be in writing in order to be paid under Unum's other settlement options.

The Education Benefit will be paid to your qualified child or the qualified child's legal representative.

All other benefits will be paid to you.

WHAT HAPPENS IF UNUM OVERPAYS YOUR CLAIM?

Unum has the right to recover any overpayments due to:

- fraud; and
- any error Unum makes in processing a claim.

You must reimburse us in full. We will determine the method by which the repayment is to be made.

Unum will not recover more money than the amount we paid you.

WHAT ARE YOUR ASSIGNABILITY RIGHTS FOR THE DEATH BENEFITS UNDER YOUR ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE BENEFITS? (Assignability Rights)

The rights provided to you by the plan(s) for accidental death insurance benefits are owned by you, unless:

- you have previously assigned these rights to someone else (known as an "assignee"); or
- you assign your rights under the plan(s) to an assignee.

We will recognize an assignee as the owner of the rights assigned only if:

- the assignment is in writing, signed by you, and acceptable to us in form; and
- a signed or certified copy of the written assignment has been received and registered by us at our home office.

We will not be responsible for the legal, tax or other effects of any assignment, or for any action taken under the plan(s') provisions before receiving and registering an assignment.

GENERAL PROVISIONS

WHAT IS THE CERTIFICATE OF COVERAGE?

This certificate of coverage is a written statement prepared by Unum and may include attachments. It tells you:

- the coverage for which you may be entitled;
- to whom Unum will make a payment; and
- the limitations, exclusions and requirements that apply within a plan.

WHEN ARE YOU ELIGIBLE FOR COVERAGE?

If you are working for your Employer in an eligible group, the date you are eligible for coverage is the later of:

- the plan effective date; or
- the day after you complete your **waiting period**.

WHEN DOES YOUR COVERAGE BEGIN?

When your Employer pays 100% of the cost of your coverage under a plan, you will be covered at 12:01 a.m. on the later of:

- the date you are eligible for coverage; or
- the date Unum approves your evidence of insurability form, if **evidence of insurability** is required.

When you and your Employer share the cost of your coverage under a plan or when you pay 100% of the cost yourself, you will be covered at 12:01 a.m. on the latest of:

- the date you are eligible for coverage, if you apply for insurance on or before that date;
- the date you apply for insurance, if you apply within 31 days after your eligibility date; or
- the date Unum approves your evidence of insurability form, if evidence of insurability is required.

Evidence of insurability is required if you:

- are a late applicant, which means you apply for coverage more than 31 days after the date you are eligible for coverage; or
- voluntarily cancelled your coverage and are reapplying.

An evidence of insurability form can be obtained from your Employer.

WHAT IF YOU ARE ABSENT FROM WORK ON THE DATE YOUR COVERAGE WOULD NORMALLY BEGIN?

If you are absent from work due to injury, sickness, temporary layoff or leave of absence, your coverage will begin on the date you return to **active employment**.

ONCE YOUR COVERAGE BEGINS, WHAT HAPPENS IF YOU ARE NOT WORKING DUE TO INJURY OR SICKNESS?

If you are not working due to injury or sickness, and if premium is paid, you may continue to be covered up to your retirement date.

ONCE YOUR COVERAGE BEGINS, WHAT HAPPENS IF YOU ARE TEMPORARILY NOT WORKING?

If you are on a temporary **layoff**, and if premium is paid, you will be covered through the end of the month that immediately follows the month in which your temporary layoff begins.

If you are on a **leave of absence**, and if premium is paid, you will be covered through the end of the month that immediately follows the month in which your leave of absence begins.

WHEN WILL CHANGES TO YOUR COVERAGE TAKE EFFECT?

Once your coverage begins, any increased or additional coverage due to a change in your annual earnings or due to a plan change requested by your Employer will take effect immediately or on the date Unum approves your evidence of insurability form, if evidence of insurability is required. You must be in active employment or on a covered layoff or leave of absence.

If you are not in active employment due to injury or sickness, any increased or additional coverage due to a change in your annual earnings or due to a plan change will begin on the date you return to active employment.

Any decrease in coverage will take effect immediately but will not affect a **payable claim** that occurs prior to the decrease.

WHEN DOES YOUR COVERAGE END?

Your coverage under the Summary of Benefits or a plan ends on the earliest of:

- the date the Summary of Benefits or a plan is cancelled;
- the date you no longer are in an eligible group;
- the date your eligible group is no longer covered;
- the last day of the period for which you made any required contributions; or
- the last day you are in active employment unless continued due to a covered layoff or leave of absence or due to an injury or sickness, as described in this certificate of coverage.

Unum will provide coverage for a payable claim which occurs while you are covered under the Summary of Benefits or plan.

WHAT ARE THE TIME LIMITS FOR LEGAL PROCEEDINGS?

You or your authorized representative can start legal action regarding a claim 60 days after proof of claim has been given and up to 3 years from the time proof of claim is required, unless otherwise provided under federal law.

HOW CAN STATEMENTS MADE IN YOUR APPLICATION FOR THIS COVERAGE BE USED?

Unum considers any statements you or your Employer make in a signed application for coverage or an evidence of insurability form a representation and not a warranty. If any of the statements you or your Employer make are not complete and/or not true at the time they are made, we can:

- reduce or deny any claim; or
- cancel your coverage from the original effective date.

We will use only statements made in a signed application or an evidence of insurability form as a basis for doing this.

Except in the case of fraud, Unum can take action only in the first 2 years coverage is in force.

If the Employer gives us information about you that is incorrect, we will:

- use the facts to decide whether you have coverage under the plan and in what amounts; and
- make a fair adjustment of the premium.

HOW WILL UNUM HANDLE INSURANCE FRAUD?

Unum wants to ensure you and your Employer do not incur additional insurance costs as a result of the undermining effects of insurance fraud. Unum promises to focus on all means necessary to support fraud detection, investigation, and prosecution.

It is a crime if you knowingly, and with intent to injure, defraud or deceive Unum, or provide any information, including filing a claim, that contains any false, incomplete or misleading information. These actions, as well as submission of materially false information, will result in denial of your claim, and are subject to prosecution and punishment to the full extent under state and/or federal law. Unum will pursue all appropriate legal remedies in the event of insurance fraud.

DOES THE SUMMARY OF BENEFITS REPLACE OR AFFECT ANY WORKERS' COMPENSATION OR STATE DISABILITY INSURANCE?

The Summary of Benefits does not replace or affect the requirements for coverage by any workers' compensation or state disability insurance.

DOES YOUR EMPLOYER ACT AS YOUR AGENT OR UNUM'S AGENT?

For the purposes of the Summary of Benefits, your Employer acts on its own behalf or as your agent. Under no circumstances will your Employer be deemed the agent of Unum.

LIFE INSURANCE

BENEFIT INFORMATION

WHEN WILL YOUR BENEFICIARY RECEIVE PAYMENT?

Your beneficiary(ies) will receive payment when Unum approves your death claim.

WHAT DOCUMENTS ARE REQUIRED FOR PROOF OF DEATH?

Unum will require a certified copy of the death certificate, enrollment documents and a Notice and Proof of Claim form.

HOW MUCH WILL UNUM PAY YOUR BENEFICIARY IF UNUM APPROVES YOUR DEATH CLAIM?

Unum will determine the payment according to the amount of insurance shown in the LIFE INSURANCE **"BENEFITS AT A GLANCE"** page.

WHAT HAPPENS TO YOUR LIFE INSURANCE COVERAGE IF YOU BECOME DISABLED?

Your life insurance coverage may be continued for a specific time and your life insurance premium will be waived if you qualify as described below.

HOW LONG MUST YOU BE DISABLED BEFORE YOU ARE ELIGIBLE TO HAVE LIFE PREMIUMS WAIVED?

You must be disabled through your **elimination period**.

Your elimination period is 9 months.

WHEN WILL YOUR LIFE INSURANCE PREMIUM WAIVER BEGIN?

Your life insurance premium waiver will begin when we approve your claim, if the elimination period has ended and you meet the following conditions. Your Employer may continue premium payments until Unum notifies your Employer of the date your life insurance premium waiver begins.

Your life insurance premium will be waived if you meet these conditions:

- you are less than 60 and insured under the plan.
- you become disabled and remain disabled during the elimination period.
- you meet the notice and proof of claim requirements for disability while your life insurance is in effect or within three months after it ends.
- your claim is approved by Unum.

After we approve your claim, Unum does not require further premium payments for you while you remain disabled according to the terms and provisions of the plan.

Your life insurance amount will not increase while your life insurance premiums are being waived. Your life insurance amount will reduce or cease at any time it would reduce or cease if you had not been disabled.

WHEN WILL YOUR LIFE INSURANCE PREMIUM WAIVER END?

The life insurance premium waiver will automatically end if:

- you recover and you no longer are disabled;
- you fail to give us proper proof that you remain disabled;
- you refuse to have an examination by a physician chosen by Unum;
- you reach age 65; or
- premium has been waived for 12 months and you are considered to reside outside the United States or Canada. You will be considered to reside outside the United States or Canada when you have been outside these countries for a total period of 6 months or more during any 12 consecutive months for which premium has been waived.

HOW DOES UNUM DEFINE DISABILITY?

You are disabled when Unum determines that:

- during the elimination period, you are not working in any occupation due to your **injury** or **sickness**; and
- after the elimination period, due to the same injury or sickness, you are unable to perform the duties of any **gainful occupation** for which you are reasonably fitted by training, education or experience.

You must be under the regular care of a physician in order to be considered disabled.

The loss of a professional or occupational license or certification does not, in itself, constitute disability.

We may require you to be examined by a physician, other medical practitioner or vocational expert of our choice. Unum will pay for this examination. We can require an examination as often as it is reasonable to do so. We may also require you to be interviewed by an authorized Unum Representative.

APPLYING FOR LIFE INSURANCE PREMIUM WAIVER

Ask your Employer for a life insurance premium waiver claim form.

The form has instructions on how to complete and where to send the claim.

WHAT INSURANCE IS AVAILABLE WHILE YOU ARE SATISFYING THE DISABILITY REQUIREMENTS? (See Conversion Privilege)

You may use this life conversion privilege when your life insurance terminates while you are satisfying the disability requirements. Please refer to the conversion privilege below. You are not eligible to apply for this life conversion if you return to work and, again, become covered under the plan.

If an individual life insurance policy is issued to you, any benefit for your death under this plan will be paid only if the individual policy is returned for surrender to Unum. Unum will refund all premiums paid for the individual policy.

The amount of your death benefit will be paid to your named beneficiary for the plan. If, however, you named a different beneficiary for the individual policy and the policy is returned to Unum for surrender, that different beneficiary will not be paid.

If you want to name a different beneficiary for this group plan, you must change your beneficiary as described in the Beneficiary Designation page of this group plan.

WHAT INSURANCE IS AVAILABLE WHEN COVERAGE ENDS? (Conversion Privilege)

When coverage ends under the plan, you can convert your coverage to an individual life policy, without evidence of insurability. The maximum amount that you can convert is the amount you are insured for under the plan. You may convert a lower amount of life insurance.

You must apply for individual life insurance under this life conversion privilege and pay the first premium within 31 days after the date:

- your employment terminates; or
- you no longer are eligible to participate in the coverage of the plan.

If you convert to an individual life policy, then return to work, and, again, become insured under the plan, you are not eligible to convert to an individual life policy again. However, you do not need to surrender that individual life policy when you return to work.

Converted insurance may be of any type of the level premium whole life plans then in use by Unum. The individual policy will not contain disability or other extra benefits.

WHAT LIMITED CONVERSION IS AVAILABLE IF THE SUMMARY OF BENEFITS OR THE PLAN IS CANCELLED? (Conversion Privilege)

You may convert a limited amount of life insurance if you have been insured under your Employer's group plan with Unum for at least five (5) years and the Summary of Benefits or the plan:

- is cancelled with Unum; or
- changes so that you no longer are eligible.

The individual life policy maximum will be the lesser of:

- $10,000; or
- your coverage amount under the plan less any amount that becomes available under any other group life plan offered by your Employer within 31 days after the date the Summary of Benefits or the plan is cancelled.

PREMIUMS

Premiums for the converted insurance will be based on:

- your then attained age on the effective date of the individual life policy;
- the type and amount of insurance to be converted;
- Unum's customary rates in use at that time; and

- the class of risk to which you belong.

If the premium payment has been made, the individual life policy will be effective at the end of the 31 day conversion application period.

DEATH DURING THE THIRTY-ONE DAY CONVERSION APPLICATION PERIOD

If you die within the 31 day conversion application period, Unum will pay the beneficiary(ies) the amount of insurance that could have been converted. This coverage is available whether or not you have applied for an individual life policy under the conversion privilege.

APPLYING FOR CONVERSION

Ask your Employer for a conversion application form which includes cost information.

When you complete the application, send it with the first premium amount to:

Unum - Conversion Unit
2211 Congress Street
Portland, Maine 04122-1350
1-800-343-5406

WILL UNUM ACCELERATE YOUR DEATH BENEFIT FOR THE PLAN IF YOU BECOME TERMINALLY ILL? (Accelerated Benefit)

If you become terminally ill while you are insured by the plan, Unum will pay you a portion of your life insurance benefit one time. The payment will be based on 50% of your life insurance amount. However, the one-time benefit paid will not be greater than $750,000.

Your right to exercise this option and to receive payment is subject to the following:

- you request this election, in writing, on a form acceptable to Unum;
- you must be terminally ill at the time of payment of the Accelerated Benefit;
- your physician must certify, in writing, that you are terminally ill and your life expectancy has been reduced to less than 12 months; and
- the physician's certification must be deemed satisfactory to Unum.

The Accelerated Benefit is available on a voluntary basis. Therefore, you are not eligible for benefits if:

- you are required by law to use this benefit to meet the claims of creditors, whether in bankruptcy or otherwise; or
- you are required by a government agency to use this benefit in order to apply for, get, or otherwise keep a government benefit or entitlement.

Premium payments must continue to be paid on the full amount of life insurance unless you qualify to have your life premium waived.

If you have assigned your rights under the plan to an assignee or made an irrevocable beneficiary designation, Unum must receive consent, in writing, that the

assignee or irrevocable beneficiary has agreed to the Accelerated Benefit payment on your behalf in a form acceptable to Unum before benefits are payable.

An election to receive an Accelerated Benefit will have the following effect on other benefits:

- the death benefit payable will be reduced by any amount of Accelerated Benefit that has been paid; and
- any amount of life insurance that would be continued under a disability continuation provision or that may be available under the conversion privilege will be reduced by the amount of the Accelerated Benefit paid. The remaining life insurance amount will be paid according to the terms of the Summary of Benefits subject to any reduction and termination provisions.

Benefits paid may be taxable. Unum is not responsible for any tax or other effects of any benefit paid. As with all tax matters, you should consult your personal tax advisor to assess the impact of this benefit.

WHAT LOSSES ARE NOT COVERED UNDER YOUR PLAN?

Your plan does not cover any losses where death is caused by, contributed to by, or results from:

- suicide occurring within 24 months after your initial effective date of insurance; and
- suicide occurring within 24 months after the date any increases or additional insurance becomes effective for you.

The suicide exclusion will apply to any amounts of insurance for which you pay all or part of the premium.

The suicide exclusion also will apply to any amount that is subject to evidence of insurability requirements and Unum approves the evidence of insurability form and the amount you applied for at that time.

LIFE INSURANCE

OTHER BENEFIT FEATURES

WHAT IF YOU ARE NOT IN ACTIVE EMPLOYMENT WHEN YOUR EMPLOYER CHANGES GROUP INSURANCE CARRIERS TO UNUM? (CONTINUITY OF COVERAGE)

Unum will provide coverage for you if you were covered by the prior policy on the day before the effective date of this Summary of Benefits, and if you would be eligible for coverage under this Summary of Benefits if you were in active employment on the effective date of this Summary of Benefits.

If you are on a covered layoff or leave of absence on the effective date of this Summary of Benefits, we will consider your layoff or leave of absence to have started on that date, and coverage for you under this provision will continue for the layoff or leave of absence period provided in this Summary of Benefits, or the layoff or leave of absence period remaining under the prior policy on the effective date of this Summary of Benefits, whichever period is shorter.

If you are absent from work due to injury or sickness on the effective date of this Summary of Benefits, then coverage under this provision will continue until the earliest of the date:

- you are no longer injured or sick,
- you return to active employment,
- you are approved for a disability extension of benefits or accrued liability under the prior policy, including premium waiver, or
- your employment ends.

Also, if you incur a covered loss but are not in active employment under this Summary of Benefits, any benefits payable under this Summary of Benefits will be limited to the amount that would have been paid by the prior carrier. Unum will reduce your payment by any amount for which the prior carrier is liable.

Coverage for you is subject to payment of required premium and all other terms of this Summary of Benefits, except that the portable insurance coverage terms of this Summary of Benefits will not apply to coverage provided under this provision.

WHAT COVERAGE IS AVAILABLE IF YOU END EMPLOYMENT OR YOU WORK REDUCED HOURS? (Portability)

If your employment ends with or you retire from your Employer or you are working less than the minimum number of hours as described under Eligible Groups in this plan, you may elect portable coverage for yourself.

PORTABLE INSURANCE COVERAGE AND AMOUNTS AVAILABLE

The portable insurance coverage will be the current coverage and amounts that you are insured for under your Employer's group plan.

However, the amount of portable coverage for you will not be more than:

- the highest amount of life insurance available for employees under the plan; or

- 5x your annual earnings; or
- $750,000 from all Unum group life and accidental death and dismemberment plans combined,

whichever is less.

The amount of ported life insurance must be equal to or greater than the amount of ported accidental death and dismemberment insurance.

The minimum amount of coverage that can be ported is $5,000. If the current amounts under the plan are less than $5,000, you may port the lesser amounts.

Your amount of life insurance will reduce or cease at any time it would reduce or cease for your eligible group if you had continued in active employment with your Employer.

APPLYING FOR PORTABLE COVERAGE

You must apply for portable coverage for yourself and pay the first premium within 31 days after the date:

- your coverage ends or you retire from your Employer; or
- you begin working less than the minimum number of hours as described under Eligible Groups in this plan.

You are not eligible to apply for portable coverage for yourself if:

- you have an **injury** or **sickness**, under the terms of this plan, which has a material effect on life expectancy;
- the policy is cancelled (the Policy is the group policy issued to the Trustees of the Select Group Insurance Trust in which your Employer participates); or
- you failed to pay the required premium under the terms of this plan.

If we determine that because of an injury or sickness, which has a material effect on life expectancy, you were not eligible for portability at the time you elected portable coverage, the benefit will be adjusted to the amount of whole life coverage the premium would have purchased under the Conversion Privilege.

APPLYING FOR INCREASES OR DECREASES IN PORTABLE COVERAGE

You may increase or decrease the amount of life insurance coverage. The minimum and maximum benefit amounts are shown above. However, the amount of life insurance coverage cannot be decreased below $5,000. All increases are subject to evidence of insurability. Portable coverage will reduce at the ages and amounts shown in the LIFE INSURANCE **"BENEFITS AT A GLANCE"** page.

WHEN PORTABLE COVERAGE ENDS

Portable coverage for you will end for the following reasons:

- the date you fail to pay any required premium; or
- the date the policy is cancelled (the Policy is the group policy issued to the Trustees of the Select Group Insurance Trust in which your Employer participates).

If portable coverage ends due to failure to pay required premium, portable coverage cannot be reinstated.

PREMIUM RATE CHANGES FOR PORTABLE COVERAGE

Unum may change premium rates for portable coverage at any time for reasons which affect the risk assumed, including those reasons shown below:

- changes occur in the coverage levels;
- changes occur in the overall use of benefits by all insureds;
- changes occur in other risk factors; or
- a new law or a change in any existing law is enacted which applies to portable coverage.

The change in premium rates will be made on a class basis according to Unum's underwriting risk studies. Unum will notify the insured in writing at least 31 days before a premium rate is changed.

APPLYING FOR CONVERSION, IF PORTABLE COVERAGE ENDS OR IS NOT AVAILABLE

If you are not eligible to apply for portable coverage or portable coverage ends, then you may qualify for conversion coverage. Refer to Conversion Privilege under this plan.

Ask your Employer for a conversion application form which includes cost information.

When you complete the application, send it with the first premium amount to:

Unum - Conversion Unit
2211 Congress Street
Portland, Maine 04122-1350
1-800-343-5406

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

BENEFIT INFORMATION

WHEN WILL YOUR BENEFICIARY RECEIVE PAYMENT IN THE EVENT OF YOUR DEATH IF YOUR DEATH IS THE DIRECT RESULT OF AN ACCIDENT?

Your beneficiary(ies) will receive payment when Unum approves your death claim providing you meet certain conditions.

WHAT DOCUMENTS ARE REQUIRED FOR PROOF OF ACCIDENTAL DEATH?

Unum will require a certified copy of the death certificate, enrollment documents and a Notice and Proof of Claim form.

WHEN WILL YOU RECEIVE PAYMENT IN THE EVENT OF CERTAIN OTHER COVERED LOSSES IF THE LOSS IS THE DIRECT RESULT OF AN ACCIDENT?

You will receive payment when Unum approves the claim.

HOW MUCH WILL UNUM PAY YOUR BENEFICIARY IN THE EVENT OF YOUR ACCIDENTAL DEATH OR YOU FOR CERTAIN OTHER COVERED LOSSES?

If Unum approves the claim, Unum will determine the payment according to the Covered Losses and Benefits List below. The benefit Unum will pay is listed opposite the corresponding covered loss.

The benefit will be paid only if an **accidental bodily injury** results in one or more of the covered losses listed below within 365 days from the date of the accident.

Also, the accident must occur while you are insured under the plan.

Covered Losses	**Benefit Amounts**
Life	The Full Amount
Both Hands or Both Feet or Sight of Both Eyes	The Full Amount
One Hand and One Foot	The Full Amount
One Hand and Sight of One Eye	The Full Amount
One Foot and Sight of One Eye	The Full Amount
Speech and Hearing	The Full Amount
One Hand or One Foot	One Half The Full Amount
Sight of One Eye	One Half The Full Amount

Speech or Hearing	One Half The Full Amount
Thumb and Index Finger of Same Hand	One Quarter The Full Amount

The most Unum will pay for any combination of Covered Losses from any one accident is the full amount.

The Full Amount is the amount shown in the ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE **"BENEFITS AT A GLANCE"** page.

WHAT REPATRIATION BENEFIT WILL UNUM PROVIDE?

Unum will pay an additional benefit for the preparation and transportation of your body to a mortuary chosen by you or your authorized representative. Payment will be made if, as the result of a covered accident, you suffer loss of life at least 100 miles away from your principal place of residence.

However, when combined with two or more Unum accidental death and dismemberment insurance plans, the combined overall maximum for these plans together cannot exceed the actual expenses for the preparation and transportation of your body to a mortuary.

The maximum benefit amount is shown in the ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE **"BENEFITS AT A GLANCE"** page.

WHAT SEATBELT(S) AND AIR BAG BENEFIT WILL UNUM PROVIDE?

Unum will pay you or your authorized representative an additional benefit if you sustain an accidental bodily injury which causes your death while you are driving or riding in a **Private Passenger Car**, provided:

For Seatbelt(s):

- the Private Passenger Car is equipped with seatbelt(s); and
- the seatbelt(s) were in actual use and properly fastened at the time of the covered accident; and
- the position of the seatbelt(s) are certified in the official report of the covered accident, or by the investigating officer. A copy of the police accident report must be submitted with the claim.

Also, if such certification is not available, and it is clear that you were properly wearing seatbelt(s), then we will pay the additional seatbelt benefit.

However, if such certification is not available, and it is unclear whether you were properly wearing seatbelt(s), then we will pay a fixed benefit of $1,000.

An automatic harness seatbelt will not be considered properly fastened unless a lap belt is also used.

For Air Bag:

- the Private Passenger Car is equipped with an air bag for the seat in which you are seated; and
- the seatbelt(s) must be in actual use and properly fastened at the time of the covered accident.

No benefit will be paid if you are the driver of the Private Passenger Car and do not hold a current and valid driver's license.

No benefit will be paid if Unum is able to verify that the air bag(s) had been disengaged prior to the accident.

The accident causing your death must occur while you are insured under the plan.

The maximum benefit amount is shown in the ACCIDENTAL DEATH AND DISMEMBERMENT **"BENEFITS AT A GLANCE"** page.

WHAT EDUCATION BENEFIT WILL UNUM PROVIDE FOR YOUR QUALIFIED CHILDREN?

Unum will pay your authorized representative on behalf of each of your qualified children a lump sum payment if:

- you lose your life:
  - as a result of an accidental bodily injury; and
  - within 365 days after the date of the accident causing the accidental bodily injury;
- the accident causing your accidental bodily injury occurred while you were insured under the plan;
- proof is furnished to Unum that the child is a qualified child; and
- the qualified child continues to be enrolled as a full-time student in an accredited post-secondary institution of higher learning beyond the 12th grade level.

The benefit amount per academic year, maximum benefit payments, maximum benefit amount and maximum benefit period are shown in the ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE **"BENEFITS AT A GLANCE"** page.

WHEN WILL THE EDUCATION BENEFIT END FOR EACH QUALIFIED CHILD?

The education benefit will terminate for each qualified child on the earliest of the following dates:

- the date your qualified child fails to furnish proof as required by us;
- the date your qualified child no longer qualifies as a dependent child for any reason except your death; or
- the end of the maximum benefit period.

WHAT COVERAGE FOR EXPOSURE AND DISAPPEARANCE BENEFIT WILL UNUM PROVIDE?

Unum will pay a benefit if you sustain an accidental bodily injury and are unavoidably exposed to the elements and suffer a loss.

We will presume you suffered loss of life due to an accident if:
- you are riding in a common public passenger carrier that is involved in an accident covered under the Summary of Benefits; and

- as a result of the accident, the common public passenger carrier is wrecked, sinks, is stranded, or disappears; and
- your body is not found within 1 year of the accident.

Also, the accident must occur while you are insured under the plan.

The maximum benefit amount is shown in the ACCIDENTAL DEATH AND DISMEMBERMENT **"BENEFITS AT A GLANCE"** page.

WHAT ACCIDENTAL LOSSES ARE NOT COVERED UNDER YOUR PLAN?

Your plan does not cover any accidental losses caused by, contributed to by, or resulting from:

- suicide, self destruction while sane, intentionally self-inflicted injury while sane, or self-inflicted injury while sane, or self-inflicted injury while insane.
- active participation in a riot.
- an attempt to commit or commission of a crime.
- the use of any prescription or non-prescription drug, poison, fume, or other chemical substance unless used according to the prescription or direction of your physician. This exclusion will not apply to you if the chemical substance is ethanol.
- disease of the body or diagnostic, medical or surgical treatment or mental disorder as set forth in the latest edition of the Diagnostic and Statistical Manual of Mental Disorders.
- being **intoxicated**.
- war, declared or undeclared, or any act of war.

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

OTHER BENEFIT FEATURES

WHAT IF YOU ARE NOT IN ACTIVE EMPLOYMENT WHEN YOUR EMPLOYER CHANGES GROUP INSURANCE CARRIERS TO UNUM? (CONTINUITY OF COVERAGE)

Unum will provide coverage for you if you were covered by the prior policy on the day before the effective date of this Summary of Benefits, and if you would be eligible for coverage under this Summary of Benefits if you were in active employment on the effective date of this Summary of Benefits.

If you are on a covered layoff or leave of absence on the effective date of this Summary of Benefits, we will consider your layoff or leave of absence to have started on that date, and coverage for you under this provision will continue for the layoff or leave of absence period provided in this Summary of Benefits, or the layoff or leave of absence period remaining under the prior policy on the effective date of this Summary of Benefits, whichever period is shorter.

If you are absent from work due to injury or sickness on the effective date of this Summary of Benefits, then coverage under this provision will continue until the earliest of the date:

- you are no longer injured or sick,
- you return to active employment,
- you are approved for a disability extension of benefits or accrued liability under the prior policy, including premium waiver, or
- your employment ends.

Also, if you incur a covered loss but are not in active employment under this Summary of Benefits, any benefits payable under this Summary of Benefits will be limited to the amount that would have been paid by the prior carrier. Unum will reduce your payment by any amount for which the prior carrier is liable.

Coverage for you is subject to payment of required premium and all other terms of this Summary of Benefits, except that the portable insurance coverage terms of this Summary of Benefits will not apply to coverage provided under this provision.

WHAT COVERAGE IS AVAILABLE IF YOU END EMPLOYMENT OR YOU WORK REDUCED HOURS? (Portability)

If your employment ends with or you retire from your Employer or you are working less than the minimum number of hours as described under Eligible Groups in this plan, you may elect portable coverage for yourself.

PORTABLE INSURANCE COVERAGE AND AMOUNTS AVAILABLE

The portable insurance coverage will be the current coverage and amounts that you are insured for under your Employer's group plan.

However, the amount of portable coverage for you will not be more than:

- the highest amount of accidental death and dismemberment insurance available for employees under the plan; or
- 5x your annual earnings; or
- $750,000 from all Unum group life and accidental death and dismemberment plans combined,

whichever is less.

The amount of ported life insurance must be equal to or greater than the amount of ported accidental death and dismemberment insurance.

The minimum amount of coverage that can be ported is $5,000. If the current amounts under the plan are less than $5,000, you may port the lesser amounts.

Your amount of AD&D insurance will reduce or cease at any time it would reduce or cease for your eligible group if you had continued in active employment with your Employer.

APPLYING FOR PORTABLE COVERAGE

You must apply for portable coverage for yourself and pay the first premium within 31 days after the date:

- your coverage ends or you retire from your Employer; or
- you begin working less than the minimum number of hours as described under Eligible Groups in this plan.

You are not eligible to apply for portable coverage for yourself if:

- you have an **injury** or **sickness**, under the terms of this plan, which has a material effect on life expectancy;
- the policy is cancelled (the Policy is the group policy issued to the Trustees of the Select Group Insurance Trust in which your Employer participates); or
- you failed to pay the required premium under the terms of this plan.

APPLYING FOR INCREASES OR DECREASES IN PORTABLE COVERAGE

You may increase or decrease the amount of AD&D insurance coverage. The minimum and maximum benefit amounts are shown above. However, the amount of accidental death and dismemberment insurance coverage cannot be decreased below $5,000. Portable coverage will reduce at the ages and amounts shown in the ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE **"BENEFITS AT A GLANCE"** page.

WHEN PORTABLE COVERAGE ENDS

Portable coverage for you will end for the following reasons:

- the date you fail to pay any required premium; or
- the date the policy is cancelled (the Policy is the group policy issued to the Trustees of the Select Group Insurance Trust in which your Employer participates).

If portable coverage ends due to failure to pay required premium, portable coverage cannot be reinstated.

PREMIUM RATE CHANGES FOR PORTABLE COVERAGE

Unum may change premium rates for portable coverage at any time for reasons which affect the risk assumed, including those reasons shown below:

- changes occur in the coverage levels;
- changes occur in the overall use of benefits by all insureds;
- changes occur in other risk factors; or
- a new law or a change in any existing law is enacted which applies to portable coverage.

The change in premium rates will be made on a class basis according to Unum's underwriting risk studies. Unum will notify the insured in writing at least 31 days before a premium rate is changed.

GLOSSARY

ACCIDENTAL BODILY INJURY means bodily harm caused solely by external, violent and accidental means and not contributed to by any other cause.

