

**UNIVERSITY OF FLORIDA  
COLLEGE OF MEDICINE**

**MEDICAL AND PRESCRIPTION DRUG BENEFITS**

**EFFECTIVE JANUARY 1, 2002  
REVISED JULY 1, 2002**

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## PLAN DESCRIPTION INFORMATION

1. Proper Name of Plan: University of Florida College of Medicine
2. Plan Sponsor and *Employer*: University of Florida College of Medicine  
Office of the Dean  
P.O. Box 100014  
Gainesville, FL 32610  
Telephone: (352) 392-8188
3. Plan Administrator and Named Fiduciary:  
  
University of Florida College of Medicine  
Office of the Dean  
P.O. Box 100014  
Gainesville, FL 32610  
Telephone: (352) 392-8188
4. *Employer* Identification Number: 59-6002052  
The Plan number assigned for government reporting purposes is 501.
5. The Plan provides medical and prescription drug benefits for participating *employees* and their enrolled *dependents*.
6. Plan benefits described in this booklet are effective January 1, 2002, revised July 1, 2002.
7. The *Plan year* is January 1 through December 31 of each year. The fiscal year is July 1 through June 30 of each year.
8. Service of legal process may be served upon the Plan Administrator as shown above or the following agent for service of legal process:  
  
University of Florida College of Medicine  
Dr. C. Craig Tisher, Dean, College of Medicine  
Office of the Dean  
P.O. Box 100014  
Gainesville, FL 32610  
Telephone: (352) 392-8188
9. The *Plan Manager* is responsible for performing certain delegated administrative duties, including the processing of claims. The *Plan Manager* is:  
  
Humana Insurance Company  
500 West Main Street  
Louisville, KY 40202  
Toll Free: 1-877-782-5360

## Plan Description Information Continued

10. This is a self-insured and self-administered health benefit plan. The cost of the Plan is paid with contributions made by the *employer*. Benefits under the Plan are provided from the general assets of the *employer* and are used to fund payment of covered claims under the Plan plus administrative expenses. Please see *your employer* for the method of calculating contributions and the funding mechanism used for the accumulation of assets through which benefits are provided under this Plan.
11. Each *employee* of the *employer* who participates in the Plan receives a Summary Plan Description, which is this booklet. This booklet will be provided to *employees* by the *employer*. It contains information regarding eligibility requirements, termination provisions, a description of the benefits provided, and other Plan information.
12. The Plan benefits and/or contributions may be modified or amended from time to time, or may be terminated at any time by the Plan Sponsor. Significant changes to the Plan, including termination, will be communicated to participants as required by applicable law.
13. Upon termination of the Plan, the rights of the participants to benefits are limited to claims incurred and payable by the Plan up to the date of termination. Plan assets, if any, will be allocated and disposed of for the exclusive benefit of the participating *employees* and their *dependents* covered by the Plan, except that any taxes and administration expenses may be made from the Plan assets.
14. The Plan does not constitute a contract between the *employer* and any *covered person* and will not be considered as an inducement or condition of the employment of any *employee*. Nothing in the Plan will give any *employee* the right to be retained in the service of the *employer*, or for the *employer* to discharge any *employee* at any time.
15. This Plan is not in lieu of and does not affect any requirement for coverage by Workers' Compensation insurance.

# SCHEDULE OF BENEFITS

## AN IMPORTANT MESSAGE ABOUT YOUR PLAN

*Services* are subject to all provisions of the Plan, including the limitations and exclusions.

Italicized terms within the text are defined in the Definitions section of this booklet.

## PRECERTIFICATION

Medical Management is a Utilization/Case Management Program provided by the *Plan Manager*.

The Medical Management team will provide *precertification* as required by *your* Plan. Medical Management recommends calling as soon as possible to receive proper *precertification*. Refer to *your* ID card for the phone number to call for *precertification*.

The following benefits require *precertification*:

PRECERTIFICATION		
BENEFIT	REQUIREMENTS	PENALTY
Inpatient Hospitalization	The <i>Plan Manager</i> must be notified before <i>you</i> are admitted. If the admission is on an <i>emergency</i> basis, the <i>Plan Manager</i> must be notified no later than the second weekday after <i>you</i> were admitted.	If the admission is not <i>precertified</i> , benefits for the <i>hospital</i> or <i>qualified treatment facility</i> will be subject to a \$500 penalty per <i>confinement</i> . The penalty does not apply to the deductible, coinsurance or out-of-pocket maximums.
Inpatient <i>Mental Disorder</i> , Chemical Dependence or Alcoholism	The <i>Plan Manager</i> must be notified before <i>you</i> are admitted. If the admission is on an <i>emergency</i> basis, the <i>Plan Manager</i> must be notified no later than the second weekday after <i>you</i> were admitted.	If the admission is not <i>precertified</i> , benefits for the <i>hospital</i> or <i>qualified treatment facility</i> will be subject to a \$500 penalty per <i>confinement</i> . The penalty does not apply to the deductible, coinsurance or out-of-pocket maximums.
Skilled Nursing Facility	The <i>Plan Manager</i> must be notified before <i>you</i> are admitted.	If the skilled nursing facility <i>confinement</i> is not <i>precertified</i> , benefits will be subject to a \$500 penalty per occurrence. The penalty does not apply to the deductible, coinsurance or out-of-pocket maximums.

## PREFERRED PROVIDER AND FACILITY PLAN OPTION

Agreements have been made with certain providers and facilities of health care called Preferred Providers (PAR providers) and Preferred Facilities (PAR facilities). *You* may select any provider to provide *your* medical care.

The Plan Administrator will automatically provide, without charge, information to *you* about how *you* can access a directory of PAR Providers, appropriate to *your* service area. The PAR provider directory will be available either in hard copy as a separate document, or in electronic format. Because health care providers enter and exit networks unpredictably, the *Plan Manager* or Plan Administrator can be contacted for network provider verification.

It is important to note that services performed by providers that are not billed by Shands Hospitals and Facilities, Sacred Heart Hospital and Facilities or University of Florida physicians may be subject to deductible, coinsurance or *copayments*. Please refer to the provider directory for a participating network provider at [www.humana.com](http://www.humana.com) (choose physician finder, then select Humana/ChoiceCare Network PPO).

*Services* rendered by the College of Medicine, PAR and Non-PAR providers and facilities are payable as shown on the Schedule of Benefits. Some *services* may be subject to a \$25 *copayment* per visit, this *copayment* will apply toward the coinsurance and out-of-pocket limits shown on the Schedule of Benefits.

*Covered expenses* are payable on a *maximum allowable fee* basis.

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

<b>MEDICAL DEDUCTIBLE AND COINSURANCE INFORMATION</b>			
Lifetime Maximum	\$5,000,000 per <i>covered person</i> .		
Deductible (all plans):			
Individual	\$1,000		
Family	\$2,000 aggregate		
<b>BENEFIT</b>	<b>COLLEGE OF MEDICINE</b>	<b>PAR PROVIDER (Humana/ChoiceCare)</b>	<b>NON-PAR PROVIDER</b>
Coinsurance	100% ( <i>you</i> pay 0%)	80% ( <i>you</i> pay 20%)	60% ( <i>you</i> pay 40%)
Out-of-Pocket Limit:			
Individual	\$0	\$2,500	\$5,000
Family	\$0	\$5,000	\$10,000
When the amount of <i>covered expenses</i> paid by <i>you</i> and/or all <i>your</i> covered <i>dependents</i> satisfy the deductible and out-of-pocket limits as shown on the Schedule of Benefits, the Plan will pay 100% of <i>covered expenses</i> for the remainder of the <i>calendar year</i> , unless specifically indicated, subject to any <i>calendar year</i> maximums and the lifetime maximum of the Plan.			
If <i>you</i> and <i>your</i> covered <i>dependents</i> use a combination of PAR and Non-PAR providers, the combined out-of-pocket will not exceed the Non-PAR provider out-of-pocket limit.			

Some *services* may be subject to a *copayment*. If more than one service is performed during the same visit, only one *copayment* will be taken.

<b>MEDICAL COVERED EXPENSES</b>			
<b>BENEFIT</b>	<b>COLLEGE OF MEDICINE</b>	<b>PAR PROVIDER (Humana/ChoiceCare)</b>	<b>NON-PAR PROVIDER</b>
<b>INPATIENT HOSPITAL</b>	Payable at 100%.	Subject to 80% coinsurance.	Subject to deductible and 60% coinsurance.
	<i>Precertification</i> is required. If <i>precertification</i> is not received, benefits are subject to the penalty described on the Schedule of Benefits.		
<b>OUTPATIENT HOSPITAL</b>	Payable at 100%.	Subject to 80% coinsurance.	Subject to 60% coinsurance.
<b>AMBULANCE SERVICE</b>	Not applicable.	Subject to 80% coinsurance.	Subject to 80% coinsurance.
<b>URGENT CARE FACILITY</b>	Payable at 100%.	Subject to a \$25 <i>copayment</i> , then payable at 100%.	Subject to 80% coinsurance.
<b>EMERGENCY ROOM SERVICES</b>	Subject to 80% coinsurance.	Subject to 80% coinsurance.	Subject to 80% coinsurance.
<b>LABORATORY AND X-RAY (FACILITY)</b>	Payable at 100%.	Subject to 80% coinsurance.	Subject to 80% coinsurance.
<b>OUTPATIENT SURGERY:</b>			
Facility	Payable at 100%.	Subject to 80% coinsurance.	Subject to 60% coinsurance.
<i>Qualified Practitioner</i>	Subject to 80% coinsurance.	Subject to 80% coinsurance.	Subject to 60% coinsurance.

**\*NOTE: Physicians may be practicing in facilities belonging to Shands hospitals and facilities, as well as Sacred Heart facilities that *are not* University of Florida physicians. These physicians may be in the PAR networks or may be non-network providers. All claims will be processed according to the Plan specifications, however, University of Florida physicians will not balance bill those covered by this Plan, the exception would be for those who are in the retiree class and eligible for Medicare. Those individuals will be balance billed.**

<b>MEDICAL COVERED EXPENSES</b>			
<b>BENEFIT</b>	<b>COLLEGE OF MEDICINE</b>	<b>PAR PROVIDER (Humana/ChoiceCare)</b>	<b>NON-PAR PROVIDER</b>
<b><i>QUALIFIED PRACTITIONER (OFFICE VISITS)</i></b>	Subject to deductible and 80% coinsurance.	Subject to a \$25 <i>copayment</i> , then payable at 100%. This benefit also applies for office surgery.	Subject to deductible and 60% coinsurance.
<b><i>QUALIFIED PRACTITIONER (OTHER THAN OFFICE VISITS):</i></b>			
Diagnostic X-ray and Laboratory, Radiologist	Subject to 80% coinsurance.	Subject to 80% coinsurance.	Subject to 80% coinsurance.
Anesthesiologist	Subject to deductible and 80% coinsurance.	Subject to 80% coinsurance.	Subject to 60% coinsurance.
<i>In-Hospital Physicians</i>	Subject to deductible and 80% coinsurance.	Subject to deductible and 80% coinsurance.	Subject to deductible and 60% coinsurance.
Assistant Surgeon and Physician Assistant	25% of the primary surgeon's fee.	25% of the primary surgeon's fee.	25% of the primary surgeon's fee.

