

# **Your Benefit Plan Document**



Administrative Office:  
500 West Main Street  
Louisville, Kentucky 40202

## Certificate of Coverage Humana Health Plan, Inc.

**Group Plan Sponsor:**

FORD MOTOR COMPANY

**Group Plan Number:** J3031      **Plan:** 075      **Option:** 850

**Effective Date:** 08/01/11

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

Michael B. McCallister  
President

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

H200200IL 07/07

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## **TABLE OF CONTENTS**

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**Understanding your coverage**

**Schedule of benefits**

**Schedule of benefits - infertility**

**Schedule of benefits - behavioral health**

**Schedule of benefits - serious mental illness**

**Schedule of benefits - transplant services**

**Covered expenses**

**Covered expenses - infertility**

**Covered expenses - behavioral health**

**Covered expenses - serious mental illness**

**Covered expenses - transplant services**

**Limitations and exclusions**

**Eligibility and effective dates**

**Replacement of coverage**

**Termination provisions**

**Extension of benefits**

**Continuation**

**Medical conversion privilege**

**Coordination of benefits**

**Coordination of benefits for Medicare eligibles**

**Claims**

**Complaint and appeals procedures**

**Miscellaneous provisions**

**Glossary**

---

## **TABLE OF CONTENTS (continued)**

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**Prescription drug benefit rider**

**Domestic partner benefit rider**

*H2010001L 03/05*

## Exhibit A

HUMANA HEALTH PLAN, INC.  
ILLINOIS**PPACA Endorsement****PATIENT PROTECTION AND AFFORDABLE CARE ACT OF 2010**

## Non-grandfathered GROUP POLICY/CERTIFICATE RIDER

The Policy/Certificate, to which this rider is attached and becomes a part, is amended as stated below.

A new section titled "Patient Protection and Affordable Care Act" is hereby added to the Policy/Certificate as follows:

**PATIENT PROTECTION AND AFFORDABLE CARE ACT OF 2010**

Effective 08/01/11, some of the benefits, terms, conditions, limitations, and exclusions contained in Your Policy/Certificate will change as a result of the Patient Protection and Affordable Care Act of 2010.

Notwithstanding any other provision of Your Policy/Certificate, the provisions below shall apply. In the event of a conflict between the provisions of any other Section of Your Policy/Certificate and the provisions of this Rider, the provisions of this Rider shall prevail, except to the extent the provisions of Your Policy/Certificate are more beneficial to You than are the provisions of this Rider.

**Definitions**

For the purposes of this Rider, the following definitions shall apply:

"Essential health benefits" means benefits covered under the Policy/Certificate, in at least the following categories: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, including behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services, including oral and vision care. Such benefits shall be consistent with those set forth under the Patient Protection and Affordable Care Act of 2010 and any regulations issued pursuant thereto.

"Patient Protection and Affordable Care Act of 2010" means the Patient Protection and Affordable Care Act of 2010 (Public Law 111-148) as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152).

**Lifetime Dollar Limits**

If Your Policy/Certificate contains a lifetime dollar maximum on the value of all benefits, such lifetime dollar maximum no longer applies. If Your Policy/Certificate contains a lifetime dollar maximum(s) on the value of specific benefits that are Essential Health Benefits, such lifetime dollar maximum(s) no longer apply.

If coverage under this Policy/Certificate, for You or another person in Your family, ended by reason of reaching a lifetime dollar maximum, and You or Your family member are eligible for benefits under this Policy/Certificate, You will receive written notice that You or Your family member are once again eligible for benefits under this Policy/Certificate. If Your family member is no longer enrolled under this Policy/Certificate, he or she will be given an opportunity to re-enroll. We must provide You this written notice and, if applicable, the opportunity to re-enroll, by 08/01/11 .

### **Annual Dollar Limits**

Essential Health Benefits provided within Your Policy/Certificate are not subject to any annual dollar maximum(s).

### **Rescissions**

We may not rescind Your Policy/Certificate based on a misrepresentation by You unless You have performed an act or practice that constitutes fraud, or made an intentional misrepresentation of material fact, as prohibited by the terms of Your Policy/Certificate. We must provide at least 30 days advance written notice before Your Policy/Certificate may be rescinded. You have the right to appeal any such rescission.