ACTIVE EMPLOYMENT means you are working for your Employer for earnings that are paid regularly and that you are performing the material and substantial duties of your regular occupation. You must be working at least the minimum number of hours as described under Eligible Group(s) in each plan.

Your work site must be:

- your Employer's usual place of business;
- an alternative work site at the direction of your Employer, including your home; or
- a location to which your job requires you to travel.

Normal vacation is considered active employment.
Temporary and seasonal workers are excluded from coverage.

ELIMINATION PERIOD means a period of continuous disability which must be satisfied before you are eligible to have your life premium waived by Unum.

EMPLOYEE means a person who is in active employment in the United States with the Employer.

EMPLOYER means the Employer/Applicant named in the Application For Participation in the Select Group Insurance Trust, on the first page of the Summary of Benefits and in all amendments. It includes any division, subsidiary or affiliated company named in the Summary of Benefits.

EVIDENCE OF INSURABILITY means a statement of your medical history which Unum will use to determine if you are approved for coverage. Evidence of insurability will be at Unum's expense.

GAINFUL OCCUPATION means an occupation that within 12 months of your return to work is or can be expected to provide you with an income that is at least equal to 60% of your annual earnings in effect just prior to the date your disability began.

GRACE PERIOD means the period of time following the premium due date during which premium payment may be made.

HOSPITAL OR INSTITUTION means an accredited facility licensed to provide care and treatment for the condition causing your disability.

INJURY means:

- **for purposes of Portability**, a bodily injury that is the direct result of an accident and not related to any other cause.
- **for all other purposes**, a bodily injury that is the direct result of an accident and not related to any other cause. Disability must begin while you are covered under the plan.

INSURED means any person covered under a plan.

INTOXICATED means that your blood alcohol level equals or exceeds the legal limit for operating a motor vehicle in the state where the accident occurred.

LAYOFF or **LEAVE OF ABSENCE** means you are temporarily absent from active employment for a period of time that has been agreed to in advance in writing by your Employer.

Your normal vacation time or any period of disability is not considered a temporary layoff or leave of absence.

LOSS OF A FOOT means that all of the foot is cut off at or above the ankle joint.

LOSS OF A HAND means that all four fingers are cut off at or above the knuckles joining each to the hand.

LOSS OF HEARING means the total and irrecoverable loss of hearing in both ears.

LOSS OF SIGHT means the eye is totally blind and that no sight can be restored in that eye.

LOSS OF SPEECH means the total and irrecoverable loss of speech.

LOSS OF THUMB AND INDEX FINGER means that all of the thumb and index finger are cut off at or above the joint closest to the wrist.

PAYABLE CLAIM means a claim for which Unum is liable under the terms of the Summary of Benefits.

PHYSICIAN means:

- a person performing tasks that are within the limits of his or her medical license; and
- a person who is licensed to practice medicine and prescribe and administer drugs or to perform surgery; or
- a person with a doctoral degree in Psychology (Ph.D. or Psy.D.) whose primary practice is treating patients; or
- a person who is a legally qualified medical practitioner according to the laws and regulations of the governing jurisdiction.

Unum will not recognize you, or your spouse, children, parents or siblings as a physician for a claim that you send to us.

PLAN means a line of coverage under the Summary of Benefits.

PRIVATE PASSENGER CAR means a validly registered four-wheel private passenger car (including Employer-owned cars), station wagons, jeeps, pick-up trucks, and vans that are used only as private passenger cars.

QUALIFIED CHILD is any of your unmarried dependent children under age 25 who, on the date of your death as a result of an accidental bodily injury, was either:

- enrolled as a full-time student in an accredited post-secondary institution of higher learning beyond the 12th grade level; or

- at the 12th grade level and enrolls as a full-time student in an accredited post-secondary institution of higher learning beyond the 12th grade level within 365 days following the date of your death.

Children include your own natural offspring, lawfully adopted children and stepchildren. They also include foster children and other children who are dependent on you for main support and living with you in a regular parent-child relationship. A child will be considered adopted on the date of placement in your home.

REGULAR CARE means:

- you personally visit a physician as frequently as is medically required, according to generally accepted medical standards, to effectively manage and treat your disabling condition(s); and
- you are receiving the most appropriate treatment and care which conforms with generally accepted medical standards, for your disabling condition(s) by a physician whose specialty or experience is the most appropriate for your disabling condition(s), according to generally accepted medical standards.

RETAINED ASSET ACCOUNT:

- **for Life Insurance**, is an interest bearing account established through an intermediary bank in the name of your beneficiary, as owner.
- **for Accidental Death and Dismemberment Insurance**, is an interest bearing account established through an intermediary bank in the name of you or your beneficiary, as owner.

SICKNESS means:

- **for purposes of Portability**, an illness, disease or symptoms for which a person, in the exercise of ordinary prudence, would have consulted a health care provider.
- **for all other purposes**, an illness or disease. Disability must begin while you are covered under the plan.

TRUST means the policyholder trust named on the first page of the Summary of Benefits and all amendments to the policy.

WAITING PERIOD means the continuous period of time (shown in each plan) that you must be in active employment in an eligible group before you are eligible for coverage under a plan.

WE, US and **OUR** means Unum Life Insurance Company of America.

YOU means an employee who is eligible for Unum coverage.

THE FOLLOWING NOTICES AND CHANGES TO YOUR COVERAGE ARE REQUIRED BY THE STATE OF WASHINGTON. PLEASE READ CAREFULLY.

If you have a complaint about your insurance you may contact Unum at 1-800-321-3889, or the department of insurance in your state of residence. Links to the websites of each state department of insurance can be found at www.naic.org.

Si usted tiene alguna queja acerca de su seguro puede comunicarse con Unum al 1-800-321-3889, o al departamento de seguros de su estado de residencia.
Puede encontrar enlaces a los sitios web de los departamentos de seguros de cada estado en www.naic.org.

If you are a resident of one of the states noted below, and the provisions referenced below appear in your Certificate in a form less favorable to you as an insured, they are amended as follows:

If you had group life coverage in place with your employer through another carrier when your employer changed carriers to Unum, your prior coverage may be continued under the Unum plan to the extent the laws of your resident state require such right to continue and within the design limits of the Unum plan.

Full effect will be given to your state's civil union, domestic partner and same sex marriage laws to the extent they apply to you under a group insurance policy issued in another state.

For residents of Washington

The definition for **ACTIVE EMPLOYMENT** in the **GLOSSARY** section is amended to include the following:

> A period of up to 6 months during which you are not working due to a strike, lockout or other labor dispute is considered active employment. Your employer may require you to pay premium during this period of time.

The ***WILL UNUM ACCELERATE YOUR OR YOUR DEPENDENT'S DEATH BENEFIT FOR THE PLAN IF YOU OR YOUR DEPENDENT BECOMES TERMINALLY ILL?*** **(Accelerated Benefit)** in the **Life Insurance Benefit Information** section is amended by changing the life expectancy requirement to 24 months or less, or such longer period as stated in the policy.

The ***WHAT LOSSES ARE NOT COVERED UNDER YOUR PLAN?*** provision in the **Life Insurance Benefit Information** section is amended to remove any exclusion for death caused by suicide.

Additional Claim and Appeal Information

APPLICABILITY OF ERISA

If this Summary of Benefits provides benefits under a Plan which is subject to the Employee Retirement Income Security Act of 1974 (ERISA), the following provisions apply. Whether a Plan is governed by ERISA is determined by a court, however, your Employer may have information related to ERISA applicability. If ERISA applies, the following items constitute the Plan: the additional information contained in this document, the Summary of Benefits, including your certificate of coverage, and any additional summary plan description information provided by the Plan Administrator. Benefit determinations are controlled exclusively by the Summary of Benefits, your certificate of coverage, and the information in this document.

HOW TO FILE A CLAIM

If you wish to file a claim for benefits, you should follow the claim procedures described in your insurance certificate. To complete your claim filing, Unum must receive the claim information it requests from you (or your authorized representative), your attending physician and your Employer. If you or your authorized representative has any questions about what to do, you or your authorized representative should contact Unum directly.

CLAIMS PROCEDURES

If a claim is based on death, a covered loss not based on disability or for the Education Benefit

In the event that your claim is denied, either in full or in part, Unum will notify you in writing within 90 days after your claim was filed. Under special circumstances, Unum is allowed an additional period of not more than 90 days (180 days in total) within which to notify you of its decision. If such an extension is required, you will receive a written notice from Unum indicating the reason for the delay and the date you may expect a final decision. Unum's notice of denial shall include:

- the specific reason or reasons for denial with reference to those Plan provisions on which the denial is based;
- a description of any additional material or information necessary to complete the claim and why that material or information is necessary; and
- a description of the Plan's procedures and applicable time limits for appealing the determination, including a statement of your right to bring a lawsuit under Section 502(a) of ERISA following an adverse determination from Unum on appeal.

Notice of the determination may be provided in written or electronic form. Electronic notices will be provided in a form that complies with any applicable legal requirements.

If a claim is based on your disability

Unum will give you notice of the decision no later than 45 days after the claim is filed. This time period may be extended twice by 30 days if Unum both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies you of the circumstances requiring the extension of time and the date by

which Unum expects to render a decision. If such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information, and you will be afforded at least 45 days within which to provide the specified information. If you deliver the requested information within the time specified, any 30 day extension period will begin after you have provided that information. If you fail to deliver the requested information within the time specified, Unum may decide your claim without that information.

If your claim for benefits is wholly or partially denied, the notice of adverse benefit determination under the Plan will:

- state the specific reason(s) for the determination;

- reference specific Plan provision(s) on which the determination is based;

- describe additional material or information necessary to complete the claim and why such information is necessary;

- describe Plan procedures and time limits for appealing the determination, and your right to obtain information about those procedures and the right to bring a lawsuit under Section 502(a) of ERISA following an adverse determination from Unum on appeal; and

- disclose any internal rule, guidelines, protocol or similar criterion relied on in making the adverse determination (or state that such information will be provided free of charge upon request).

Notice of the determination may be provided in written or electronic form. Electronic notices will be provided in a form that complies with any applicable legal requirements.

APPEAL PROCEDURES

If an appeal is based on death, a covered loss not based on disability or for the Education Benefit

If you or your authorized representative appeal a denied claim, it must be submitted within 90 days after you receive Unum's notice of denial. You have the right to:

- submit a request for review, in writing, to Unum;
- upon request and free of charge, reasonable access to and copies of, all relevant documents as defined by applicable U.S. Department of Labor regulations; and
- submit written comments, documents, records and other information relating to the claim to Unum.

Unum will make a full and fair review of the claim and all new information submitted whether or not presented or available at the initial determination, and may require additional documents as it deems necessary or desirable in making such a review. A final decision on the review shall be made not later than 60 days following receipt of the written request for review. If special circumstances require an extension of time for processing, you will be notified of the reasons for the extension and the date by which the Plan expects to make a decision. If an extension is required due to your failure to submit the information necessary to decide the claim, the notice of

extension will specifically describe the necessary information and the date by which you need to provide it to us. The 60-day extension of the appeal review period will begin after you have provided that information.

The final decision on review shall be furnished in writing and shall include the reasons for the decision with reference, again, to those Summary of Benefits' provisions upon which the final decision is based. It will also include a statement describing your access to documents and describing your right to bring a lawsuit under Section 502(a) of ERISA if you disagree with the determination.

Notice of the determination may be provided in written or electronic form. Electronic notices will be provided in a form that complies with any applicable legal requirements.

Unless there are special circumstances, this administrative appeal process must be completed before you begin any legal action regarding your claim.

If an appeal is based on your disability

You have 180 days from the receipt of notice of an adverse benefit determination to file an appeal. Requests for appeals should be sent to the address specified in the claim denial. A decision on review will be made not later than 45 days following receipt of the written request for review. If Unum determines that special circumstances require an extension of time for a decision on review, the review period may be extended by an additional 45 days (90 days in total). Unum will notify you in writing if an additional 45 day extension is needed.

If an extension is necessary due to your failure to submit the information necessary to decide the appeal, the notice of extension will specifically describe the required information, and you will be afforded at least 45 days to provide the specified information. If you deliver the requested information within the time specified, the 45 day extension of the appeal period will begin after you have provided that information. If you fail to deliver the requested information within the time specified, Unum may decide your appeal without that information.

You will have the opportunity to submit written comments, documents, or other information in support of your appeal. You will have access to all relevant documents as defined by applicable U.S. Department of Labor regulations. The review of the adverse benefit determination will take into account all new information, whether or not presented or available at the initial determination. No deference will be afforded to the initial determination.

The review will be conducted by Unum and will be made by a person different from the person who made the initial determination and such person will not be the original decision maker's subordinate. In the case of a claim denied on the grounds of a medical judgment, Unum will consult with a health professional with appropriate training and experience. The health care professional who is consulted on appeal will not be the individual who was consulted during the initial determination or a subordinate. If the advice of a medical or vocational expert was obtained by the Plan in connection with the denial of your claim, Unum will provide you with the names of each such expert, regardless of whether the advice was relied upon.

A notice that your request on appeal is denied will contain the following information:

- the specific reason(s) for the determination;

- a reference to the specific Plan provision(s) on which the determination is based;

- a statement disclosing any internal rule, guidelines, protocol or similar criterion relied on in making the adverse determination (or a statement that such information will be provided free of charge upon request);

- a statement describing your right to bring a lawsuit under Section 502(a) of ERISA if you disagree with the decision;

- the statement that you are entitled to receive upon request, and without charge, reasonable access to or copies of all documents, records or other information relevant to the determination; and

- the statement that "You or your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency".

Notice of the determination may be provided in written or electronic form. Electronic notices will be provided in a form that complies with any applicable legal requirements.

Unless there are special circumstances, this administrative appeal process must be completed before you begin any legal action regarding your claim.

BULLOCK PEN WATER DISTRICT

FLEXIBLE SPENDING BENEFITS PLAN

PLAN DOCUMENT

FLEXIBLE SPENDING BENEFITS PLAN

TABLE OF CONTENTS

ARTICLE I
DEFINITIONS

ARTICLE II
PARTICIPATION

2.1 ELIGIBILITY 3
2.2 EFFECTIVE DATE OF PARTICIPATION 3
2.3 APPLICATION TO PARTICIPATE 3
2.4 TERMINATION OF PARTICIPATION 3
2.5 TERMINATION OF EMPLOYMENT 3
2.6 DEATH 4

ARTICLE III
CONTRIBUTIONS TO THE PLAN

3.1 SALARY REDIRECTION 4
3.2 APPLICATION OF CONTRIBUTIONS 4
3.3 PERIODIC CONTRIBUTIONS 4

ARTICLE IV
BENEFITS

4.1 BENEFIT OPTIONS 4
4.2 HEALTH FLEXIBLE SPENDING ACCOUNT BENEFIT 5
4.3 DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT BENEFIT 5
4.4 HEALTH INSURANCE BENEFIT 5
4.5 CANCER INSURANCE BENEFIT 5
4.6 OTHER INSURANCE BENEFIT 5
4.7 NONDISCRIMINATION REQUIREMENTS 5

ARTICLE V
PARTICIPANT ELECTIONS

5.1 INITIAL ELECTIONS 6
5.2 SUBSEQUENT ANNUAL ELECTIONS 6
5.3 FAILURE TO ELECT 6
5.4 CHANGE IN STATUS 6

ARTICLE VI
HEALTH FLEXIBLE SPENDING ACCOUNT

6.1 ESTABLISHMENT OF PLAN 8
6.2 DEFINITIONS 9
6.3 FORFEITURES 9
6.4 LIMITATION ON ALLOCATIONS 9
6.5 NONDISCRIMINATION REQUIREMENTS 10
6.6 COORDINATION WITH CAFETERIA PLAN 10
6.7 HEALTH FLEXIBLE SPENDING ACCOUNT CLAIMS 10
6.8 DEBIT AND CREDIT CARDS 11

ARTICLE VII
DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

7.1 ESTABLISHMENT OF ACCOUNT 12
7.2 DEFINITIONS 12
7.3 DEPENDENT CARE FLEXIBLE SPENDING ACCOUNTS 13
7.4 INCREASES IN DEPENDENT CARE FLEXIBLE SPENDING ACCOUNTS 13
7.5 DECREASES IN DEPENDENT CARE FLEXIBLE SPENDING ACCOUNTS 13
7.6 ALLOWABLE DEPENDENT CARE REIMBURSEMENT 13
7.7 ANNUAL STATEMENT OF BENEFITS 13
7.8 FORFEITURES 13
7.9 LIMITATION ON PAYMENTS 13
7.10 NONDISCRIMINATION REQUIREMENTS 13
7.11 COORDINATION WITH CAFETERIA PLAN 14
7.12 DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT CLAIMS 14

ARTICLE VIII
BENEFITS AND RIGHTS

8.1 CLAIM FOR BENEFITS 15
8.2 APPLICATION OF BENEFIT PLAN SURPLUS 15

ARTICLE IX
ADMINISTRATION

9.1 PLAN ADMINISTRATION 16
9.2 EXAMINATION OF RECORDS 17
9.3 PAYMENT OF EXPENSES 17
9.4 INSURANCE CONTROL CLAUSE 17
9.5 INDEMNIFICATION OF ADMINISTRATOR 17

ARTICLE X
AMENDMENT OR TERMINATION OF PLAN

10.1 AMENDMENT 17
10.2 TERMINATION 17

ARTICLE XI
MISCELLANEOUS

11.1 PLAN INTERPRETATION 18
11.2 GENDER AND NUMBER 18
11.3 WRITTEN DOCUMENT 18
11.4 EXCLUSIVE BENEFIT 18
11.5 PARTICIPANT'S RIGHTS 18
11.6 ACTION BY THE EMPLOYER 18
11.7 EMPLOYER'S PROTECTIVE CLAUSES 18
11.8 NO GUARANTEE OF TAX CONSEQUENCES 18
11.9 INDEMNIFICATION OF EMPLOYER BY PARTICIPANTS 18
11.10 FUNDING 19
11.11 GOVERNING LAW 19

11.12 SEVERABILITY 19
11.13 CAPTIONS 19
11.14 FAMILY AND MEDICAL LEAVE ACT (FMLA) 19
11.15 HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) 19
11.16 UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA) 19
11.17 COMPLIANCE WITH HIPAA PRIVACY STANDARDS 19
11.18 COMPLIANCE WITH HIPAA ELECTRONIC SECURITY STANDARDS 21
11.19 MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT 21
11.20 GENETIC INFORMATION NONDISCRIMINATION ACT (GINA) 21
11.21 WOMEN'S HEALTH AND CANCER RIGHTS ACT 21
11.22 NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT 21

FLEXIBLE SPENDING BENEFITS PLAN

INTRODUCTION

The Employer has amended this Plan effective 01/01/2021, to recognize the contribution made to the Employer by its Employees. Its purpose is to reward them by providing benefits for those Employees who shall qualify hereunder and their Dependents and beneficiaries. The concept of this Plan is to allow Employees to choose among different types of benefits based on their own particular goals, desires and needs. This Plan is a restatement of a Plan which was originally effective on 1/1/2014. The Plan shall be known as Flexible Spending Benefits Plan (the "Plan").

The intention of the Employer is that the Plan qualify as a "Cafeteria Plan" within the meaning of Section 125 of the Internal Revenue Code of 1986, as amended, and that the benefits which an Employee elects to receive under the Plan be excludable from the Employee's income under Section 125(a) and other applicable sections of the Internal Revenue Code of 1986, as amended.

ARTICLE I
DEFINITIONS

1.1 **"Administrator"** means the Employer unless another person or entity has been designated by the Employer pursuant to Section 9.1 to administer the Plan on behalf of the Employer. If the Employer is the Administrator, the Employer may appoint any person, including, but not limited to, the Employees of the Employer, to perform the duties of the Administrator. Any person so appointed shall signify acceptance by filing written acceptance with the Employer. Upon the resignation or removal of any individual performing the duties of the Administrator, the Employer may designate a successor.

1.2 **"Affiliated Employer"** means the Employer and any corporation which is a member of a controlled group of corporations (as defined in Code Section 414(b)) which includes the Employer; any trade or business (whether or not incorporated) which is under common control (as defined in Code Section 414(c)) with the Employer; any organization (whether or not incorporated) which is a member of an affiliated service group (as defined in Code Section 414(m)) which includes the Employer; and any other entity required to be aggregated with the Employer pursuant to Treasury regulations under Code Section 414(o).

1.3 **"Benefit"** or **"Benefit Options"** means any of the optional benefit choices available to a Participant as outlined in Section 4.1.

1.4 **"Cafeteria Plan Benefit Dollars"** means the amount available to Participants to purchase Benefit Options as provided under Section 4.1. Each dollar contributed to this Plan shall be converted into one Cafeteria Plan Benefit Dollar.

1.5 **"Code"** means the Internal Revenue Code of 1986, as amended or replaced from time to time.

1.6 **"Compensation"** means the amounts received by the Participant from the Employer during a Plan Year.

1.7 **"Dependent"** means any individual who qualifies as a dependent under an Insurance Contract for purposes of coverage under that Contract only or under Code Section 152 (as modified by Code Section 105(b)).

"Dependent" shall include any Child of a Participant who is covered under an Insurance Contract, as defined in the Contract, or under the Health Flexible Spending Account or as allowed by reason of the Affordable Care Act.

For purposes of the Health Flexible Spending Account, a Participant's "Child" includes his/her natural child, stepchild, foster child, adopted child, or a child placed with the Participant for adoption. A Participant's Child will be an eligible Dependent until reaching the limiting age of 26, without regard to student status, marital status, financial dependency or residency status with the Employee or any other person. When the child reaches the applicable limiting age, coverage will end at the end of the calendar year.

The phrase "placed for adoption" refers to a child whom the Participant intends to adopt, whether or not the adoption has become final, who has not attained the age of 18 as of the date of such placement for adoption. The term "placed" means the assumption and retention by such Employee of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption and the legal process must have commenced.

1.8 **"Effective Date"** means 1/1/2014.

1.9 **"Election Period"** means the period immediately preceding the beginning of each Plan Year established by the Administrator, such period to be applied on a uniform and nondiscriminatory basis for all Employees and Participants. However, an Employee's initial Election Period shall be determined pursuant to Section 5.1.

1.10 **"Eligible Employee"** means any Employee who has satisfied the provisions of Section 2.1.

An individual shall not be an "Eligible Employee" if such individual is not reported on the payroll records of the Employer as a common law employee. In particular, it is expressly intended that individuals not treated as common law employees by the Employer on its payroll records are not "Eligible Employees" and are excluded from Plan participation even if a court or administrative agency determines that such individuals are common law employees and not independent contractors.

1.11 **"Employee"** means any person who is employed by the Employer. The term Employee shall include leased employees within the meaning of Code Section 414(n)(2).

1.12 **"Employer"** means Bullock Pen Water District and any successor which shall maintain this Plan; and any predecessor which has maintained this Plan. In addition, where appropriate, the term Employer shall include any Participating, Affiliated or Adopting Employer.

1.13 **"Insurance Contract"** means any contract issued by an Insurer underwriting a Benefit.

1.14 **"Insurance Premium Payment Plan"** means the plan of benefits contained in Section 4.1 of this Plan, which provides for the payment of Premium Expenses.

1.15 **"Insurer"** means any insurance company that underwrites a Benefit under this Plan.

1.16 **"Key Employee"** means an Employee described in Code Section 416(i)(1) and the Treasury regulations thereunder.

1.17 **"Participant"** means any Eligible Employee who elects to become a Participant pursuant to Section 2.3 and has not for any reason become ineligible to participate further in the Plan.

1.18 **"Plan"** means this instrument, including all amendments thereto.

1.19 **"Plan Year"** means the 12-month period beginning 1/1 and ending 12/31. The Plan Year shall be the coverage period for the Benefits provided for under this Plan. In the event a Participant commences participation during a Plan Year, then the initial coverage period shall be that portion of the Plan Year commencing on such Participant's date of entry and ending on the last day of such Plan Year.

1.20 **"Premium Expenses"** or **"Premiums"** mean the Participant's cost for the Benefits described in Section 4.1.

1.21 **"Premium Expense Reimbursement Account"** means the account established for a Participant pursuant to this Plan to which part of his Cafeteria Plan Benefit Dollars may be allocated and from which Premiums of the Participant may be paid or reimbursed. If more than one type of insured Benefit is elected, sub-accounts shall be established for each type of insured Benefit.

1.22 **"Salary Redirection"** means the contributions made by the Employer on behalf of Participants pursuant to Section 3.1. These contributions shall be converted to Cafeteria Plan Benefit Dollars and allocated to the funds or accounts established under the Plan pursuant to the Participants' elections made under Article V.

1.23 **"Salary Redirection Agreement"** means an agreement between the Participant and the Employer under which the Participant agrees to reduce his Compensation or to forego all or part of the increases in such Compensation and to have such amounts contributed by the Employer to the Plan on the Participant's behalf. The Salary Redirection Agreement shall apply only to Compensation that has not been actually or constructively received by the Participant as of the date of the agreement (after taking this Plan and Code Section 125 into account) and, subsequently does not become currently available to the Participant.

1.24 **"Spouse"** means spouse as determined under Federal law.

ARTICLE II
PARTICIPATION

2.1 ELIGIBILITY

Any Eligible Employee shall be eligible to participate hereunder as of the date he satisfies the eligibility conditions for the Employer's group medical plan, the provisions of which are specifically incorporated herein by reference. However, any Eligible Employee who was a Participant in the Plan on the effective date of this amendment shall continue to be eligible to participate in the Plan.

2.2 EFFECTIVE DATE OF PARTICIPATION

An Eligible Employee shall become a Participant effective as of the entry date under the Employer's group medical plan, the provisions of which are specifically incorporated herein by reference.

2.3 APPLICATION TO PARTICIPATE

An Employee who is eligible to participate in this Plan shall, during the applicable Election Period, complete an application to participate in a manner set forth by the Administrator. The election shall be irrevocable until the end of the applicable Plan Year unless the Participant is entitled to change his Benefit elections pursuant to Section 5.4 hereof.

An Eligible Employee shall also be required to complete a Salary Redirection Agreement during the Election Period for the Plan Year during which he wishes to participate in this Plan. Any such Salary Redirection Agreement shall be effective for the first pay period beginning on or after the Employee's effective date of participation pursuant to Section 2.2.

2.4 TERMINATION OF PARTICIPATION

A Participant shall no longer participate in this Plan upon the occurrence of any of the following events:

(a) **Termination of employment.** The Participant's termination of employment, subject to the provisions of Section 2.5;

(b) **Death.** The Participant's death, subject to the provisions of Section 2.6; or

(c) **Termination of the plan.** The termination of this Plan, subject to the provisions of Section 10.2.

2.5 TERMINATION OF EMPLOYMENT

If a Participant's employment with the Employer is terminated for any reason other than death, his participation in the Benefit Options provided under Section 4.1 shall be governed in accordance with the following:

(a) **Insurance Benefit.** With regard to Benefits which are insured, the Participant's participation in the Plan shall cease, subject to the Participant's right to continue coverage under any Insurance Contract for which premiums have already been paid.

(b) **Dependent Care FSA.** With regard to the Dependent Care Flexible Spending Account, the Participant's participation in the Plan shall cease and no further Salary Redirection contributions shall be made. However, such Participant may submit claims for employment related Dependent Care Expense reimbursements for claims incurred up to the date of termination and submitted within 90 days after termination, based on the level of the Participant's Dependent Care Flexible Spending Account as of the date of termination.

(c) **Health FSA.** With regard to the Health Flexible Spending Account, the Participant's participation in the Plan shall cease and no further Salary Redirection contributions shall be made. However, such Participant may submit claims for expenses that were incurred during the portion of the Plan Year before the end of the period for which payments to the Health Flexible Spending Account have already been made for claims incurred up to the date of termination and submitted within 90 days after termination.

(d) **Health FSA treatment.** In the event a Participant terminates his participation in the Health Flexible Spending Account during the Plan Year, if Salary Redirections are made other than on a pro rata basis, upon termination the Participant shall be entitled to a reimbursement for any Salary Redirection previously paid for coverage or benefits relating to the period after the date of the Participant's separation from service regardless of the Participant's claims or reimbursements as of such date.

2.6 DEATH

If a Participant dies, his participation in the Plan shall cease. However, such Participant's spouse or Dependents may submit claims for expenses or benefits for the remainder of the Plan Year or until the Cafeteria Plan Benefit Dollars allocated to each specific benefit are exhausted. In no event may reimbursements be paid to someone who is not a spouse or Dependent.

ARTICLE III
CONTRIBUTIONS TO THE PLAN

3.1 SALARY REDIRECTION

Benefits under the Plan shall be financed by Salary Redirections sufficient to support Benefits that a Participant has elected hereunder and to pay the Participant's Premium Expenses. The salary administration program of the Employer shall be revised to allow each Participant to agree to reduce his pay during a Plan Year by an amount determined necessary to purchase the elected Benefit Options. The amount of such Salary Redirection shall be specified in the Salary Redirection Agreement and shall be applicable for a Plan Year. Notwithstanding the above, for new Participants, the Salary Redirection Agreement shall only be applicable from the first day of the pay period following the Employee's entry date up to and including the last day of the Plan Year. These contributions shall be converted to Cafeteria Plan Benefit Dollars and allocated to the funds or accounts established under the Plan pursuant to the Participants' elections made under Article IV.

Any Salary Redirection shall be determined prior to the beginning of a Plan Year (subject to initial elections pursuant to Section 5.1) and prior to the end of the Election Period and shall be irrevocable for such Plan Year. However, a Participant may revoke a Benefit election or a Salary Redirection Agreement after the Plan Year has commenced and make a new election with respect to the remainder of the Plan Year, if both the revocation and the new election are on account of and consistent with a change in status and such other permitted events as determined under Article V of the Plan and consistent with the rules and regulations of the Department of the Treasury. Salary Redirection amounts shall be contributed on a pro rata basis for each pay period during the Plan Year. All individual Salary Redirection Agreements are deemed to be part of this Plan and incorporated by reference hereunder.

3.2 APPLICATION OF CONTRIBUTIONS

As soon as reasonably practical after each payroll period, the Employer shall apply the Salary Redirection to provide the Benefits elected by the affected Participants. Any contribution made or withheld for the Health Flexible Spending Account or Dependent Care Flexible Spending Account shall be credited to such fund or account. Amounts designated for the Participant's Premium Expense Reimbursement Account shall likewise be credited to such account for the purpose of paying Premium Expenses.

3.3 PERIODIC CONTRIBUTIONS

Notwithstanding the requirement provided above and in other Articles of this Plan that Salary Redirections be contributed to the Plan by the Employer on behalf of an Employee on a level and pro rata basis for each payroll period, the Employer and Administrator may implement a procedure in which Salary Redirections are contributed throughout the Plan Year on a periodic basis that is not pro rata for each payroll period. However, with regard to the Health Flexible Spending Account, the payment schedule for the required contributions may not be based on the rate or amount of reimbursements during the Plan Year. In the event Salary Redirections to the Health Flexible Spending Account are not made on a pro rata basis, upon termination of participation, a Participant may be entitled to a refund of such Salary Redirections pursuant to Section 2.5.

ARTICLE IV
BENEFITS

4.1 BENEFIT OPTIONS

Each Participant may elect any one or more of the following optional Benefits:

(1) Health Flexible Spending Account

(2) Dependent Care Flexible Spending Account

(3) Insurance Premium Payment Plan

(i) Health Insurance Benefit

(ii) Cancer Insurance Benefit

(iii) Other Insurance Benefit

4.2 HEALTH FLEXIBLE SPENDING ACCOUNT BENEFIT

Each Participant may elect to participate in the Health Flexible Spending Account option, in which case Article VI shall apply.