<b>MEDICAL COVERED EXPENSES</b>			
<b>BENEFIT</b>	<b>COLLEGE OF MEDICINE</b>	<b>PAR PROVIDER (Humana/ChoiceCare)</b>	<b>NON-PAR PROVIDER</b>
<b>ROUTINE CARE (TO AGE 26):</b>  Routine Exams and Immunizations	Subject to 80% coinsurance.	Subject to a \$25 <i>copayment</i> , then payable at 100%.	Subject to 80% coinsurance.
<b>ROUTINE CARE (AGE 26 AND OLDER):</b>  Routine Exam, Laboratory and X-ray, Pap Smear* and Prostate Antigen Testing  Routine Mammogram  Routine Immunizations	Payable at 100%.  Payable at 100%.  Subject to 80% coinsurance.	Payable at 100%.  Subject to 80% coinsurance.  Subject to a \$25 <i>copayment</i> , then payable at 100%.	Payable at 100%.  Subject to 80% coinsurance.  Subject to 80% coinsurance.
<p><b>College of Medicine, PAR and Non-PAR routine care (age 26 and older) covered expenses aggregate to a combined <i>maximum benefit</i> of \$250 per calendar year. Routine mammograms do not apply to this maximum.</b></p> <p><b>*Routine Pap Smears are limited to one per calendar year and are subject to the \$250 per calendar year maximum.</b></p>			

<b>MEDICAL COVERED EXPENSES</b>			
<b>BENEFIT</b>	<b>COLLEGE OF MEDICINE</b>	<b>PAR PROVIDER (Humana/ChoiceCare)</b>	<b>NON-PAR PROVIDER</b>
<b>CHIROPRACTIC CARE:</b>			
Exams	Not applicable.	Subject to a \$25 <i>copayment</i> , then payable at 100%.	Subject to deductible and 60% coinsurance.
Laboratory and X-ray, Manipulations	Not applicable.	Subject to a \$25 <i>copayment</i> , then payable at 100%.	Subject to 80% coinsurance.
Therapy	Not applicable.	Subject to a \$25 <i>copayment</i> , then payable at 100%.	Subject to deductible and 60% coinsurance.
<b>PREGNANCY BENEFITS:</b>			
Facility	Payable at 100%.	Subject to 80% coinsurance.	Subject to deductible and 60% coinsurance.
<i>Qualified Practitioner</i>	Subject to deductible and 80% coinsurance.	Subject to deductible and 80% coinsurance.	Subject to deductible and 60% coinsurance.
<b>NEWBORN BENEFITS (Facility)</b>	Payable at 100%.	Subject to 80% coinsurance.	Subject to 60% coinsurance.
<b>BIRTHING CENTERS</b>	Not applicable.	Subject to 80% coinsurance.	Subject to 60% coinsurance.
<b>SKILLED NURSING FACILITY</b>	Payable at 100%.	Subject to 80% coinsurance.	Subject to 80% coinsurance.
	College of Medicine, PAR and Non-PAR <i>covered expenses</i> aggregate to a maximum of 60 days per <i>calendar year</i> . <i>Precertification</i> is required. If <i>precertification</i> is not received, benefits are subject to the penalty described on the Schedule of Benefits.		
<b>HOME HEALTH CARE</b>	Payable at 100%.	Subject to deductible and 80% coinsurance.	Subject to deductible and 60% coinsurance.
	College of Medicine, PAR and Non-PAR aggregate to a maximum of 60 visits per <i>calendar year</i> .		
<b>HOSPICE CARE</b>	Not applicable.	Subject to deductible and 80% coinsurance.	Subject to deductible and 60% coinsurance.
	College of Medicine, PAR and Non-PAR aggregate to a lifetime <i>maximum benefit</i> of \$10,000.		
<b>PRIVATE DUTY NURSING</b>	Not applicable.	Subject to deductible and 80% coinsurance.	Subject to deductible and 60% coinsurance.

<b>MEDICAL COVERED EXPENSES</b>			
<b>BENEFIT</b>	<b>COLLEGE OF MEDICINE</b>	<b>PAR PROVIDER (Humana/ChoiceCare)</b>	<b>NON-PAR PROVIDER</b>
<b><i>MENTAL DISORDER, CHEMICAL DEPENDENCE AND ALCOHOLISM THERAPIES:</i></b>	Payable as shown in text.	Payable as shown in text.	Payable as shown in text.
*Speech, Physical and Occupational Therapy (Facility)	Payable at 100%.	Subject to 80% coinsurance.	Subject to deductible and 80% coinsurance.
*Speech, Physical and Occupational Therapy ( <i>Qualified Practitioner</i> )	Subject to deductible and 80% coinsurance.	Subject to a \$25 <i>copayment</i> , then payable at 100%.	Subject to deductible and 80% coinsurance.
Respiratory Therapy and Chemotherapy (Facility)	Payable at 100%.	Subject to 80% coinsurance.	Subject to deductible and 80% coinsurance.
Respiratory Therapy and Chemotherapy ( <i>Qualified Practitioner</i> )	Payable at 100%.	Subject to a \$25 <i>copayment</i> , then payable at 100%.	Subject to deductible and 80% coinsurance.
Radiation Therapy (Facility)	Payable at 100%	Subject to deductible and 80% coinsurance.	Subject to deductible and 60% coinsurance.
Radiation Therapy ( <i>Qualified Practitioner</i> )	Payable at 100%.	Subject to a \$25 <i>copayment</i> then payable at 100%.	Subject to deductible and 60% coinsurance.
Massage Therapy	Payable at 100%.	Subject to a \$25 <i>copayment</i> then payable at 100%.	Subject to deductible and 80% coinsurance.
*College of Medicine, PAR and Non-PAR <i>covered expenses</i> aggregate to a maximum of 40 visits each for speech, physical and occupational therapy.			

<b>MEDICAL COVERED EXPENSES</b>			
<b>BENEFIT</b>	<b>COLLEGE OF MEDICINE</b>	<b>PAR PROVIDER (Humana/ChoiceCare)</b>	<b>NON-PAR PROVIDER</b>
<b>OTHER COVERED EXPENSES:</b>			
Cardiac Rehabilitation (Phases I & II)	Payable at 100%.	Subject to a \$25 <i>copayment</i> , then payable at 100%.	Subject to deductible and 60% coinsurance.
<i>Durable Medical Equipment (DME)</i> and Supplies	Not applicable.	Subject to a \$25 <i>copayment</i> then payable at 100%.	Subject to deductible and 80% coinsurance.
Injections, other than routine (including allergy injections and vials and birth control injections)	Payable at 100%.	Subject to a \$25 <i>copayment</i> , then payable at 100%.	Subject to 60% coinsurance.
Birth Control Devices and Implant Systems	Payable at 100%.	Subject to a \$25 <i>copayment</i> , then payable at 100%.	Subject to 60% coinsurance.
Sexual Dysfunction/ Impotence	Subject to deductible and 80% coinsurance.	Subject to a \$25 <i>copayment</i> then payable at 100%.	Subject to deductible and 60% coinsurance.
Organ Transplants Facility (College of Medicine, PAR and Non-PAR aggregate to a <i>maximum benefit</i> of \$300,000 per <i>calendar year</i> . Alternative benefits may be available outside of this Plan, please see <i>your employer</i> for details).	Payable at 100%.	Subject to 80% coinsurance.	Subject to deductible and 60% coinsurance.

**SCHEDULE OF PRESCRIPTION DRUG BENEFITS**

<b>RETAIL COPAYMENT STRUCTURE</b>	
<i>Generic medication copayment per prescription</i>	\$10*
<i>Brand name medication copayment per prescription</i>	\$15*
Retail Prescription Drug Maximum Supply	30 days
<b>MAIL ORDER COPAYMENT STRUCTURE</b>	
<i>Generic maintenance medication copayment per prescription</i>	\$10*
<i>Brand name maintenance medication copayment per prescription</i>	\$15*
Mail Order Drug Maximum Supply	90 days

**\*Prescription Drug Copayments do not apply toward the Out-of-Pocket Limits.**

**ADDITIONAL PRESCRIPTION DRUG BENEFIT INFORMATION**

**Participating Pharmacy**

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

**Non-participating Pharmacy**

When a *non-participating pharmacy* is used, *you* must pay the *pharmacy* the full price of the drug and submit the *pharmacy* receipt to Humana at the address listed below. *You* will be responsible for 30% of the actual charge made by the dispensing *pharmacy* after this charge has been reduced by the applicable *copayment*.

Mail *pharmacy* receipts to:

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

## **UTILIZATION/CASE MANAGEMENT**

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

## **PRECERTIFICATION**

*Utilization review* includes *precertification* and *concurrent review*.

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

If *you* or *your covered dependent* are to receive a *service* which requires *precertification*, *you* or *your qualified practitioner* must contact the *Plan Manager* by telephone or in writing. Refer to the Schedule of Benefits for time requirements.

After *you* or *your qualified practitioner* have provided the *Plan Manager* with *your* diagnosis and treatment plan, the *Plan* will:

1. Advise *you* in writing if the proposed treatment plan is *medically necessary*;
2. Advise *you* in writing the number of days the *confinement* is initially *precertified*; and
3. Conduct *concurrent review* as necessary.

If *your qualified practitioner* extends *your confinement* beyond the number of days initially *precertified*, the extension must be *precertified* through *concurrent review*.

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

## **PENALTY FOR NOT OBTAINING PRECERTIFICATION**

If *you* do not obtain *precertification* for *services* being rendered, *your* benefits for the *hospital* may be reduced. Refer to the Schedule of Benefits for the applicable penalty.

## **SECOND SURGICAL OPINION**

Benefits for a second surgical opinion, including any *medically necessary* x-ray and laboratory tests performed by the second *qualified practitioner* are payable at 100%.

If the two opinions disagree, *you* may obtain a third opinion. Benefits for the third opinion are payable the same as for the second opinion.

### **Utilization/Case Management Continued**

The *qualified practitioners* providing the surgical opinions MUST NOT be in the same group practice or clinic. The *qualified practitioner* providing the second or third surgical opinion may confirm the need for *surgery* or present other treatment options. The decision whether or not to have the *surgery* is always *yours*.

### **PREDETERMINATION OF MEDICAL BENEFITS**

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

If treatment is to commence more than 90 days after the date treatment is authorized, the *Plan Manager* will require *you* to submit another treatment plan.

## **MEDICAL DEDUCTIBLE AND COINSURANCE INFORMATION**

*Covered expenses* are payable, after satisfaction of the deductible, to a *maximum allowable fee* at the coinsurance percentages and up to the *maximum benefits* shown on the Schedule of Benefits.

### **DEDUCTIBLE**

The deductible applies to each *covered person* each *calendar year*. Only charges which qualify as a *covered expense* may be used to satisfy the deductible. The amount of the deductible is stated on the Schedule of Benefits. Any *covered expense* incurred during the last three months of the *calendar year* that is used to satisfy all or part of the deductible for that year, will be used to satisfy all or part of the deductible for the following *calendar year*.