### **Preventive Services**

In addition to the Covered Services listed in the Schedule of Benefits of Your Policy/Certificate, the following services shall be covered without regard to any deductible, copayment, or coinsurance requirement that would otherwise apply:

- (1) evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force;
- (2) immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the Covered Person involved;
- (3) with respect to Covered Persons who are infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration;
- (4) with respect to Covered Persons who are women, such additional preventive care and screenings not described in paragraph (1) as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

For purposes of this section, recommendations of the United States Preventive Service Task Force regarding breast cancer screening, mammography, and prevention issued in or around November 2009 are not considered to be current. No recommendation of the United States Preventive Service Task Force shall serve to reduce the mammogram benefits required by Illinois law 215 ILCS 356g(a) and described on the Covered Expenses of your Policy/Certificate.

### **Extension of Coverage to Dependents**

Notwithstanding the eligibility requirements described in the Glossary of Your Policy/Certificate, a child in Your family is eligible to become a Covered Person if the child: 1) is under age 26, and 2) is related to You by one of the relationships listed in the Glossary of Your Policy/Certificate.

A child in Your family who is age 26 or older is also eligible to become a Covered Person if the child: 1) is an Illinois resident; 2) served as a member of the active or reserve components of any of the branches of the Armed Forces of the United States; 3) received a release or discharge other than a dishonorable discharge; 4) is under age 30; and 5) meets any additional eligibility requirements described in the Glossary of Your Policy/Certificate.

**Right to Appeal**

You have the right to appeal any decision or action taken by Us to deny, reduce or terminate the provision of or payment for health care services requested or received under Your Policy/Certificate. When We have denied, reduced, or terminated a requested service or payment for a service covered by Your Policy/Certificate based on a judgment as to the medical necessity, appropriateness, health care setting, level of care, or effectiveness of the health care service, You have the right to have Our decision reviewed by an independent review organization not associated with Us.

We must provide you with certain written information, including the specific reason for Our decision and a description of Your appeal rights and procedures, every time We make a determination to deny, reduce or terminate the provision of or payment for health care services requested or received under Your Policy/Certificate.

**Emergency Services**

We shall cover Emergency Services without the need for any prior authorization determination and without regard as to whether the health care provider furnishing such services is a Participating Provider. Care provided by a Non-participating Provider will be paid at no greater cost to the Covered Person than if the services were provided by a Participating Provider.

**Direct Access to Obstetricians and Gynecologists**

In addition to the Woman's Principal Health Care Provider described in Understanding Your Coverage of Your Policy/Certificate, a female Covered Person may see any available participating health care professional who specializes in obstetrics or gynecology without referral from her Primary Care Provider.

Obstetrical and gynecological care authorized or ordered by a health care professional who specializes in obstetrics or gynecology will be treated as authorized by the Primary Care Provider.

**Selection of a Primary Care Provider**

You may designate any available participating Primary Care Provider who is available to accept You to be Your Primary Care Provider as required under Understanding Your Coverage of Your Policy/Certificate.

Your child's legal representative may designate a physician (allopathic or osteopathic) who specializes in pediatrics as his or her Primary Care Provider as required under Understanding Your Coverage of Your Policy/Certificate.

**Preexisting Condition Limitations**

With respect to Covered Persons who are under 19 years of age, notwithstanding the Preexisting Condition Limitations described in the Limitations and Exclusions of Your Policy/Certificate, no health care service or treatment will be denied, limited, or excluded based on the fact that a medical condition was present before the effective date of Your Policy/Certificate, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that day.

With respect to Covered Persons who are under 19 years of age, any provision previously attached to the Policy/Certificate excluding coverage for a specific condition is removed and shall be considered null and void.

**Questions/Contact Information**

Questions regarding this Rider can be directed to the Customer Care number on the back of your Humana identification card. You may also contact the Illinois Department of Insurance at (877) 527-9431 or <http://insurance.illinois.gov>.

This Rider takes effect on the effective date of the Policy / Certificate to which it is attached. This Rider terminates concurrently with the Policy / Certificate to which it is attached. It is subject to all the definitions, limitations, exclusions and conditions of the Policy / Certificate except as stated.

IN WITNESS WHEREOF:

Humana Health Plan, Inc.

A handwritten signature in black ink, appearing to read "Michael B. McCallister". The signature is fluid and cursive, with a long horizontal stroke extending to the right.

Michael B. McCallister  
President

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## UNDERSTANDING YOUR COVERAGE

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As *you* read through this *certificate*, *you* will notice certain words and phrases are printed in italics. An italicized word may have a different meaning in the context of this *certificate* than it does in general usage. Please check the "Glossary" section for the definitions of italicized words, so *you* can understand their meaning as it relates to *your* coverage.