4.3 DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT BENEFIT

Each Participant may elect to participate in the Dependent Care Flexible Spending Account option, in which case Article VII shall apply.

4.4 HEALTH INSURANCE BENEFIT

(a) **Coverage for Participant and Dependents.** Each Participant may elect to be covered under a health Insurance Contract for the Participant, his or her Spouse, and his or her Dependents.

(b) **Employer selects contracts.** The Employer may select suitable health Insurance Contracts for use in providing this health insurance benefit, which policies will provide uniform benefits for all Participants electing this Benefit.

(c) **Contract incorporated by reference.** The rights and conditions with respect to the benefits payable from such health Insurance Contract shall be determined therefrom, and such Insurance Contract shall be incorporated herein by reference.

4.5 CANCER INSURANCE BENEFIT

(a) **Coverage for Participant and/or Dependents.** Each Participant may elect to be covered under the Employer's cancer Insurance Contract. In addition, the Participant may elect either individual or family coverage.

(b) **Employer selects contracts.** The Employer may select suitable cancer Insurance Contracts for use in providing this cancer insurance benefit, which policies will provide uniform benefits for all Participants electing this Benefit.

(c) **Contract incorporated by reference.** The rights and conditions with respect to the benefits payable from such cancer Insurance Contract shall be determined therefrom, and such cancer Insurance Contract shall be incorporated herein by reference.

4.6 OTHER INSURANCE BENEFIT

(a) **Employer selects contracts.** The Employer may select additional health or other policies allowed under Code Section 125 or allow the purchase of additional health or other policies by and for Participants, which policies will provide uniform benefits for all Participants electing this Benefit.

(b) **Contract incorporated by reference.** The rights and conditions with respect to the benefits payable from any additional Insurance Contract shall be determined therefrom, and such Insurance Contract shall be incorporated herein by reference.

4.7 NONDISCRIMINATION REQUIREMENTS

(a) **Intent to be nondiscriminatory.** It is the intent of this Plan to provide benefits to a classification of employees which the Secretary of the Treasury finds not to be discriminatory in favor of the group in whose favor discrimination may not occur under Code Section 125.

(b) **25% concentration test.** It is the intent of this Plan not to provide qualified benefits as defined under Code Section 125 to Key Employees in amounts that exceed 25% of the aggregate of such Benefits provided for

all Eligible Employees under the Plan. For purposes of the preceding sentence, qualified benefits shall not include benefits which (without regard to this paragraph) are includible in gross income.

(c) **Adjustment to avoid test failure.** If the Administrator deems it necessary to avoid discrimination or possible taxation to Key Employees or a group of employees in whose favor discrimination may not occur in violation of Code Section 125, it may, but shall not be required to, reject any election or reduce contributions or non-taxable Benefits in order to assure compliance with the Code and regulations. Any act taken by the Administrator shall be carried out in a uniform and nondiscriminatory manner. With respect to any affected Participant who has had Benefits reduced pursuant to this Section, the reduction shall be made proportionately among Health Flexible Spending Account Benefits and Dependent Care Flexible Spending Account Benefits, and once all these Benefits are expended, proportionately among insured Benefits. Contributions which are not utilized to provide Benefits to any Participant by virtue of any administrative act under this paragraph shall be forfeited and deposited into the benefit plan surplus.

ARTICLE V
PARTICIPANT ELECTIONS

5.1 INITIAL ELECTIONS

An Employee who meets the eligibility requirements of Section 2.1 on the first day of, or during, a Plan Year may elect to participate in this Plan for all or the remainder of such Plan Year, provided he elects to do so on or before his effective date of participation pursuant to Section 2.2.

5.2 SUBSEQUENT ANNUAL ELECTIONS

During the Election Period prior to each subsequent Plan Year, each Participant shall be given the opportunity to elect, on an election of benefits form to be provided by the Administrator, which Benefit options he wishes to select. Any such election shall be effective for any Benefit expenses incurred during the Plan Year which follows the end of the Election Period. With regard to subsequent annual elections, the following options shall apply:

(a) A Participant or Employee who failed to initially elect to participate may elect different or new Benefits under the Plan during the Election Period;

(b) A Participant may terminate his participation in the Plan by notifying the Administrator in writing during the Election Period that he does not want to participate in the Plan for the next Plan Year, or by not electing any Benefit options;

(c) An Employee who elects not to participate for the Plan Year following the Election Period will have to wait until the next Election Period before again electing to participate in the Plan, except as provided for in Section 5.4.

5.3 FAILURE TO ELECT

Any Participant failing to complete an election of benefits form pursuant to Section 5.2 by the end of the applicable Election Period shall be deemed to have elected not to participate in the Plan for the upcoming Plan Year. No further Salary Redirections shall therefore be authorized for such subsequent Plan Year.

5.4 CHANGE IN STATUS

(a) **Change in status defined.** Any Participant may change a Benefit election after the Plan Year (to which such election relates) has commenced and make new elections with respect to the remainder of such Plan Year if, under the facts and circumstances, the changes are necessitated by and are consistent with a change in status which is acceptable under rules and regulations adopted by the Department of the Treasury, the provisions of which are incorporated by reference. Notwithstanding anything herein to the contrary, if the rules and regulations conflict, then such rules and regulations shall control.

In general, a change in election is not consistent if the change in status is the Participant's divorce, annulment or legal separation from a Spouse, the death of a Spouse or Dependent, or a Dependent ceasing to satisfy the eligibility requirements for coverage, and the Participant's election under the Plan is to cancel accident or health insurance coverage for any individual other than the one involved in such event. In addition, if the Participant, Spouse or Dependent gains or loses eligibility for coverage, then a Participant's election under the Plan to cease or decrease coverage for that individual

under the Plan corresponds with that change in status only if coverage for that individual becomes applicable or is increased under the family member plan.

Regardless of the consistency requirement, if the individual, the individual's Spouse, or Dependent becomes eligible for continuation coverage under the Employer's group health plan as provided in Code Section 4980B or any similar state law, then the individual may elect to increase payments under this Plan in order to pay for the continuation coverage. However, this does not apply for COBRA eligibility due to divorce, annulment or legal separation.

Any new election shall be effective at such time as the Administrator shall prescribe, but not earlier than the first pay period beginning after the election form is completed and returned to the Administrator. For the purposes of this subsection, a change in status shall only include the following events or other events permitted by Treasury regulations:

(1) Legal Marital Status: events that change a Participant's legal marital status, including marriage, divorce, death of a Spouse, legal separation or annulment;

(2) Number of Dependents: Events that change a Participant's number of Dependents, including birth, adoption, placement for adoption, or death of a Dependent;

(3) Employment Status: Any of the following events that change the employment status of the Participant, Spouse, or Dependent: termination or commencement of employment, a strike or lockout, commencement or return from an unpaid leave of absence, or a change in worksite. In addition, if the eligibility conditions of this Plan or other employee benefit plan of the Employer of the Participant, Spouse, or Dependent depend on the employment status of that individual and there is a change in that individual's employment status with the consequence that the individual becomes (or ceases to be) eligible under the plan, then that change constitutes a change in employment under this subsection;

(4) Dependent satisfies or ceases to satisfy the eligibility requirements: An event that causes the Participant's Dependent to satisfy or cease to satisfy the requirements for coverage due to attainment of age, student status, or any similar circumstance; and

(5) Residency: A change in the place of residence of the Participant, Spouse or Dependent, that would lead to a change in status (such as a loss of HMO coverage).

For the Dependent Care Flexible Spending Account, a Dependent becoming or ceasing to be a "Qualifying Dependent" as defined under Code Section 21(b) shall also qualify as a change in status.

Notwithstanding anything in this Section to the contrary, the gain of eligibility or change in eligibility of a child, as allowed under Code Sections 105(b) and 106, and guidance thereunder, shall qualify as a change in status.

(b) **Special enrollment rights.** Notwithstanding subsection (a), the Participants may change an election for group health coverage during a Plan Year and make a new election that corresponds with the special enrollment rights provided in Code Section 9801(f), including those authorized under the provisions of the Children's Health Insurance Program Reauthorization Act of 2009 (SCHIP); provided that such Participant meets the sixty (60) day notice requirement imposed by Code Section 9801(f) (or such longer period as may be permitted by the Plan and communicated to Participants). Such change shall take place on a prospective basis, unless otherwise required by Code Section 9801(f) to be retroactive.

(c) **Qualified Medical Support Order.** Notwithstanding subsection (a), in the event of a judgment, decree, or order (including approval of a property settlement) ("order") resulting from a divorce, legal separation, annulment, or change in legal custody which requires accident or health coverage for a Participant's child (including a foster child who is a Dependent of the Participant):

(1) The Plan may change an election to provide coverage for the child if the order requires coverage under the Participant's plan; or

(2) The Participant shall be permitted to change an election to cancel coverage for the child if the order requires the former Spouse to provide coverage for such child, under that individual's plan and such coverage is actually provided.

(d) **Medicare or Medicaid.** Notwithstanding subsection (a), a Participant may change elections to cancel accident or health coverage for the Participant or the Participant's Spouse or Dependent if the Participant or the Participant's Spouse or Dependent is enrolled in the accident or health coverage of the Employer and becomes entitled to

coverage (i.e., enrolled) under Part A or Part B of the Title XVIII of the Social Security Act (Medicare) or Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under Section 1928 of the Social Security Act (the program for distribution of pediatric vaccines). If the Participant or the Participant's Spouse or Dependent who has been entitled to Medicaid or Medicare coverage loses eligibility, that individual may prospectively elect coverage under the Plan if a benefit package option under the Plan provides similar coverage.

(e) **Cost increase or decrease.** If the cost of a Benefit provided under the Plan increases or decreases during a Plan Year, then the Plan shall automatically increase or decrease, as the case may be, the Salary Redirections of all affected Participants for such Benefit. Alternatively, if the cost of a benefit package option increases significantly, the Administrator shall permit the affected Participants to either make corresponding changes in their payments or revoke their elections and, in lieu thereof, receive on a prospective basis coverage under another benefit package option with similar coverage, or drop coverage prospectively if there is no benefit package option with similar coverage.

A cost increase or decrease refers to an increase or decrease in the amount of elective contributions under the Plan, whether resulting from an action taken by the Participants or an action taken by the Employer.

(f) **Loss of coverage.** If the coverage under a Benefit is significantly curtailed or ceases during a Plan Year, affected Participants may revoke their elections of such Benefit and, in lieu thereof, elect to receive on a prospective basis coverage under another plan with similar coverage, or drop coverage prospectively if no similar coverage is offered.

(g) **Addition of a new benefit.** If, during the period of coverage, a new benefit package option or other coverage option is added, an existing benefit package option is significantly improved, or an existing benefit package option or other coverage option is eliminated, then the affected Participants may elect the newly-added option, or elect another option if an option has been eliminated prospectively and make corresponding election changes with respect to other benefit package options providing similar coverage. In addition, those Eligible Employees who are not participating in the Plan may opt to become Participants and elect the new or newly improved benefit package option.

(h) **Loss of coverage under certain other plans.** A Participant may make a prospective election change to add group health coverage for the Participant, the Participant's Spouse or Dependent if such individual loses group health coverage sponsored by a governmental or educational institution, including a state children's health insurance program under the Social Security Act, the Indian Health Service or a health program offered by an Indian tribal government, a state health benefits risk pool, or a foreign government group health plan.

(i) **Change of coverage due to change under certain other plans.** A Participant may make a prospective election change that is on account of and corresponds with a change made under the plan of a Spouse's, former Spouse's or Dependent's employer if (1) the cafeteria plan or other benefits plan of the Spouse's, former Spouse's or Dependent's employer permits its participants to make a change; or (2) the cafeteria plan permits participants to make an election for a period of coverage that is different from the period of coverage under the cafeteria plan of a Spouse's, former Spouse's or Dependent's employer.

(j) **Change in dependent care provider.** A Participant may make a prospective election change that is on account of and corresponds with a change by the Participant in the dependent care provider. The availability of dependent care services from a new childcare provider is similar to a new benefit package option becoming available. A cost change is allowable in the Dependent Care Flexible Spending Account only if the cost change is imposed by a dependent care provider who is not related to the Participant, as defined in Code Section 152(a)(1) through (8).

(k) **Health FSA cannot change due to insurance change.** A Participant shall not be permitted to change an election to the Health Flexible Spending Account as a result of a cost or coverage change under any health insurance benefits.

ARTICLE VI
HEALTH FLEXIBLE SPENDING ACCOUNT

6.1 ESTABLISHMENT OF PLAN

This Health Flexible Spending Account is intended to qualify as a medical reimbursement plan under Code Section 105 and shall be interpreted in a manner consistent with such Code Section and the Treasury regulations thereunder. Participants who elect to participate in this Health Flexible Spending Account may submit claims for the reimbursement of Medical Expenses. All amounts reimbursed shall be periodically paid from amounts allocated to the Health Flexible Spending Account. Periodic

payments reimbursing Participants from the Health Flexible Spending Account shall in no event occur less frequently than monthly.

6.2 DEFINITIONS

For the purposes of this Article and the Cafeteria Plan, the terms below have the following meaning:

(a) **"Health Flexible Spending Account"** means the account established for Participants pursuant to this Plan to which part of their Cafeteria Plan Benefit Dollars may be allocated and from which all allowable Medical Expenses incurred by a Participant, his or her Spouse and his or her Dependents may be reimbursed.

(b) **"Highly Compensated Participant"** means, for the purposes of this Article and determining discrimination under Code Section 105(h), a participant who is:

(1) one of the 5 highest paid officers;

(2) a shareholder who owns (or is considered to own applying the rules of Code Section 318) more than 10 percent in value of the stock of the Employer; or

(3) among the highest paid 25 percent of all Employees (other than exclusions permitted by Code Section 105(h)(3)(B) for those individuals who are not Participants).

(c) **"Medical Expenses"** means any expense for medical care within the meaning of the term "medical care" as defined in Code Section 213(d) and the rulings and Treasury regulations thereunder, and not otherwise used by the Participant as a deduction in determining his tax liability under the Code. "Medical Expenses" can be incurred by the Participant, his or her Spouse and his or her Dependents. "Incurred" means, with regard to Medical Expenses, when the Participant is provided with the medical care that gives rise to the Medical Expense and not when the Participant is formally billed or charged for, or pays for, the medical care.

A Participant may not be reimbursed for the cost of any medicine or drug that is not "prescribed" within the meaning of Code Section 106(f) or is not insulin.

A Participant may not be reimbursed for the cost of other health coverage such as premiums paid under plans maintained by the employer of the Participant's Spouse or individual policies maintained by the Participant or his Spouse or Dependent.

A Participant may not be reimbursed for "qualified long-term care services" as defined in Code Section 7702B(c).

(d) The definitions of Article I are hereby incorporated by reference to the extent necessary to interpret and apply the provisions of this Health Flexible Spending Account.

6.3 FORFEITURES

The amount in the Health Flexible Spending Account as of the end of any Plan Year (and after the processing of all claims for such Plan Year pursuant to Section 6.7 hereof, excluding any carryover) shall be forfeited and credited to the benefit plan surplus. In such event, the Participant shall have no further claim to such amount for any reason, subject to Section 8.2.

6.4 LIMITATION ON ALLOCATIONS

(a) Notwithstanding any provision contained in this Health Flexible Spending Account to the contrary, the maximum amount that may be allocated to the Health Flexible Spending Account by a Participant in or on account of any Plan Year isup to the IRS maximum.

(b) For any short Plan Year, the maximum amount that may be allocated to the Health Flexible Spending Account is prorated.

(c) **Participation in Other Plans.** All employers that are treated as a single employer under Code Sections 414(b), (c), or (m), relating to controlled groups and affiliated service groups, are treated as a single employer for purposes of the statutory limit. If a Participant participates in multiple cafeteria plans offering health flexible spending accounts maintained by members of a controlled group or affiliated service group, the Participant's total Health Flexible Spending Account contributions under all of the cafeteria plans are limited to the statutory limit (as

adjusted). However, a Participant employed by two or more employers that are not members of the same controlled group may elect up to the statutory limit (as adjusted) under each Employer's Health Flexible Spending Account.

(d) **Carryover.** A Participant in the Health Flexible Spending Account may roll over up to the Carryover IRS maximum of unused amounts in the Health Flexible Spending Account remaining at the end of one Plan Year to the immediately following Plan Year. These amounts can be used during the following Plan Year for expenses incurred in that Plan Year. Amounts carried over do not affect the maximum amount of salary redirection contributions for the Plan Year to which they are carried over. Unused amounts are those remaining after expenses have been reimbursed during the runout period. These amounts may not be cashed out or converted to any other taxable or nontaxable benefit. Amounts in excess of the Carryover IRS maximum will be forfeited. The Plan is allowed, but not required, to treat claims as being paid first from the current year amounts, then from the carryover amounts.

6.5 NONDISCRIMINATION REQUIREMENTS

(a) **Intent to be nondiscriminatory.** It is the intent of this Health Flexible Spending Account not to discriminate in violation of the Code and the Treasury regulations thereunder.

(b) **Adjustment to avoid test failure.** If the Administrator deems it necessary to avoid discrimination under this Health Flexible Spending Account, it may, but shall not be required to, reject any elections or reduce contributions or Benefits in order to assure compliance with this Section. Any act taken by the Administrator under this Section shall be carried out in a uniform and nondiscriminatory manner. If the Administrator decides to reject any elections or reduce contributions or Benefits, it shall be done in the following manner. First, the Benefits designated for the Health Flexible Spending Account by the member of the group in whose favor discrimination may not occur pursuant to Code Section 105 that elected to contribute the highest amount to the fund for the Plan Year shall be reduced until the nondiscrimination tests set forth in this Section or the Code are satisfied, or until the amount designated for the fund equals the amount designated for the fund by the next member of the group in whose favor discrimination may not occur pursuant to Code Section 105 who has elected the second highest contribution to the Health Flexible Spending Account for the Plan Year. This process shall continue until the nondiscrimination tests set forth in this Section or the Code are satisfied. Contributions which are not utilized to provide Benefits to any Participant by virtue of any administrative act under this paragraph shall be forfeited and credited to the benefit plan surplus.

6.6 COORDINATION WITH CAFETERIA PLAN

All Participants under the Cafeteria Plan are eligible to receive Benefits under this Health Flexible Spending Account. The enrollment under the Cafeteria Plan shall constitute enrollment under this Health Flexible Spending Account. In addition, other matters concerning contributions, elections and the like shall be governed by the general provisions of the Cafeteria Plan.

6.7 HEALTH FLEXIBLE SPENDING ACCOUNT CLAIMS

(a) **Expenses must be incurred during Plan Year.** All Medical Expenses incurred by a Participant, his or her Spouse and his or her Dependents during the Plan Year shall be reimbursed during the Plan Year subject to Section 2.5, even though the submission of such a claim occurs after his participation hereunder ceases; but provided that the Medical Expenses were incurred during the applicable Plan Year. Medical Expenses are treated as having been incurred when the Participant is provided with the medical care that gives rise to the medical expenses, not when the Participant is formally billed or charged for, or pays for the medical care.

(b) **Reimbursement available throughout Plan Year.** The Administrator shall direct the reimbursement to each eligible Participant for all allowable Medical Expenses, up to a maximum of the amount designated by the Participant for the Health Flexible Spending Account for the Plan Year. Reimbursements shall be made available to the Participant throughout the year without regard to the level of Cafeteria Plan Benefit Dollars which have been allocated to the fund at any given point in time. Furthermore, a Participant shall be entitled to reimbursements only for amounts in excess of any payments or other reimbursements under any health care plan covering the Participant and/or his Spouse or Dependents.

(c) **Payments.** Reimbursement payments under this Plan shall be made directly to the Participant. However, in the Administrator's discretion, payments may be made directly to the service provider. The application for payment or reimbursement shall be made to the Administrator on an acceptable form within a reasonable time of incurring the debt or paying for the service. The application shall include a written statement from an independent third party stating that the Medical Expense has been incurred and the amount of such expense. Furthermore, the Participant shall provide a written statement that the Medical Expense has not been reimbursed or is not reimbursable under any

other health plan coverage and, if reimbursed from the Health Flexible Spending Account, such amount will not be claimed as a tax deduction. The Administrator shall retain a file of all such applications.

(d) **Claims for reimbursement.** Claims for the reimbursement of Medical Expenses incurred in any Plan Year shall be paid as soon after a claim has been filed as is administratively practicable; provided however, that if a Participant fails to submit a claim within 90 days after the end of the Plan Year, those Medical Expense claims shall not be considered for reimbursement by the Administrator. However, if a Participant terminates employment during the Plan Year, claims for the reimbursement of Medical Expenses must be submitted within 90 days after termination of employment.

6.8 DEBIT AND CREDIT CARDS

Participants may, subject to a procedure established by the Administrator and applied in a uniform nondiscriminatory manner, use debit and/or credit (stored value) cards ("cards") provided by the Administrator and the Plan for payment of Medical Expenses, subject to the following terms:

(a) **Card only for medical expenses.** Each Participant issued a card shall certify that such card shall only be used for Medical Expenses. The Participant shall also certify that any Medical Expense paid with the card has not already been reimbursed by any other plan covering health benefits and that the Participant will not seek reimbursement from any other plan covering health benefits.

(b) **Card issuance.** Such card shall be issued upon the Participant's Effective Date of Participation and reissued for each Plan Year the Participant remains a Participant in the Health Flexible Spending Account. Such card shall be automatically cancelled upon the Participant's death or termination of employment, or if such Participant has a change in status that results in the Participant's withdrawal from the Health Flexible Spending Account.

(c) **Maximum dollar amount available.** The dollar amount of coverage available on the card shall be the amount elected by the Participant for the Plan Year. The maximum dollar amount of coverage available shall be the maximum amount for the Plan Year as set forth in Section 6.4.

(d) **Only available for use with certain service providers.** The cards shall only be accepted by such merchants and service providers as have been approved by the Administrator following IRS guidelines.

(e) **Card use.** The cards shall only be used for Medical Expense purchases at these providers, including, but not limited to, the following:

(1) Co-payments for doctor and other medical care;

(2) Purchase of drugs prescribed by a health care provider, including, if permitted by the Administrator, over-the-counter medications as allowed under IRS regulations;

(3) Purchase of medical items such as eyeglasses, syringes, crutches, etc.

(f) **Substantiation.** Such purchases by the cards shall be subject to substantiation by the Administrator, usually by submission of a receipt from a service provider describing the service, the date and the amount. The Administrator shall also follow the requirements set forth in Revenue Ruling 2003-43 and Notice 2006-69. All charges shall be conditional pending confirmation and substantiation.

(g) **Correction methods.** If such purchase is later determined by the Administrator to not qualify as a Medical Expense, the Administrator, in its discretion, shall use one of the following correction methods to make the Plan whole. Until the amount is repaid, the Administrator shall take further action to ensure that further violations of the terms of the card do not occur, up to and including denial of access to the card.

(1) Repayment of the improper amount by the Participant;

(2) Withholding the improper payment from the Participant's wages or other compensation to the extent consistent with applicable federal or state law;

(3) Claims substitution or offset of future claims until the amount is repaid; and

(4) if subsections (1) through (3) fail to recover the amount, consistent with the Employer's business practices, the Employer may treat the amount as any other business indebtedness.

ARTICLE VII
DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

7.1 ESTABLISHMENT OF ACCOUNT

This Dependent Care Flexible Spending Account is intended to qualify as a program under Code Section 129 and shall be interpreted in a manner consistent with such Code Section. Participants who elect to participate in this program may submit claims for the reimbursement of Employment-Related Dependent Care Expenses. All amounts reimbursed shall be paid from amounts allocated to the Participant's Dependent Care Flexible Spending Account.

7.2 DEFINITIONS

For the purposes of this Article and the Cafeteria Plan the terms below shall have the following meaning:

(a) **"Dependent Care Flexible Spending Account"** means the account established for a Participant pursuant to this Article to which part of his Cafeteria Plan Benefit Dollars may be allocated and from which Employment-Related Dependent Care Expenses of the Participant may be reimbursed for the care of the Qualifying Dependents of Participants.

(b) **"Earned Income"** means earned income as defined under Code Section 32(c)(2), but excluding such amounts paid or incurred by the Employer for dependent care assistance to the Participant.

(c) **"Employment-Related Dependent Care Expenses"** means the amounts paid for expenses of a Participant for those services which if paid by the Participant would be considered employment related expenses under Code Section 21(b)(2). Generally, they shall include expenses for household services and for the care of a Qualifying Dependent, to the extent that such expenses are incurred to enable the Participant to be gainfully employed for any period for which there are one or more Qualifying Dependents with respect to such Participant. Employment-Related Dependent Care Expenses are treated as having been incurred when the Participant's Qualifying Dependents are provided with the dependent care that gives rise to the Employment-Related Dependent Care Expenses, not when the Participant is formally billed or charged for, or pays for the dependent care. The determination of whether an amount qualifies as an Employment-Related Dependent Care Expense shall be made subject to the following rules:

(1) If such amounts are paid for expenses incurred outside the Participant's household, they shall constitute Employment-Related Dependent Care Expenses only if incurred for a Qualifying Dependent as defined in Section 7.2(d)(1) (or deemed to be, as described in Section 7.2(d)(1) pursuant to Section 7.2(d)(3)), or for a Qualifying Dependent as defined in Section 7.2(d)(2) (or deemed to be, as described in Section 7.2(d)(2) pursuant to Section 7.2(d)(3)) who regularly spends at least 8 hours per day in the Participant's household;

(2) If the expense is incurred outside the Participant's home at a facility that provides care for a fee, payment, or grant for more than 6 individuals who do not regularly reside at the facility, the facility must comply with all applicable state and local laws and regulations, including licensing requirements, if any; and

(3) Employment-Related Dependent Care Expenses of a Participant shall not include amounts paid or incurred to a child of such Participant who is under the age of 19 or to an individual who is a Dependent of such Participant or such Participant's Spouse.

(d) **"Qualifying Dependent"** means, for Dependent Care Flexible Spending Account purposes,

(1) a Participant's Dependent (as defined in Code Section 152(a)(1)) who has not attained age 13;

(2) a Dependent or the Spouse of a Participant who is physically or mentally incapable of caring for himself or herself and has the same principal place of abode as the Participant for more than one-half of such taxable year; or

(3) a child that is deemed to be a Qualifying Dependent described in paragraph (1) or (2) above, whichever is appropriate, pursuant to Code Section 21(e)(5).

(e) The definitions of Article I are hereby incorporated by reference to the extent necessary to interpret and apply the provisions of this Dependent Care Flexible Spending Account.

7.3 DEPENDENT CARE FLEXIBLE SPENDING ACCOUNTS

The Administrator shall establish a Dependent Care Flexible Spending Account for each Participant who elects to apply Cafeteria Plan Benefit Dollars to Dependent Care Flexible Spending Account benefits.

7.4 INCREASES IN DEPENDENT CARE FLEXIBLE SPENDING ACCOUNTS

A Participant's Dependent Care Flexible Spending Account shall be increased each pay period by the portion of Cafeteria Plan Benefit Dollars that he has elected to apply toward his Dependent Care Flexible Spending Account pursuant to elections made under Article V hereof.

7.5 DECREASES IN DEPENDENT CARE FLEXIBLE SPENDING ACCOUNTS

A Participant's Dependent Care Flexible Spending Account shall be reduced by the amount of any Employment-Related Dependent Care Expense reimbursements paid or incurred on behalf of a Participant pursuant to Section 7.12 hereof.

7.6 ALLOWABLE DEPENDENT CARE REIMBURSEMENT

Subject to limitations contained in Section 7.9 of this Program, and to the extent of the amount contained in the Participant's Dependent Care Flexible Spending Account, a Participant who incurs Employment-Related Dependent Care Expenses shall be entitled to receive from the Employer full reimbursement for the entire amount of such expenses incurred during the Plan Year or portion thereof during which he is a Participant.

7.7 ANNUAL STATEMENT OF BENEFITS

On or before January 31st of each calendar year, the Employer shall furnish to each Employee who was a Participant and received benefits under Section 7.6 during the prior calendar year, a statement of all such benefits paid to or on behalf of such Participant during the prior calendar year. This statement is set forth on the Participant's Form W-2.

7.8 FORFEITURES

The amount in a Participant's Dependent Care Flexible Spending Account as of the end of any Plan Year (and after the processing of all claims for such Plan Year pursuant to Section 7.12 hereof) shall be forfeited and credited to the benefit plan surplus. In such event, the Participant shall have no further claim to such amount for any reason.

7.9 LIMITATION ON PAYMENTS

(a) **Code limits.** Notwithstanding any provision contained in this Article to the contrary, amounts paid from a Participant's Dependent Care Flexible Spending Account in or on account of any taxable year of the Participant shall not exceed the lesser of the Earned Income limitation described in Code Section 129(b) or $5,000 ($2,500 if a separate tax return is filed by a Participant who is married as determined under the rules of paragraphs (3) and (4) of Code Section 21(e)).

7.10 NONDISCRIMINATION REQUIREMENTS

(a) **Intent to be nondiscriminatory.** It is the intent of this Dependent Care Flexible Spending Account that contributions or benefits not discriminate in favor of the group of employees in whose favor discrimination may not occur under Code Section 129(d).

(b) **25% test for shareholders.** It is the intent of this Dependent Care Flexible Spending Account that not more than 25 percent of the amounts paid by the Employer for dependent care assistance during the Plan Year will be provided for the class of individuals who are shareholders or owners (or their Spouses or Dependents), each of whom (on any day of the Plan Year) owns more than 5 percent of the stock or of the capital or profits interest in the Employer.

(c) **Adjustment to avoid test failure.** If the Administrator deems it necessary to avoid discrimination or possible taxation to a group of employees in whose favor discrimination may not occur in violation of Code Section 129 it may, but shall not be required to, reject any elections or reduce contributions or non-taxable benefits in order to assure compliance with this Section. Any act taken by the Administrator under this Section shall be carried out in a uniform and nondiscriminatory manner. If the Administrator decides to reject any elections or reduce contributions or

Benefits, it shall be done in the following manner. First, the Benefits designated for the Dependent Care Flexible Spending Account by the affected Participant that elected to contribute the highest amount to such account for the Plan Year shall be reduced until the nondiscrimination tests set forth in this Section are satisfied, or until the amount designated for the account equals the amount designated for the account of the affected Participant who has elected the second highest contribution to the Dependent Care Flexible Spending Account for the Plan Year. This process shall continue until the nondiscrimination tests set forth in this Section are satisfied. Contributions which are not utilized to provide Benefits to any Participant by virtue of any administrative act under this paragraph shall be forfeited.

7.11 COORDINATION WITH CAFETERIA PLAN

All Participants under the Cafeteria Plan are eligible to receive Benefits under this Dependent Care Flexible Spending Account. The enrollment and termination of participation under the Cafeteria Plan shall constitute enrollment and termination of participation under this Dependent Care Flexible Spending Account. In addition, other matters concerning contributions, elections and the like shall be governed by the general provisions of the Cafeteria Plan.