### **MAXIMUM FAMILY DEDUCTIBLE**

The total deductible applied to all *covered persons* in one family in a *calendar year* is subject to the maximum shown on the Schedule of Benefits.

### **COMMON ACCIDENT DEDUCTIBLE**

When three or more *covered persons* in one family incur *covered expenses* due to the same accident, only one deductible per *calendar year* will be applied to the total of all *covered expenses* incurred as a result of that accident.

### **COINSURANCE**

The term coinsurance means the shared financial responsibility for *covered expenses* between the *covered person* and the self-insured plan.

*Covered expenses* are payable at the applicable percentage rate shown on the Schedule of Benefits after the deductible is satisfied each *calendar year*.

### **OUT-OF-POCKET LIMIT**

When the amount of combined *covered expenses* paid by *you* and/or all *your covered dependents* satisfy the deductible and out-of-pocket limits as shown on the Schedule of Benefits, the Plan will pay 100% of *covered expenses* for the remainder of the *calendar year*, unless specifically indicated, subject to any *calendar year* maximums and the lifetime maximum of the Plan.

If *you* and *your covered dependents* use a combination of PAR and Non-PAR providers, the combined out-of-pocket will not exceed the Non-PAR provider out-of-pocket limit. Office visit *copayments* are applied to the out-of-pocket limit.

### **LIFETIME MAXIMUM**

Lifetime maximum means the maximum amount of benefits available while *you* are covered under the Plan. Under no circumstances does lifetime mean during the lifetime of the *covered person*.

## **MEDICAL COVERED EXPENSES**

### **INPATIENT HOSPITAL**

*Covered expenses* are payable as shown on the Schedule of Benefits and include charges made by a:

1. *Hospital* for daily semi-private, ward, intensive care or coronary care room and board charges for each day of *confinement*. The maximum amount payable is shown on the Schedule of Benefits. Benefits for a private or single-bed room are limited to the *maximum allowable fee* charged for a semi-private room in the *hospital* while a registered bed patient;
2. *Hospital* for *services* furnished for *your* treatment during *confinement*.

### **OUTPATIENT HOSPITAL**

*Covered expenses* are payable as shown on the Schedule of Benefits and include charges made by a *hospital* for *services* and equipment that are supplied by and used in the outpatient department.

### **FREE-STANDING SURGICAL FACILITY**

Charges made by a *free-standing surgical facility*, for surgical procedures performed and for *services* rendered in the facility are payable as shown on the Schedule of Benefits.

### **QUALIFIED PRACTITIONER**

*Covered expenses* are payable as shown on the Schedule of Benefits and include charges made by a *qualified practitioner* when incurred for:

1. Office, home, *emergency* room physician or inpatient *hospital* visits;
2. Diagnostic x-ray or laboratory tests;
3. Professional *services* of a radiologist or pathologist for diagnostic x-ray examination or laboratory tests, including x-ray, radon, radium, and radioactive isotope therapy;
4. Other covered medical *services* received from or at the direction of a *qualified practitioner*;
5. Administration of anesthesia;
6. A surgical procedure, including pre-operative and post-operative care.

If multiple surgical procedures are performed at one operative session, the amount payable for these procedures will be limited to the *maximum allowable fee* for the primary procedure and 50% of the *maximum allowable fee* for subsequent procedures when performed independently.

No benefits will be payable for incidental procedures.

7. Assisting the surgeon;
8. Physician assistant;

### **Qualified Practitioner Continued**

9. Charges made by a *qualified practitioner* for *services* in performing certain oral surgical operations due to *bodily injury* or *sickness* are covered as follows:
  - a. Excision of partially or completely unerupted impacted teeth;
  - b. Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth when such conditions require pathological examination;
  - c. Surgical procedures required to correct accidental injuries of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
  - d. Reduction of fractures and dislocations of the jaw;
  - e. External incision and drainage of cellulitis;
  - f. Incision of accessory sinuses, salivary glands or ducts; and
  - g. Frenectomy (the cutting of the tissue in the midline of the tongue).

### **ROUTINE CARE**

The following expenses are payable for *you* or *your* covered *dependent*, up to the amount shown on the Schedule of Benefits, subject to all terms and provisions of the Plan, except the exclusion for *services* which are not *medically necessary*, if *you* are not confined in a *hospital* or *qualified treatment facility* and if such expenses are not incurred for diagnosis of a specific *bodily injury* or *sickness*.

Benefits include:

1. Routine exams and annual checkups;
2. Immunizations;
3. Pap smears, limited to one per *calendar year*;
4. Mammograms;
5. Routine x-ray and laboratory tests;
6. Prostate antigen testing.

No benefits are payable under this benefit for:

1. Any dental examinations;
2. Hearing examinations;

### **Routine Care Continued**

3. Medical examination for *bodily injury* or *sickness*;
4. Medical examination caused by or resulting from pregnancy.

### **CHIROPRACTIC CARE**

Chiropractic care for treatment of a *bodily injury* or *sickness*, is payable as shown on the Schedule of Benefits. *Maintenance care* is not covered.

### **THERAPIES**

*Covered expenses* are payable as shown on the Schedule of Benefits for the following therapies:

1. Speech therapy, limited to 40 visits per *calendar year*;
2. Occupational therapy, limited to 40 visits per *calendar year*;
3. Physical therapy, limited to 40 visits per *calendar year*;
4. Chemotherapy;
5. Radiation therapy;
6. Respiratory therapy; and
7. Massage therapy.

### **AMBULANCE SERVICE**

Local professional ambulance service within 100 miles equipped to provide the necessary treatment is covered as shown on the Schedule of Benefits. Ambulance service must not be provided primarily for the convenience of the patient or the *qualified practitioner*.

### **HUMANA BEGINNINGS**

The "Humana Beginnings Program" is a service provided to *employees* and their eligible *dependents* of this Plan by the *Plan Manager*. This program is designed as a special service that helps mothers receive appropriate prenatal care.

- First, call the *precertification* phone number shown on the back of *your* ID card as soon as *your* pregnancy has been confirmed by a *qualified practitioner*. When *you* call, one of the nurses will ask *you* questions such as: *your* estimated date of delivery, if *you* had any problems with previous pregnancies, and *your* ongoing medical conditions, just to name a few. These questions are held in confidence between *you* and the nurse *you* are speaking to. Answers to these questions, along with *your* approval, will help the nurse and *your* doctor decide whether *you* need special care during *your* pregnancy.

## **Humana Beginnings Continued**

- If *you* and/or *your* baby need special care before or after delivery, a nurse is available to assist in managing *your* care. The nurse will obtain the necessary consents from *you* to manage *your* care. The nurse case manager will then monitor the treatment plan and facilitate with *your* health care professional to ensure *you* are receiving the best care while getting the most out of *your* health insurance benefits.
- If *your* health care professional admits *you* to a *hospital* during *your* pregnancy, please follow the *precertification* requirements defined in *your* benefit booklet for *emergency* and planned admissions.
- When *you* deliver *your* baby, *you* may not feel up to calling the *Plan Manager* (or as indicated on *your* ID card). Remind *your* partner, relative or health care professional to call for *you*.

If *you* have any questions, call the *Plan Manager* (or as indicated on *your* ID card) and one of our nurses will help *you*.

## **PREGNANCY BENEFITS**

Pregnancy is a *covered expense* for any *covered person* payable as shown on the Schedule of Benefits. *Complications of pregnancy* are payable as any other covered *sickness* at the point the complication sets in for any *covered person*.

Pregnancy benefits are subject to all terms and provisions of the Plan, with the exception of the *pre-existing condition* limitation as defined within the Definitions section of this booklet.

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any *hospital* length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans may not, under Federal law, require that a provider obtain authorization from the Plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

## **NEWBORN BENEFITS**

Benefits for newborns are subject to the Eligibility and Effective Date of Coverage section of this booklet, as well as all terms and provisions of the Plan, with the exception of the *pre-existing condition* limitation as defined within the Definitions section of this booklet.

## **WELL NEWBORN**

*Covered expenses* incurred during a well-newborn child's initial inpatient *hospital confinement* include *hospital* expenses for nursery room and board and miscellaneous *services*; *qualified practitioner's* expenses for circumcision; and *qualified practitioner's* expenses for routine examination before release from the *hospital*.

## **Newborn Benefits Continued**

### **SICK-NEWBORN**

*Covered expenses* for a sick-newborn are *expenses incurred* for the treatment of a *bodily injury* or *sickness*.

### **BIRTHING CENTERS**

A birthing center is a free standing facility, licensed by the state, which provides prenatal care, delivery and immediate postpartum care, and care of the newborn child.

*Expense incurred* within 24 hours after *confinement* in a birthing center for *services* and supplies furnished for prenatal care and delivery of child(ren) are payable as shown on the Schedule of Benefits.

### **SKILLED NURSING FACILITY**

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

1. Begins while *you* or an eligible *dependent* are covered under this Plan;
2. Begins within 24 hours after discharge from a *hospital confinement* of at least three or more days or a prior covered skilled nursing facility *confinement*;
3. Is necessary for care or treatment of the same *bodily injury* or *sickness* which caused the prior *confinement*; and
4. Occurs while *you* or an eligible *dependent* are under the regular care of the physician who *precertified* the required skilled nursing facility *confinement*.

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

1. Permanent and full-time bed care facilities for resident patients;
2. A physician's *services* available at all times;
3. 24-hour-a-day skilled nursing *services* under the full-time supervision of a physician or registered nurse (R.N.);
4. A daily record for each patient;
5. Continuous skilled nursing care for sick or injured persons during their convalescence from *sickness* or *bodily injury*; and
6. A utilization review plan.

A skilled nursing facility is not except by incident, a rest home, a home for care of the aged, or engaged in the care and treatment of *mental disorders*, chemical dependence, or alcoholism.

## Skilled Nursing Facility Continued

### BENEFITS PAYABLE

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

### HOME HEALTH CARE

*Expense incurred* for home health care as described below is payable as shown on the Schedule of Benefits.

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

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

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

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

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

The home health care plan consists of:

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

## Home Health Care Continued

### LIMITATIONS ON HOME HEALTH CARE BENEFITS

Home health care benefits do not include:

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

### HOSPICE CARE

Hospice *services* must be furnished in a hospice facility or in *your* home. A *qualified practitioner* must certify *you* are terminally ill with a life expectancy of six months or less.

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

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

1. Room and board and other *services* and supplies;
2. Part-time nursing care by or supervised by a R.N. for up to 8 hours per day;
3. Counseling *services* by a *qualified practitioner* for the hospice patient and the immediate family;
4. Medical social *services* provided to *you* or *your* immediate family under the direction of a *qualified practitioner*, which include the following:
  - a. Assessment of social, emotional and medical needs, and the home and family situation,
  - b. Identification of the community resources available, and
  - c. Assistance in obtaining those resources;
5. Nutritional counseling;
6. Physical or occupational therapy;
7. Part-time home health aide service for up to 8 hours in any one day;
8. Medical supplies, drugs and medicines prescribed by a *qualified practitioner*; and
9. Bereavement counseling *services* by a *qualified practitioner* for *your* immediate family.