### How to use your certificate

This *certificate* provides *you* with detailed information regarding *your* coverage. It explains what is covered and what is not covered. It also identifies *your* duties and how much *you* must pay when obtaining services. Although *your* coverage is broad in scope, it is important to remember that *your* coverage has limitations. Be sure to read *your certificate* carefully before using *your* benefits.

Please note the provisions and conditions of this *certificate* apply to *you* as the subscriber and to each of *your* covered dependents.

H202000

### Covered and non-covered expenses

Benefits are subject to the specific conditions, limitations and applicable maximums of the *certificate* and are payable only if services are considered a *covered expense*. The benefit payable for *covered expenses* will not exceed the *usual and customary fee(s)*.

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

If *you* incur *non-covered expenses*, whether from a *network provider* or *non-network provider*, *you* are responsible for making the full payment to the health care provider. The fact that a *health care practitioner* has performed or prescribed a procedure, treatment, or supply, or the fact that it may be the only available treatment for a *bodily injury* or *sickness*, does not mean the procedure, treatment, or supply is covered under the *master group contract*.

Please refer to the "Schedule of Benefits," the "Covered Expenses" and the "Limitations and Exclusions" sections of this *certificate* for more information about *covered expenses* and *non-covered expenses*. Also, be sure to check *your certificate* for any attached amendments or supplemental benefit riders that may modify *your* benefits.

H202100IL 01/06

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## UNDERSTANDING YOUR COVERAGE (continued)

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### How to find a network provider

An online directory of *network providers* will be made available to *you* and accessible via the Internet on *our* Website at [www.humana.com](http://www.humana.com) at the time of *your* enrollment. This directory is subject to change. Due to the possibility of *network providers* changing status, please check the online directory of *network providers* prior to obtaining services. If *you* do not have access to the online directory, *you* may telephone *our* customer service center prior to services being rendered or to request a directory.

H202200 05/05

### Use of network providers

In most instances, there are *network providers* available to provide *medically necessary* health care services. *Network providers* have agreed to accept discounted or negotiated fees. *You* will not be billed for charges in excess of the *usual and customary fee*. *You* are responsible to pay the *network provider* for any applicable *deductible* and *copayment* for services received.

When receiving services from *network providers*, *you* should make sure the provider participates as a *network provider* for this plan. *We* offer many managed care plans, and a provider who participates in one plan may not necessarily be a *network provider* for this plan.

*We* may designate limited panels of *network providers* from which certain kinds of services must be obtained. If these services are not obtained from the designated network providers, benefits for these services may be reduced or denied. *We* reserve the right, at *our* discretion, to make changes to the list of *network providers* at any time.

H202300 10/06

### Selecting your primary care physician

*You* may select a *primary care physician* for *yourself* and for each enrolled *dependent*. A *network provider* who practices in the areas of family medicine, general practice or internal medicine may be selected for each adult. *You* may choose a *network provider* who practices in the areas of pediatrics, family medicine, or general practice for each child. If *you* fail to select a *primary care physician*, one will be assigned to *you*.

*You* may change *your primary care physician* online or by calling *our* customer service center. *You* must notify *our* customer service center before receiving services from a new *primary care physician*. A new identification card will be issued to *you* with the new *primary care physician's* name. *You* must arrange to have *your* medical files transferred to *your* new *primary care physician*.

#### NOTICE TO ALL FEMALE COVERED PERSONS:

Illinois law allows *you* to select a *woman's principal health care provider* in addition to *your primary care physician*. A *woman's principal health care provider* may be seen without referrals from *your primary care physician* as long as he or she is a *network health care practitioner*.

H202500IL

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## UNDERSTANDING YOUR COVERAGE (continued)

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### Role of the primary care physician

*Your primary care physician* is responsible for providing primary medical care and helping to guide any care *you* receive from other medical care providers, including *specialty care physicians*. Referrals to *specialty care physicians* are required by *us*.

H202600 09/04

### When your primary care physician is not available

When *your primary care physician* is unavailable, *you* may need to obtain services from the back-up *network provider* designated by *your primary care physician*. Please be sure to discuss these back-up arrangements with *your primary care physician*.