7.12 DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT CLAIMS

The Administrator shall direct the payment of all such Dependent Care claims to the Participant upon the presentation to the Administrator of documentation of such expenses in a form satisfactory to the Administrator. However, in the Administrator's discretion, payments may be made directly to the service provider. In its discretion in administering the Plan, the Administrator may utilize forms and require documentation of costs as may be necessary to verify the claims submitted. At a minimum, the form shall include a statement from an independent third party as proof that the expense has been incurred during the Plan Year and the amount of such expense. In addition, the Administrator may require that each Participant who desires to receive reimbursement under this Program for Employment-Related Dependent Care Expenses submit a statement which may contain some or all of the following information:

(a) The Dependent or Dependents for whom the services were performed;

(b) The nature of the services performed for the Participant, the cost of which he wishes reimbursement;

(c) The relationship, if any, of the person performing the services to the Participant;

(d) If the services are being performed by a child of the Participant, the age of the child;

(e) A statement as to where the services were performed;

(f) If any of the services were performed outside the home, a statement as to whether the Dependent for whom such services were performed spends at least 8 hours a day in the Participant's household;

(g) If the services were being performed in a day care center, a statement:

(1) that the day care center complies with all applicable laws and regulations of the state of residence,

(2) that the day care center provides care for more than 6 individuals (other than individuals residing at the center), and

(3) of the amount of fee paid to the provider.

(h) If the Participant is married, a statement containing the following:

(1) the Spouse's salary or wages if he or she is employed, or

(2) if the Participant's Spouse is not employed, that

(i) he or she is incapacitated, or

(ii) he or she is a full-time student attending an educational institution and the months during the year which he or she attended such institution.

(i) **Claims for reimbursement.** If a Participant fails to submit a claim within 90 days after the end of the Plan Year, those claims shall not be considered for reimbursement by the Administrator. However, if a Participant

terminates employment during the Plan Year, claims for reimbursement must be submitted within 90 days after termination of employment.

ARTICLE VIII
BENEFITS AND RIGHTS

8.1 CLAIM FOR BENEFITS

(a) **Insurance claims.** Any claim for Benefits underwritten by Insurance Contract(s) shall be made to the Insurer. If the Insurer denies any claim, the Participant or beneficiary shall follow the Insurer's claims review procedure.

(b) **Dependent Care Flexible Spending Account or Health Flexible Spending Account claims.** Any claim for Dependent Care Flexible Spending Account or Health Flexible Spending Account Benefits shall be made to the Administrator. For the Health Flexible Spending Account, if a Participant fails to submit a claim within 90 days after the end of the Plan Year, those claims shall not be considered for reimbursement by the Administrator. However, if a Participant terminates employment during the Plan Year, claims for the reimbursement of Medical Expenses must be submitted within 90 days after termination of employment. For the Dependent Care Flexible Spending Account, if a Participant fails to submit a claim within 90 days after the end of the Plan Year, those claims shall not be considered for reimbursement by the Administrator. However, if a Participant terminates employment during the Plan Year, claims for reimbursement must be submitted within 90 days after termination of employment. If the Administrator denies a claim, the Administrator may provide notice to the Participant or beneficiary, in writing, within 90 days after the claim is filed unless special circumstances require an extension of time for processing the claim. The notice of a denial of a claim shall be written in a manner calculated to be understood by the claimant and shall set forth:

(1) specific references to the pertinent Plan provisions on which the denial is based;

(2) a description of any additional material or information necessary for the claimant to perfect the claim and an explanation as to why such information is necessary; and

(3) an explanation of the Plan's claim procedure.

(c) **Appeal.** Within 180 days after receipt of the above material, the claimant shall have a reasonable opportunity to appeal the claim denial to the Administrator for a full and fair review. The claimant or his duly authorized representative may:

(1) request a review upon written notice to the Administrator;

(2) review pertinent documents; and

(3) submit issues and comments in writing.

(d) **Review of appeal.** A decision on the review by the Administrator will be made not later than 60 days after receipt of a request for review, unless special circumstances require an extension of time for processing (such as the need to hold a hearing), in which event a decision should be rendered as soon as possible, but in no event later than 120 days after such receipt. The decision of the Administrator shall be written and shall include specific reasons for the decision, written in a manner calculated to be understood by the claimant, with specific references to the pertinent Plan provisions on which the decision is based.

(e) **Forfeitures.** Any balance remaining in the Participant's Health Flexible Spending Account (excluding any carryover) or Dependent Care Flexible Spending Account as of the end of the time for claims reimbursement for each Plan Year shall be forfeited and deposited in the benefit plan surplus of the Employer pursuant to Section 6.3 or Section 7.8, whichever is applicable, unless the Participant had made a claim for such Plan Year, in writing, which has been denied or is pending; in which event the amount of the claim shall be held in his account until the claim appeal procedures set forth above have been satisfied or the claim is paid. If any such claim is denied on appeal, the amount held beyond the end of the Plan Year shall be forfeited and credited to the benefit plan surplus.

8.2 APPLICATION OF BENEFIT PLAN SURPLUS

Any forfeited amounts credited to the benefit plan surplus by virtue of the failure of a Participant to incur a qualified expense or seek reimbursement in a timely manner may, but need not be, separately accounted for after the close of the Plan Year

(or after such further time specified herein for the filing of claims) in which such forfeitures arose. In no event shall such amounts be carried over to reimburse a Participant for expenses incurred during a subsequent Plan Year for the same or any other Benefit available under the Plan (excepting any carryover); nor shall amounts forfeited by a particular Participant be made available to such Participant in any other form or manner, except as permitted by Treasury regulations. Amounts in the benefit plan surplus shall be used to defray any administrative costs and experience losses or used to provide additional benefits under the Plan.

ARTICLE IX
ADMINISTRATION

9.1 PLAN ADMINISTRATION

The Employer shall be the Administrator, unless the Employer elects otherwise. The Employer may appoint any person, including, but not limited to, the Employees of the Employer, to perform the duties of the Administrator. Any person so appointed shall signify acceptance by filing acceptance in writing (or such other form as acceptable to both parties) with the Employer. Upon the resignation or removal of any individual performing the duties of the Administrator, the Employer may designate a successor.

If the Employer elects, the Employer shall appoint one or more Administrators. Any person, including, but not limited to, the Employees of the Employer, shall be eligible to serve as an Administrator. Any person so appointed shall signify acceptance by filing acceptance in writing (or such other form as acceptable to both parties) with the Employer. An Administrator may resign by delivering a resignation in writing (or such other form as acceptable to both parties) to the Employer or be removed by the Employer by delivery of notice of removal (in writing or such other form as acceptable to both parties), to take effect at a date specified therein, or upon delivery to the Administrator if no date is specified. The Employer shall be empowered to appoint and remove the Administrator from time to time as it deems necessary for the proper administration of the Plan to ensure that the Plan is being operated for the exclusive benefit of the Employees entitled to participate in the Plan in accordance with the terms of the Plan and the Code.

The operation of the Plan shall be under the supervision of the Administrator. It shall be a principal duty of the Administrator to see that the Plan is carried out in accordance with its terms, and for the exclusive benefit of Employees entitled to participate in the Plan. The Administrator shall have full power and discretion to administer the Plan in all of its details and determine all questions arising in connection with the administration, interpretation, and application of the Plan. The Administrator may establish procedures, correct any defect, supply any information, or reconciles any inconsistency in such manner and to such extent as shall be deemed necessary or advisable to carry out the purpose of the Plan. The Administrator shall have all powers necessary or appropriate to accomplish the Administrator's duties under the Plan. The Administrator shall be charged with the duties of the general administration of the Plan as set forth under the Plan, including, but not limited to, in addition to all other powers provided by this Plan:

(a) To make and enforce such procedures, rules and regulations as the Administrator deems necessary or proper for the efficient administration of the Plan;

(b) To interpret the provisions of the Plan, the Administrator's interpretations thereof in good faith to be final and conclusive on all persons claiming benefits by operation of the Plan;

(c) To decide all questions concerning the Plan and the eligibility of any person to participate in the Plan and to receive benefits provided by operation of the Plan;

(d) To reject elections or to limit contributions or Benefits for certain highly compensated participants if it deems such to be desirable in order to avoid discrimination under the Plan in violation of applicable provisions of the Code;

(e) To provide Employees with a reasonable notification of their benefits available by operation of the Plan and to assist any Participant regarding the Participant's rights, benefits or elections under the Plan;

(f) To keep and maintain the Plan documents and all other records pertaining to and necessary for the administration of the Plan;

(g) To review and settle all claims against the Plan, to approve reimbursement requests, and to authorize the payment of benefits if the Administrator determines such shall be paid if the Administrator decides in its discretion that the applicant is entitled to them. This authority specifically permits the Administrator to settle disputed claims for benefits and any other disputed claims made against the Plan;

(h) To appoint such agents, counsel, accountants, consultants, and other persons or entities as may be required to assist in administering the Plan.

Any procedure, discretionary act, interpretation or construction taken by the Administrator shall be done in a nondiscriminatory manner based upon uniform principles consistently applied and shall be consistent with the intent that the Plan shall continue to comply with the terms of Code Section 125 and the Treasury regulations thereunder.

9.2 EXAMINATION OF RECORDS

The Administrator shall make available to each Participant, Eligible Employee and any other Employee of the Employer such records as pertain to their interest under the Plan for examination at reasonable times during normal business hours.

9.3 PAYMENT OF EXPENSES

Any reasonable administrative expenses shall be paid by the Employer unless the Employer determines that administrative costs shall be borne by the Participants under the Plan or by any Trust Fund which may be established hereunder. The Administrator may impose reasonable conditions for payments, provided that such conditions shall not discriminate in favor of highly compensated employees.

9.4 INSURANCE CONTROL CLAUSE

In the event of a conflict between the terms of this Plan and the terms of an Insurance Contract of an independent third party Insurer whose product is then being used in conjunction with this Plan, the terms of the Insurance Contract shall control as to those Participants receiving coverage under such Insurance Contract. For this purpose, the Insurance Contract shall control in defining the persons eligible for insurance, the dates of their eligibility, the conditions which must be satisfied to become insured, if any, the benefits Participants are entitled to and the circumstances under which insurance terminates.

9.5 INDEMNIFICATION OF ADMINISTRATOR

The Employer agrees to indemnify and to defend to the fullest extent permitted by law any Employee serving as the Administrator or as a member of a committee designated as Administrator (including any Employee or former Employee who previously served as Administrator or as a member of such committee) against all liabilities, damages, costs and expenses (including attorney's fees and amounts paid in settlement of any claims approved by the Employer) occasioned by any act or omission to act in connection with the Plan, if such act or omission is in good faith.

ARTICLE X
AMENDMENT OR TERMINATION OF PLAN

10.1 AMENDMENT

The Employer, at any time or from time to time, may amend any or all of the provisions of the Plan without the consent of any Employee or Participant. No amendment shall have the effect of modifying any benefit election of any Participant in effect at the time of such amendment, unless such amendment is made to comply with Federal, state or local laws, statutes or regulations.

10.2 TERMINATION

The Employer reserves the right to terminate this Plan, in whole or in part, at any time. In the event the Plan is terminated, no further contributions shall be made. Benefits under any Insurance Contract shall be paid in accordance with the terms of the Insurance Contract.

No further additions shall be made to the Health Flexible Spending Account or Dependent Care Flexible Spending Account, but all payments from such fund shall continue to be made according to the elections in effect until 90 days after the termination date of the Plan. Any amounts remaining in any such fund or account as of the end of such period shall be forfeited and deposited in the benefit plan surplus after the expiration of the filing period.

ARTICLE XI
MISCELLANEOUS

11.1 PLAN INTERPRETATION

All provisions of this Plan shall be interpreted and applied in a uniform, nondiscriminatory manner. This Plan shall be read in its entirety and not severed except as provided in Section 11.12.

11.2 GENDER AND NUMBER

Wherever any words are used herein in the masculine, feminine or neuter gender, they shall be construed as though they were also used in another gender in all cases where they would so apply, and whenever any words are used herein in the singular or plural form, they shall be construed as though they were also used in the other form in all cases where they would so apply.

11.3 WRITTEN DOCUMENT

This Plan, in conjunction with any separate written document which may be required by law, is intended to satisfy the written Plan requirement of Code Section 125 and any Treasury regulations thereunder relating to cafeteria plans.

11.4 EXCLUSIVE BENEFIT

This Plan shall be maintained for the exclusive benefit of the Employees who participate in the Plan.

11.5 PARTICIPANT'S RIGHTS

This Plan shall not be deemed to constitute an employment contract between the Employer and any Participant or to be a consideration or an inducement for the employment of any Participant or Employee. Nothing contained in this Plan shall be deemed to give any Participant or Employee the right to be retained in the service of the Employer or to interfere with the right of the Employer to discharge any Participant or Employee at any time regardless of the effect which such discharge shall have upon him as a Participant of this Plan.

11.6 ACTION BY THE EMPLOYER

Whenever the Employer under the terms of the Plan is permitted or required to do or perform any act or matter or thing, it shall be done and performed by a person duly authorized by its legally constituted authority.

11.7 EMPLOYER'S PROTECTIVE CLAUSES

(a) **Insurance purchase.** Upon the failure of either the Participant or the Employer to obtain the insurance contemplated by this Plan (whether as a result of negligence, gross neglect or otherwise), the Participant's Benefits shall be limited to the insurance premium(s), if any, that remained unpaid for the period in question and the actual insurance proceeds, if any, received by the Employer or the Participant as a result of the Participant's claim.

(b) **Validity of insurance contract.** The Employer shall not be responsible for the validity of any Insurance Contract issued hereunder or for the failure on the part of the Insurer to make payments provided for under any Insurance Contract. Once insurance is applied for or obtained, the Employer shall not be liable for any loss which may result from the failure to pay Premiums to the extent Premium notices are not received by the Employer.

11.8 NO GUARANTEE OF TAX CONSEQUENCES

Neither the Administrator nor the Employer makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant under the Plan will be excludable from the Participant's gross income for federal or state income tax purposes, or that any other federal or state tax treatment will apply to or be available to any Participant. It shall be the obligation of each Participant to determine whether each payment under the Plan is excludable from the Participant's gross income for federal and state income tax purposes, and to notify the Employer if the Participant has reason to believe that any such payment is not so excludable. Notwithstanding the foregoing, the rights of Participants under this Plan shall be legally enforceable.

11.9 INDEMNIFICATION OF EMPLOYER BY PARTICIPANTS

If any Participant receives one or more payments or reimbursements under the Plan that are not for a permitted Benefit, such Participant shall indemnify and reimburse the Employer for any liability it may incur for failure to withhold federal or state

income tax or Social Security tax from such payments or reimbursements. However, such indemnification and reimbursement shall not exceed the amount of additional federal and state income tax (plus any penalties) that the Participant would have owed if the payments or reimbursements had been made to the Participant as regular cash compensation, plus the Participant's share of any Social Security tax that would have been paid on such compensation, less any such additional income and Social Security tax actually paid by the Participant.

11.10 FUNDING

Unless otherwise required by law, contributions to the Plan need not be placed in trust or dedicated to a specific Benefit, but may instead be considered general assets of the Employer. Furthermore, and unless otherwise required by law, nothing herein shall be construed to require the Employer or the Administrator to maintain any fund or segregate any amount for the benefit of any Participant, and no Participant or other person shall have any claim against, right to, or security or other interest in, any fund, account or asset of the Employer from which any payment under the Plan may be made.

11.11 GOVERNING LAW

This Plan is governed by the Code and the Treasury regulations issued thereunder (as they might be amended from time to time). In no event shall the Employer guarantee the favorable tax treatment sought by this Plan. To the extent not preempted by Federal law, the provisions of this Plan shall be construed, enforced and administered according to the laws of the Commonwealth of Kentucky.

11.12 SEVERABILITY

If any provision of the Plan is held invalid or unenforceable, its invalidity or unenforceability shall not affect any other provisions of the Plan, and the Plan shall be construed and enforced as if such provision had not been included herein.

11.13 CAPTIONS

The captions contained herein are inserted only as a matter of convenience and for reference, and in no way define, limit, enlarge or describe the scope or intent of the Plan, nor in any way shall affect the Plan or the construction of any provision thereof.

11.14 FAMILY AND MEDICAL LEAVE ACT (FMLA)

Notwithstanding anything in the Plan to the contrary, in the event any benefit under this Plan becomes subject to the requirements of the Family and Medical Leave Act and regulations thereunder, this Plan shall be operated in accordance with Regulation 1.125-3.

11.15 HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

Notwithstanding anything in this Plan to the contrary, this Plan shall be operated in accordance with HIPAA and regulations thereunder.

11.16 UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)

Notwithstanding any provision of this Plan to the contrary, contributions, benefits and service credit with respect to qualified military service shall be provided in accordance with the Uniform Services Employment And Reemployment Rights Act (USERRA) and the regulations thereunder.

11.17 COMPLIANCE WITH HIPAA PRIVACY STANDARDS

(a) **Application.** If any benefits under this Cafeteria Plan are subject to the Standards for Privacy of Individually Identifiable Health Information (45 CFR Part 164, the "Privacy Standards"), then this Section shall apply.

(b) **Disclosure of PHI.** The Plan shall not disclose Protected Health Information to any member of the Employer's workforce unless each of the conditions set out in this Section are met. "Protected Health Information" shall have the same definition as set forth in the Privacy Standards but generally shall mean individually identifiable information about the past, present or future physical or mental health or condition of an individual, including genetic information and information about treatment or payment for treatment.

(c) **PHI disclosed for administrative purposes.** Protected Health Information disclosed to members of the Employer's workforce shall be used or disclosed by them only for purposes of Plan administrative functions. The

Plan's administrative functions shall include all Plan payment functions and health care operations. The terms "payment" and "health care operations" shall have the same definitions as set out in the Privacy Standards, but the term "payment" generally shall mean activities taken to determine or fulfill Plan responsibilities with respect to eligibility, coverage, provision of benefits, or reimbursement for health care. Protected Health Information that consists of genetic information will not be used or disclosed for underwriting purposes.

(d) **PHI disclosed to certain workforce members.** The Plan shall disclose Protected Health Information only to members of the Employer's workforce who are designated and authorized to receive such Protected Health Information, and only to the extent and in the minimum amount necessary for that person to perform his or her duties with respect to the Plan. "Members of the Employer's workforce" shall refer to all employees and other persons under the control of the Employer. The Employer shall keep an updated list of those authorized to receive Protected Health Information.

(1) An authorized member of the Employer's workforce who receives Protected Health Information shall use or disclose the Protected Health Information only to the extent necessary to perform his or her duties with respect to the Plan.

(2) In the event that any member of the Employer's workforce uses or discloses Protected Health Information other than as permitted by this Section and the Privacy Standards, the incident shall be reported to the Plan's privacy official. The privacy official shall take appropriate action, including:

(i) investigation of the incident to determine whether the breach occurred inadvertently, through negligence or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach;

(ii) appropriate sanctions against the persons causing the breach which, depending upon the nature of the breach, may include oral or written reprimand, additional training, or termination of employment;

(iii) mitigation of any harm caused by the breach, to the extent practicable; and

(iv) documentation of the incident and all actions taken to resolve the issue and mitigate any damages.

(e) **Certification.** The Employer must provide certification to the Plan that it agrees to:

(1) Not use or further disclose the information other than as permitted or required by the Plan documents or as required by law;

(2) Ensure that any agent or subcontractor, to whom it provides Protected Health Information received from the Plan, agrees to the same restrictions and conditions that apply to the Employer with respect to such information;

(3) Not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer;

(4) Report to the Plan any use or disclosure of the Protected Health Information of which it becomes aware that is inconsistent with the uses or disclosures permitted by this Section, or required by law;

(5) Make available Protected Health Information to individual Plan members in accordance with Section 164.524 of the Privacy Standards;

(6) Make available Protected Health Information for amendment by individual Plan members and incorporate any amendments to Protected Health Information in accordance with Section 164.526 of the Privacy Standards;

(7) Make available the Protected Health Information required to provide an accounting of disclosures to individual Plan members in accordance with Section 164.528 of the Privacy Standards;

(8) Make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Department of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Standards;

(9) If feasible, return or destroy all Protected Health Information received from the Plan that the Employer still maintains in any form, and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and

(10) Ensure the adequate separation between the Plan and members of the Employer's workforce, as required by Section 164.504(f)(2)(iii) of the Privacy Standards and set out in (d) above.

11.18 COMPLIANCE WITH HIPAA ELECTRONIC SECURITY STANDARDS

Under the Security Standards for the Protection of Electronic Protected Health Information (45 CFR Part 164.300 et. seq., the "Security Standards"):

(a) **Implementation.** The Employer agrees to implement reasonable and appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of Electronic Protected Health Information that the Employer creates, maintains or transmits on behalf of the Plan. "Electronic Protected Health Information" shall have the same definition as set out in the Security Standards, but generally shall mean Protected Health Information that is transmitted by or maintained in electronic media.

(b) **Agents or subcontractors shall meet security standards.** The Employer shall ensure that any agent or subcontractor to whom it provides Electronic Protected Health Information shall agree, in writing, to implement reasonable and appropriate security measures to protect the Electronic Protected Health Information.

(c) **Employer shall ensure security standards.** The Employer shall ensure that reasonable and appropriate security measures are implemented to comply with the conditions and requirements set forth in Section 11.17.

11.19 MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT

Notwithstanding anything in the Plan to the contrary, the Plan will comply with the Mental Health Parity and Addiction Equity Act.

11.20 GENETIC INFORMATION NONDISCRIMINATION ACT (GINA)

Notwithstanding anything in the Plan to the contrary, the Plan will comply with the Genetic Information Nondiscrimination Act.

11.21 WOMEN'S HEALTH AND CANCER RIGHTS ACT

Notwithstanding anything in the Plan to the contrary, the Plan will comply with the Women's Health and Cancer Rights Act of 1998.

11.22 NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

Notwithstanding anything in the Plan to the contrary, the Plan will comply with the Newborns' and Mothers' Health Protection Act.

IN WITNESS WHEREOF, this Plan document is hereby executed this 24th day of March.

Bullock Pen Water District

By _____
EMPLOYER

BULLOCK PEN WATER DISTRICT

FLEXIBLE SPENDING BENEFITS PLAN

PLAN DOCUMENT

FLEXIBLE SPENDING BENEFITS PLAN

TABLE OF CONTENTS

ARTICLE I
DEFINITIONS

ARTICLE II
PARTICIPATION

2.1 ELIGIBILITY 2
2.2 EFFECTIVE DATE OF PARTICIPATION 2
2.3 APPLICATION TO PARTICIPATE 2
2.4 TERMINATION OF PARTICIPATION 3
2.5 TERMINATION OF EMPLOYMENT 3
2.6 DEATH 3

ARTICLE III
CONTRIBUTIONS TO THE PLAN

3.1 SALARY REDIRECTION 3
3.2 APPLICATION OF CONTRIBUTIONS 4
3.3 PERIODIC CONTRIBUTIONS 4

ARTICLE IV
BENEFITS

4.1 BENEFIT OPTIONS 4
4.2 HEALTH FLEXIBLE SPENDING ACCOUNT BENEFIT 4
4.3 DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT BENEFIT 4
4.4 HEALTH INSURANCE BENEFIT 4
4.5 DENTAL INSURANCE BENEFIT 5
4.6 CANCER INSURANCE BENEFIT 5
4.7 VISION INSURANCE BENEFIT 5
4.8 OTHER INSURANCE BENEFIT 5
4.9 NONDISCRIMINATION REQUIREMENTS 5

ARTICLE V
PARTICIPANT ELECTIONS

5.1 INITIAL ELECTIONS 6
5.2 SUBSEQUENT ANNUAL ELECTIONS 6
5.3 FAILURE TO ELECT 6
5.4 CHANGE IN STATUS 6

ARTICLE VI
HEALTH FLEXIBLE SPENDING ACCOUNT

6.1 ESTABLISHMENT OF PLAN 8
6.2 DEFINITIONS 8
6.3 FORFEITURES 9
6.4 LIMITATION ON ALLOCATIONS 9
6.5 NONDISCRIMINATION REQUIREMENTS 9
6.6 COORDINATION WITH CAFETERIA PLAN 9

6.7 HEALTH FLEXIBLE SPENDING ACCOUNT CLAIMS 9
6.8 DEBIT AND CREDIT CARDS 10

ARTICLE VII
DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

7.1 ESTABLISHMENT OF ACCOUNT 11
7.2 DEFINITIONS 11
7.3 DEPENDENT CARE FLEXIBLE SPENDING ACCOUNTS 12
7.4 INCREASES IN DEPENDENT CARE FLEXIBLE SPENDING ACCOUNTS 12
7.5 DECREASES IN DEPENDENT CARE FLEXIBLE SPENDING ACCOUNTS 12
7.6 ALLOWABLE DEPENDENT CARE REIMBURSEMENT 12
7.7 ANNUAL STATEMENT OF BENEFITS 12
7.8 FORFEITURES 12
7.9 LIMITATION ON PAYMENTS 12
7.10 NONDISCRIMINATION REQUIREMENTS 12
7.11 COORDINATION WITH CAFETERIA PLAN 13
7.12 DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT CLAIMS 13

ARTICLE VIII
BENEFITS AND RIGHTS

8.1 CLAIM FOR BENEFITS 13
8.2 APPLICATION OF BENEFIT PLAN SURPLUS 14

ARTICLE IX
ADMINISTRATION

9.1 PLAN ADMINISTRATION 14
9.2 EXAMINATION OF RECORDS 15
9.3 PAYMENT OF EXPENSES 15
9.4 INSURANCE CONTROL CLAUSE 15
9.5 INDEMNIFICATION OF ADMINISTRATOR 15

ARTICLE X
AMENDMENT OR TERMINATION OF PLAN

10.1 AMENDMENT 16
10.2 TERMINATION 16

ARTICLE XI
MISCELLANEOUS

11.1 PLAN INTERPRETATION 16
11.2 GENDER, NUMBER AND TENSE 16
11.3 WRITTEN DOCUMENT 16
11.4 EXCLUSIVE BENEFIT 16
11.5 PARTICIPANT'S RIGHTS 16
11.6 ACTION BY THE EMPLOYER 16
11.7 EMPLOYER'S PROTECTIVE CLAUSES 16
11.8 NO GUARANTEE OF TAX CONSEQUENCES 17

11.9 INDEMNIFICATION OF EMPLOYER BY PARTICIPANTS 17
11.10 FUNDING 17
11.11 GOVERNING LAW 17
11.12 SEVERABILITY 17
11.13 CAPTIONS 17
11.14 HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) 17
11.15 UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA) 17
11.16 COMPLIANCE WITH HIPAA PRIVACY STANDARDS 17
11.17 COMPLIANCE WITH HIPAA ELECTRONIC SECURITY STANDARDS 19
11.18 MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT 19
11.19 GENETIC INFORMATION NONDISCRIMINATION ACT (GINA) 19
11.20 WOMEN'S HEALTH AND CANCER RIGHTS ACT 19
11.21 NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT 19

FLEXIBLE SPENDING BENEFITS PLAN

INTRODUCTION

The Employer has amended this Plan effective 01/01/2023, to recognize the contribution made to the Employer by its Employees. Its purpose is to reward them by providing benefits for those Employees who shall qualify hereunder and their Dependents and beneficiaries. The concept of this Plan is to allow Employees to choose among different types of benefits based on their own particular goals, desires and needs. This Plan is a restatement of a Plan which was originally effective on 01/01/2014. The Plan shall be known as Flexible Spending Benefits Plan (the "Plan").

The intention of the Employer is that the Plan qualify as a "Cafeteria Plan" within the meaning of Section 125 of the Internal Revenue Code of 1986, as amended, and that the benefits which an Employee elects to receive under the Plan be excludable from the Employee's income under Section 125(a) and other applicable sections of the Internal Revenue Code of 1986, as amended.

ARTICLE I
DEFINITIONS

1.1 **"Administrator"** means the Employer unless another person or entity has been designated by the Employer pursuant to Section 9.1 to administer the Plan on behalf of the Employer. If the Employer is the Administrator, the Employer may appoint any person, including, but not limited to, the Employees of the Employer, to perform the duties of the Administrator. Any person so appointed shall signify acceptance by filing written acceptance with the Employer. Upon the resignation or removal of any individual performing the duties of the Administrator, the Employer may designate a successor.

1.2 **"Affiliated Employer"** means the Employer and any corporation which is a member of a controlled group of corporations (as defined in Code Section 414(b)) which includes the Employer; any trade or business (whether or not incorporated) which is under common control (as defined in Code Section 414(c)) with the Employer; any organization (whether or not incorporated) which is a member of an affiliated service group (as defined in Code Section 414(m)) which includes the Employer; and any other entity required to be aggregated with the Employer pursuant to Treasury regulations under Code Section 414(o).

1.3 **"Benefit"** or **"Benefit Options"** means any of the optional benefit choices available to a Participant as outlined in Section 4.1.

1.4 **"Cafeteria Plan Benefit Dollars"** means the amount available to Participants to purchase Benefit Options as provided under Section 4.1. Each dollar contributed to this Plan shall be converted into one Cafeteria Plan Benefit Dollar.

1.5 **"Code"** means the Internal Revenue Code of 1986, as amended or replaced from time to time.

1.6 **"Compensation"** means the amounts received by the Participant from the Employer during a Plan Year.

1.7 **"Dependent"** means any individual who qualifies as a dependent under an Insurance Contract for purposes of coverage under that Contract only or under Code Section 152 (as modified by Code Section 105(b)).

"Dependent" shall include any Child of a Participant who is covered under an Insurance Contract, as defined in the Contract, or under the Health Flexible Spending Account or as allowed by reason of the Affordable Care Act.

For purposes of the Health Flexible Spending Account, a Participant's "Child" includes his/her natural child, stepchild, foster child, adopted child, or a child placed with the Participant for adoption. A Participant's Child will be an eligible Dependent until reaching the limiting age of 26, without regard to student status, marital status, financial dependency or residency status with the Employee or any other person. When the child reaches the applicable limiting age, coverage will end at the end of the calendar year.

The phrase "placed for adoption" refers to a child whom the Participant intends to adopt, whether or not the adoption has become final, who has not attained the age of 18 as of the date of such placement for adoption. The term "placed" means the assumption and retention by such Employee of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption and the legal process must have commenced.

1.8 **"Effective Date"** means 01/01/2014.

1.9 **"Election Period"** means the period immediately preceding the beginning of each Plan Year established by the Administrator, such period to be applied on a uniform and nondiscriminatory basis for all Employees and Participants. However, an Employee's initial Election Period shall be determined pursuant to Section 5.1.

1.10 **"Eligible Employee"** means any Employee who has satisfied the provisions of Section 2.1.

An individual shall not be an "Eligible Employee" if such individual is not reported on the payroll records of the Employer as a common law employee. In particular, it is expressly intended that individuals not treated as common law employees by the Employer on its payroll records are not "Eligible Employees" and are excluded from Plan participation even if a court or administrative agency determines that such individuals are common law employees and not independent contractors.

1.11 **"Employee"** means any person who is employed by the Employer. The term Employee shall include leased employees within the meaning of Code Section 414(n)(2).

1.12 **"Employer"** means Bullock Pen Water District and any successor which shall maintain this Plan; and any predecessor which has maintained this Plan. In addition, where appropriate, the term Employer shall include any Participating, Affiliated or Adopting Employer.

1.13 **"Insurance Contract"** means any contract issued by an Insurer underwriting a Benefit.

1.14 **"Insurance Premium Payment Plan"** means the plan of benefits contained in Section 4.1 of this Plan, which provides for the payment of Premium Expenses.