## **Hospice Care Continued**

### **LIMITATIONS ON HOSPICE CARE BENEFITS**

Hospice care benefits do NOT include: (1) private duty nursing *services* when confined in a hospice facility; (2) a *confinement* not required for pain control or other acute chronic symptom management; (3) funeral arrangements; (4) financial or legal counseling, including estate planning or drafting of a will; (5) homemaker or caretaker *services*, including a sitter or companion *services*; (6) housecleaning and household maintenance; (7) *services* of a social worker other than a licensed clinical social worker; (8) *services* by volunteers or persons who do not regularly charge for their *services*; or (9) *services* by a licensed pastoral counselor to a member of his or her congregation when *services* are in the course of the duties to which he or she is called as a pastor or minister.

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

Hospice facility means a licensed facility or part of a facility which principally provides hospice care, keeps medical records of each patient, has an ongoing quality assurance program and has a physician on call at all times.

A hospice facility provides 24-hour-a-day nursing *services* under the direction of a R.N. and has a full-time administrator.

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

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

### **MENTAL DISORDER, CHEMICAL DEPENDENCE OR ALCOHOLISM BENEFIT**

*Expense incurred* by you during a plan of treatment for *mental disorder*, chemical dependence or alcoholism is payable for:

1. Charges made by a *qualified practitioner*;
2. Charges made by a *hospital*;
3. Charges made by a *qualified treatment facility*.

## Mental Disorder, Chemical Dependence or Alcoholism Benefit Continued

### INPATIENT BENEFITS/TRANSITIONAL BENEFITS

*Covered expenses* while confined as a registered bed patient in a *hospital* or *qualified treatment facility* are payable as shown below:

#### MENTAL DISORDERS, CHEMICAL DEPENDENCE/ALCOHOLISM

COLLEGE OF MEDICINE	PAR PROVIDER	NON-PAR PROVIDER
Payable at 100%.	Subject to 80% coinsurance.	Subject to deductible and 60% coinsurance.
College of Medicine, PAR and Non-PAR inpatient treatment aggregate to a maximum of 90 days for <i>mental disorder</i> and a separate 90 days for chemical dependence or alcoholism. Two days of transitional treatment equals one inpatient day.		

### OUTPATIENT BENEFITS

*Covered expenses* for outpatient treatment received while not confined in a *hospital* or *qualified treatment facility* are payable as shown below:

#### MENTAL DISORDERS

COLLEGE OF MEDICINE	PAR PROVIDER	NON-PAR PROVIDER
Subject to deductible and 80% coinsurance.	Subject to a \$25 <i>copayment</i> , then payable at 100%.	Subject to a \$25 <i>copayment</i> , then payable at 100%.
College of Medicine, PAR and Non-PAR outpatient treatment of a <i>mental disorder</i> aggregate to 52 visits per <i>calendar year</i> .		

#### CHEMICAL DEPENDENCE/ALCOHOLISM

COLLEGE OF MEDICINE	PAR PROVIDER	NON-PAR PROVIDER
Subject to deductible and 80% coinsurance.	Subject to a \$25 <i>copayment</i> , then payable at 100%.	Subject to a \$25 <i>copayment</i> , then payable at 100%.
College of Medicine, PAR and Non-PAR outpatient treatment of chemical dependence or alcoholism aggregate to 52 visits per <i>calendar year</i> .		

Transitional treatment arrangements mean *covered expenses* for the treatment of *mental disorders*, chemical dependence or alcoholism that are provided to *you* in a less restrictive manner than are inpatient *hospital services*, but in a more intensive manner than are outpatient *services* (includes but is not limited to day hospitalization).

*Covered expenses* for inpatient, outpatient and transitional treatment aggregate toward the coinsurance and out-of-pocket limits described on the Schedule of Benefits.

**Mental Disorder, Chemical Dependence or Alcoholism Benefit Continued**

**LIMITATIONS ON MENTAL DISORDER, CHEMICAL DEPENDENCE OR ALCOHOLISM BENEFITS**

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

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

## OTHER COVERED EXPENSES

### \*BENEFITS PAYABLE ARE APPLICABLE TO THE SERVICE PROVIDED

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

1. Blood and blood plasma are payable as long as it is NOT replaced by donation, and administration of blood and blood products including blood extracts or derivatives;
2. Oxygen and rental of equipment for its administration;
3. Initial prosthetic devices or supplies, including but not limited to, limbs, and eyes. Coverage will be provided for prosthetic devices necessary to restore minimal basic function. Replacement is a *covered expense* if due to pathological changes. *Covered expense* includes repair of the prosthetic device if not covered by the manufacturer. The initial loss necessitating the prosthetic device or supply must happen while *you* are covered under the Plan;
4. Casts, trusses, crutches, splints except for dental splints, and braces except for orthodontic braces;
5. Supplies, up to a 30-day supply, when prescribed by *your* attending physician;
6. Initial contact lenses or eyeglasses following cataract *surgery*;
7. The rental, up to but not to exceed the purchase price, of a wheelchair, hospital bed, ventilator, hospital type equipment or other *durable medical equipment (DME)*. The Plan, at its option, may authorize the purchase of *DME* in lieu of its rental, if the rental price is projected to exceed the purchase price. Repair, maintenance, or duplicate *DME* rental is not considered a *covered expense*;
8. *Services* for the treatment of a *dental injury* to a *sound natural tooth*, including but not limited to extraction and initial replacement, payable as shown on the Schedule of Benefits. The *dental injury* and replacement must occur while *you* are covered under the Plan. *Services* must begin within 12 months after the date of the *dental injury*. Benefits will be paid only for *expense incurred* for the least expensive *service* that will, in the *Plan Manager's* opinion, produce a professionally adequate result;
9. Osteotomies;
10. Installation and use of an insulin infusion pump, diabetic self-management education programs and other equipment or supplies in the treatment of diabetes, except as specifically described within the Prescription Drug section;
11. Surgical or non-surgical treatment including but not limited to, appliances and therapy, for any jaw joint problem including any temporomandibular joint disorder, craniomaxillary, craniomandibular disorder or other conditions of the joint linking the jaw bone and skull; surgical or non-surgical treatment of the facial muscles used in expression and mastication functions, for symptoms including but not limited to, headaches. These expenses do not include charges for orthodontic *services*;

## Other Covered Expenses Continued

12. Reconstructive *surgery* due to *bodily injury*, infection or other disease of the involved part which occurs while *you* are covered under this Plan, or congenital disease or anomaly of a covered *dependent* child which resulted in a functional defect;
13. Reconstructive *services* following a covered mastectomy including but not limited to:
  - a. reconstruction of the breast on which the mastectomy was performed;
  - b. reconstruction of the other breast to achieve symmetry;
  - c. prosthesis; and
  - d. treatment of physical complications of all stages of the mastectomy, including lymphedemas;
14. *Services* performed as a result of a complication, regardless of whether the original *service* was a *covered expense* under the Plan;
15. Transplants are subject to all provisions of the Plan applicable at the time the expense is incurred, including but not limited to, the limitations and exclusions and the definitions found in this Plan and the following additional Plan provisions:
  - a. when both the recipient and the donor are covered by the Plan, each is entitled to the benefits of the Plan;
  - b. when only the recipient is covered by the Plan, the recipient is entitled to the benefits of the Plan. The donor's benefits are limited to only those eligible charges for services to donate the tissue, joint or human organ and not provided or available to the donor from any other source. Another source includes, but is not limited to, any insurance coverage, medical plan, or any government program. Benefits provided to the donor are charged against the recipient's coverage under the Plan;
  - c. when only the donor is covered by the Plan, the donor is entitled to the benefits of the Plan. The benefits are limited to only those not provided or available to the donor from any other source. Another source includes, but is not limited to, any insurance coverage or any governmental program available to the recipient. No benefits are provided to the non-covered transplant recipient;
  - d. if any organ tissue is sold rather than donated to the covered recipient, no benefits are payable for the purchase price of such organ or tissue; however, other costs related to the evaluation and procurement are covered for the recipient up to the benefit limitation of the Plan.
16. Cardiac rehabilitation, limited to phases I and II;
17. *Services* for morbid obesity;
18. Injections other than routine;

### **Other Covered Expenses Continued**

19. Allergy Injections;
20. Vials;
21. All fertility testing and *services*, except any artificial means to achieve pregnancy or ovulation, such as artificial insemination, in vitro fertilization, spermatogenesis, gamete intra fallopian transfer (GIFT), zygote intra fallopian transfer (ZIFT), tubal ovum transfer, embryo freezing or transfer and sperm banking.

The following *services* are considered other *covered expenses* and are payable as shown on the Schedule of Benefits, subject to all terms and provisions of the Plan, except the exclusion for *services* which are not *medically necessary*:

1. Elective sterilizations;
2. Birth control devices, injections, implant systems or the removal of implant systems;
3. Diagnosis and/or treatment of sexual dysfunction/impotence.

## LIMITATIONS AND EXCLUSIONS

The Plan does not provide benefits for:

1. *Services:*
  - a. Not furnished by a *qualified practitioner* or *qualified treatment facility*;
  - b. Not authorized or prescribed by a *qualified practitioner*;
  - c. Not covered by this Plan whether or not prescribed by a *qualified practitioner*;
  - d. Which are not provided;
  - e. For which no charge is made, or for which *you* would not be required to pay if *you* were not covered under this Plan unless charges are received from and reimbursable to the United States Government or any of its agencies as required by law; or
  - f. Furnished by or payable under any plan or law through any government or any political subdivision (this does not include *Medicare* or *Medicaid*);
  - g. Furnished for a military service connected *sickness* or *bodily injury* by or under an agreement with a department or agency of the United States Government, including the Department of Veterans Affairs;
  - h. Performed in association with a *service* that is not covered under this Plan;
2. Routine eye exams, *services* to correct eye refractive disorders, eyeglass frames and lenses or contact lenses, the fitting or repair of eyeglass frames and lenses or contact lenses, unless specifically indicated in Other Covered Expenses #6;
3. Routine hearing exams, hearing aids, the fitting, or repair of hearing aids;
4. Elective abortions, unless the pregnancy is a life-threatening physical condition of the covered female person;
5. *Services* related to gender change;
6. *Services* for a reversal of sterilization;
7. Treatment of any *bodily injury* or *sickness* that is sustained by an *employee* or a covered *dependent* that arises out of, or as the result of, any work for wage or profit when coverage under any Workers' Compensation Act or similar law is required for the *employee* or covered *dependent*;
8. *Services* for *cosmetic surgery*;
9. Dental *services* or appliances for the treatment of the teeth, gums, jaws or alveolar processes, including but not limited to, implants and related procedures, and orthodontic procedures, unless specifically provided under this Plan;

## Limitations and Exclusions Continued

10. Any loss caused by or contributed to:
  - a. War or any act of war, whether declared or not, or
  - b. Any act of armed conflict, or any conflict involving armed forces of any authority;
11. Any drug, medicine or device which does not have the United States Food and Drug Administration formal market approval through a New Drug Application, Premarket Approval, 510K, or PLA;
12. Any *service* which is *experimental, investigational or for research purposes*;
13. *Pre-existing conditions* to the extent specified in the Definitions section;
14. *Custodial care and maintenance care*;
15. *Services* provided by a person who ordinarily resides in *your* home or who is a *family member*;
16. Charges in excess of the *maximum allowable fee* for the *service*;
17. Any *expense incurred* prior to *your* effective date under the Plan or after the date *your* coverage under the Plan terminates, except as specifically described in this Plan;
18. Any expense due to commission or attempt to commit a civil or criminal battery or felony;
19. *Services* not *medically necessary* for diagnosis and treatment of a *bodily injury* or *sickness*;
20. *Expenses incurred* for which *you* are entitled to receive benefits under *your* previous dental or medical plan;
21. *Expenses incurred* for artificial means to achieve pregnancy or ovulation, such as artificial insemination, in vitro fertilization, spermatogenesis, gamete intra fallopian transfer (GIFT), zygote intra fallopian transfer (ZIFT), tubal ovum transfer, embryo freezing or transfer and sperm banking;
22. Therapy and testing for treatment of allergies, including but not limited to, *services* related to clinical ecology, environmental allergy and allergic immune system dysregulation and sublingual antigen(s), extracts, neutralization test and/or treatment UNLESS such therapy or testing is approved by:
  - a. The American Academy of Allergy and Immunology, or
  - b. The Department of Health and Human Services or any of its offices or agencies;

### **Limitations and Exclusions Continued**

23. Professional pathology or radiology charges, including but not limited to, blood counts, multi-channel testing, and other clinical chemistry tests, when:
  - a. The *services* do not require a professional interpretation, or
  - b. The *qualified practitioner* did not provide a specific professional interpretation of the test results of the *covered person*;
24. *Prescription drugs* for which coverage is available under the Prescription Drug Benefit;
25. Vision therapy.