H202700

### Seeing a specialist

*You* should discuss all of *your* medical needs with *your primary care physician*. If *you* and *your primary care physician* determine *you* need to see a *specialty care physician*, *your primary care physician* may recommend one. Services received from a *specialty care physician* without the required *primary care physician* referral will not be considered *covered expenses*.

Illinois law allows *you* to apply for a *standing referral* to a *specialty care physician*. The application shall be made to *your primary care physician*. The *specialty care physician* must be a *network health care practitioner*. In the case that a *network specialty care physician* is not available, *you* may have services provided by a *non-network health care practitioner* at no additional cost beyond what *you* would otherwise pay to a *network specialty care physician*. *Our* authorization must be obtained before receiving services from a *non-network health care practitioner*.

H202800IL

### Seeking emergency care

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

- If *your* medical condition permits, proceed to the nearest *emergency care network provider* in this plan.
- If *your* medical condition does not permit going to a *network provider*, *you* should go to the nearest *emergency care* medical facility. If *you* are admitted to a *non-network hospital* for *emergency care*, *you* (or someone acting for *you*) must contact *us* within forty-eight (48) hours of *your admission*, or if this is not possible, as soon as *your* medical condition permits. If two good faith efforts to request *preauthorization* are made by *you* or the *health care practitioner*, post-stabilization services will be covered subject to the *usual and customary fee*, and any other limitations of the *master group contract*.

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## UNDERSTANDING YOUR COVERAGE (continued)

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- If *you* are admitted to a *non-network hospital* for *emergency care*, we may require *you* be transferred (at *our* expense) to a *network hospital* in the *service area* when *your* condition has been stabilized.
- *You* must receive any follow-up services from a *network health care practitioner*.

In emergencies requiring *mental health services*, *serious mental illness* services or *chemical dependency* services, *you* should do the following:

- *Your* coverage includes 24-hour access to a phone line for crisis intervention, intake, and triage services. In an emergency requiring *mental health services*, *serious mental illness* services or *chemical dependency* services, *you* should call the mental health access telephone number found on the back of *your* member identification card. *You* will be given assistance, and any *emergency care* or treatment *you* require will be arranged at that time.
- If *your* medical condition does not permit *you* to call the 24-hour mental health access telephone number, *you* should proceed to the nearest *emergency care* facility at a *network hospital* in this plan. If *you* are admitted to a *non-network hospital* for *emergency care*, *you* (or someone acting for *you*) must call the mental health access telephone number found on *your* member identification card within forty-eight (48) hours of *your* admission. If this is not possible, a call to the mental health access telephone number should be made as soon as *your* medical condition permits.
- If *you* are admitted to a *non-network hospital* for *emergency care*, we may require that *you* be transferred (at *our* expense) to a *network hospital* in the *service area* when *your* condition has been stabilized.
- *You* must receive any follow-up *mental health services*, *serious mental illness* services or *chemical dependency* services from the provider designated by the mental health management organization's case manager.

H203000IL 10/06

### Seeking urgent care

The steps for seeking *urgent care* are as follows:

- Contact *your primary care physician* or his or her back up.
- If *your primary care physician* is unavailable, *you* may go to an *urgent care center* that is a *network provider* under this plan. (*You* can obtain the names of *network provider urgent care centers* by calling *our* customer service center or accessing *your* network detail on *our* website.)
- *You* must receive any follow-up services from *your primary care physician* or a *network health care practitioner*.
- *You* must pay the required *copayment* for *urgent care*.

H203100

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## UNDERSTANDING YOUR COVERAGE (continued)

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### Use of non-network providers

*Our* authorization must be obtained before receiving services from a *non-network provider*, unless such authorization cannot reasonably be obtained. In the event that *network providers* are unable to provide *covered expenses*, or *you* feel that the services available to treat *your* condition are not adequate, *you* and *your* provider must receive *our* authorization for non-network services before any procedure, treatment, or supply is provided. Only those services authorized by *us* to be provided by a *non-network provider* will be *covered expenses*.

*You* or *your health care practitioner* should verify network participation status, only from *us*, by either calling *our* customer service center or accessing *your* network detail on *our* Website. In other words, if *your network primary care physician, specialty care physician*, or other provider recommends that *you* receive care or services from another entity, please verify the network participation status of that entity before receiving such care or services.