1.15 **"Insurer"** means any insurance company that underwrites a Benefit under this Plan.

1.16 **"Key Employee"** means an Employee described in Code Section 416(i)(1) and the Treasury regulations thereunder.

1.17 **"Participant"** means any Eligible Employee who elects to become a Participant pursuant to Section 2.3 and has not for any reason become ineligible to participate further in the Plan.

1.18 **"Plan"** means this instrument, including all amendments thereto.

1.19 **"Plan Year"** means the 12-month period beginning 01/01 and ending 12/31. The Plan Year shall be the coverage period for the Benefits provided for under this Plan. In the event a Participant commences participation during a Plan Year, then the initial coverage period shall be that portion of the Plan Year commencing on such Participant's date of entry and ending on the last day of such Plan Year.

1.20 **"Premium Expenses"** or **"Premiums"** mean the Participant's cost for the Benefits described in Section 4.1.

1.21 **"Premium Expense Reimbursement Account"** means the account established for a Participant pursuant to this Plan to which part of his Cafeteria Plan Benefit Dollars may be allocated and from which Premiums of the Participant may be paid or reimbursed. If more than one type of insured Benefit is elected, sub-accounts shall be established for each type of insured Benefit.

1.22 **"Salary Redirection"** means the contributions made by the Employer on behalf of Participants pursuant to Section 3.1. These contributions shall be converted to Cafeteria Plan Benefit Dollars and allocated to the funds or accounts established under the Plan pursuant to the Participants' elections made under Article V.

1.23 **"Salary Redirection Agreement"** means an agreement between the Participant and the Employer under which the Participant agrees to reduce his Compensation or to forego all or part of the increases in such Compensation and to have such amounts contributed by the Employer to the Plan on the Participant's behalf. The Salary Redirection Agreement shall apply only to Compensation that has not been actually or constructively received by the Participant as of the date of the agreement (after taking this Plan and Code Section 125 into account) and, subsequently does not become currently available to the Participant.

1.24 **"Spouse"** means spouse as determined under Federal law.

ARTICLE II
PARTICIPATION

2.1 ELIGIBILITY

Any Eligible Employee shall be eligible to participate hereunder as of the date he satisfies the eligibility conditions for the Employer's group medical plan, the provisions of which are specifically incorporated herein by reference. However, any Eligible Employee who was a Participant in the Plan on the effective date of this amendment shall continue to be eligible to participate in the Plan.

2.2 EFFECTIVE DATE OF PARTICIPATION

An Eligible Employee shall become a Participant effective as of the entry date under the Employer's group medical plan, the provisions of which are specifically incorporated herein by reference.

2.3 APPLICATION TO PARTICIPATE

An Employee who is eligible to participate in this Plan shall, during the applicable Election Period, complete an application to participate in a manner set forth by the Administrator. The election shall be irrevocable until the end of the applicable Plan Year unless the Participant is entitled to change his Benefit elections pursuant to Section 5.4 hereof.

An Eligible Employee shall also be required to complete a Salary Redirection Agreement during the Election Period for the Plan Year during which he wishes to participate in this Plan. Any such Salary Redirection Agreement shall be effective for the first pay period beginning on or after the Employee's effective date of participation pursuant to Section 2.2.

2.4 TERMINATION OF PARTICIPATION

A Participant shall no longer participate in this Plan upon the occurrence of any of the following events:

(a) **Termination of employment.** The Participant's termination of employment, subject to the provisions of Section 2.5;

(b) **Death.** The Participant's death, subject to the provisions of Section 2.6; or

(c) **Termination of the plan.** The termination of this Plan, subject to the provisions of Section 10.2.

2.5 TERMINATION OF EMPLOYMENT

If a Participant's employment with the Employer is terminated for any reason other than death, his participation in the Benefit Options provided under Section 4.1 shall be governed in accordance with the following:

(a) **Insurance Benefit.** With regard to Benefits which are insured, the Participant's participation in the Plan shall cease, subject to the Participant's right to continue coverage under any Insurance Contract for which premiums have already been paid.

(b) **Dependent Care FSA.** With regard to the Dependent Care Flexible Spending Account, the Participant's participation in the Plan shall cease and no further Salary Redirection contributions shall be made. However, such Participant may submit claims for employment related Dependent Care Expense reimbursements for claims incurred up to the date of termination and submitted within 90 days after termination, based on the level of the Participant's Dependent Care Flexible Spending Account as of the date of termination.

(c) **Health FSA.** With regard to the Health Flexible Spending Account, the Participant's participation in the Plan shall cease and no further Salary Redirection contributions shall be made. However, such Participant may submit claims for expenses that were incurred during the portion of the Plan Year before the end of the period for which payments to the Health Flexible Spending Account have already been made for claims incurred up to the date of termination and submitted within 90 days after termination.

(d) **Health FSA treatment.** In the event a Participant terminates his participation in the Health Flexible Spending Account during the Plan Year, if Salary Redirections are made other than on a pro rata basis, upon termination the Participant shall be entitled to a reimbursement for any Salary Redirection previously paid for coverage or benefits relating to the period after the date of the Participant's separation from service regardless of the Participant's claims or reimbursements as of such date.

2.6 DEATH

If a Participant dies, his participation in the Plan shall cease. However, such Participant's spouse or Dependents may submit claims for expenses or benefits for the remainder of the Plan Year or until the Cafeteria Plan Benefit Dollars allocated to each specific benefit are exhausted. In no event may reimbursements be paid to someone who is not a spouse or Dependent.

ARTICLE III
CONTRIBUTIONS TO THE PLAN

3.1 SALARY REDIRECTION

Benefits under the Plan shall be financed by Salary Redirections sufficient to support Benefits that a Participant has elected hereunder and to pay the Participant's Premium Expenses. The salary administration program of the Employer shall be revised to allow each Participant to agree to reduce his pay during a Plan Year by an amount determined necessary to purchase the elected Benefit Options. The amount of such Salary Redirection shall be specified in the Salary Redirection Agreement and shall be applicable for a Plan Year. Notwithstanding the above, for new Participants, the Salary Redirection Agreement shall only be applicable from the first day of the pay period following the Employee's entry date up to and including the last day of the Plan Year. These contributions shall be converted to Cafeteria Plan Benefit Dollars and allocated to the funds or accounts established under the Plan pursuant to the Participants' elections made under Article IV.

Any Salary Redirection shall be determined prior to the beginning of a Plan Year (subject to initial elections pursuant to Section 5.1) and prior to the end of the Election Period and shall be irrevocable for such Plan Year. However, a Participant may revoke a Benefit election or a Salary Redirection Agreement after the Plan Year has commenced and make a new election with respect to the remainder of the Plan Year, if both the revocation and the new election are on account of and consistent with a change in status and such other permitted

events as determined under Article V of the Plan and consistent with the rules and regulations of the Department of the Treasury. Salary Redirection amounts shall be contributed on a pro rata basis for each pay period during the Plan Year. All individual Salary Redirection Agreements are deemed to be part of this Plan and incorporated by reference hereunder.

3.2 APPLICATION OF CONTRIBUTIONS

As soon as reasonably practical after each payroll period, the Employer shall apply the Salary Redirection to provide the Benefits elected by the affected Participants. Any contribution made or withheld for the Health Flexible Spending Account or Dependent Care Flexible Spending Account shall be credited to such fund or account. Amounts designated for the Participant's Premium Expense Reimbursement Account shall likewise be credited to such account for the purpose of paying Premium Expenses.

3.3 PERIODIC CONTRIBUTIONS

Notwithstanding the requirement provided above and in other Articles of this Plan that Salary Redirections be contributed to the Plan by the Employer on behalf of an Employee on a level and pro rata basis for each payroll period, the Employer and Administrator may implement a procedure in which Salary Redirections are contributed throughout the Plan Year on a periodic basis that is not pro rata for each payroll period. However, with regard to the Health Flexible Spending Account, the payment schedule for the required contributions may not be based on the rate or amount of reimbursements during the Plan Year. In the event Salary Redirections to the Health Flexible Spending Account are not made on a pro rata basis, upon termination of participation, a Participant may be entitled to a refund of such Salary Redirections pursuant to Section 2.5.

ARTICLE IV
BENEFITS

4.1 BENEFIT OPTIONS

Each Participant may elect any one or more of the following optional Benefits:

(1) Health Flexible Spending Account

(2) Dependent Care Flexible Spending Account

(3) Insurance Premium Payment Plan

(i) Health Insurance Benefit

(ii) Dental Insurance Benefit

(iii) Cancer Insurance Benefit

(iv) Vision Insurance Benefit

(v) Other Insurance Benefit

4.2 HEALTH FLEXIBLE SPENDING ACCOUNT BENEFIT

Each Participant may elect to participate in the Health Flexible Spending Account option, in which case Article VI shall apply.

4.3 DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT BENEFIT

Each Participant may elect to participate in the Dependent Care Flexible Spending Account option, in which case Article VII shall apply.

4.4 HEALTH INSURANCE BENEFIT

(a) **Coverage for Participant and Dependents.** Each Participant may elect to be covered under a health Insurance Contract for the Participant, his or her Spouse, and his or her Dependents.

(b) **Employer selects contracts.** The Employer may select suitable health Insurance Contracts for use in providing this health insurance benefit, which policies will provide uniform benefits for all Participants electing this Benefit.

(c) **Contract incorporated by reference.** The rights and conditions with respect to the benefits payable from such health Insurance Contract shall be determined therefrom, and such Insurance Contract shall be incorporated herein by reference.

4.5 DENTAL INSURANCE BENEFIT

(a) **Coverage for Participant and/or Dependents.** Each Participant may elect to be covered under the Employer's dental Insurance Contract. In addition, the Participant may elect either individual or family coverage under such Insurance Contract.

(b) **Employer selects contracts.** The Employer may select suitable dental Insurance Contracts for use in providing this dental insurance benefit, which policies will provide uniform benefits for all Participants electing this Benefit.

(c) **Contract incorporated by reference.** The rights and conditions with respect to the benefits payable from such dental Insurance Contract shall be determined therefrom, and such dental Insurance Contract shall be incorporated herein by reference.

4.6 CANCER INSURANCE BENEFIT

(a) **Coverage for Participant and/or Dependents.** Each Participant may elect to be covered under the Employer's cancer Insurance Contract. In addition, the Participant may elect either individual or family coverage.

(b) **Employer selects contracts.** The Employer may select suitable cancer Insurance Contracts for use in providing this cancer insurance benefit, which policies will provide uniform benefits for all Participants electing this Benefit.

(c) **Contract incorporated by reference.** The rights and conditions with respect to the benefits payable from such cancer Insurance Contract shall be determined therefrom, and such cancer Insurance Contract shall be incorporated herein by reference.

4.7 VISION INSURANCE BENEFIT

(a) **Coverage for Participant and/or Dependents.** Each Participant may elect to be covered under the Employer's vision Insurance Contract. In addition, the Participant may elect either individual or family coverage.

(b) **Employer selects contracts.** The Employer may select suitable vision Insurance Contracts for use in providing this vision insurance benefit, which policies will provide uniform benefits for all Participants electing this Benefit.

(c) **Contract incorporated by reference.** The rights and conditions with respect to the benefits payable from such vision Insurance Contract shall be determined therefrom, and such vision Insurance Contract shall be incorporated herein by reference.

4.8 OTHER INSURANCE BENEFIT

(a) **Employer selects contracts.** The Employer may select additional health or other policies allowed under Code Section 125 or allow the purchase of additional health or other policies by and for Participants, which policies will provide uniform benefits for all Participants electing this Benefit.

(b) **Contract incorporated by reference.** The rights and conditions with respect to the benefits payable from any additional Insurance Contract shall be determined therefrom, and such Insurance Contract shall be incorporated herein by reference.

4.9 NONDISCRIMINATION REQUIREMENTS

(a) **Intent to be nondiscriminatory.** It is the intent of this Plan to provide benefits to a classification of employees which the Secretary of the Treasury finds not to be discriminatory in favor of the group in whose favor discrimination may not occur under Code Section 125.

(b) **25% concentration test.** It is the intent of this Plan not to provide qualified benefits as defined under Code Section 125 to Key Employees in amounts that exceed 25% of the aggregate of such Benefits provided for all Eligible Employees under the Plan. For purposes of the preceding sentence, qualified benefits shall not include benefits which (without regard to this paragraph) are includible in gross income.

(c) **Adjustment to avoid test failure.** If the Administrator deems it necessary to avoid discrimination or possible taxation to Key Employees or a group of employees in whose favor discrimination may not occur in violation of Code Section 125, it may, but shall not be required to, reject any election or reduce contributions or non-taxable Benefits in order to assure compliance with the Code and regulations. Any act taken by the Administrator shall be carried out in a uniform and nondiscriminatory manner. With respect to any affected Participant who has had Benefits reduced pursuant to this Section, the reduction shall be made proportionately among Health Flexible Spending Account Benefits and Dependent Care Flexible Spending Account Benefits, and once all these Benefits are expended, proportionately among insured Benefits. Contributions which are not utilized to provide Benefits to any Participant by virtue of any administrative act under this paragraph shall be forfeited and deposited into the benefit plan surplus.

ARTICLE V
PARTICIPANT ELECTIONS

5.1 INITIAL ELECTIONS

An Employee who meets the eligibility requirements of Section 2.1 on the first day of, or during, a Plan Year may elect to participate in this Plan for all or the remainder of such Plan Year, provided he elects to do so on or before his effective date of participation pursuant to Section 2.2.

5.2 SUBSEQUENT ANNUAL ELECTIONS

During the Election Period prior to each subsequent Plan Year, each Participant shall be given the opportunity to elect, on an election of benefits form to be provided by the Administrator, which Benefit options he wishes to select. Any such election shall be effective for any Benefit expenses incurred during the Plan Year which follows the end of the Election Period. With regard to subsequent annual elections, the following options shall apply:

(a) A Participant or Employee who failed to initially elect to participate may elect different or new Benefits under the Plan during the Election Period;

(b) A Participant may terminate his participation in the Plan by notifying the Administrator in writing during the Election Period that he does not want to participate in the Plan for the next Plan Year, or by not electing any Benefit options;

(c) An Employee who elects not to participate for the Plan Year following the Election Period will have to wait until the next Election Period before again electing to participate in the Plan, except as provided for in Section 5.4.

5.3 FAILURE TO ELECT

Any Participant failing to complete an election of benefits form pursuant to Section 5.2 by the end of the applicable Election Period shall be deemed to have elected not to participate in the Plan for the upcoming Plan Year. No further Salary Redirections shall therefore be authorized for such subsequent Plan Year.

5.4 CHANGE IN STATUS

(a) **Change in status defined.** Any Participant may change a Benefit election after the Plan Year (to which such election relates) has commenced and make new elections with respect to the remainder of such Plan Year if, under the facts and circumstances, the changes are necessitated by and are consistent with a change in status which is acceptable under rules and regulations adopted by the Department of the Treasury, the provisions of which are incorporated by reference. Notwithstanding anything herein to the contrary, if the rules and regulations conflict, then such rules and regulations shall control.

In general, a change in election is not consistent if the change in status is the Participant's divorce, annulment or legal separation from a Spouse, the death of a Spouse or Dependent, or a Dependent ceasing to satisfy the eligibility requirements for coverage, and the Participant's election under the Plan is to cancel accident or health insurance coverage for any individual other than the one involved in such event. In addition, if the Participant, Spouse or Dependent gains or loses eligibility for coverage, then a Participant's election under the Plan to cease or decrease coverage for that individual under the Plan corresponds with that change in status only if coverage for that individual becomes applicable or is increased under the family member plan.

Regardless of the consistency requirement, if the individual, the individual's Spouse, or Dependent becomes eligible for continuation coverage under the Employer's group health plan as provided in Code Section 4980B or any similar state law, then the individual may elect to increase payments under this Plan in order to pay for the continuation coverage. However, this does not apply for COBRA eligibility due to divorce, annulment or legal separation.

Any new election shall be effective at such time as the Administrator shall prescribe, but not earlier than the first pay period beginning after the election form is completed and returned to the Administrator. For the purposes of this subsection, a change in status shall only include the following events or other events permitted by Treasury regulations:

(1) Legal Marital Status: events that change a Participant's legal marital status, including marriage, divorce, death of a Spouse, legal separation or annulment;

(2) Number of Dependents: Events that change a Participant's number of Dependents, including birth, adoption, placement for adoption, or death of a Dependent;

(3) Employment Status: Any of the following events that change the employment status of the Participant, Spouse, or Dependent: termination or commencement of employment, a strike or lockout, commencement or return from an unpaid leave of absence, or a change in worksite. In addition, if the eligibility conditions of this Plan or other employee benefit plan of the Employer of the Participant, Spouse, or Dependent depend on the employment status of that individual and there is a change in that individual's employment status with the consequence that the individual becomes (or ceases to be) eligible under the plan, then that change constitutes a change in employment under this subsection;

(4) Dependent satisfies or ceases to satisfy the eligibility requirements: An event that causes the Participant's Dependent to satisfy or cease to satisfy the requirements for coverage due to attainment of age, student status, or any similar circumstance; and

(5) Residency: A change in the place of residence of the Participant, Spouse or Dependent, that would lead to a change in status (such as a loss of HMO coverage).

For the Dependent Care Flexible Spending Account, a Dependent becoming or ceasing to be a "Qualifying Dependent" as defined under Code Section 21(b) shall also qualify as a change in status.

Notwithstanding anything in this Section to the contrary, the gain of eligibility or change in eligibility of a child, as allowed under Code Sections 105(b) and 106, and guidance thereunder, shall qualify as a change in status.

(b) **Special enrollment rights.** Notwithstanding subsection (a), the Participants may change an election for group health coverage during a Plan Year and make a new election that corresponds with the special enrollment rights provided in Code Section 9801(f), including those authorized under the provisions of the Children's Health Insurance Program Reauthorization Act of 2009 (SCHIP); provided that such Participant meets the sixty (60) day notice requirement imposed by Code Section 9801(f) (or such longer period as may be permitted by the Plan and communicated to Participants). Such change shall take place on a prospective basis, unless otherwise required by Code Section 9801(f) to be retroactive.

(c) **Qualified Medical Support Order.** Notwithstanding subsection (a), in the event of a judgment, decree, or order (including approval of a property settlement) ("order") resulting from a divorce, legal separation, annulment, or change in legal custody which requires accident or health coverage for a Participant's child (including a foster child who is a Dependent of the Participant):

(1) The Plan may change an election to provide coverage for the child if the order requires coverage under the Participant's plan; or

(2) The Participant shall be permitted to change an election to cancel coverage for the child if the order requires the former Spouse to provide coverage for such child, under that individual's plan and such coverage is actually provided.

(d) **Medicare or Medicaid.** Notwithstanding subsection (a), a Participant may change elections to cancel or reduce accident or health coverage for the Participant or the Participant's Spouse or Dependent if the Participant or the Participant's Spouse or Dependent is enrolled in the accident or health coverage of the Employer and becomes entitled to coverage (i.e., enrolled) under Part A or Part B of the Title XVIII of the Social Security Act (Medicare) or Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under Section 1928 of the Social Security Act (the program for distribution of pediatric vaccines). If the Participant or the Participant's Spouse or Dependent who has been entitled to Medicaid or Medicare coverage loses eligibility, that individual may prospectively elect coverage under the Plan if a benefit package option under the Plan provides similar coverage.

(e) **Cost increase or decrease.** If the cost of a Benefit provided under the Plan increases or decreases during a Plan Year, then the Plan shall automatically increase or decrease, as the case may be, the Salary Redirections of all affected Participants for such Benefit. Alternatively, if the cost of a benefit package option increases significantly, the Administrator shall permit the affected Participants to either make corresponding changes in their payments or revoke their elections and, in lieu thereof, receive on a prospective basis coverage under another benefit package option with similar coverage, or drop coverage prospectively if there is no benefit package option with similar coverage.

A cost increase or decrease refers to an increase or decrease in the amount of elective contributions under the Plan, whether resulting from an action taken by the Participants or an action taken by the Employer.

(f) **Loss of coverage.** If the coverage under a Benefit is significantly curtailed or ceases during a Plan Year, affected Participants may revoke their elections of such Benefit and, in lieu thereof, elect to receive on a prospective basis coverage under another plan with similar coverage, or drop coverage prospectively if no similar coverage is offered.

(g) **Addition of a new benefit.** If, during the period of coverage, a new benefit package option or other coverage option is added, an existing benefit package option is significantly improved, or an existing benefit package option or other coverage option is eliminated, then the affected Participants may elect the newly-added option, or elect another option if an option has been eliminated prospectively and make corresponding election changes with respect to other benefit package options providing similar coverage. In addition, those Eligible Employees who are not participating in the Plan may opt to become Participants and elect the new or newly improved benefit package option.

(h) **Loss of coverage under certain other plans.** A Participant may make a prospective election change to add group health coverage for the Participant, the Participant's Spouse or Dependent if such individual loses group health coverage sponsored by a governmental or educational institution, including a state children's health insurance program under the Social Security Act, the Indian Health Service or a health program offered by an Indian tribal government, a state health benefits risk pool, or a foreign government group health plan.

(i) **Change of coverage due to change under certain other plans.** A Participant may make a prospective election change that is on account of and corresponds with a change made under the plan of a Spouse's, former Spouse's or Dependent's employer if (1) the cafeteria plan or other benefits plan of the Spouse's, former Spouse's or Dependent's employer permits its participants to make a change; or (2) the cafeteria plan permits participants to make an election for a period of coverage that is different from the period of coverage under the cafeteria plan of a Spouse's, former Spouse's or Dependent's employer.

(j) **Change in dependent care provider.** A Participant may make a prospective election change that is on account of and corresponds with a change by the Participant in the dependent care provider. The availability of dependent care services from a new childcare provider is similar to a new benefit package option becoming available. A cost change is allowable in the Dependent Care Flexible Spending Account only if the cost change is imposed by a dependent care provider who is not related to the Participant, as defined in Code Section 152(a)(1) through (8).

(k) **Health FSA cannot change due to insurance change.** A Participant shall not be permitted to change an election to the Health Flexible Spending Account as a result of a cost or coverage change under any health insurance benefits.

ARTICLE VI
HEALTH FLEXIBLE SPENDING ACCOUNT

6.1 ESTABLISHMENT OF PLAN

This Health Flexible Spending Account is intended to qualify as a medical reimbursement plan under Code Section 105 and shall be interpreted in a manner consistent with such Code Section and the Treasury regulations thereunder. Participants who elect to participate in this Health Flexible Spending Account may submit claims for the reimbursement of Medical Expenses. All amounts reimbursed shall be periodically paid from amounts allocated to the Health Flexible Spending Account. Periodic payments reimbursing Participants from the Health Flexible Spending Account shall in no event occur less frequently than monthly.

6.2 DEFINITIONS

For the purposes of this Article and the Cafeteria Plan, the terms below have the following meaning:

(a) **"Health Flexible Spending Account"** means the account established for Participants pursuant to this Plan to which part of their Cafeteria Plan Benefit Dollars may be allocated and from which all allowable Medical Expenses incurred by a Participant, his or her Spouse and his or her Dependents may be reimbursed.

(b) **"Highly Compensated Participant"** means, for the purposes of this Article and determining discrimination under Code Section 105(h), a participant who is:

(1) one of the 5 highest paid officers;

(2) a shareholder who owns (or is considered to own applying the rules of Code Section 318) more than 10 percent in value of the stock of the Employer; or

(3) among the highest paid 25 percent of all Employees (other than exclusions permitted by Code Section 105(h)(3)(B) for those individuals who are not Participants).

(c) **"Medical Expenses"** means any expense for medical care within the meaning of the term "medical care" as defined in Code Section 213(d) and the rulings and Treasury regulations thereunder, and not otherwise used by the Participant as a deduction in determining his tax liability under the Code. "Medical Expenses" can be incurred by the Participant, his or her Spouse and his or her Dependents. "Incurred" means, with regard to Medical Expenses, when the Participant is provided with the medical care that gives rise to the Medical Expense and not when the Participant is formally billed or charged for, or pays for, the medical care.

A Participant may not be reimbursed for the cost of other health coverage such as premiums paid under plans maintained by the employer of the Participant's Spouse or individual policies maintained by the Participant or his Spouse or Dependent.

A Participant may not be reimbursed for "qualified long-term care services" as defined in Code Section 7702B(c).

(d) The definitions of Article I are hereby incorporated by reference to the extent necessary to interpret and apply the provisions of this Health Flexible Spending Account.

6.3 FORFEITURES

The amount in the Health Flexible Spending Account as of the end of any Plan Year (and after the processing of all claims for such Plan Year pursuant to Section 6.7 hereof, excluding any carryover) shall be forfeited and credited to the benefit plan surplus. In such event, the Participant shall have no further claim to such amount for any reason, subject to Section 8.2.

6.4 LIMITATION ON ALLOCATIONS

(a) Notwithstanding any provision contained in this Health Flexible Spending Account to the contrary, the maximum amount that may be allocated to the Health Flexible Spending Account by a Participant in or on account of any Plan Year is up to the IRS maximum.

(b) For any short Plan Year, the maximum amount that may be allocated to the Health Flexible Spending Account is prorated. For any Eligible Employee who enters the Plan after the first day of the Plan Year, the maximum amount that may be allocated to Health Flexible Spending Account by a Participant in or on account of any Plan Year is prorated.

(c) **Participation in Other Plans.** All employers that are treated as a single employer under Code Sections 414(b), (c), or (m), relating to controlled groups and affiliated service groups, are treated as a single employer for purposes of the statutory limit. If a Participant participates in multiple cafeteria plans offering health flexible spending accounts maintained by members of a controlled group or affiliated service group, the Participant's total Health Flexible Spending Account contributions under all of the cafeteria plans are limited to the statutory limit (as adjusted). However, a Participant employed by two or more employers that are not members of the same controlled group may elect up to the statutory limit (as adjusted) under each Employer's Health Flexible Spending Account.

(d) **Carryover.** A Participant in the Health Flexible Spending Account may roll over up to the carryover IRS maximum of unused amounts in the Health Flexible Spending Account remaining at the end of one Plan Year to the immediately following Plan Year. These amounts can be used during the following Plan Year for expenses incurred in that Plan Year. Amounts carried over do not affect the maximum amount of salary redirection contributions for the Plan Year to which they are carried over. Unused amounts are those remaining after expenses have been reimbursed during the runout period. These amounts may not be cashed out or converted to any other taxable or nontaxable benefit. Amounts in excess will be forfeited. The Plan is allowed, but not required, to treat claims as being paid first from the current year amounts, then from the carryover amounts.

6.5 NONDISCRIMINATION REQUIREMENTS

(a) **Intent to be nondiscriminatory.** It is the intent of this Health Flexible Spending Account not to discriminate in violation of the Code and the Treasury regulations thereunder.

(b) **Adjustment to avoid test failure.** If the Administrator deems it necessary to avoid discrimination under this Health Flexible Spending Account, it may, but shall not be required to, reject any elections or reduce contributions or Benefits in order to assure compliance with this Section. Any act taken by the Administrator under this Section shall be carried out in a uniform and nondiscriminatory manner. If the Administrator decides to reject any elections or reduce contributions or Benefits, it shall be done in the following manner. First, the Benefits designated for the Health Flexible Spending Account by the member of the group in whose favor discrimination may not occur pursuant to Code Section 105 that elected to contribute the highest amount to the fund for the Plan Year shall be reduced until the nondiscrimination tests set forth in this Section or the Code are satisfied, or until the amount designated for the fund equals the amount designated for the fund by the next member of the group in whose favor discrimination may not occur pursuant to Code Section 105 who has elected the second highest contribution to the Health Flexible Spending Account for the Plan Year. This process shall continue until the nondiscrimination tests set forth in this Section or the Code are satisfied. Contributions which are not utilized to provide Benefits to any Participant by virtue of any administrative act under this paragraph shall be forfeited and credited to the benefit plan surplus.

6.6 COORDINATION WITH CAFETERIA PLAN

All Participants under the Cafeteria Plan are eligible to receive Benefits under this Health Flexible Spending Account. The enrollment under the Cafeteria Plan shall constitute enrollment under this Health Flexible Spending Account. In addition, other matters concerning contributions, elections and the like shall be governed by the general provisions of the Cafeteria Plan.

6.7 HEALTH FLEXIBLE SPENDING ACCOUNT CLAIMS

(a) **Expenses must be incurred during Plan Year.** All Medical Expenses incurred by a Participant, his or her Spouse and his or her Dependents during the Plan Year shall be reimbursed during the Plan Year subject to Section 2.5, even though the submission of such a claim occurs after his participation hereunder ceases; but provided that the Medical Expenses were incurred during the applicable Plan Year. Medical Expenses are treated as having been incurred when the Participant is provided with the medical care that gives rise to the medical expenses, not when the Participant is formally billed or charged for, or pays for the medical care.

(b) **Reimbursement available throughout Plan Year.** The Administrator shall direct the reimbursement to each eligible Participant for all allowable Medical Expenses, up to a maximum of the amount designated by the Participant for the Health Flexible Spending Account for the Plan Year. Reimbursements shall be made available to the Participant throughout the

year without regard to the level of Cafeteria Plan Benefit Dollars which have been allocated to the fund at any given point in time. Furthermore, a Participant shall be entitled to reimbursements only for amounts in excess of any payments or other reimbursements under any health care plan covering the Participant and/or his Spouse or Dependents.

(c) **Payments.** Reimbursement payments under this Plan shall be made directly to the Participant. However, in the Administrator's discretion, payments may be made directly to the service provider. The application for payment or reimbursement shall be made to the Administrator on an acceptable form within a reasonable time of incurring the debt or paying for the service. The application shall include a written statement from an independent third party stating that the Medical Expense has been incurred and the amount of such expense. Furthermore, the Participant shall provide a written statement that the Medical Expense has not been reimbursed or is not reimbursable under any other health plan coverage and, if reimbursed from the Health Flexible Spending Account, such amount will not be claimed as a tax deduction. The Administrator shall retain a file of all such applications.

(d) **Claims for reimbursement.** Claims for the reimbursement of Medical Expenses incurred in any Plan Year shall be paid as soon after a claim has been filed as is administratively practicable; provided however, that if a Participant fails to submit a claim within 90 days after the end of the Plan Year, those Medical Expense claims shall not be considered for reimbursement by the Administrator. However, if a Participant terminates employment during the Plan Year, claims for the reimbursement of Medical Expenses must be submitted within 90 days after termination of employment.

6.8 DEBIT AND CREDIT CARDS

Participants may, subject to a procedure established by the Administrator and applied in a uniform nondiscriminatory manner, use debit and/or credit (stored value) cards ("cards") provided by the Administrator and the Plan for payment of Medical Expenses, subject to the following terms:

(a) **Card only for medical expenses.** Each Participant issued a card shall certify that such card shall only be used for Medical Expenses. The Participant shall also certify that any Medical Expense paid with the card has not already been reimbursed by any other plan covering health benefits and that the Participant will not seek reimbursement from any other plan covering health benefits.

(b) **Card issuance.** Such card shall be issued upon the Participant's Effective Date of Participation and reissued for each Plan Year the Participant remains a Participant in the Health Flexible Spending Account. Such card shall be automatically cancelled upon the Participant's death or termination of employment, or if such Participant has a change in status that results in the Participant's withdrawal from the Health Flexible Spending Account.