## **PRESCRIPTION DRUG BENEFITS**

### **RETAIL PRESCRIPTIONS**

#### **HOW TO USE YOUR PRESCRIPTION DRUG PROGRAM CARD**

*Your* retail *prescription* drug program is provided through AdvancePCS. *You* will receive an identification (ID) card which includes information such as *your* name, group number and the effective date of *your* coverage.

Present *your* ID card at a participating Humana Pharmacy Network or AdvancePCS Client Based Network when purchasing a *prescription*.

#### **PRESCRIPTION DRUG BENEFIT**

*Prescription* drug benefits are payable for covered *prescription* expenses incurred by *you* and *your* covered *dependents*. Benefits are payable for such expenses for charges made by a *participating pharmacy* for each separate *prescription*, subject to the applicable *copayment* payable as shown on the Schedule of Benefits.

As a participant in this program, *you* must pay for:

- The cost of medication not covered under the *prescription* benefit;
- The cost of any quantity of medication dispensed in excess of a consecutive 30-day non-*maintenance medication* supply.

#### **MAIL ORDER PRESCRIPTIONS**

The mail order benefits of *your prescription* drug program are provided by AdvancePCS. Their mail order pharmacy service is called AdvanceRX.com. This mail service program provides participants with an easy and convenient way to obtain *maintenance medications*. A mail order kit that explains the mail service program in greater detail can be obtained through *your* Human Resources Department or by contacting AdvanceRX.com at 1-888-678-6093.

When *your* doctor writes a *prescription* for a *maintenance medication*, ask him/her to write for up to a 90 day supply. AdvanceRX.com will only fill *your prescription* with the quantity prescribed by the physician.

## COVERED PRESCRIPTION DRUG BENEFITS

Benefits are available for covered *prescription* drugs, medicine or medication that are received by *you* or *your dependents* while covered under the Plan. The following are covered *prescription* drugs:

1. Drugs, medicines or medications that under federal or state law, may be dispensed only by *prescription* from a *qualified practitioner*.
2. Insulin and diabetic supplies (on *prescription*), which include:
  - a. Disposable needles/syringes;
  - b. Disposable blood/urine glucose/acetone testing agents (e.g. Chemstrips, Clinitest tablets, Diastix Strips, and Tes-Tape);
  - c. Alcohol swabs;
  - d. Blood glucose monitors;
  - e. Insulin delivery devices (e.g. Novopen, Novolinpen, and BD pen);
  - f. Lancet devices;
  - g. Lancets.
3. Tretinoin topical (e.g. Retin-A) for individuals through the age of 25 years.
4. Compounded medication of which at least one ingredient is a *legend drug*.
5. Legend contraceptives; including, but not limited to: oral, devices, injectables (e.g. Depo-Provera), and Norplant.
6. Legend multi vitamins.
7. Viagra, limited to 12 doses per month or 36 doses per 90 days at mail order.
8. Growth Hormones.
9. Anorectics.
10. Self -injectable drugs, unless excluded below.

Covered *prescription* drugs, medicine or medications must:

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

Contrary to any other provisions of the Plan, *prescription* drug expenses covered under this benefit are not covered under any other provisions of this Plan. Any amount in excess of the maximum amount provided under this benefit, if any, is not covered under any other provision in the Plan. Any *expenses incurred* under provisions of this section do not apply toward *your calendar year* deductible or out-of-pocket limits.

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

## LIMITATIONS FOR PRESCRIPTION DRUG BENEFITS

*Expense incurred* will not be payable for the following:

1. Abortifacients (drugs used to induce abortions).
2. Anabolic Steroids.
3. Anti-obesity medications.
4. Antacids.
5. Any drug used for cosmetic purposes, including but not limited to:
  - a. Tretinoin (e.g. Retin A), except if *you* are under age 26 or are diagnosed as having adult acne;
  - b. Anti-wrinkle agents (e.g. Renova);
  - c. Dermatological or hair growth stimulants;
  - d. Pigmenting or de-pigmenting agents, (e.g. Solaquin);
  - e. Cosmetic hair removal products (e.g. Vaniqa).
6. Treatment for onychomycosis (nail fungus: e.g. Penlac).
7. Fluoride Supplements.
8. Impotence; except Viagra.
9. Infertility medications.
10. Mineral and Nutrient Supplements. Exception: Calcium Acetate 667 mg tablets (Phoslo) are covered.
11. *Non-legend drugs* other than those listed above.
12. Ostomy supplies.
13. Progesterone crystals and powder in any compounded dosage form.
14. Ribavirin powder.
15. Smoking Deterrent Medications containing nicotine or any other smoking cessation aids, all dosage forms.
16. Therapeutic devices or appliances, including:
  - a. Hypodermic needles, syringes, (except needles and syringes for diabetes and *self-administered injectable drugs* approved by the Plan);
  - b. Support garments;
  - c. Test reagent;
  - d. Mechanical pumps for delivery of medications and;
  - e. Other non-medical substances.
17. Charges for the administration or injection of any drug.
18. Drugs labeled "Caution-limited by federal law to investigational use," or experimental drugs, even though a charge is made to the individual.
19. *Prescriptions* that are to be taken by or administered to the *covered person*, in whole or in part, while he or she is a patient in a facility where drugs are ordinarily provided by the facility on an inpatient basis. Inpatient facilities include, but are not limited to:
  - a. *Hospital*;
  - b. Rest home;
  - c. Sanitarium;
  - d. Skilled nursing facility;
  - e. Convalescent *hospital*;
  - f. Hospice facility.
20. Any drug prescribed for intended use other than for:
  - a. Indications approved by the FDA; or
  - b. Recognized off-label indications through peer-reviewed medical literature.
21. *Prescription* refills:
  - a. In excess of the number specified by the *qualified practitioner*; or
  - b. Dispensed more than one year from the date of the original order.

## Limitations for Prescription Drug Benefits Continued

22. Any drug for which a charge is customarily not made, or for which the dispenser's charge is less than the co-payment amount in the absence of this benefit.
23. Any drug prescribed for a *sickness* or *bodily injury* not covered under this Plan.
24. Any drug, medicine or medication received by the *covered person*:
  - a. Before becoming covered under the Plan; or
  - b. After the date the *covered person's* coverage under the Plan has ended.
25. Any costs related to the mailing, sending, or delivery of *prescription* drugs.
26. Any fraudulent misuse of this benefit including *prescriptions* purchased for consumption by someone other than the *covered person*.
27. *Prescription* or refill for drugs, medicines, or medications that are lost, stolen, spilled, spoiled, or damaged.
28. Any drug or medicine that is:
  - a. Lawfully obtainable without a *prescription* (over the counter drugs), except Insulin; or
  - b. Available in *prescription* strength without a *prescription*.
29. More than one *prescription* for the same drug or therapeutic equivalent medication prescribed by one or more *qualified practitioners* and dispensed by one or more pharmacies until at least 75% of the previous retail *prescription* has been used by the *covered person*. If the drug or therapeutic equivalent medication is dispensed at a mail order service, then at least 66% of the previous *prescription* must have been used by the *covered person*.
30. Any drug or biological that has received an "orphan drug" designation, unless approved by the Plan Administrator.
31. Any co-payments or coinsurance a member 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 DATE OF COVERAGE**

### **EMPLOYEE ELIGIBILITY**

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

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

*Your* eligibility date is *your* first day of employment with the *employer*.

### **EMPLOYEE EFFECTIVE DATE OF COVERAGE**

*You* must enroll on forms acceptable to the *Plan Manager*.

1. If *your* completed enrollment forms are received by the *Plan Manager* before *your* eligibility date or within 30 days after *your* eligibility date, *your* coverage is effective on *your* eligibility date.
2. If *your* completed enrollment forms are received by the *Plan Manager* more than 30 days after *your* eligibility date, *you* are a *late applicant* and *your* coverage will be subject to the *pre-existing condition* limitation as defined within the Definitions section of this booklet. *Your* coverage is effective on the date the enrollment form is received by the *Plan Manager*.

### **EMPLOYEE DELAYED EFFECTIVE DATE**

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

### **DEPENDENT ELIGIBILITY**

Each *dependent* is eligible for coverage on:

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

The covered *employee* may cover *dependents* only if the *employee* is also covered. Check with *your employer* immediately on how to enroll for *dependent* coverage. Late enrollment will result in *your dependents'* coverage being subject to the *pre-existing condition* limitation as defined within the Definitions section of this booklet. In any event, no person may be simultaneously covered as both an *employee* and a *dependent*. If both parents are eligible for coverage, only one may enroll for *dependent* coverage.

## **Eligibility and Effective Date of Coverage Continued**

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

If the *employee* wishes to add a newborn *dependent* to the Plan and a change in the *employee’s* level of coverage is not required, an enrollment form must be completed and submitted to the *Plan Manager*.

The newborn *dependent* will be covered on the date he or she is eligible.

If the *employee* wishes to add a *dependent* (other than a newborn) to the Plan and a change in the *employee’s* level of coverage is not required, the *dependent’s* effective date of coverage is determined as follows:

1. If the completed enrollment forms are received by the *Plan Manager* before the *dependent’s* eligibility date or within 30 days after the *dependent’s* eligibility date, that *dependent* is covered on the date he or she is eligible.
2. If the completed enrollment forms are received by the *Plan Manager* more than 30 days after the *dependent’s* eligibility date, the *dependent* is a *late applicant*. The *dependent’s* coverage will be subject to the *pre-existing condition* limitation as defined within the Definitions section of this booklet. The *dependent* is covered on the date the enrollment form is received by the *Plan Manager*.