(c) **Maximum dollar amount available.** The dollar amount of coverage available on the card shall be the amount elected by the Participant for the Plan Year. The maximum dollar amount of coverage available shall be the maximum amount for the Plan Year as set forth in Section 6.4.

(d) **Only available for use with certain service providers.** The cards shall only be accepted by such merchants and service providers as have been approved by the Administrator following IRS guidelines.

(e) **Card use.** The cards shall only be used for Medical Expense purchases at these providers, including, but not limited to, the following:

(1) Co-payments for doctor and other medical care;

(2) Purchase of drugs prescribed by a health care provider, including, if permitted by the Administrator, over-the-counter medications as allowed under IRS regulations;

(3) Purchase of medical items such as eyeglasses, syringes, crutches, etc.

(f) **Substantiation.** Such purchases by the cards shall be subject to substantiation by the Administrator, usually by submission of a receipt from a service provider describing the service, the date and the amount. The Administrator shall also follow the requirements set forth in Revenue Ruling 2003-43 and Notice 2006-69. All charges shall be conditional pending confirmation and substantiation.

(g) **Correction methods.** If such purchase is later determined by the Administrator to not qualify as a Medical Expense, the Administrator, in its discretion, shall use one of the following correction methods to make the Plan whole. Until the amount is repaid, the Administrator shall take further action to ensure that further violations of the terms of the card do not occur, up to and including denial of access to the card.

(1) Repayment of the improper amount by the Participant;

(2) Withholding the improper payment from the Participant's wages or other compensation to the extent consistent with applicable federal or state law;

(3) Claims substitution or offset of future claims until the amount is repaid; and

(4) if subsections (1) through (3) fail to recover the amount, consistent with the Employer's business practices, the Employer may treat the amount as any other business indebtedness.

ARTICLE VII
DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

7.1 ESTABLISHMENT OF ACCOUNT

This Dependent Care Flexible Spending Account is intended to qualify as a program under Code Section 129 and shall be interpreted in a manner consistent with such Code Section. Participants who elect to participate in this program may submit claims for the reimbursement of Employment-Related Dependent Care Expenses. All amounts reimbursed shall be paid from amounts allocated to the Participant's Dependent Care Flexible Spending Account.

7.2 DEFINITIONS

For the purposes of this Article and the Cafeteria Plan the terms below shall have the following meaning:

(a) **"Dependent Care Flexible Spending Account"** means the account established for a Participant pursuant to this Article to which part of his Cafeteria Plan Benefit Dollars may be allocated and from which Employment-Related Dependent Care Expenses of the Participant may be reimbursed for the care of the Qualifying Dependents of Participants.

(b) **"Earned Income"** means earned income as defined under Code Section 32(c)(2), but excluding such amounts paid or incurred by the Employer for dependent care assistance to the Participant.

(c) **"Employment-Related Dependent Care Expenses"** means the amounts paid for expenses of a Participant for those services which if paid by the Participant would be considered employment related expenses under Code Section 21(b)(2). Generally, they shall include expenses for household services and for the care of a Qualifying Dependent, to the extent that such expenses are incurred to enable the Participant to be gainfully employed for any period for which there are one or more Qualifying Dependents with respect to such Participant. Employment-Related Dependent Care Expenses are treated as having been incurred when the Participant's Qualifying Dependents are provided with the dependent care that gives rise to the Employment-Related Dependent Care Expenses, not when the Participant is formally billed or charged for, or pays for the dependent care. The determination of whether an amount qualifies as an Employment-Related Dependent Care Expense shall be made subject to the following rules:

(1) If such amounts are paid for expenses incurred outside the Participant's household, they shall constitute Employment-Related Dependent Care Expenses only if incurred for a Qualifying Dependent as defined in Section 7.2(d)(1) (or deemed to be, as described in Section 7.2(d)(1) pursuant to Section 7.2(d)(3)), or for a Qualifying Dependent as defined in Section 7.2(d)(2) (or deemed to be, as described in Section 7.2(d)(2) pursuant to Section 7.2(d)(3)) who regularly spends at least 8 hours per day in the Participant's household;

(2) If the expense is incurred outside the Participant's home at a facility that provides care for a fee, payment, or grant for more than 6 individuals who do not regularly reside at the facility, the facility must comply with all applicable state and local laws and regulations, including licensing requirements, if any; and

(3) Employment-Related Dependent Care Expenses of a Participant shall not include amounts paid or incurred to a child of such Participant who is under the age of 19 or to an individual who is a Dependent of such Participant or such Participant's Spouse.

(d) **"Qualifying Dependent"** means, for Dependent Care Flexible Spending Account purposes,

(1) a Participant's Dependent (as defined in Code Section 152(a)(1)) who has not attained age 13;

(2) a Dependent or the Spouse of a Participant who is physically or mentally incapable of caring for himself or herself and has the same principal place of abode as the Participant for more than one-half of such taxable year; or

(3) a child that is deemed to be a Qualifying Dependent described in paragraph (1) or (2) above, whichever is appropriate, pursuant to Code Section 21(e)(5).

(e) The definitions of Article I are hereby incorporated by reference to the extent necessary to interpret and apply the provisions of this Dependent Care Flexible Spending Account.

7.3 DEPENDENT CARE FLEXIBLE SPENDING ACCOUNTS

The Administrator shall establish a Dependent Care Flexible Spending Account for each Participant who elects to apply Cafeteria Plan Benefit Dollars to Dependent Care Flexible Spending Account benefits.

7.4 INCREASES IN DEPENDENT CARE FLEXIBLE SPENDING ACCOUNTS

A Participant's Dependent Care Flexible Spending Account shall be increased each pay period by the portion of Cafeteria Plan Benefit Dollars that he has elected to apply toward his Dependent Care Flexible Spending Account pursuant to elections made under Article V hereof.

7.5 DECREASES IN DEPENDENT CARE FLEXIBLE SPENDING ACCOUNTS

A Participant's Dependent Care Flexible Spending Account shall be reduced by the amount of any Employment-Related Dependent Care Expense reimbursements paid or incurred on behalf of a Participant pursuant to Section 7.12 hereof.

7.6 ALLOWABLE DEPENDENT CARE REIMBURSEMENT

Subject to limitations contained in Section 7.9 of this Program, and to the extent of the amount contained in the Participant's Dependent Care Flexible Spending Account, a Participant who incurs Employment-Related Dependent Care Expenses shall be entitled to receive from the Employer full reimbursement for the entire amount of such expenses incurred during the Plan Year or portion thereof during which he is a Participant.

7.7 ANNUAL STATEMENT OF BENEFITS

On or before January 31st of each calendar year, the Employer shall furnish to each Employee who was a Participant and received benefits under Section 7.6 during the prior calendar year, a statement of all such benefits paid to or on behalf of such Participant during the prior calendar year. This statement is set forth on the Participant's Form W-2.

7.8 FORFEITURES

The amount in a Participant's Dependent Care Flexible Spending Account as of the end of any Plan Year (and after the processing of all claims for such Plan Year pursuant to Section 7.12 hereof) shall be forfeited and credited to the benefit plan surplus. In such event, the Participant shall have no further claim to such amount for any reason.

7.9 LIMITATION ON PAYMENTS

(a) **Code limits.** Notwithstanding any provision contained in this Article to the contrary, amounts paid from a Participant's Dependent Care Flexible Spending Account in or on account of any taxable year of the Participant shall not exceed the lesser of the Earned Income limitation described in Code Section 129(b) or $5,000 ($2,500 if a separate tax return is filed by a Participant who is married as determined under the rules of paragraphs (3) and (4) of Code Section 21(e)).

7.10 NONDISCRIMINATION REQUIREMENTS

(a) **Intent to be nondiscriminatory.** It is the intent of this Dependent Care Flexible Spending Account that contributions or benefits not discriminate in favor of the group of employees in whose favor discrimination may not occur under Code Section 129(d).

(b) **25% test for shareholders.** It is the intent of this Dependent Care Flexible Spending Account that not more than 25 percent of the amounts paid by the Employer for dependent care assistance during the Plan Year will be provided for the class of individuals who are shareholders or owners (or their Spouses or Dependents), each of whom (on any day of the Plan Year) owns more than 5 percent of the stock or of the capital or profits interest in the Employer.

(c) **Adjustment to avoid test failure.** If the Administrator deems it necessary to avoid discrimination or possible taxation to a group of employees in whose favor discrimination may not occur in violation of Code Section 129 it may, but shall not be required to, reject any elections or reduce contributions or non-taxable benefits in order to assure compliance with this Section. Any act taken by the Administrator under this Section shall be carried out in a uniform and nondiscriminatory manner. If the Administrator decides to reject any elections or reduce contributions or Benefits, it shall be done in the following manner. First, the Benefits designated for the Dependent Care Flexible Spending Account by the affected Participant that elected to contribute the highest amount to such account for the Plan Year shall be reduced until the nondiscrimination tests set forth in this Section are satisfied, or until the amount designated for the account equals the amount designated for the account of the affected Participant who has elected the second highest contribution to the Dependent Care Flexible Spending Account for the Plan Year. This process shall continue until the nondiscrimination tests set forth in this Section are satisfied. Contributions which are not utilized to provide Benefits to any Participant by virtue of any administrative act under this paragraph shall be forfeited.

7.11 COORDINATION WITH CAFETERIA PLAN

All Participants under the Cafeteria Plan are eligible to receive Benefits under this Dependent Care Flexible Spending Account. The enrollment and termination of participation under the Cafeteria Plan shall constitute enrollment and termination of participation under this Dependent Care Flexible Spending Account. In addition, other matters concerning contributions, elections and the like shall be governed by the general provisions of the Cafeteria Plan.

7.12 DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT CLAIMS

The Administrator shall direct the payment of all such Dependent Care claims to the Participant upon the presentation to the Administrator of documentation of such expenses in a form satisfactory to the Administrator. However, in the Administrator's discretion, payments may be made directly to the service provider. In its discretion in administering the Plan, the Administrator may utilize forms and require documentation of costs as may be necessary to verify the claims submitted. At a minimum, the form shall include a statement from an independent third party as proof that the expense has been incurred during the Plan Year and the amount of such expense. In addition, the Administrator may require that each Participant who desires to receive reimbursement under this Program for Employment-Related Dependent Care Expenses submit a statement which may contain some or all of the following information:

(a) The Dependent or Dependents for whom the services were performed;

(b) The nature of the services performed for the Participant, the cost of which he wishes reimbursement;

(c) The relationship, if any, of the person performing the services to the Participant;

(d) If the services are being performed by a child of the Participant, the age of the child;

(e) A statement as to where the services were performed;

(f) If any of the services were performed outside the home, a statement as to whether the Dependent for whom such services were performed spends at least 8 hours a day in the Participant's household;

(g) If the services were being performed in a day care center, a statement:

(1) that the day care center complies with all applicable laws and regulations of the state of residence,

(2) that the day care center provides care for more than 6 individuals (other than individuals residing at the center), and

(3) of the amount of fee paid to the provider.

(h) If the Participant is married, a statement containing the following:

(1) the Spouse's salary or wages if he or she is employed, or

(2) if the Participant's Spouse is not employed, that

(i) he or she is incapacitated, or

(ii) he or she is a full-time student attending an educational institution and the months during the year which he or she attended such institution.

(i) **Claims for reimbursement.** If a Participant fails to submit a claim within 90 days after the end of the Plan Year, those claims shall not be considered for reimbursement by the Administrator. However, if a Participant terminates employment during the Plan Year, claims for reimbursement must be submitted within 90 days after termination of employment.

ARTICLE VIII
BENEFITS AND RIGHTS

8.1 CLAIM FOR BENEFITS

(a) **Insurance claims.** Any claim for Benefits underwritten by Insurance Contract(s) shall be made to the Insurer. If the Insurer denies any claim, the Participant or beneficiary shall follow the Insurer's claims review procedure.

(b) **Dependent Care Flexible Spending Account or Health Flexible Spending Account claims.** Any claim for Dependent Care Flexible Spending Account or Health Flexible Spending Account Benefits shall be made to the Administrator. For the Health Flexible Spending Account, if a Participant fails to submit a claim within 90 days after the end of the Plan Year, those claims shall not be considered for reimbursement by the Administrator. However, if a Participant terminates employment during the Plan Year, claims for the reimbursement of Medical Expenses must be submitted within 90 days after termination of

employment. For the Dependent Care Flexible Spending Account, if a Participant fails to submit a claim within 90 days after the end of the Plan Year, those claims shall not be considered for reimbursement by the Administrator. However, if a Participant terminates employment during the Plan Year, claims for reimbursement must be submitted within 90 days after termination of employment. If the Administrator denies a claim, the Administrator may provide notice to the Participant or beneficiary, in writing, within 90 days after the claim is filed unless special circumstances require an extension of time for processing the claim. The notice of a denial of a claim shall be written in a manner calculated to be understood by the claimant and shall set forth:

(1) specific references to the pertinent Plan provisions on which the denial is based;

(2) a description of any additional material or information necessary for the claimant to perfect the claim and an explanation as to why such information is necessary; and

(3) an explanation of the Plan's claim procedure.

(c) **Appeal.** Within 180 days after receipt of the above material, the claimant shall have a reasonable opportunity to appeal the claim denial to the Administrator for a full and fair review. The claimant or his duly authorized representative may:

(1) request a review upon written notice to the Administrator;

(2) review pertinent documents; and

(3) submit issues and comments in writing.

(d) **Review of appeal.** A decision on the review by the Administrator will be made not later than 60 days after receipt of a request for review, unless special circumstances require an extension of time for processing (such as the need to hold a hearing), in which event a decision should be rendered as soon as possible, but in no event later than 120 days after such receipt. The decision of the Administrator shall be written and shall include specific reasons for the decision, written in a manner calculated to be understood by the claimant, with specific references to the pertinent Plan provisions on which the decision is based.

(e) **Forfeitures.** Any balance remaining in the Participant's Health Flexible Spending Account (excluding any carryover) or Dependent Care Flexible Spending Account as of the end of the time for claims reimbursement for each Plan Year shall be forfeited and deposited in the benefit plan surplus of the Employer pursuant to Section 6.3 or Section 7.8, whichever is applicable, unless the Participant had made a claim for such Plan Year, in writing, which has been denied or is pending; in which event the amount of the claim shall be held in his account until the claim appeal procedures set forth above have been satisfied or the claim is paid. If any such claim is denied on appeal, the amount held beyond the end of the Plan Year shall be forfeited and credited to the benefit plan surplus.

8.2 APPLICATION OF BENEFIT PLAN SURPLUS

Any forfeited amounts credited to the benefit plan surplus by virtue of the failure of a Participant to incur a qualified expense or seek reimbursement in a timely manner may, but need not be, separately accounted for after the close of the Plan Year (or after such further time specified herein for the filing of claims) in which such forfeitures arose. In no event shall such amounts be carried over to reimburse a Participant for expenses incurred during a subsequent Plan Year for the same or any other Benefit available under the Plan (excepting any carryover); nor shall amounts forfeited by a particular Participant be made available to such Participant in any other form or manner, except as permitted by Treasury regulations. Amounts in the benefit plan surplus shall be used to defray any administrative costs and experience losses or used to provide additional benefits under the Plan.

ARTICLE IX
ADMINISTRATION

9.1 PLAN ADMINISTRATION

The Employer shall be the Administrator, unless the Employer elects otherwise. The Employer may appoint any person, including, but not limited to, the Employees of the Employer, to perform the duties of the Administrator. Any person so appointed shall signify acceptance by filing acceptance in writing (or such other form as acceptable to both parties) with the Employer. Upon the resignation or removal of any individual performing the duties of the Administrator, the Employer may designate a successor.

If the Employer elects, the Employer shall appoint one or more Administrators. Any person, including, but not limited to, the Employees of the Employer, shall be eligible to serve as an Administrator. Any person so appointed shall signify acceptance by filing acceptance in writing (or such other form as acceptable to both parties) with the Employer. An Administrator may resign by delivering a resignation in writing (or such other form as acceptable to both parties) to the Employer or be removed by the Employer by delivery of notice of removal (in writing or such other form as acceptable to both parties), to take effect at a date specified therein, or upon delivery to the Administrator if no date is specified. The Employer shall be empowered to appoint and remove the Administrator from time to time as it deems necessary for the proper administration of the Plan to ensure that the Plan is being operated for the exclusive benefit of the Employees entitled to participate in the Plan in accordance with the terms of the Plan and the Code.

The operation of the Plan shall be under the supervision of the Administrator. It shall be a principal duty of the Administrator to see that the Plan is carried out in accordance with its terms, and for the exclusive benefit of Employees entitled to participate in the Plan. The Administrator shall have full power and discretion to administer the Plan in all of its details and determine all questions arising in connection with the administration, interpretation, and application of the Plan. The Administrator may establish procedures, correct any defect, supply any information, or reconciles any inconsistency in such manner and to such extent as shall be deemed necessary or advisable to carry out the purpose of the Plan. The Administrator shall have all powers necessary or appropriate to accomplish the Administrator's duties under the Plan. The Administrator shall be charged with the duties of the general administration of the Plan as set forth under the Plan, including, but not limited to, in addition to all other powers provided by this Plan:

(a) To make and enforce such procedures, rules and regulations as the Administrator deems necessary or proper for the efficient administration of the Plan;

(b) To interpret the provisions of the Plan, the Administrator's interpretations thereof in good faith to be final and conclusive on all persons claiming benefits by operation of the Plan;

(c) To decide all questions concerning the Plan and the eligibility of any person to participate in the Plan and to receive benefits provided by operation of the Plan;

(d) To reject elections or to limit contributions or Benefits for certain highly compensated participants if it deems such to be desirable in order to avoid discrimination under the Plan in violation of applicable provisions of the Code;

(e) To provide Employees with a reasonable notification of their benefits available by operation of the Plan and to assist any Participant regarding the Participant's rights, benefits or elections under the Plan;

(f) To keep and maintain the Plan documents and all other records pertaining to and necessary for the administration of the Plan;

(g) To review and settle all claims against the Plan, to approve reimbursement requests, and to authorize the payment of benefits if the Administrator determines such shall be paid if the Administrator decides in its discretion that the applicant is entitled to them. This authority specifically permits the Administrator to settle disputed claims for benefits and any other disputed claims made against the Plan;

(h) To appoint such agents, counsel, accountants, consultants, and other persons or entities as may be required to assist in administering the Plan.

Any procedure, discretionary act, interpretation or construction taken by the Administrator shall be done in a nondiscriminatory manner based upon uniform principles consistently applied and shall be consistent with the intent that the Plan shall continue to comply with the terms of Code Section 125 and the Treasury regulations thereunder.

9.2 EXAMINATION OF RECORDS

The Administrator shall make available to each Participant, Eligible Employee and any other Employee of the Employer such records as pertain to their interest under the Plan for examination at reasonable times during normal business hours.

9.3 PAYMENT OF EXPENSES

Any reasonable administrative expenses shall be paid by the Employer unless the Employer determines that administrative costs shall be borne by the Participants under the Plan or by any Trust Fund which may be established hereunder. The Administrator may impose reasonable conditions for payments, provided that such conditions shall not discriminate in favor of highly compensated employees.

9.4 INSURANCE CONTROL CLAUSE

In the event of a conflict between the terms of this Plan and the terms of an Insurance Contract of an independent third party Insurer whose product is then being used in conjunction with this Plan, the terms of the Insurance Contract shall control as to those Participants receiving coverage under such Insurance Contract. For this purpose, the Insurance Contract shall control in defining the persons eligible for insurance, the dates of their eligibility, the conditions which must be satisfied to become insured, if any, the benefits Participants are entitled to and the circumstances under which insurance terminates.

9.5 INDEMNIFICATION OF ADMINISTRATOR

The Employer agrees to indemnify and to defend to the fullest extent permitted by law any Employee serving as the Administrator or as a member of a committee designated as Administrator (including any Employee or former Employee who previously served as Administrator or as a member of such committee) against all liabilities, damages, costs and expenses (including attorney's fees and amounts paid in settlement of any claims approved by the Employer) occasioned by any act or omission to act in connection with the Plan, if such act or omission is in good faith.

ARTICLE X
AMENDMENT OR TERMINATION OF PLAN

10.1 AMENDMENT

The Employer, at any time or from time to time, may amend any or all of the provisions of the Plan without the consent of any Employee or Participant. No amendment shall have the effect of modifying any benefit election of any Participant in effect at the time of such amendment, unless such amendment is made to comply with Federal, state or local laws, statutes or regulations.

10.2 TERMINATION

The Employer reserves the right to terminate this Plan, in whole or in part, at any time. In the event the Plan is terminated, no further contributions shall be made. Benefits under any Insurance Contract shall be paid in accordance with the terms of the Insurance Contract.

No further additions shall be made to the Health Flexible Spending Account or Dependent Care Flexible Spending Account, but all payments from such fund shall continue to be made according to the elections in effect until 90 days after the termination date of the Plan. Any amounts remaining in any such fund or account as of the end of such period shall be forfeited and deposited in the benefit plan surplus after the expiration of the filing period.

ARTICLE XI
MISCELLANEOUS

11.1 PLAN INTERPRETATION

All provisions of this Plan shall be interpreted and applied in a uniform, nondiscriminatory manner. This Plan shall be read in its entirety and not severed except as provided in Section 11.12.

11.2 GENDER, NUMBER AND TENSE

Wherever any words are used herein in one gender, they shall be construed as though they were also used in all genders in all cases where they would so apply; whenever any words are used herein in the singular or plural form, they shall be construed as though they were also used in the other form in all cases where they would so apply; and whenever any words are used herein in the past or present tense, they shall be construed as though they were also used in the other form in all cases where they would so apply.

11.3 WRITTEN DOCUMENT

This Plan, in conjunction with any separate written document which may be required by law, is intended to satisfy the written Plan requirement of Code Section 125 and any Treasury regulations thereunder relating to cafeteria plans.

11.4 EXCLUSIVE BENEFIT

This Plan shall be maintained for the exclusive benefit of the Employees who participate in the Plan.

11.5 PARTICIPANT'S RIGHTS

This Plan shall not be deemed to constitute an employment contract between the Employer and any Participant or to be a consideration or an inducement for the employment of any Participant or Employee. Nothing contained in this Plan shall be deemed to give any Participant or Employee the right to be retained in the service of the Employer or to interfere with the right of the Employer to discharge any Participant or Employee at any time regardless of the effect which such discharge shall have upon him as a Participant of this Plan.

11.6 ACTION BY THE EMPLOYER

Whenever the Employer under the terms of the Plan is permitted or required to do or perform any act or matter or thing, it shall be done and performed by a person duly authorized by its legally constituted authority.

11.7 EMPLOYER'S PROTECTIVE CLAUSES

(a) **Insurance purchase.** Upon the failure of either the Participant or the Employer to obtain the insurance contemplated by this Plan (whether as a result of negligence, gross neglect or otherwise), the Participant's Benefits shall be limited to the insurance premium(s), if any, that remained unpaid for the period in question and the actual insurance proceeds, if any, received by the Employer or the Participant as a result of the Participant's claim.

(b) **Validity of insurance contract.** The Employer shall not be responsible for the validity of any Insurance Contract issued hereunder or for the failure on the part of the Insurer to make payments provided for under any Insurance

Contract. Once insurance is applied for or obtained, the Employer shall not be liable for any loss which may result from the failure to pay Premiums to the extent Premium notices are not received by the Employer.

11.8 NO GUARANTEE OF TAX CONSEQUENCES

Neither the Administrator nor the Employer makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant under the Plan will be excludable from the Participant's gross income for federal or state income tax purposes, or that any other federal or state tax treatment will apply to or be available to any Participant. It shall be the obligation of each Participant to determine whether each payment under the Plan is excludable from the Participant's gross income for federal and state income tax purposes, and to notify the Employer if the Participant has reason to believe that any such payment is not so excludable. Notwithstanding the foregoing, the rights of Participants under this Plan shall be legally enforceable.

11.9 INDEMNIFICATION OF EMPLOYER BY PARTICIPANTS

If any Participant receives one or more payments or reimbursements under the Plan that are not for a permitted Benefit, such Participant shall indemnify and reimburse the Employer for any liability it may incur for failure to withhold federal or state income tax or Social Security tax from such payments or reimbursements. However, such indemnification and reimbursement shall not exceed the amount of additional federal and state income tax (plus any penalties) that the Participant would have owed if the payments or reimbursements had been made to the Participant as regular cash compensation, plus the Participant's share of any Social Security tax that would have been paid on such compensation, less any such additional income and Social Security tax actually paid by the Participant.

11.10 FUNDING

Unless otherwise required by law, contributions to the Plan need not be placed in trust or dedicated to a specific Benefit, but may instead be considered general assets of the Employer. Furthermore, and unless otherwise required by law, nothing herein shall be construed to require the Employer or the Administrator to maintain any fund or segregate any amount for the benefit of any Participant, and no Participant or other person shall have any claim against, right to, or security or other interest in, any fund, account or asset of the Employer from which any payment under the Plan may be made.

11.11 GOVERNING LAW

This Plan is governed by the Code and the Treasury regulations issued thereunder (as they might be amended from time to time). In no event shall the Employer guarantee the favorable tax treatment sought by this Plan. To the extent not preempted by Federal law, the provisions of this Plan shall be construed, enforced and administered according to the laws of the Commonwealth of Kentucky.

11.12 SEVERABILITY

If any provision of the Plan is held invalid or unenforceable, its invalidity or unenforceability shall not affect any other provisions of the Plan, and the Plan shall be construed and enforced as if such provision had not been included herein.

11.13 CAPTIONS

The captions contained herein are inserted only as a matter of convenience and for reference, and in no way define, limit, enlarge or describe the scope or intent of the Plan, nor in any way shall affect the Plan or the construction of any provision thereof.

11.14 HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

Notwithstanding anything in this Plan to the contrary, this Plan shall be operated in accordance with HIPAA and regulations thereunder.

11.15 UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)

Notwithstanding any provision of this Plan to the contrary, contributions, benefits and service credit with respect to qualified military service shall be provided in accordance with the Uniform Services Employment And Reemployment Rights Act (USERRA) and the regulations thereunder.

11.16 COMPLIANCE WITH HIPAA PRIVACY STANDARDS

(a) **Application.** If any benefits under this Cafeteria Plan are subject to the Standards for Privacy of Individually Identifiable Health Information (45 CFR Part 164, the "Privacy Standards"), then this Section shall apply.

(b) **Disclosure of PHI.** The Plan shall not disclose Protected Health Information to any member of the Employer's workforce unless each of the conditions set out in this Section are met. "Protected Health Information" shall have the same definition as set forth in the Privacy Standards but generally shall mean individually identifiable information about the past, present or future physical or mental health or condition of an individual, including genetic information and information about treatment or payment for treatment.

(c) **PHI disclosed for administrative purposes.** Protected Health Information disclosed to members of the Employer's workforce shall be used or disclosed by them only for purposes of Plan administrative functions. The Plan's administrative functions shall include all Plan payment functions and health care operations. The terms "payment" and "health care operations" shall have the same definitions as set out in the Privacy Standards, but the term "payment" generally shall mean activities taken to determine or fulfill Plan responsibilities with respect to eligibility, coverage, provision of benefits, or reimbursement for health care. Protected Health Information that consists of genetic information will not be used or disclosed for underwriting purposes.

(d) **PHI disclosed to certain workforce members.** The Plan shall disclose Protected Health Information only to members of the Employer's workforce who are designated and authorized to receive such Protected Health Information, and only to the extent and in the minimum amount necessary for that person to perform his or her duties with respect to the Plan. "Members of the Employer's workforce" shall refer to all employees and other persons under the control of the Employer. The Employer shall keep an updated list of those authorized to receive Protected Health Information.

(1) An authorized member of the Employer's workforce who receives Protected Health Information shall use or disclose the Protected Health Information only to the extent necessary to perform his or her duties with respect to the Plan.

(2) In the event that any member of the Employer's workforce uses or discloses Protected Health Information other than as permitted by this Section and the Privacy Standards, the incident shall be reported to the Plan's privacy official. The privacy official shall take appropriate action, including:

(i) investigation of the incident to determine whether the breach occurred inadvertently, through negligence or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach;

(ii) appropriate sanctions against the persons causing the breach which, depending upon the nature of the breach, may include oral or written reprimand, additional training, or termination of employment;

(iii) mitigation of any harm caused by the breach, to the extent practicable; and

(iv) documentation of the incident and all actions taken to resolve the issue and mitigate any damages.

(e) **Certification.** The Employer must provide certification to the Plan that it agrees to:

(1) Not use or further disclose the information other than as permitted or required by the Plan documents or as required by law;

(2) Ensure that any agent or subcontractor, to whom it provides Protected Health Information received from the Plan, agrees to the same restrictions and conditions that apply to the Employer with respect to such information;

(3) Not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer;

(4) Report to the Plan any use or disclosure of the Protected Health Information of which it becomes aware that is inconsistent with the uses or disclosures permitted by this Section, or required by law;

(5) Make available Protected Health Information to individual Plan members in accordance with Section 164.524 of the Privacy Standards;

(6) Make available Protected Health Information for amendment by individual Plan members and incorporate any amendments to Protected Health Information in accordance with Section 164.526 of the Privacy Standards;

(7) Make available the Protected Health Information required to provide an accounting of disclosures to individual Plan members in accordance with Section 164.528 of the Privacy Standards;

(8) Make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Department of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Standards;

(9) If feasible, return or destroy all Protected Health Information received from the Plan that the Employer still maintains in any form, and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and

(10) Ensure the adequate separation between the Plan and members of the Employer's workforce, as required by Section 164.504(f)(2)(iii) of the Privacy Standards and set out in (d) above.

11.17 COMPLIANCE WITH HIPAA ELECTRONIC SECURITY STANDARDS

Under the Security Standards for the Protection of Electronic Protected Health Information (45 CFR Part 164.300 et. seq., the "Security Standards"):

(a) **Implementation.** The Employer agrees to implement reasonable and appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of Electronic Protected Health Information that the Employer creates, maintains or transmits on behalf of the Plan. "Electronic Protected Health Information" shall have the same definition as set out in the Security Standards, but generally shall mean Protected Health Information that is transmitted by or maintained in electronic media.

(b) **Agents or subcontractors shall meet security standards.** The Employer shall ensure that any agent or subcontractor to whom it provides Electronic Protected Health Information shall agree, in writing, to implement reasonable and appropriate security measures to protect the Electronic Protected Health Information.

(c) **Employer shall ensure security standards.** The Employer shall ensure that reasonable and appropriate security measures are implemented to comply with the conditions and requirements set forth in Section 11.16.

11.18 MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT

Notwithstanding anything in the Plan to the contrary, the Plan will comply with the Mental Health Parity and Addiction Equity Act.

11.19 GENETIC INFORMATION NONDISCRIMINATION ACT (GINA)

Notwithstanding anything in the Plan to the contrary, the Plan will comply with the Genetic Information Nondiscrimination Act.

11.20 WOMEN'S HEALTH AND CANCER RIGHTS ACT

Notwithstanding anything in the Plan to the contrary, the Plan will comply with the Women's Health and Cancer Rights Act of 1998.

11.21 NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

Notwithstanding anything in the Plan to the contrary, the Plan will comply with the Newborns' and Mothers' Health Protection Act.

IN WITNESS WHEREOF, this Plan document is hereby executed this _____ day of 12/2/2022 | 13:33:51 EST.

Bullock Pen Water District

DocuSigned by:

By Ashley Dyer
C82E09E3569441E...