No *dependent’s* effective date will be prior to the covered *employee’s* effective date of coverage. A *dependent* child who becomes eligible for other group coverage through any employment is no longer eligible for coverage under this Plan. If *your dependent* child becomes an eligible *employee* of the *employer*, he or she is no longer eligible as *your dependent* and must make application as an eligible *employee*.

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

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

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

1. If the completed enrollment forms are received by the *Plan Manager* before the *dependent’s* eligibility date or within 30 days after the *dependent’s* eligibility date, that *dependent* is covered on the date he or she is eligible.
2. If the completed enrollment forms are received by the *Plan Manager* more than 30 days after the *dependent’s* eligibility date, the *dependent* is a *late applicant*. The *dependent’s* coverage will be subject to the *pre-existing condition* limitation as defined within the Definitions section of this booklet. The *dependent* is covered on the date the enrollment form is received by the *Plan Manager*.

No *dependent’s* effective date will be prior to the covered *employee’s* effective date of coverage. A *dependent* child who becomes eligible for other group coverage through any employment is no longer eligible for coverage under this Plan. If *your dependent* child becomes an eligible *employee* of the *employer*, he or she is no longer eligible as *your dependent* and must make application as an eligible *employee*.

## Eligibility and Effective Date of Coverage Continued

### MEDICAL CHILD SUPPORT ORDERS

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

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

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

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

### PRE-EXISTING CONDITION LIMITATION

Benefits for *pre-existing conditions* are limited under the Plan. *Pre-existing condition* is defined in the Definitions section of this booklet.

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

Prior to imposing a *pre-existing condition* limitation, the *Plan Manager* will:

1. Notify *you* in writing of the existence and terms of any *pre-existing condition* limitation;
2. Notify *you* of *your* right to request a certificate of *creditable coverage* from any applicable prior plans;
3. Notify *you* of *your* right to submit evidence of *creditable coverage* to the *Plan Manager* to reduce the length of any *pre-existing condition* limitation; and
4. Offer to request a certificate of prior *creditable coverage* on *your* behalf.

If, after receiving evidence of *creditable coverage*, the *Plan Manager* determines the *creditable coverage* is not sufficient to completely offset the Plan's *pre-existing condition* limitation period, the *Plan Manager* will:

1. Notify *you* in writing of its determination;

## **Eligibility and Effective Date of Coverage Continued**

2. Notify *you* of the source and substance of any information on which it relied; and
3. Provide an explanation of appeal procedures and allow a reasonable opportunity to submit additional evidence of *creditable coverage*.

The *Plan Manager* may modify an initial determination of *creditable coverage* if it determines the individual did not have the claimed *creditable coverage*, provided the *Plan Manager*:

1. Notifies *you* of such reconsideration in writing disclosing its determination;
2. Notifies *you* with the source and substance of any information on which it relied; and
3. Provides an explanation of appeal procedures and allows a reasonable opportunity to submit additional evidence of *creditable coverage*.

Alternate means of providing evidence of *creditable coverage* may include an explanation of benefits, correspondence from a plan, pay stubs showing a payroll deduction of premium for health plan coverage, third party statements verifying period(s) of coverage, information obtained by telephone, and any other relevant document providing evidence of period(s) of health coverage.

## **SPECIAL PROVISIONS FOR NOT BEING IN ACTIVE STATUS**

If *your employer* continues to pay required contributions and does not terminate the Plan, *your* coverage will remain in force for no longer than twelve consecutive months, or as determined by the Dean, during an approved leave of absence or *total disability*.

## **REINSTATEMENT OF COVERAGE FOLLOWING INACTIVE STATUS**

If *your* coverage under the Plan was terminated after a period of layoff, *total disability* or approved leave of absence, and *you* are now returning to work, *your* coverage is effective immediately on the day *you* return to work. The eligibility period requirement will be waived with respect to the reinstatement of *your* coverage. The *pre-existing condition* limitation will be waived with respect to the reinstatement of *your* coverage due to an approved medical leave of absence or *total disability*. The pre-existing condition limitation will apply with respect to the reinstatement of *your* coverage due to a layoff or non-medical leave of absence.

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

## **FAMILY AND MEDICAL LEAVE ACT (FMLA)**

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

## Eligibility and Effective Date of Coverage Continued

### EXTENDED BENEFITS

If, on the date *your* coverage terminates under the Plan, *you* or *your* covered *dependents* are *totally disabled* as a result of a covered *bodily injury* or *sickness*, the Plan will continue to provide medical benefits until the earliest of the following:

1. The date *your* physician certifies *you* are no longer *totally disabled*; or
2. The date *you* receive benefits equal to any *maximum benefit* shown on the Schedule of Benefits; or
3. The end of twelve consecutive months immediately following the date of *your* termination of coverage. This period of time is measured from the date *your* coverage is terminated under the Plan, to the same calendar day of the next succeeding months.

The Extended Benefits provision applies only to *covered expenses* for the disabling condition which existed on the date *your* coverage terminated. The Plan must remain in effect.

### RETIREE COVERAGE

If *you* are an early retiree with at least 10 years of continuous service, *you* may continue coverage under the Plan with benefits for *you* and any of *your* eligible *dependents* until *you* turn age 65, provided such coverage was effective at the time of *your* retirement. Please see *your employer* for more details.

If *you* are a *retiree* age 65 and over *you* may continue coverage under the Plan with benefits for *you* and any of *your* eligible *dependents* provided such coverage was effective at the time of *your* retirement. Any *dependents* acquired through marriage after retirement may be added by timely enrollment. Please see *your employer* for more details.

### SPECIAL ENROLLMENT

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

1. Loss of eligibility for the coverage due to any of the following:
  - a. Legal separation;
  - b. Divorce;
  - c. Death;
  - d. Termination of employment;
  - e. Reduction in the number of hours of employment;
  - f. Any loss of eligibility after a period that is measured by reference to any of the foregoing.

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

## Eligibility and Effective Date of Coverage Continued

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

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

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

1. Marriage;
2. Birth; or
3. Adoption or placement for adoption.

*You* may elect coverage under this Plan provided enrollment is within 30 days from the qualifying event. *You* MUST provide proof that the qualifying event has occurred due to one of the reasons listed before coverage under this Plan will be effective. Coverage under this Plan will be effective the date immediately following the date of the qualifying event, unless otherwise specified in this section.

In the case of a *dependent's* birth, enrollment is effective on the date of such birth.

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

If *you* become eligible for coverage under this Plan through the special enrollment provision, benefits under the Plan will be subject to the *pre-existing condition* limitation as defined within the Definitions section of this booklet.

If *you* apply more than 30 days after a qualifying event, *you* are considered a *late applicant* and coverage will be subject to the *pre-existing condition* limitation as defined within the Definitions section of this booklet.

Please see *your employer* for more details.

## TERMINATION OF COVERAGE

Coverage terminates on the earliest of the following:

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

IF *YOU* OR ANY OF *YOUR COVERED DEPENDENTS* NO LONGER MEET THE ELIGIBILITY REQUIREMENTS, *YOU* AND *YOUR EMPLOYER* ARE RESPONSIBLE FOR NOTIFYING THE *PLAN MANAGER* OF THE CHANGE IN STATUS. COVERAGE WILL NOT CONTINUE BEYOND THE LAST DATE OF ELIGIBILITY EVEN IF NOTICE HAS NOT BEEN GIVEN TO THE *PLAN MANAGER*.

## **IMPORTANT NOTICE FOR EMPLOYEES AND SPOUSES AGE 65 AND OVER**

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

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

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

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

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

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

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

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

## CONTINUATION OF MEDICAL BENEFITS

### THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1986 (COBRA)

#### CONTINUATION OF BENEFITS

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

#### ELIGIBILITY

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

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

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

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

- The death of the *employee*;
- Termination of the *employee's* employment (for reasons other than gross misconduct) or reduction of the *employee's* hours of employment with the *employer*;
- Divorce or legal separation from the *employee*;
- The *employee* becomes entitled to *Medicare* benefits; or
- Termination of a retiree spouse's coverage when the former *employer* discontinues retiree coverage within one year before or one year after filing for Chapter 11 bankruptcy.

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

- The death of the *employee* parent;
- The termination of the *employee* parent's employment (for reasons other than gross misconduct) or reduction in the *employee* parent's hours of employment with the *employer*;
- The *employee* parent's divorce or legal separation;
- Ceasing to be a "*dependent* child" under the Plan;
- The *employee* parent becomes entitled to *Medicare* benefits; or
- Termination of the retiree parent's coverage when the former *employer* discontinues retiree coverage within one year before or one year after filing for Chapter 11 bankruptcy.

## **COBRA Continued**

### **LOSS OF COVERAGE**

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

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

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

### **NOTICES AND ELECTION**

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

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

For termination of employment, reduction in work hours, the death of the *employee*, the *employee* becoming covered by *Medicare* or loss of retiree benefits due to bankruptcy, it is the Plan Administrator's responsibility to notify the qualified beneficiary of the right to elect continuation coverage.

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

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

## **COBRA Continued**

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

## **MAXIMUM COVERAGE PERIOD**

Coverage may continue up to:

- 18 months for an *employee* and/or *dependent* whose group coverage ended due to termination of the *employee's* employment or reduction in hours of employment;
- 36 months for a spouse whose coverage ended due to the death of the *employee* or retiree, divorce, or the *employee* becoming entitled to *Medicare* at the time of the initial qualifying event;
- 36 months for a *dependent* child whose coverage ended due to the divorce of the *employee* parent, the *employee* becoming entitled to *Medicare* at the time of the initial qualifying event, the death of the *employee*, or the child ceasing to be a *dependent* under the Plan;
- For the retiree, until the date of death of the retiree who is on continuation due to loss of coverage within one year before or one year after the *employer* filed Chapter 11 bankruptcy;
- 29 months for all qualified beneficiaries if an *employee* or family member is determined to be disabled under the Social Security Act at any time during the first 60 days of continuation coverage (remaining from the date of termination of employment or reduction in hours). The qualified beneficiary must provide notice of such determination prior to the end of the initial 18-month continuation period to be entitled to the additional 11 months of coverage. For the purpose of COBRA, family member means the *employee* and any eligible *dependent*.

If a second qualifying event occurs (for example, the *employee* dies or becomes divorced) within the 18 month or 29 month coverage period, the maximum coverage period becomes 36 months from the date of the termination or reduction in hours.

The maximum coverage period is measured from the date of the qualifying event even if the qualifying event does not result in a loss of coverage under the Plan until some later date. However, if alternative coverage (i.e. state continuation) is provided after a qualifying event without regard to COBRA continuation and such coverage does not satisfy all the requirements of COBRA continuation, the *employer* must offer the covered qualified beneficiary the right to elect COBRA continuation. If COBRA coverage is rejected in favor of the alternative coverage, COBRA coverage need not be offered at the end of the alternative coverage period.

## **SPECIAL RULE INVOLVING EMPLOYEE'S ENTITLEMENT TO MEDICARE BENEFITS**

A special rule exists where the *employee* is entitled to *Medicare* at the time of an initial qualifying event due to termination or reduction of hours worked, or becomes entitled to *Medicare* within the initial 18 or 36 month continuation period following an initial qualifying event. If the *employee* is entitled to *Medicare* at the time of an initial qualifying event due to termination or reduction of hours worked, then the period of continuation for other qualified beneficiaries is the later of 36 months from the date of *Medicare* entitlement, or 18 months from the date of the qualifying event. If, on the other hand, the *employee* becomes entitled to *Medicare* during the initial continuation period of 18 months following the original qualifying event, then the other qualified beneficiaries will be entitled to continuation not to exceed 36 months from the date of the original qualifying event.