EMPLOYER

BULLOCK PEN WATER DISTRICT

FLEXIBLE SPENDING BENEFITS PLAN

SUMMARY PLAN DESCRIPTION

TABLE OF CONTENTS

I
ELIGIBILITY

1. When can I become a participant in the Plan? 1
2. What are the eligibility requirements for our Plan? 1
3. When is my entry date? 1
4. What must I do to enroll in the Plan? 1

II
OPERATION

1. How does this Plan operate? 1

III
CONTRIBUTIONS

1. How much of my pay may the Employer redirect? 2
2. What happens to contributions made to the Plan? 2
3. When must I decide which accounts I want to use? 2
4. When is the election period for our Plan? 2
5. May I change my elections during the Plan Year? 2
6. May I make new elections in future Plan Years? 3

IV
BENEFITS

1. Health Flexible Spending Account 3
2. Dependent Care Flexible Spending Account 3
3. Premium Expense Account 4

V
BENEFIT PAYMENTS

1. When will I receive payments from my accounts? 4
2. What happens if I don't spend all Plan contributions during the Plan Year? 4
3. Family and Medical Leave Act (FMLA) 5
4. Uniformed Services Employment and Reemployment Rights Act (USERRA) 5
5. What happens if I terminate employment? 5
6. Will my Social Security benefits be affected? 5

VI
HIGHLY COMPENSATED AND KEY EMPLOYEES

1. Do limitations apply to highly compensated employees? 5

VII
PLAN ACCOUNTING

1. Periodic Statements 6

VIII
GENERAL INFORMATION ABOUT OUR PLAN

1. General Plan Information 6
2. Employer Information 6
3. Plan Administrator Information 6
4. Service of Legal Process 6
5. Type of Administration 6
6. Claims Submission 6

IX
ADDITIONAL PLAN INFORMATION

1. Claims Process 7

X
SUMMARY

FLEXIBLE SPENDING BENEFITS PLAN

INTRODUCTION

We have amended the "Flexible Benefits Plan" that we previously established for you and other eligible employees. Under this Plan, you will be able to choose among certain benefits that we make available. The benefits that you may choose are outlined in this Summary Plan Description. We will also tell you about other important information concerning the amended Plan, such as the rules you must satisfy before you can join and the laws that protect your rights.

One of the most important features of our Plan is that the benefits being offered are generally ones that you are already paying for, but normally with money that has first been subject to income and Social Security taxes. Under our Plan, these same expenses will be paid for with a portion of your pay before Federal income or Social Security taxes are withheld. This means that you will pay less tax and have more money to spend and save.

Read this Summary Plan Description carefully so that you understand the provisions of our amended Plan and the benefits you will receive. This SPD describes the Plan's benefits and obligations as contained in the legal Plan document, which governs the operation of the Plan. The Plan document is written in much more technical and precise language. If the non-technical language in this SPD and the technical, legal language of the Plan document conflict, the Plan document always governs. Also, if there is a conflict between an insurance contract and either the Plan document or this Summary Plan Description, the insurance contract will control. If you wish to receive a copy of the legal Plan document, please contact the Administrator.

This SPD describes the current provisions of the Plan which are designed to comply with applicable legal requirements. The Plan is subject to federal laws, such as the Internal Revenue Code and other federal and state laws which may affect your rights. The provisions of the Plan are subject to revision due to a change in laws or due to pronouncements by the Internal Revenue Service (IRS) or other federal agencies. We may also amend or terminate this Plan. If the provisions of the Plan that are described in this SPD change, we will notify you.

We have attempted to answer most of the questions you may have regarding your benefits in the Plan. If this SPD does not answer all of your questions, please contact the Administrator (or other plan representative). The name and address of the Administrator can be found in the Article of this SPD entitled "General Information About the Plan."

I
ELIGIBILITY

1. When can I become a participant in the Plan?

Before you become a Plan member (referred to in this Summary Plan Description as a "Participant"), there are certain rules which you must satisfy. First, you must meet the eligibility requirements and be an active employee. After that, the next step is to actually join the Plan on the "entry date" that we have established for all employees. The "entry date" is defined in Question 3 below. You will also be required to complete certain application forms before you can enroll in the Plan.

2. What are the eligibility requirements for our Plan?

You will be eligible to join the Plan once you have satisfied the conditions for coverage under our group medical plan. Of course, if you were already a participant before this amendment, you will remain a participant.

3. When is my entry date?

You can join the Plan on the same day you can enter our group medical plan.

4. What must I do to enroll in the Plan?

Before you can join the Plan, you must complete an application to participate in the Plan. The application includes your personal choices for each of the benefits which are being offered under the Plan. You must also authorize us to set some of your earnings aside in order to pay for the benefits you have elected.

II
OPERATION

1. How does this Plan operate?

Before the start of each Plan Year, you will be able to elect to have some of your upcoming pay contributed to the Plan. These amounts will be used to pay for the benefits you have chosen. The portion of your pay that is paid to the Plan is not subject to Federal income or Social Security taxes. In other words, this allows you to use tax-free dollars to pay for certain kinds of benefits and expenses which you normally pay for with out-of-pocket, taxable dollars. However, if you receive a reimbursement for an expense under the Plan, you cannot claim a Federal income tax credit or deduction on your return. (See the Article entitled "General Information About Our Plan" for the definition of "Plan Year.")

III
CONTRIBUTIONS

1. How much of my pay may the Employer redirect?

Each year, you may elect to have us contribute on your behalf enough of your compensation to pay for the benefits that you elect under the Plan. These amounts will be deducted from your pay over the course of the year.

2. What happens to contributions made to the Plan?

Before each Plan Year begins, you will select the benefits you want and how much of the contributions should go toward each benefit. It is very important that you make these choices carefully based on what you expect to spend on each covered benefit or expense during the Plan Year. Later, they will be used to pay for the expenses as they arise during the Plan Year.

3. When must I decide which accounts I want to use?

You are required by Federal law to decide before the Plan Year begins, during the election period (defined below). You must decide two things. First, which benefits you want and, second, how much should go toward each benefit.

4. When is the election period for our Plan?

You will make your initial election on or before your entry date. (You should review Section I on Eligibility to better understand the eligibility requirements and entry date.) Then, for each following Plan Year, the election period is established by the Administrator and applied uniformly to all Participants. It will normally be a period of time prior to the beginning of each Plan Year. The Administrator will inform you each year about the election period. (See the Article entitled "General Information About Our Plan" for the definition of Plan Year.)

5. May I change my elections during the Plan Year?

Generally, you cannot change the elections you have made after the beginning of the Plan Year. However, there are certain limited situations when you can change your elections. You are permitted to change elections if you have a "change in status" and you make an election change that is consistent with the change in status. Currently, Federal law considers the following events to be a change in status:

-- Marriage, divorce, death of a spouse, legal separation or annulment;

-- Change in the number of dependents, including birth, adoption, placement for adoption, or death of a dependent;

-- Any of the following events for you, your spouse or dependent: termination or commencement of employment, a strike or lockout, commencement or return from an unpaid leave of absence, a change in worksite, or any other change in employment status that affects eligibility for benefits;

-- One of your dependents satisfies or ceases to satisfy the requirements for coverage due to change in age, student status, or any similar circumstance; and

-- A change in the place of residence of you, your spouse or dependent that would lead to a change in status, such as moving out of a coverage area for insurance.

In addition, if you are participating in the Dependent Care Flexible Spending Account, then there is a change in status if your dependent no longer meets the qualifications to be eligible for dependent care.

There are detailed rules on when a change in election is deemed to be consistent with a change in status. In addition, there are laws that give you rights to change health coverage for you, your spouse, or your dependents. If you change coverage due to rights you have under the law, then you can make a corresponding change in your elections under the Plan. If any of these conditions apply to you, you should contact the Administrator.

If the cost of a benefit provided under the Plan increases or decreases during a Plan Year, then we will automatically increase or decrease, as the case may be, your salary redirection election. If the cost increases significantly, you will be permitted to either make corresponding changes in your payments or revoke your election and obtain coverage under another benefit package option with similar coverage, or revoke your election entirely.

If the coverage under a Benefit is significantly curtailed or ceases during a Plan Year, then you may revoke your elections and elect to receive on a prospective basis coverage under another plan with similar coverage. In addition, if we add a new coverage option or eliminate an existing option, you may elect the newly-added option (or elect another option if an option has been eliminated) and make corresponding election changes to other options providing similar coverage. If you are not a Participant, you may elect to join the Plan. There are also certain situations when you may be able to change your elections on account of a change under the plan of your spouse's, former spouse's or dependent's employer.

These rules on change due to cost or coverage do not apply to the Health Flexible Spending Account, and you may not change your election to the Health Flexible Spending Account if you make a change due to cost or coverage for insurance.

You may not change your election under the Dependent Care Flexible Spending Account if the cost change is imposed by a dependent care provider who is your relative.

6. May I make new elections in future Plan Years?

Yes, you may. For each new Plan Year, you may change the elections that you previously made. You may also choose not to participate in the Plan for the upcoming Plan Year. If you do not make new elections during the election period before a new Plan Year begins, we will consider that to mean you have elected not to participate for the upcoming Plan Year.

IV
BENEFITS

1. Health Flexible Spending Account

The Health Flexible Spending Account enables you to pay for expenses allowed under Sections 105 and 213(d) of the Internal Revenue Code which are not covered by our insured medical plan and save taxes at the same time. The Health Flexible Spending Account allows you to be reimbursed by the Employer for expenses incurred by you and your dependents.

Drug costs, including insulin, may be reimbursed.

You may be reimbursed for "over the counter" drugs only if those drugs are prescribed for you. You may not, however, be reimbursed for the cost of other health care coverage maintained outside of the Plan, or for long-term care expenses. A list of covered expenses is available from the Administrator.

The most that you can contribute to your Health Flexible Spending Account each Plan Year is up to the IRS maximum. For any short Plan Year, the most that you can contribute to your Health Flexible Spending Account each Plan Year is prorated. In addition, you will be eligible to carryover amounts left in your Health Flexible Spending Account, up to the Carryover IRS maximum. This means that amounts you do not use during a Plan Year can be carried over to the next Plan Year and used for expenses incurred in the next Plan Year.

In order to be reimbursed for a health care expense, you must submit to the Administrator an itemized bill from the service provider. We will also provide you with a debit or credit card to use to pay for medical expenses. The Administrator will provide you with further details. Amounts reimbursed from the Plan may not be claimed as a deduction on your personal income tax return. Reimbursement from the fund shall be paid at least once a month. Expenses under this Plan are treated as being "incurred" when you are provided with the care that gives rise to the expenses, not when you are formally billed or charged, or you pay for the medical care.

You may be reimbursed for expenses for any child until the end of the calendar year in which the child reaches age 26. A child is a natural child, stepchild, foster child, adopted child, or a child placed with you for adoption. If a child gains or regains eligibility due to these new rules, that qualifies as a change in status to change coverage.

Newborns' and Mothers' Health Protection Act: Group health plans generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers 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).

Women's Health and Cancer Rights Act: This plan, as required by the Women's Health and Cancer Rights Act of 1998, will reimburse up to plan limits for benefits for mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema). Contact your Plan Administrator for more information.

2. Dependent Care Flexible Spending Account

The Dependent Care Flexible Spending Account enables you to pay for out-of-pocket, work-related dependent day-care cost with pre-tax dollars. If you are married, you can use the account if you and your spouse both work or, in some situations, if your spouse goes to school full-time. Single employees can also use the account.

An eligible dependent is someone for whom you can claim expenses on Federal Income Tax Form 2441 "Credit for Child and Dependent Care Expenses." Children must be under age 13. Other dependents must be physically or mentally unable to care for themselves. Dependent Care arrangements which qualify include:

(a) A Dependent (Day) Care Center, provided that if care is provided by the facility for more than six individuals, the facility complies with applicable state and local laws;

(b) An Educational Institution for pre-school children. For older children, only expenses for non-school care are eligible; and

(c) An "Individual" who provides care inside or outside your home: The "Individual" may not be a child of yours under age 19 or anyone you claim as a dependent for Federal tax purposes.

You should make sure that the dependent care expenses you are currently paying for qualify under our Plan.

The law places limits on the amount of money that can be paid to you in a calendar year from your Dependent Care Flexible Spending Account. Generally, your reimbursements may not exceed the lesser of: (a) $5,000 (if you are married filing a joint return or you are head of a household) or $2,500 (if you are married filing separate returns); (b) your taxable compensation; (c) your spouse's actual or deemed earned income (a spouse who is a full time student or incapable of caring for himself/herself has a monthly earned income of $250 for one dependent or $500 for two or more dependents).

Also, in order to have the reimbursements made to you from this account be excludable from your income, you must provide a statement from the service provider including the name, address, and in most cases, the taxpayer identification number of the service provider on your tax form for the year, as well as the amount of such expense as proof that the expense has been incurred. In addition, Federal tax laws permit a tax credit for certain dependent care expenses you may be paying for even if you are not a Participant in this Plan. You may save more money if you take advantage of this tax credit rather than using the Dependent Care Flexible Spending Account under our Plan. Ask your tax adviser which is better for you.

3. Premium Expense Account

A Premium Expense Account allows you to use tax-free dollars to pay for certain premium expenses under various insurance programs that we offer you. These premium expenses include:

-- Health care premiums under our insured group medical plan.

-- Cancer insurance premiums.

-- Other insurance coverage that we may provide.

Under our Plan, we will establish sub-accounts for you for each different type of insurance coverage that is available. Also, certain limits on the amount of coverage may apply.

The Administrator may terminate or modify Plan benefits at any time, subject to the provisions of any insurance contracts providing benefits described above. We will not be liable to you if an insurance company fails to provide any of the benefits described above. Also, your insurance will end when you leave employment, are no longer eligible under the terms of any insurance policies, or when insurance terminates.

Any benefits to be provided by insurance will be provided only after (1) you have provided the Administrator the necessary information to apply for insurance, and (2) the insurance is in effect for you.

If you cover your children up to age 26 under your insurance, you can pay for that coverage through the Plan.

V
BENEFIT PAYMENTS

1. When will I receive payments from my accounts?

During the course of the Plan Year, you may submit requests for reimbursement of expenses you have incurred. Expenses are considered "incurred" when the service is performed, not necessarily when it is paid for. The Administrator will provide you with acceptable forms for submitting these requests for reimbursement. If the request qualifies as a benefit or expense that the Plan has agreed to pay, you will receive a reimbursement payment soon thereafter. Remember, these reimbursements which are made from the Plan are generally not subject to federal income tax or withholding. Nor are they subject to Social Security taxes. Requests for payment of insured benefits should be made directly to the insurer. You will only be reimbursed from the Dependent Care Flexible Spending Account to the extent that there are sufficient funds in the Account to cover your request.

2. What happens if I don't spend all Plan contributions during the Plan Year?

Any monies left at the end of the Plan Year will be forfeited, except for $500 that can be carried over into the next Plan Year. Obviously, qualifying expenses that you incur late in the Plan Year for which you seek reimbursement after the end of such Plan Year will be paid first before any amount is forfeited. For the Health Flexible Spending Account, you must submit claims no later than 90 days after the end of the Plan Year. For the Dependent Care Flexible Spending Account, you must submit claims no later than 90 days after the end of the Plan Year. Because it is possible that you might forfeit amounts in the Plan if you do not fully use the contributions that have been made, it is important that you decide how much to place in each account carefully and conservatively. Remember, you must decide which

benefits you want to contribute to and how much to place in each account before the Plan Year begins. You want to be as certain as you can that the amount you decide to place in each account will be used up entirely.

3. Family and Medical Leave Act (FMLA)

If you take leave under the Family and Medical Leave Act, you may revoke or change your existing elections for health insurance and the Health Flexible Spending Account. If your coverage in these benefits terminates, due to your revocation of the benefit while on leave or due to your non-payment of contributions, you will be permitted to reinstate coverage for the remaining part of the Plan Year upon your return. For the Health Flexible Spending Account, you may continue your coverage or you may revoke your coverage and resume it when you return. You can resume your coverage at its original level and make payments for the time that you are on leave. For example, if you elect $1,200 for the year and are out on leave for 3 months, then return and elect to resume your coverage at that level, your remaining payments will be increased to cover the difference - from $100 per month to $150 per month. Alternatively your maximum amount will be reduced proportionately for the time that you were gone. For example, if you elect $1,200 for the year and are out on leave for 3 months, your amount will be reduced to $900. The expenses you incur during the time you are not in the Health Flexible Spending Account are not reimbursable.

If you continue your coverage during your unpaid leave, you may pre-pay for the coverage, you may pay for your coverage on an after-tax basis while you are on leave, or you and your Employer may arrange a schedule for you to "catch up" your payments when you return.

4. Uniformed Services Employment and Reemployment Rights Act (USERRA)

If you are going into or returning from military service, you may have special rights to health care coverage under your Health Flexible Spending Account under the Uniformed Services Employment and Reemployment Rights Act of 1994. These rights can include extended health care coverage. If you may be affected by this law, ask your Administrator for further details.

5. What happens if I terminate employment?

If you terminate employment during the Plan Year, your right to benefits will be determined in the following manner:

(a) You will remain covered by insurance, but only for the period for which premiums have been paid prior to your termination of employment.

(b) You will still be able to request reimbursement for qualifying dependent care expenses incurred prior to your date of termination from the balance remaining in your dependent care account at the time of termination of employment. However, no further salary redirection contributions will be made on your behalf after you terminate. You must submit claims within 90 days after termination.

(c) Your participation in the Health Flexible Spending Account will cease, and no further salary redirection contributions will be contributed on your behalf. However, you will be able to submit claims for health care expenses that were incurred before the end of the period for which payments to the Health Flexible Spending Account have already been made. You must submit claims within 90 days after termination.

6. Will my Social Security benefits be affected?

Your Social Security benefits may be slightly reduced because when you receive tax-free benefits under our Plan, it reduces the amount of contributions that you make to the Federal Social Security system as well as our contribution to Social Security on your behalf.

VI
HIGHLY COMPENSATED AND KEY EMPLOYEES

1. Do limitations apply to highly compensated employees?

Under the Internal Revenue Code, highly compensated employees and key employees generally are Participants who are officers, shareholders or highly paid. You will be notified by the Administrator each Plan Year whether you are a highly compensated employee or a key employee.

If you are within these categories, the amount of contributions and benefits for you may be limited so that the Plan as a whole does not unfairly favor those who are highly paid, their spouses or their dependents. Federal tax laws state that a plan will be considered to unfairly favor the key employees if they as a group receive more than 25% of all of the nontaxable benefits provided for under our Plan.

Plan experience will dictate whether contribution limitations on highly compensated employees or key employees will apply. You will be notified of these limitations if you are affected.

VII
PLAN ACCOUNTING

1. Periodic Statements

The Administrator will provide you with a statement of your account periodically during the Plan Year that shows your account balance. It is important to read these statements carefully so you understand the balance remaining to pay for a benefit. Remember, you want to spend all the money you have designated for a particular benefit by the end of the Plan Year.

VIII
GENERAL INFORMATION ABOUT OUR PLAN

This Section contains certain general information which you may need to know about the Plan.

1. General Plan Information

Flexible Spending Benefits Plan is the name of the Plan.

Your Employer has assigned Plan Number 501 to your Plan.

The provisions of your amended Plan become effective on 01/01/2020. Your Plan was originally effective on 1/1/2014.

Your Plan's records are maintained on a twelve-month period of time. This is known as the Plan Year. The Plan Year begins on 1/1 and ends on 12/31.

2. Employer Information

Your Employer's name, address, and identification number are:

Bullock Pen Water District
1 Farrell Drive
Crittenden, Kentucky 41030
61-6017292

3. Plan Administrator Information

The name, address and business telephone number of your Plan's Administrator are:

Bullock Pen Water District
1 Farrell Drive
Crittenden, Kentucky 41030
(859) 428-2112

The Administrator keeps the records for the Plan and is responsible for the administration of the Plan. The Administrator will also answer any questions you may have about our Plan. You may contact the Administrator for any further information about the Plan.

4. Service of Legal Process

The name and address of the Plan's agent for service of legal process are:
Bullock Pen Water District
1 Farrell Drive
Crittenden, Kentucky 41030

5. Type of Administration

The type of Administration is Employer Administration.

6. Claims Submission

Claims for expenses should be submitted to:

Chard, Snyder & Associates, LLC
P.O. Box 249
Fort Washington, PA 19034-9998

IX
ADDITIONAL PLAN INFORMATION

1. Claims Process

You should submit all reimbursement claims during the Plan Year. For the Health Flexible Spending Account, you must submit claims no later than 90 days after the end of the Plan Year. However, if you terminate employment during the Plan Year, you must submit your Health Flexible Spending Account claims within 90 days after your termination of employment. For the Dependent Care Flexible Spending Account, you must submit claims no later than 90 days after the end of the Plan Year. However, if you terminate employment during the Plan Year, you must submit your Dependent Care Flexible Spending Account claims within 90 days after your termination of employment. Any claims submitted after that time will not be considered.

Claims that are insured will be handled in accordance with procedures contained in the insurance policies. All other general requests should be directed to the Administrator of our Plan. If a dependent care or medical expense claim under the Plan is denied in whole or in part, you or your beneficiary will receive written notification. The notification will include the reasons for the denial, with reference to the specific provisions of the Plan on which the denial was based, a description of any additional information needed to process the claim and an explanation of the claims review procedure. Within 180 days after denial, you or your beneficiary may submit a written request for reconsideration of the denial to the Administrator.

Any such request should be accompanied by documents or records in support of your appeal. You or your beneficiary may review pertinent documents and submit issues and comments in writing. The Administrator will review the claim and provide, within 60 days, a written response to the appeal. (This period may be extended an additional 60 days under certain circumstances.) In this response, the Administrator will explain the reason for the decision, with specific reference to the provisions of the Plan on which the decision is based. The Administrator has the exclusive right to interpret the appropriate plan provisions. Decisions of the Administrator are conclusive and binding.

X
SUMMARY

The money you earn is important to you and your family. You need it to pay your bills, enjoy recreational activities and save for the future. Our flexible benefits plan will help you keep more of the money you earn by lowering the amount of taxes you pay. The Plan is the result of our continuing efforts to find ways to help you get the most for your earnings.

If you have any questions, please contact the Administrator.

BULLOCK PEN WATER DISTRICT

FLEXIBLE SPENDING BENEFITS PLAN

SUMMARY PLAN DESCRIPTION

TABLE OF CONTENTS

I
ELIGIBILITY

1. When can I become a participant in the Plan? 1
2. What are the eligibility requirements for our Plan? 1
3. When is my entry date? 1
4. What must I do to enroll in the Plan? 1

II
OPERATION

1. How does this Plan operate? 1

III
CONTRIBUTIONS

1. How much of my pay may the Employer redirect? 2
2. What happens to contributions made to the Plan? 2
3. When must I decide which accounts I want to use? 2
4. When is the election period for our Plan? 2
5. May I change my elections during the Plan Year? 2
6. May I make new elections in future Plan Years? 3

IV
BENEFITS

1. Health Flexible Spending Account 3
2. Dependent Care Flexible Spending Account 3
3. Premium Expense Account 4

V
BENEFIT PAYMENTS

1. When will I receive payments from my accounts? 4
2. What happens if I don't spend all Plan contributions during the Plan Year? 5
3. Uniformed Services Employment and Reemployment Rights Act (USERRA) 5
4. What happens if I terminate employment? 5
5. Will my Social Security benefits be affected? 5

VI
HIGHLY COMPENSATED AND KEY EMPLOYEES

1. Do limitations apply to highly compensated employees? 5

VII
PLAN ACCOUNTING

1. Periodic Statements 5

VIII
GENERAL INFORMATION ABOUT OUR PLAN

1. General Plan Information 6
2. Employer Information 6

3. Plan Administrator Information 6
4. Service of Legal Process 6
5. Type of Administration 6
6. Claims Submission 6

IX
ADDITIONAL PLAN INFORMATION

1. Claims Process 6

X
SUMMARY

FLEXIBLE SPENDING BENEFITS PLAN

INTRODUCTION

We have amended the "Flexible Benefits Plan" that we previously established for you and other eligible employees. Under this Plan, you will be able to choose among certain benefits that we make available. The benefits that you may choose are outlined in this Summary Plan Description. We will also tell you about other important information concerning the amended Plan, such as the rules you must satisfy before you can join and the laws that protect your rights.

One of the most important features of our Plan is that the benefits being offered are generally ones that you are already paying for, but normally with money that has first been subject to income and Social Security taxes. Under our Plan, these same expenses will be paid for with a portion of your pay before Federal income or Social Security taxes are withheld. This means that you will pay less tax and have more money to spend and save.

Read this Summary Plan Description carefully so that you understand the provisions of our amended Plan and the benefits you will receive. This SPD describes the Plan's benefits and obligations as contained in the legal Plan document, which governs the operation of the Plan. The Plan document is written in much more technical and precise language. If the non-technical language in this SPD and the technical, legal language of the Plan document conflict, the Plan document always governs. Also, if there is a conflict between an insurance contract and either the Plan document or this Summary Plan Description, the insurance contract will control. If you wish to receive a copy of the legal Plan document, please contact the Administrator.

This SPD describes the current provisions of the Plan which are designed to comply with applicable legal requirements. The Plan is subject to federal laws, such as the Internal Revenue Code and other federal and state laws which may affect your rights. The provisions of the Plan are subject to revision due to a change in laws or due to pronouncements by the Internal Revenue Service (IRS) or other federal agencies. We may also amend or terminate this Plan. If the provisions of the Plan that are described in this SPD change, we will notify you.

We have attempted to answer most of the questions you may have regarding your benefits in the Plan. If this SPD does not answer all of your questions, please contact the Administrator (or other plan representative). The name and address of the Administrator can be found in the Article of this SPD entitled "General Information About the Plan."

I
ELIGIBILITY

1. When can I become a participant in the Plan?

Before you become a Plan member (referred to in this Summary Plan Description as a "Participant"), there are certain rules which you must satisfy. First, you must meet the eligibility requirements and be an active employee. After that, the next step is to actually join the Plan on the "entry date" that we have established for all employees. The "entry date" is defined in Question 3 below. You will also be required to complete certain application forms before you can enroll in the Plan.

2. What are the eligibility requirements for our Plan?

You will be eligible to join the Plan once you have satisfied the conditions for coverage under our group medical plan. Of course, if you were already a participant before this amendment, you will remain a participant.

3. When is my entry date?

You can join the Plan on the same day you can enter our group medical plan.

4. What must I do to enroll in the Plan?

Before you can join the Plan, you must complete an application to participate in the Plan. The application includes your personal choices for each of the benefits which are being offered under the Plan. You must also authorize us to set some of your earnings aside in order to pay for the benefits you have elected.

II
OPERATION

1. How does this Plan operate?

Before the start of each Plan Year, you will be able to elect to have some of your upcoming pay contributed to the Plan. These amounts will be used to pay for the benefits you have chosen. The portion of your pay that is paid to the Plan is not subject to Federal income or Social Security taxes. In other words, this allows you to use tax-free dollars to pay for certain kinds of benefits and expenses which you normally pay for with out-of-pocket, taxable dollars. However, if you receive a reimbursement for an expense under the Plan, you cannot claim a Federal income tax credit or deduction on your return. (See the Article entitled "General Information About Our Plan" for the definition of "Plan Year.")

III
CONTRIBUTIONS

1. How much of my pay may the Employer redirect?

Each year, you may elect to have us contribute on your behalf enough of your compensation to pay for the benefits that you elect under the Plan. These amounts will be deducted from your pay over the course of the year.

2. What happens to contributions made to the Plan?

Before each Plan Year begins, you will select the benefits you want and how much of the contributions should go toward each benefit. It is very important that you make these choices carefully based on what you expect to spend on each covered benefit or expense during the Plan Year. Later, they will be used to pay for the expenses as they arise during the Plan Year.

3. When must I decide which accounts I want to use?

You are required by Federal law to decide before the Plan Year begins, during the election period (defined below). You must decide two things. First, which benefits you want and, second, how much should go toward each benefit.

4. When is the election period for our Plan?

You will make your initial election on or before your entry date. (You should review Section I on Eligibility to better understand the eligibility requirements and entry date.) Then, for each following Plan Year, the election period is established by the Administrator and applied uniformly to all Participants. It will normally be a period of time prior to the beginning of each Plan Year. The Administrator will inform you each year about the election period. (See the Article entitled "General Information About Our Plan" for the definition of Plan Year.)

5. May I change my elections during the Plan Year?

Generally, you cannot change the elections you have made after the beginning of the Plan Year. However, there are certain limited situations when you can change your elections. You are permitted to change elections if you have a "change in status" and you make an election change that is consistent with the change in status. Currently, Federal law considers the following events to be a change in status:

-- Marriage, divorce, death of a spouse, legal separation or annulment;

-- Change in the number of dependents, including birth, adoption, placement for adoption, or death of a dependent;

-- Any of the following events for you, your spouse or dependent: termination or commencement of employment, a strike or lockout, commencement or return from an unpaid leave of absence, a change in worksite, or any other change in employment status that affects eligibility for benefits;

-- One of your dependents satisfies or ceases to satisfy the requirements for coverage due to change in age, student status, or any similar circumstance; and

-- A change in the place of residence of you, your spouse or dependent that would lead to a change in status, such as moving out of a coverage area for insurance.

In addition, if you are participating in the Dependent Care Flexible Spending Account, then there is a change in status if your dependent no longer meets the qualifications to be eligible for dependent care.

There are detailed rules on when a change in election is deemed to be consistent with a change in status. In addition, there are laws that give you rights to change health coverage for you, your spouse, or your dependents. If you change coverage due to rights you have under the law, then you can make a corresponding change in your elections under the Plan. If any of these conditions apply to you, you should contact the Administrator.

If the cost of a benefit provided under the Plan increases or decreases during a Plan Year, then we will automatically increase or decrease, as the case may be, your salary redirection election. If the cost increases significantly, you will be permitted to either make corresponding changes in your payments or revoke your election and obtain coverage under another benefit package option with similar coverage, or revoke your election entirely.

If the coverage under a Benefit is significantly curtailed or ceases during a Plan Year, then you may revoke your elections and elect to receive on a prospective basis coverage under another plan with similar coverage. In addition, if we add a new coverage option or eliminate an existing option, you may elect the newly-added option (or elect another option if an option has been eliminated) and make corresponding election changes to other options providing similar coverage. If you are not a Participant, you may elect to join the Plan. There are also certain situations when you may be able to change your elections on account of a change under the plan of your spouse's, former spouse's or dependent's employer.

These rules on change due to cost or coverage do not apply to the Health Flexible Spending Account, and you may not change your election to the Health Flexible Spending Account if you make a change due to cost or coverage for insurance.

You may not change your election under the Dependent Care Flexible Spending Account if the cost change is imposed by a dependent care provider who is your relative.

6. May I make new elections in future Plan Years?

Yes, you may. For each new Plan Year, you may change the elections that you previously made. You may also choose not to participate in the Plan for the upcoming Plan Year. If you do not make new elections during the election period before a new Plan Year begins, we will consider that to mean you have elected not to participate for the upcoming Plan Year.

IV
BENEFITS

1. Health Flexible Spending Account

The Health Flexible Spending Account enables you to pay for expenses allowed under Sections 105 and 213(d) of the Internal Revenue Code which are not covered by our insured medical plan and save taxes at the same time. The Health Flexible Spending Account allows you to be reimbursed by the Employer for expenses incurred by you and your dependents.