## **COBRA Continued**

### **TERMINATION BEFORE THE END OF MAXIMUM COVERAGE PERIOD**

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

- The *employer* no longer provides group health coverage to any of its *employees*;
- The premium for continuation is not paid timely;
- The individual on continuation becomes covered under another group health plan (as an *employee* or otherwise); however, if the new plan coverage contains any exclusion or limitation with respect to any pre-existing condition; then continuation coverage will end for this reason only after the exclusion or limitation no longer applies or prior creditable coverage satisfies the exclusion or limitation;
- NOTE: the federal Health Insurance Portability and Accountability Act of 1996 requires portability of health care coverage effective for plan years beginning after June 30, 1997, an exclusion or limitation under the other group health plan may not apply at all to the qualified beneficiary, depending on the length of his or her prior creditable coverage. Portability means once *you* obtain health insurance, *you* will be able to use evidence of that insurance to reduce or eliminate any pre-existing medical condition limitation period (under certain circumstances) when *you* move from one health plan to another.
- The individual on continuation becomes entitled to *Medicare* benefits;
- If there is a final determination under Title II or XVI of the Social Security Act that an individual is no longer disabled; however, continuation coverage will not end until the month that begins more than 30 days after the determination;
- The occurrence of any event (e.g. submission of a fraudulent claim) permitting termination of coverage for cause under the Plan.

### **TYPE OF COVERAGE; PREMIUM PAYMENT**

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

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

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

## **COBRA Continued**

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

## **OTHER INFORMATION**

*Employees* should contact the Plan Administrator for any question regarding continuation coverage and notify the *employer* of any changes in marital status, or a change of address.

# **THE UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994 (USERRA)**

## **CONTINUATION OF BENEFITS**

Effective October 13, 1994 federal law requires that health plans must offer to continue coverage for *employees* who are absent due to service in the uniformed services and/or their *dependents*. Coverage may continue for up to 18 months after the date the *employee* is first absent due to uniformed service.

## **ELIGIBILITY**

An *employee* is eligible for continuation under USERRA if absent from employment because of voluntary or involuntary performance of duty in the Armed Forces, Army National Guard, Air National Guard, or the 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* who have coverage under the Plan immediately prior to the date of the *employee's* covered absence are eligible to elect continuation under USERRA.

## **PREMIUM PAYMENT**

If continuation of Plan coverage is elected under USERRA, the *employee* or *dependent* is responsible for payment of the applicable cost of coverage. If the *employee* is absent for not longer than 31 days, the cost will be the amount the *employee* would otherwise pay for coverage. For absences exceeding 31 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**

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

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

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

## **OTHER INFORMATION**

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

## **COORDINATION OF BENEFITS**

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

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

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

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

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

### **EFFECT ON BENEFITS**

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

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

### **ORDER OF BENEFIT DETERMINATION**

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

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

If a plan other than this Plan does not include provision 3., then the gender rule will be followed to determine which plan is primary.

## **Coordination of Benefits Continued**

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

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

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

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

## **COORDINATION OF BENEFITS WITH MEDICARE**

In all cases, Coordination of Benefits with *Medicare* will conform with Federal Statutes and Regulations. In the case of *Medicare* each individual who is eligible for *Medicare* will be assumed to have full *Medicare* coverage (i.e. Part A hospital insurance and Part B voluntary medical insurance) whether or not the individual has enrolled for full coverage. *Your* benefits under the Plan will be coordinated to the extent benefits would otherwise have been paid under *Medicare* as allowed by Federal Statutes and Regulations.

## **RIGHT OF RECOVERY**

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

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

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

## REIMBURSEMENT/SUBROGATION

Subrogation applies when another party (person or organization) is, or may be, considered responsible for causing *bodily injury* or for payment of benefits due to a *covered person's bodily injury* or *sickness* for which benefits under the Plan have been provided or paid. To the extent of such benefits, the Plan is subrogated to all rights and claims for recovery the *covered person* has against any party (including a health care carrier) responsible for the *bodily injury* or for payment to the *covered person* on account of the *bodily injury*.

Also, the Plan has a right of reimbursement. If payment (by settlement, judgment or any other manner) is made, or may be made, in the future by, or on behalf of, a responsible party to the *covered person*, expenses arising from the *covered person's bodily injury* or *sickness* are not covered by the Plan.

However, if a claim is filed for which benefits would be payable in the absence of a responsible party as described above, benefits will be paid subject to the following conditions:

1. The Plan will automatically have a lien to the extent of benefits advanced upon any recovery, by settlement, judgement or otherwise that *you* receive from the responsible party, or any person or organization making payment on behalf of the responsible party, including first party, undercovered and uncovered motorist coverage. The lien will be in the amount of benefits provided or paid by the Plan for the treatment of the condition for which the third party is responsible.
2. *You* agree to notify the Plan, in writing, within 60 days of *your* claim against the responsible party and to take such action, furnish such information, cooperate generally, and execute any documents as the Plan may be required to facilitate enforcement of the Plan's rights.

Exclusively at the Plan's option and choice, and without any waiver of any other rights of the Plan, in the event of prejudice, non-cooperation or breach of this Plan, payments may be withheld, deducted, or retracted to or on behalf of the *covered person*.

## AGREEMENT AND COOPERATION REQUIRED

*Covered persons* under the Plan must agree to the following obligations in return for the payment of *covered expenses* by the Plan in accordance with its provisions.

The *covered person* shall cooperate by providing information and executing any documents to preserve the Plan's right and shall have the affirmative obligation of notifying the Plan that claims are being made against responsible parties to recover for injuries for which the Plan has 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, rights to recover an amount equal to any benefits that have provided or paid for the *bodily injury* or *sickness*. Failure of the *covered person* to provide such notice or cooperation, or any action by the *covered person* resulting in prejudice to the Plan's rights will be a material breach of this Plan and will result in the *covered person* being personally responsible to make repayment. In such an event, the *Plan Manager* may deduct from any pending or subsequent claim made under the Plan any amounts the *covered person* owes the Plan until such time as cooperation is provided and the prejudice ceases.

**Reimbursement/Subrogation Continued**

The Plan's right of reimbursement and the Plan's subrogation rights shall be to the fullest extent allowed by law and the provisions of this Plan shall control in the absence of any laws to the contrary. Any such right of reimbursement or subrogation provided to the Plan shall not apply or shall be limited to the extent that the Federal Statutes eliminate or restrict such rights.

## **GENERAL PROVISIONS**

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

### **CONTESTABILITY**

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

### **RIGHT TO REQUEST OVERPAYMENTS**

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

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

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

### **WORKERS' COMPENSATION NOT AFFECTED**

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

### **WORKERS' COMPENSATION**

If benefits are paid by the Plan and the Plan determines *you* received Workers' Compensation for the same incident, the Plan will exercise its right to recover against *you* even though:

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

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

## **MEDICAID**

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

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

## **CONSTRUCTION OF PLAN TERMS**

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

## **PRIVACY OF PROTECTED HEALTH INFORMATION**

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

A *covered person* will be deemed to have consented to use of *protected health information* about him or her by virtue of enrollment in the Plan. Any individual who may not have intended to provide this consent and who does not so consent must contact the Plan Administrator prior to filing any claim for Plan benefits, as coverage under the Plan is contingent upon consent.

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

Disclosure of *protected health information* is improper if it is not allowed by law or if it is made for any purpose other than Plan operation or benefits delivery. Disclosure for Plan purposes to persons authorized to receive *protected health information* may be proper, so long as the disclosure is allowed by law and appropriate under the circumstances. Improper disclosure includes disclosure to the *employer* for employment purposes, *employee* representatives, consultants, attorneys, relatives, etc. who have not executed appropriate agreements effective to authorize such disclosure.

The *Plan Manager* will afford access to *protected health information* in its possession only as necessary to discharge its obligations as a service provider, within the restrictions noted above. However, Plan records that include *protected health information* are the property of the Plan. Information received by the *Plan Manager* is information received on behalf of the Plan.

## General Provisions Continued

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

Attention: Missy Lentz  
Holloway Financial Services, Inc.  
500 NW 43<sup>rd</sup> Street  
Gainesville, FL 32606  
Telephone Number: (352) 692-3444  
FAX Number: (352) 692-3445  
E-mail Address: MissyL@HollowayFinancial.com

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

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

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

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

## CLAIMS PROCEDURES

### SUBMITTING A CLAIM

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

- A claim must be filed with the *Plan Manager* in writing and delivered to the *Plan Manager*, by mail, postage prepaid, by FAX, or by e-mail. However, a submission to obtain pre-authorization may also be filed with the *Plan Manager* by telephone (this applies to dental Plans only with respect to *urgent care claims*).
- Claims must be submitted to the *Plan Manager* at the address indicated in the documents describing the Plan or *claimant's* identification card. Claims will not be deemed submitted for purposes of these procedures unless and until received at the correct address.
- Also, claims submissions must be in a format acceptable to the *Plan Manager* and compliant with any applicable legal requirements. Claims that are not submitted in accordance with the requirements of applicable federal law respecting privacy of *protected health information* and/or electronic claims standards will not be accepted by the Plan.
- Claims submissions must be timely. Claims must be filed as soon as reasonably possible after they are incurred, and in no event later than 15 months after the date of loss, except if *you* were legally incapacitated. Plan benefits are only available for claims that are incurred by a *covered person* during the period that he or she is covered under the Plan.
- Claims submissions must be complete. They must contain, at a minimum:
  - ◆ The name of the *covered person* who incurred the *covered expense*;
  - ◆ The name and address of the health care provider;
  - ◆ The diagnosis of the condition;
  - ◆ The procedure or nature of the treatment;
  - ◆ The date of and place where the procedure or treatment has been or will be provided;
  - ◆ The amount billed and the amount of the *covered expense* not paid through coverage other than Plan coverage, as appropriate;
  - ◆ Evidence that substantiates the nature, amount, and timeliness of each *covered expense* in a format that is acceptable according to industry standards and in compliance with applicable law.

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

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

## Claims Procedures Continued

Medical claims and correspondence should be mailed to:

Humana Claims Office  
P.O. Box 14609  
Lexington, KY 40512-4609

## MISCELLANEOUS MEDICAL CHARGES

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

## PROCEDURAL DEFECTS

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

## ASSIGNMENTS AND REPRESENTATIVES

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

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

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

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

## Claims Procedures Continued

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

## CLAIMS DECISIONS

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

### **PRE-SERVICE CLAIMS**

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

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

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

### **URGENT CARE CLAIMS**

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

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

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

- The *claimant* will have a reasonable amount of time, taking into account his or her circumstances, to provide the necessary information but not less than 48 hours.

## **Claims Procedures Continued**

- The *Plan Manager* will notify the *claimant* of the Plan's *urgent care claim* determination as soon as possible, but in no event more than 48 hours after the earlier of:
  1. The Plan's receipt of the specified information; or
  2. The end of the period afforded the *claimant* to provide the specified additional information.