Drug costs, including insulin, may be reimbursed.

You may not be reimbursed for the cost of other health care coverage maintained outside of the Plan, or for long-term care expenses. A list of covered expenses is available from the Administrator.

The most that you can contribute to your Health Flexible Spending Account each Plan Year is up to the IRS maximum. For any short Plan Year, the most that you can contribute to your Health Flexible Spending Account each Plan Year is prorated. If you enter the Plan after the first day of the Plan Year, the most that you can contribute to your Health Flexible Spending Account each Plan Year is prorated. In addition, you will be eligible to carryover amounts left in your Health Flexible Spending Account, up to the carryover IRS maximum. This means that amounts you do not use during a Plan Year can be carried over to the next Plan Year and used for expenses incurred in the next Plan Year.

In order to be reimbursed for a health care expense, you must submit to the Administrator an itemized bill from the service provider. We will also provide you with a debit or credit card to use to pay for medical expenses. The Administrator will provide you with further details. Amounts reimbursed from the Plan may not be claimed as a deduction on your personal income tax return. Reimbursement from the fund shall be paid at least once a month. Expenses under this Plan are treated as being "incurred" when you are provided with the care that gives rise to the expenses, not when you are formally billed or charged, or you pay for the medical care.

You may be reimbursed for expenses for any child until the end of the calendar year in which the child reaches age 26. A child is a natural child, stepchild, foster child, adopted child, or a child placed with you for adoption. If a child gains or regains eligibility due to these new rules, that qualifies as a change in status to change coverage.

Newborns' and Mothers' Health Protection Act: Group health plans generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers 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).

Women's Health and Cancer Rights Act: This plan, as required by the Women's Health and Cancer Rights Act of 1998, will reimburse up to plan limits for benefits for mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema). Contact your Plan Administrator for more information.

2. Dependent Care Flexible Spending Account

The Dependent Care Flexible Spending Account enables you to pay for out-of-pocket, work-related dependent day-care cost with pre-tax dollars. If you are married, you can use the account if you and your spouse both work or, in some situations, if your spouse goes to school full-time. Single employees can also use the account.

An eligible dependent is someone for whom you can claim expenses on Federal Income Tax Form 2441 "Credit for Child and Dependent Care Expenses." Children must be under age 13. Other dependents must be physically or mentally unable to care for themselves. Dependent Care arrangements which qualify include:

(a) A Dependent (Day) Care Center, provided that if care is provided by the facility for more than six individuals, the facility complies with applicable state and local laws;

(b) An Educational Institution for pre-school children. For older children, only expenses for non-school care are eligible; and

(c) An "Individual" who provides care inside or outside your home: The "Individual" may not be a child of yours under age 19 or anyone you claim as a dependent for Federal tax purposes.

You should make sure that the dependent care expenses you are currently paying for qualify under our Plan.

The law places limits on the amount of money that can be paid to you in a calendar year from your Dependent Care Flexible Spending Account. Generally, your reimbursements may not exceed the lesser of: (a) $5,000 (if you are married filing a joint return or you are head of a household) or $2,500 (if you are married filing separate returns); (b) your taxable compensation; (c) your spouse's actual or deemed earned income (a spouse who is a full time student or incapable of caring for himself/herself has a monthly earned income of $250 for one dependent or $500 for two or more dependents).

Also, in order to have the reimbursements made to you from this account be excludable from your income, you must provide a statement from the service provider including the name, address, and in most cases, the taxpayer identification number of the service provider on your tax form for the year, as well as the amount of such expense as proof that the expense has been incurred. In addition, Federal tax laws permit a tax credit for certain dependent care expenses you may be paying for even if you are not a Participant in this Plan. You may save more money if you take advantage of this tax credit rather than using the Dependent Care Flexible Spending Account under our Plan. Ask your tax adviser which is better for you.

3. Premium Expense Account

A Premium Expense Account allows you to use tax-free dollars to pay for certain premium expenses under various insurance programs that we offer you. These premium expenses include:

-- Health care premiums under our insured group medical plan.

-- Dental insurance premiums.

-- Cancer insurance premiums.

-- Vision insurance premiums.

-- Other insurance coverage that we may provide.

Under our Plan, we will establish sub-accounts for you for each different type of insurance coverage that is available. Also, certain limits on the amount of coverage may apply.

The Administrator may terminate or modify Plan benefits at any time, subject to the provisions of any insurance contracts providing benefits described above. We will not be liable to you if an insurance company fails to provide any of the benefits described above. Also, your insurance will end when you leave employment, are no longer eligible under the terms of any insurance policies, or when insurance terminates.

Any benefits to be provided by insurance will be provided only after (1) you have provided the Administrator the necessary information to apply for insurance, and (2) the insurance is in effect for you.

If you cover your children up to age 26 under your insurance, you can pay for that coverage through the Plan.

V
BENEFIT PAYMENTS

1. When will I receive payments from my accounts?

During the course of the Plan Year, you may submit requests for reimbursement of expenses you have incurred. Expenses are considered "incurred" when the service is performed, not necessarily when it is paid for. The Administrator will provide you with acceptable forms for submitting these requests for reimbursement. If the request qualifies as a benefit or expense that the Plan has agreed to pay, you will receive a reimbursement payment soon thereafter. Remember, these reimbursements which are made from the Plan are generally not subject to federal income tax or withholding. Nor are they subject to Social Security taxes. Requests for payment of insured benefits should be made directly to the insurer. You will only be reimbursed from the Dependent Care Flexible Spending Account to the extent that there are sufficient funds in the Account to cover your request.

2. What happens if I don't spend all Plan contributions during the Plan Year?

Any monies left at the end of the Plan Year will be forfeited, except for amounts that can be carried over into the next Plan Year for the Health Flexible Spending Account. Obviously, qualifying expenses that you incur late in the Plan Year for which you seek reimbursement after the end of such Plan Year will be paid first before any amount is forfeited. For the Health Flexible Spending Account, you must submit claims no later than 90 days after the end of the Plan Year. For the Dependent Care Flexible Spending Account, you must submit claims no later than 90 days after the end of the Plan Year. Because it is possible that you might forfeit amounts in the Plan if you do not fully use the contributions that have been made, it is important that you decide how much to place in each account carefully and conservatively. Remember, you must decide which benefits you want to contribute to and how much to place in each account before the Plan Year begins. You want to be as certain as you can that the amount you decide to place in each account will be used up entirely.

3. Uniformed Services Employment and Reemployment Rights Act (USERRA)

If you are going into or returning from military service, you may have special rights to health care coverage under your Health Flexible Spending Account under the Uniformed Services Employment and Reemployment Rights Act of 1994. These rights can include extended health care coverage. If you may be affected by this law, ask your Administrator for further details.

4. What happens if I terminate employment?

If you terminate employment during the Plan Year, your right to benefits will be determined in the following manner:

(a) You will remain covered by insurance, but only for the period for which premiums have been paid prior to your termination of employment.

(b) You will still be able to request reimbursement for qualifying dependent care expenses incurred prior to your date of termination from the balance remaining in your dependent care account at the time of termination of employment. However, no further salary redirection contributions will be made on your behalf after you terminate. You must submit claims within 90 days after termination.

(c) Your participation in the Health Flexible Spending Account will cease, and no further salary redirection contributions will be contributed on your behalf. However, you will be able to submit claims for health care expenses that were incurred before the end of the period for which payments to the Health Flexible Spending Account have already been made. You must submit claims within 90 days after termination.

5. Will my Social Security benefits be affected?

Your Social Security benefits may be slightly reduced because when you receive tax-free benefits under our Plan, it reduces the amount of contributions that you make to the Federal Social Security system as well as our contribution to Social Security on your behalf.

VI
HIGHLY COMPENSATED AND KEY EMPLOYEES

1. Do limitations apply to highly compensated employees?

Under the Internal Revenue Code, highly compensated employees and key employees generally are Participants who are officers, shareholders or highly paid. You will be notified by the Administrator each Plan Year whether you are a highly compensated employee or a key employee.

If you are within these categories, the amount of contributions and benefits for you may be limited so that the Plan as a whole does not unfairly favor those who are highly paid, their spouses or their dependents. Federal tax laws state that a plan will be considered to unfairly favor the key employees if they as a group receive more than 25% of all of the nontaxable benefits provided for under our Plan.

Plan experience will dictate whether contribution limitations on highly compensated employees or key employees will apply. You will be notified of these limitations if you are affected.

VII
PLAN ACCOUNTING

1. Periodic Statements

The Administrator will provide you with a statement of your account periodically during the Plan Year that shows your account balance. It is important to read these statements carefully so you understand the balance remaining to pay for a benefit. Remember, you want to spend all the money you have designated for a particular benefit by the end of the Plan Year.

VIII
GENERAL INFORMATION ABOUT OUR PLAN

This Section contains certain general information which you may need to know about the Plan.

1. General Plan Information

Flexible Spending Benefits Plan is the name of the Plan.

Your Employer has assigned Plan Number 501 to your Plan.

The provisions of your amended Plan become effective on 01/01/2023. Your Plan was originally effective on 01/01/2014.

Your Plan's records are maintained on a twelve-month period of time. This is known as the Plan Year. The Plan Year begins on 01/01 and ends on 12/31.

2. Employer Information

Your Employer's name, address, and identification number are:

Bullock Pen Water District
1 Farrell Drive
Crittenden, Kentucky 41030
61-6017292

3. Plan Administrator Information

The name, address and business telephone number of your Plan's Administrator are:

Bullock Pen Water District
1 Farrell Drive
Crittenden, Kentucky 41030
(859) 428-2112

The Administrator keeps the records for the Plan and is responsible for the administration of the Plan. The Administrator will also answer any questions you may have about our Plan. You may contact the Administrator for any further information about the Plan.

4. Service of Legal Process

The name and address of the Plan's agent for service of legal process are:

Bullock Pen Water District
1 Farrell Drive
Crittenden, Kentucky 41030

5. Type of Administration

The type of Administration is Employer Administration.

6. Claims Submission

Claims for expenses should be submitted to:

Chard Snyder
PO Box 249
Fort Washington, PA 19034

IX
ADDITIONAL PLAN INFORMATION

1. Claims Process

You should submit all reimbursement claims during the Plan Year. For the Health Flexible Spending Account, you must submit claims no later than 90 days after the end of the Plan Year. However, if you terminate employment during the Plan Year, you must submit your Health Flexible Spending Account claims within 90 days after your termination of employment. For the Dependent Care Flexible Spending Account, you must submit claims no later than 90 days after the end of the Plan Year. However, if you terminate employment

during the Plan Year, you must submit your Dependent Care Flexible Spending Account claims within 90 days after your termination of employment. Any claims submitted after that time will not be considered.

Claims that are insured will be handled in accordance with procedures contained in the insurance policies. All other general requests should be directed to the Administrator of our Plan. If a dependent care or medical expense claim under the Plan is denied in whole or in part, you or your beneficiary will receive written notification. The notification will include the reasons for the denial, with reference to the specific provisions of the Plan on which the denial was based, a description of any additional information needed to process the claim and an explanation of the claims review procedure. Within 180 days after denial, you or your beneficiary may submit a written request for reconsideration of the denial to the Administrator.

Any such request should be accompanied by documents or records in support of your appeal. You or your beneficiary may review pertinent documents and submit issues and comments in writing. The Administrator will review the claim and provide, within 60 days, a written response to the appeal. (This period may be extended an additional 60 days under certain circumstances.) In this response, the Administrator will explain the reason for the decision, with specific reference to the provisions of the Plan on which the decision is based. The Administrator has the exclusive right to interpret the appropriate plan provisions. Decisions of the Administrator are conclusive and binding.

X
SUMMARY

The money you earn is important to you and your family. You need it to pay your bills, enjoy recreational activities and save for the future. Our flexible benefits plan will help you keep more of the money you earn by lowering the amount of taxes you pay. The Plan is the result of our continuing efforts to find ways to help you get the most for your earnings.

If you have any questions, please contact the Administrator.

BULLOCK PEN WATER DISTRICT
HEALTH REIMBURSEMENT ARRANGEMENT
ADOPTION AGREEMENT

The undersigned Employer adopts this Health Reimbursement Arrangement and elects the following provisions:

I EMPLOYER INFORMATION

1.1 Employer Information

Employer's name, address and taxpayer identification number is:

Bullock Pen Water District
1 Farrell Drive
Crittenden, KY 41030
61-6017292

1.2 Type of Entity

Government

II PLAN INFORMATION

2.1 Plan Name

Health Reimbursement Arrangement

2.2 Plan Number

501

2.3 Plan Effective Date or Amendment/Restatement Date

01/01/2021

2.4 Plan Original Effective Date

02/01/2010

2.5 Plan Year

The Plan Year begins on 01/01 and ends on 12/31.

2.6 Plan Administrator Information

Plan Administrator's name, address and telephone number is:

Bullock Pen Water District
1 Farrell Drive
Crittenden, KY 41030
(859) 428-2112

2.7 Claims Submission

Claims for expenses should be submitted to:

Chard Snyder
P.O. Box 249
Fort Washington, PA 19034-9998
(513) 459-9997

2.8 Affiliated Employers

The following affiliated employers have adopted to participate in this Plan:

None

III ELIGIBILITY REQUIREMENTS

3.1 Eligible Employees

HRA will be available to employees who obtain Silver status or above within the Go 365 program. Proof of obtaining Silver Status will be requested from HR prior to the HRA reimbursement being processed.

NOTE: S Corporation shareholders, partners, sole proprietors, and members of a Limited Liability Company generally cannot participate in this Plan.

3.2 Conditions of Eligibility

Any Eligible Employee will be eligible to participate in this Plan upon satisfaction of the following:

Same as Employer's group medical plan

3.3 Effective Date of Participation

An Eligible Employee who has satisfied the eligibility requirements will become a participant on:

Same as Employer's group medical plan

IV BENEFITS

4.1 Eligible Expenses

This plan will reimburse participants for the following in-network and out-of-network expenses that they are required to pay under the group health plan: all out of pocket expenses

Eligible expenses cannot also be reimbursed by another plan nor paid pre-tax by another health plan coverage or program.

4.2 Maximum Benefit Amount

Single

After Participants have met $750 of their health plan's deductible, they will be reimbursed up to $750 for eligible expenses.

Family

After Participants have met $750 of their health plan's deductible, they will be reimbursed up to $750 for eligible expenses. Then after Participants have met $750 of their health plan’s deductible, they will be reimbursed up to $750 for eligible expenses. The total amount Participants may be reimbursed is $1500.

4.3 Coverage Period

The Maximum Benefit will reset each Coverage Period. A new Coverage Period begins each:

Plan Year

4.4 Carry Forward

Unused amounts remaining in a participant's account at the end of the coverage period will not carry foward.

4.5 If the Employer Maintains a Health Flexible Spending Account, which Plan shall Pay Expenses First

HRA

4.6 Debit Cards

Debit Cards shall be provided by the Employer for eligible expenses:

No

4.7 Coverage of Dependents

This Plan will cover the following:
Participant, Spouse and Dependents who are also covered under the Participant's group medical plan. Dependents include natural and adopted children, stepchildren, and foster children

4.8 Claims

A claim may be submitted up to:

90 days after the end of the calendar year

An Explanation of Benefit (EOB) is required for reimbursement

4.9 Claims for Loss of Eligibility or Termination

Employees that lose eligibility status to participate in the Plan or terminate employment may submit claims up to:

90 days after the date of termination

4.10 Opt Out

This Plan permits a participant to elect out of the Plan annually

4.11 Health Savings Account

Health Savings Account will be provided by the Employer:

4.12 Family and Medical Leave Act

Employer subject to the Family and Medical Leave Act:

No

4.13 COBRA

Plan subject to COBRA:

No

4.14 HIPAA

Plan subject to HIPAA:

Yes

V EXECUTION

This Adoption Agreement may be used only in conjunction with the Health Reimbursement Arrangement Basic Plan Document. This Adoption Agreement and the Health Reimbursement Arrangement Basic Plan Document shall together be known as the Health Reimbursement Arrangement.

Bullock Pen Water District

By: Ashley Dyer

Printed Name: Ashley Dyer

Title: HR Manager

Date: 4/7/21

BULLOCK PEN WATER DISTRICT
HEALTH REIMBURSEMENT ARRANGEMENT
ADOPTION AGREEMENT

The undersigned Employer adopts this Health Reimbursement Arrangement and elects the following provisions:

I EMPLOYER INFORMATION

1.1 Employer Information

Employer's name, address and taxpayer identification number is:

Bullock Pen Water District
1 Farrell Drive
Crittenden, KY 41030
61-6017292

1.2 Type of Entity

Government

II PLAN INFORMATION

2.1 Plan Name

Health Reimbursement Arrangement

2.2 Plan Number

501

2.3 Plan Effective Date or Amendment/Restatement Date

01/01/2023

2.4 Plan Original Effective Date

02/01/2010

2.5 Plan Year

The Plan Year begins on 01/01 and ends on 12/31.

2.6 Plan Administrator Information

Plan Administrator's name, address and telephone number is:

Bullock Pen Water District
1 Farrell Drive
Crittenden, KY 41030
(859) 428-2112

2.7 Claims Submission

Claims for expenses should be submitted to:

Chard Snyder
PO Box 249
Fort Washington, PA 19034
(513) 459-9997

2.8 Affiliated Employers

The following affiliated employers have adopted to participate in this Plan:

None

III ELIGIBILITY REQUIREMENTS

3.1 Eligible Employees

All Employees except:

Employees not covered by the Employer's group medical plan

NOTE: S Corporation shareholders, partners, sole proprietors, and members of a Limited Liability Company generally cannot participate in this Plan.

3.2 Conditions of Eligibility

Any Eligible Employee will be eligible to participate in this Plan upon satisfaction of the following:

Same as Employer's group medical plan

3.3 Effective Date of Participation

An Eligible Employee who has satisfied the eligibility requirements will become a participant on:

Same as employer's group medical plan

IV BENEFITS

4.1 Eligible Expenses

This plan will reimburse Participants for the following in-network and out-of-network expenses that they are required to pay under the group health plan:

- All Out-of-Pocket Expenses

Eligible expenses cannot also be reimbursed by another plan nor paid pre-tax by another health plan coverage or program.

4.2 Maximum Benefit Amount

Individual

After Participants have met $825 of their health plan's deductible, they will be reimbursed up to $825 for eligible expenses.

Family

After Participants have met $825 of their health plan's deductible, they will be reimbursed up to $825 for eligible expenses. Then after Participants have met $825 of their health plan’s deductible, they will be reimbursed up to $825 for eligible expenses. The total amount Participants may be reimbursed is $1,650.

4.3 Coverage Period

The Maximum Benefit will reset each Coverage Period. A new Coverage Period begins each:

Plan Year

4.4 Carry Forward

Unused amounts remaining in a Participant's account at the end of the coverage period will not carry foward.

4.5 If the Employer Maintains a Health Flexible Spending Account, which Plan shall Pay Expenses First

HRA

4.6 Debit Cards

Debit Cards shall be provided by the Employer for eligible expenses:

No

4.7 Coverage of Dependents

This Plan will cover the following:

Participant, Spouse and Dependents who are also covered under the Participant's group medical plan. Dependents include natural and adopted children, stepchildren, and foster children

4.8 Claims

A claim may be submitted up to:

90 days after the end of the Plan Year

An Explanation of Benefit (EOB) is required for reimbursement

4.9 Claims for Loss of Eligibility or Termination

Employees that lose eligibility status to participate in the Plan or terminate employment may submit claims up to:

90 days after the date of termination

4.10 Opt Out

This Plan permits a participant to elect out of the Plan annually

4.11 Health Savings Account

Health Savings Account will be provided by the Employer:

No

4.12 Family and Medical Leave Act

Employer subject to the Family and Medical Leave Act:

No

4.13 COBRA

Plan subject to COBRA:

No

4.14 HIPAA

Plan subject to HIPAA:

Yes

V EXECUTION

This Adoption Agreement may be used only in conjunction with the Health Reimbursement Arrangement Basic Plan Document. This Adoption Agreement and the Health Reimbursement Arrangement Basic Plan Document shall together be known as the Health Reimbursement Arrangement.

Bullock Pen Water District

By: DocuSigned by: Ashley Dyer C82E09E3569441E...

Printed Name: Ashley Dyer

Title: HR Manager

Date: 12/2/2022 | 13:33:51 EST

BULLOCK PEN WATER DISTRICT
HEALTH REIMBURSEMENT ARRANGEMENT
SUMMARY PLAN DESCRIPTION

I ELIGIBILITY 2
1. What Are the Eligibility Requirements for Our Plan? 2
2. When is My Entry Date? 2
3. Are There Any Employees Who Are Not Eligible? 2
II BENEFITS 2
1. What Benefits Are Available? 2
2. When Must Expenses Be Incurred? 3
3. When Will I Receive Payments From the Plan? 3
4. What Happens If I Terminate Employment? 3
5. Can I Opt Out of the Plan? 3
6. Uniformed Services Employment and Reemployment Rights Act (USERRA) 3
7. Newborns' and Mothers' Health Protection Act 3
8. Qualified Medical Child Support Order 3
III GENERAL INFORMATION ABOUT OUR PLAN 4
1. General Plan Information 4
2. Employer Information 4
3. Plan Administrator Information 4
4. Service of Legal Process 4
5. Type of Administration 4
6. Third Party Claims Administrator Information 5
IV ADDITIONAL PLAN INFORMATION 5
1. Your Rights Under ERISA 5
2. How to Submit a Claim 6

HEALTH REIMBURSEMENT ARRANGEMENT

We are pleased to establish this Health Reimbursement Arrangement to provide you with additional health coverage benefits. The benefits available under this Plan are outlined in this summary plan description. We will also tell you about other important information concerning the Plan, such as the rules you must satisfy before you become eligible and the laws that protect your rights.

Read this summary plan description carefully so that you understand the provisions of our Plan and the benefits you will receive. You should direct any questions you have to the Administrator. There is a plan document on file, which you may review if you desire. In the event there is a conflict between this summary plan description and the plan document, the plan document will control.

I ELIGIBILITY

1. What Are the Eligibility Requirements for Our Plan?

HRA will be available to employees who obtain Silver status or above within the Go 365 program. Proof of obtaining Silver Status will be requested from HR prior to the HRA reimbursement being processed.

2. When is My Entry Date?

You can join the Plan on the same day that you enter our group medical plan.

3. Are There Any Employees Who Are Not Eligible?

Yes, there are certain employees who are not eligible to join the Plan. They are:

- Employees not covered by the Employer's group medical plan

II BENEFITS

1. What Benefits Are Available?

This plan will reimburse you for the following in-network and out-of-network expenses that you are required to pay under your group health plan:

- All out of pocket expenses

The maximum amount you are allowed to be reimbursed up to during the Coverage Period is the following:

Single

After you have met $750 of your health plan's deductible, you will be reimbursed up to $750 for eligible expenses.

Family

After you have met $750 of your health plan's deductible, you will be reimbursed up to $750 for eligible expenses. Then after you have met $750 of your health plan’s deductible, you will be reimbursed up to $750 for eligible expenses. The total amount you may be reimbursed is $1500.

Unused amounts remaining in your account at the end of the coverage period will not carry foward.

Any amounts reimbursed to you under the Plan may not be claimed as a deduction on your personal income tax return nor reimbursed by other health plan coverage including our health flexible spending account.

You may submit expenses for yourself, your spouse and your children who are also covered under your group medical plan. You may be reimbursed for expenses for any child until the end of the calendar year in which the child reaches age 26. A child is a natural child, stepchild, foster child, adopted child, or a child placed with you for adoption.

2. When Must Expenses Be Incurred?

You may submit expenses that you incur each "Coverage Period." A new "Coverage Period" begins each Plan Year. Expenses under this Plan are treated as being "incurred" when you are provided with the care that gives rise to the expenses, not when you are formally billed or charged, or you pay for the medical care.

3. When Will I Receive Payments From the Plan?

During the course of the Coverage Period, you may submit requests for reimbursement of expenses you have incurred. However, you must make your requests for reimbursements no later than 90 days after the end of the calendar year. The Administrator will provide you with acceptable forms for submitting these requests for reimbursement. In addition, you must submit Explanation of Benefit (EOB) and other documentation to the Administrator as proof of the expenses you have incurred and that they have not been paid by any other health plan coverage. If the request qualifies as a benefit or expense that the Plan has agreed to pay, you will receive a reimbursement payment soon thereafter. Remember, reimbursements made from the Plan are generally not subject to federal income tax or withholding. Nor are they subject to Social Security taxes.

4. What Happens If I Terminate Employment?

If your employment is terminated or you lose eligibility to participate in the Plan during the Plan Year for any reason, your participation in the Plan will cease. You may submit claims for eligible expenses that were incurred while were an active participant as follows:

90 days after the date of termination

5. Can I Opt Out of the Plan?

Yes, you can once a plan year, opt out of the Plan and receive no further reimbursement.

6. Uniformed Services Employment and Reemployment Rights Act (USERRA)

If you are going into or returning from military service, you may have special rights to health care coverage under the Uniformed Services Employment and Reemployment Rights Act of 1994. These rights can include extended health care coverage. If you may be affected by this law, ask your Administrator for further details.

7. Newborns' and Mothers' Health Protection Act

Group health plans generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers 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).

8. Qualified Medical Child Support Order

A medical child support order is a judgment, decree or order (including approval of a property settlement) made under state law that provides for child support or health coverage for the child of a participant. The child becomes an "alternate recipient" and can receive benefits under the health plans of the Employer, if the order is determined to be "qualified." You may obtain, without charge, a copy of the procedures governing the determination of qualified medical child support orders from the Plan Administrator.

III GENERAL INFORMATION ABOUT OUR PLAN

This Section contains certain general information, which you may need to know about the Plan.

1. General Plan Information

Health Reimbursement Arrangement is the name of the Plan.

Your Employer has assigned Plan Number 501 to your Plan.

The provisions of your Plan become effective on 01/01/2021.

Your Plan's records are maintained on a twelve-month period of time. This is known as the Plan Year. The Plan Year begins on 01/01 and ends on 12/31.

2. Employer Information

Your Employer's name, address, and identification number are:

Bullock Pen Water District
1 Farrell Drive
Crittenden, KY 41030
61-6017292

3. Plan Administrator Information

The name, address and business telephone number of your Plan's Administrator are:

Bullock Pen Water District
1 Farrell Drive
Crittenden, KY 41030
(859) 428-2112

The Plan Administrator keeps the records for the Plan and is responsible for the administration of the Plan. The Administrator will also answer any questions you may have about our Plan. The Plan Administrator has the exclusive right to interpret the appropriate plan provisions. Decisions of the Administrator are conclusive and binding. You may contact the Administrator for any further information about the Plan.

4. Service of Legal Process

The name and address of the Plan's agent for service of legal process are:

Bullock Pen Water District
1 Farrell Drive
Crittenden, KY 41030
(859) 428-2112

5. Type of Administration

The Plan is a health reimbursement arrangement and Employer is the Plan Administrator. The Plan Administrator may provide the claims administration through a Third Party Claims Administrator. The Plan is not funded or insured. Benefits are paid from the general assets of the Employer.

6. Third Party Claims Administrator Information

The name, address and business telephone of the Third Party Claims Administrator are:

Chard, Snyder & Associates, LLC
P.O. Box 249
Fort Washington, PA 19034-9998
(513) 459-9997

The Third Party Claims Administrator is responsible for the actual processing of claims on behalf of the Plan Administrator.

IV ADDITIONAL PLAN INFORMATION

1. Your Rights Under ERISA

Plan Participants, eligible employees and all other employees of the Employer may be entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA) and the Internal Revenue Code. These laws provide that Participants, eligible employees and all other employees are entitled to:

(a) Examine, without charge, at the Administrator's office, all Plan documents, including insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor, and available at the Public Disclosure Room of the Employee Benefits Security Administration.

(b) Obtain copies of all Plan documents and other Plan information upon written request to the Administrator. The Administrator may charge a reasonable fee for the copies.

(c) Continue health coverage for a Participant, Spouse, or other dependents if there is a loss of coverage under the Plan as a result of a qualifying event. Employees or dependents may have to pay for such coverage.

(d) Review this summary plan description and the documents governing the Plan on the rules governing COBRA continuation coverage rights.

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

If you have a claim for benefits, which is denied or ignored, in whole or in part, you may file suit in a state or Federal court.

Under ERISA there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within thirty (30) days, you may file suit in a Federal court. In such a case, the court may request the Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits, which is denied or ignored, in whole or in part, you may file suit in a state or Federal court.

In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court.

In addition to creating rights for Plan Participants, ERISA imposes obligations upon the individuals who are responsible for the operation of the Plan. The individuals who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of the Plan Participants and their beneficiaries. No one, including the Employer or any other person, may fire you or otherwise discriminate against you in any way to prevent the Plan Participant from obtaining a benefit or from exercising your rights under ERISA.

If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees; for example, if it finds your claim is frivolous.

If you have any questions about the Plan, you should contact the Administrator. If you have any questions about this statement, or about your rights under ERISA or the Health Insurance Portability and Accountability Act (HIPAA) or if you need assistance in obtaining

documents from the Administrator, you should contact either the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) or visit the EBSA website at www.dol.gov/ebsa/. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

2. How to Submit a Claim

When you have a claim to submit for payment, you must:

(a) Obtain a claim form from the Plan Administrator.

(b) Complete the Employee portion of the form.

(c) Attach copies of all bills from the service provider for which you are requesting reimbursement.

A claim is defined as any request for a Plan benefit, made by a claimant or by a representative of a claimant that complies with the Plan's reasonable procedure for making benefit claims. The times listed are maximum times only. A period of time begins at the time the claim is filed. Decisions will be made within a reasonable period of time appropriate to the circumstances. "Days" means calendar days.

Notification of whether claim is accepted or denied	30 days
Extension due to matters beyond the control of the Plan	15 days
Insufficient information to process the claim:	
Notification to Participant	15 days
Response by Participant	45 days
Review of claim denial	60 days

The Plan Administrator will provide written or electronic notification of any claim denial. The notice will state:

(a) The specific reason or reasons for the denial.

(b) Reference to the specific Plan provisions on which the denial was based.

(c) 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.

(d) A description of the Plan's review procedures and the time limits applicable to such procedures. This will include a statement of your right to bring a civil action under Section 502 of ERISA following a denial on review.

(e) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim; and

(f) If the denial was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the denial and a copy will be provided free of charge to the claimant upon request.

When you receive a denial, you will have 180 days following receipt of the notification in which to appeal the decision. You may submit written comments, documents, records, and other information relating to the claim. If you request, you will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim.

The period of time within which a denial on review is required to be made will begin at the time an appeal is filed in accordance with the procedures of the Plan. This timing is without regard to whether all the necessary information accompanies the filing.

A document, record, or other information shall be considered relevant to a claim if it:

(a) was relied upon in making the Claim determination;

(b) was submitted, considered, or generated in the course of making the claim determination, without regard to whether it was relied upon in making the claim determination;

(c) demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that claim determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants;

(d) or constituted a statement of policy or guidance with respect to the Plan concerning the denied claim.

The review will take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial claim determination. The review will not afford deference to the initial denial and will be conducted by a fiduciary of the Plan who is neither the individual who made the adverse determination nor a subordinate of that individual.

KEEP YOUR PLAN ADMINISTRATOR INFORMED OF ADDRESS CHANGES

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator or its designee.