### **CONCURRENT CARE DECISIONS**

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

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

### **POST-SERVICE CLAIMS**

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

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

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

### **TIMES FOR DECISIONS**

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

## Claims Procedures Continued

### PAYMENT OF CLAIMS

The *Plan Manager* will make direct payment to the *hospital*, clinic or physician's office, unless the *Plan Manager* is advised in writing that you have already paid the bill. If you have paid the bill, please indicate on the original statement, "paid by *employee*," and send it directly to the *Plan Manager*. You will receive a written explanation of the benefit determination. The *Plan Manager* reserves the right to request any information required to determine benefits or process a claim. You or the provider of *services* will be contacted if additional information is needed to process your claim.

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

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

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

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

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

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

### 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.

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

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

The notice will describe 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.

## Claims Procedures Continued

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

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

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

## APPEALS OF ADVERSE DETERMINATIONS

A *claimant* must appeal an adverse 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 the *Plan Manager*, in person, or by mail, postage prepaid.

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

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

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

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

## Claims Procedures Continued

### TIME PERIOD FOR DECISIONS ON APPEAL

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

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

### APPEAL DENIAL NOTICES

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

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

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

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

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

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

## **Claims Procedures Continued**

### **RIGHT TO REQUIRE MEDICAL EXAMS**

(Applies only to medical Plans)

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

### **EXHAUSTION**

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

### **LEGAL ACTIONS AND LIMITATIONS**

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

## STATEMENT OF ERISA RIGHTS

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

### RECEIVE INFORMATION ABOUT YOUR PLAN AND BENEFITS

1. Examine, without charge, at the Plan Administrator's office and at other specified locations, such as work sites and union halls, all documents governing the Plan, including insurance contracts and 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 Pension and Welfare Benefit Administration.
2. Obtain, upon written request from the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The administrator may make a reasonable charge for copies.
3. Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

### CONTINUE GROUP HEALTH PLAN COVERAGE

1. Continue health care coverage for yourself, spouse or *dependents* if there is a loss of coverage under the Plan as a result of a qualifying event. *You or your dependents* may have to pay for such coverage. Review this Summary Plan Description and the Plan documents on the rules governing *your* COBRA continuation coverage rights.
2. Reduction or elimination of exclusionary periods of coverage for *pre-existing conditions* under *your* group health Plan, if *you* have *creditable coverage* from another Plan. *You* should be provided a certificate of *creditable coverage*, free of charge, from *your* group Plan or insurance issuer when:
  - *you* lose coverage under the Plan,
  - *you* become entitled to elect COBRA continuation coverage,
  - *your* COBRA continuation coverage ceases, if *you* request it before losing coverage, or if *you* request it up to 24 months after losing coverage.

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

### PRUDENT ACTIONS OF PLAN FIDUCIARIES

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

## **Statement of ERISA Rights Continued**

### **ENFORCE YOUR RIGHTS**

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

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

### **ASSISTANCE WITH QUESTIONS**

If *you* have any questions about *your* Plan, *you* should contact the Plan Administrator. If *you* have any questions about this statement or about *your* rights under ERISA, or if *you* need assistance in obtaining documents from the Plan Administrator, *you* should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in *your* telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. *You* may also obtain certain publications about *your* rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

## DEFINITIONS

**Active status** means performing on a regular, full-time basis all customary occupational duties, for 20 hours per week, 48 weeks a year, at the *employer's* business locations or when required to travel for the *employer's* business purposes. Each day of a regular paid vacation and any regular non-working holiday will be deemed *active status* if *you* were in an *active status* on *your* last regular working day prior to the vacation or holiday.

**Bodily injury** means injury due directly to an accident and independent of all other causes.

**Brand name medication** means a medication that is manufactured and distributed by only one pharmaceutical manufacturer, or as defined by the national pricing standard used by the *Plan Manager*.

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

**Case management** means the process of assessing whether an alternative plan of care would more effectively provide *medically necessary* health care *services* in an appropriate setting.

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

**COBRA Service Provider** means a provider of COBRA administrative services retained by the *Plan Manager* to provide specific COBRA administrative services.

**Complications of pregnancy** means:

1. Conditions whose diagnoses are distinct from pregnancy but adversely affected by pregnancy or caused by pregnancy. Such conditions include: acute nephritis, nephrosis, cardiac decompensation, hyperemesis gravidarum, puerperal infection, toxemia, eclampsia and missed abortion;
2. A nonelective cesarean section surgical procedure;
3. Terminated ectopic pregnancy; or
4. Spontaneous termination of pregnancy which occurs during a period of gestation in which a viable birth is not possible.

**Complications of pregnancy** does not mean:

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

## Definitions Continued

**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.

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

**Confinement** means being a resident patient in a *hospital* or a *qualified treatment facility* for at least 15 consecutive hours per day. Successive *confinements* are considered one *confinement* if:

1. Due to the same *bodily injury* or *sickness*; and
2. Separated by fewer than 30 consecutive days when *you* are not confined.

**Copayment** (medical) means the amount to be paid by *you* for each applicable medical *service*.

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

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

**Covered expense** means *services* incurred by *you* or *your* covered *dependents* due to *bodily injury* or *sickness* for which benefits may be available under the Plan. *Covered expenses* are subject to all provisions of the Plan, including the limitations and exclusions.

**Covered person** means the *employee* or any of the *employee's* covered *dependents*.

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

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

**Dental injury** is an injury caused by a sudden, violent, and external force that could not be predicted in advance and could not be avoided. *Dental injury* does not include chewing injuries.

**Dependent** means a covered *employee's*:

1. Legally recognized spouse;
2. Unmarried natural blood related child, stepchild, legally adopted child or child for which the *employee* has legal guardianship whose age is less than the limiting age. Each child must legally qualify as a *dependent* as defined by the United States Internal Revenue Service.

## Definitions Dependent Continued

The limiting age for each *dependent* child is:

- a. 19 years; or
- b. The end of the *calendar year* of a child who is 25 years and in regular full-time or part-time attendance at an accredited secondary school, college or university. The *dependent* child must be enrolled for sufficient course credits to maintain full-time or part-time status as defined by that school. A *dependent* child continues to be eligible for coverage for up to four months following the close of a school term only if enrolled as a full-time student for the following school term.

Adopted children and children placed for adoption are subject to all terms and provisions of the Plan, with the exception of the *pre-existing condition* limitation.

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

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

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

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

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

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

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

***Employee*** means *you*, as an *employee*, when *you* are permanently employed and paid a salary or earnings and are in an *active status* at *your employer's* place of business.

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

## Definitions Continued

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

**Experimental, investigational or for research purposes:**

A *service* is *experimental, investigational or for research purposes* if the *Plan Manager* determines;

1. The *service* cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the *service* is furnished; or
2. The *service* or *your* informed consent document utilized with the *service* was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review and approval; or
3. Reliable evidence shows that the *service* is the subject of on-going phase I or phase II clinical trials; is the research, experimental, study or investigational arm of ongoing phase III clinical trials; or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis; or
4. Reliable evidence shows that the prevailing opinion among experts regarding the *service* is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

Reliable evidence will mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same *service*; or the written informed consent used by the treating facility or by another facility studying substantially the same *service*.

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

**Free-standing surgical facility** means a public or private establishment licensed to perform *surgery* and which has permanent facilities that are equipped and operated primarily for the purpose of performing *surgery*. It does not provide *services* or accommodations for patients to stay overnight.

**Generic medication** means a drug that is manufactured, distributed and available from several pharmaceutical manufacturers and identified by the chemical name; or as defined by the national pricing standard used by the *Plan Manager*.

**Hospital** means an institution which:

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

## Definitions Hospital Continued

6. Has surgical facilities on its premises or has a contractual agreement for surgical *services* with an institution having a valid license to provide such surgical *services*; or
7. Is a lawfully operated *qualified treatment facility* certified by the First Church of Christ Scientist, Boston, Massachusetts.

*Hospital* does not include an institution which is principally a rest home, skilled nursing facility, convalescent home or home for the aged. *Hospital* does not include a place principally for the treatment of alcoholism, chemical dependence, or *mental disorders*.

**Late applicant** means an *employee* and/or an *employee's* eligible *dependent* who applies for medical coverage more than 30 days after the eligibility date.

**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*.

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

**Maintenance medication** means *prescription* drugs, medicines or medications that are:

1. Generally prescribed for treatment of long-term chronic *sickness* or *bodily injuries*; and
2. Purchased from the *pharmacy* contracted by the *Plan Manager* to dispense drugs.

**Maximum allowable fee** for a *service* means the lesser of:

1. The fee most often charged in the geographical area where the *service* was performed;
2. The fee most often charged by the provider;
3. The fee which is recognized as reasonable by a prudent person;
4. The fee determined by comparing charges for similar *services* to a national data base adjusted to the geographical area where the *services* or procedures were performed; or
5. The fee determined by using a national relative value scale. Relative value scale means a methodology that values medical 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.

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

## Definitions Continued

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

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

**Medicare** means Title XVIII, Parts A and B of the Social Security Act, as enacted or amended.

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

**Non-participating pharmacy** means a *pharmacy* which has not entered into an agreement with the *Plan Manager* to participate as part of the Humana Pharmacy Network or the AdvancePCS Client Based Network.

**Participating pharmacy** means a *pharmacy* which has entered into an agreement to participate as part of the Humana Pharmacy Network or the AdvancePCS Client Based Network to dispense covered drugs to *you* and *your* covered *dependents* and to accept as payment the *copayment* amount to be paid by *you* and the amount of the benefit payment provided by the Plan.

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

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

**Plan Manager** means Humana Insurance Company (HIC). The *Plan Manager* provides services to the Plan Administrator, as defined under the Plan Management Agreement. The *Plan Manager* is not the Plan Administrator or the Plan Sponsor.

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

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

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

## Definitions Continued

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

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

**Pre-existing condition** means a physical or mental condition for which *you* have received medical attention (medical attention includes, but is not limited to: *services* or care) during the three month period immediately prior to the effective date of *your* medical coverage under the Plan. The Plan will pay for the first \$2,000 of *pre-existing condition* charges. Once the \$2,000 maximum has been met, *pre-existing conditions* are covered after the end of a period of twelve months during which *you* have been continuously covered under the Plan.

For the purposes of this definition, pregnancy is considered a physical condition.

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

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

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

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

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

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

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

## Definitions Continued

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

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

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

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

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

**Timely applicant** means an *employee* and/or an *employee's* eligible *dependent* who applies for medical coverage within 30 days of the eligibility date.

**Total disability or totally disabled** means:

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

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

**Urgent care claim** means a claim for medical care or treatment 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 *claimant* or the ability of the *claimant* to regain maximum function; or
- In the opinion of a physician with knowledge of the *claimant's* medical condition, would subject the *claimant* to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

## **Definitions Urgent Care Claim Continued**

- Generally, whether a claim is a claim involving urgent care will be determined by the *Plan Manager*. However, any claim that a physician with knowledge of a *claimant's* condition determines is a “claim involving urgent care” will be treated as a “claim involving urgent care.”

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

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