**Note:** Not all *health care practitioners* who provide services at *network hospitals* are *network health care practitioners*. If authorized services are provided to *you* by an on-call non-network pathologist, anesthesiologist, radiologist, or similar specialty provider at a *network hospital* and *you* have made a good faith effort to obtain such authorized services from a *network health care practitioner*, *you* will be held harmless and not liable for the difference between the *usual and customary fee* and the billed charges of the *non-network health care practitioner*. Otherwise, such *non-network health care practitioners* may require payment from *you* for any amount not paid by *us*.

H203200IL 04/08

### Transition of services

Transitional services are available for existing and new *covered persons* who are in an *ongoing course of treatment*.

### Continuity of care for existing covered persons

If an existing *covered person* is in an *ongoing course of treatment* with a *network health care practitioner* who leaves *our* network, the *covered person* may continue treatment with that *health care practitioner* under the following terms and conditions:

- The *covered person* must send *us* a request for transitional services in writing within 30 days after receipt of notification from *us* of termination of the *health care practitioner*.
- We will approve transitional services under this provision provided the *covered person's health care practitioner* agrees to:
  - Abide by *our* terms or the terms of *our* designee, including but not limited to quality assurance requirements, policies and procedures regarding referrals and obtaining *preauthorization* for treatment, and to provide to *us* or *our* designee necessary medical information related to the *covered person's* care.
  - Remain in *our* service area;
  - Continue to accept reimbursement from *us* or *our* designee at the rates applicable prior to the start of the transitional period.

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## UNDERSTANDING YOUR COVERAGE (continued)

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- If the above-mentioned conditions are met, *we* will notify the *covered person* within 15 days of receipt of the *covered person's* request that the request for transitional services has been approved.
- The transitional period will be 90 days from the date of the notice of the *health care practitioner's* termination from *our* network. If the *covered person* has entered the third trimester of pregnancy at the time of the *health care practitioner's* termination, transitional services will include post-partum care directly related to the delivery.
- This provision shall not apply to any health care practitioner whose agreement terminated for situations involving imminent harm to a patient of final disciplinary action by a State licensing board.

### Continuity of care for new covered persons

If a new *covered person* is in an *ongoing course of treatment* with a *non-network health care practitioner* at the time of the *covered person's* enrollment into the *group plan*, the *covered person* may continue treatment with that *health care practitioner* under the following terms and conditions:

- The *covered person* must send *us* a request for transitional services in writing within 15 days after receiving notification from *us* of the availability of transitional services.
- *We* will approved transitional services under this provision provided the *covered person's health care practitioner* agrees to:
  - Abide by *our* terms or those of *our* designee, including but not limited to quality assurance requirements, policies and procedures regarding referrals and obtaining *preauthorization* for treatment, and to provide to *us* or *our* designee necessary medical information related to the *covered person's* care.
  - Remain in *our service area*.
  - Agree to accept reimbursement from *us* or *our* designee at the rates established by *us* or *our* designee.
- If the above-mentioned conditions are met, *we* will notify the *covered person* within 15 days of receipt of the *covered person's* request that the request for transitional services has been approved.
- The transitional period will be 90 days from the *covered person's* effective date of enrollment. If the *covered person* has entered the third trimester of pregnancy on the effective date of enrollment, transitional services will include post-partum care directly related to the delivery.

Nothing in this provision shall be construed to require *us* to provide coverage for benefits not otherwise covered under this master group contract or to change pre-existing condition limitations, if any, contained in this master group contract.

H203250IL 05/05

### Preauthorization

All benefits payable under the *master group contract* must be for services and supplies that are *medically necessary* or for *preventive services* as stated in this *certificate*. *Preauthorization* by *us* is required for certain services and supplies. Visit *our Website* at [www.humana.com](http://www.humana.com) or call the customer service telephone number on *your* identification card to obtain a list of services and supplies that require *preauthorization*. The list of services and supplies that require *preauthorization* is subject to change. Coverage provided in the past for services or supplies that did not receive or require *preauthorization*, is not a guarantee of future coverage of the same services or supplies.

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## UNDERSTANDING YOUR COVERAGE (continued)

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

*H203300IL 11/05*

### **Our relationship with providers**

*Network providers and non-network providers are not our agents, employees or partners. Network providers are independent contractors. We do not endorse or control the clinical judgment or treatment recommendations made by network providers or non-network providers.*

Nothing contained in the *master group contract* or any agreement or reimbursement document shall, nor is it intended to, interfere with communication between *you* and health care providers regarding *your* medical condition or treatment options. When requesting authorizations and ordering services, *health care practitioners* and other providers are acting on *your* behalf. All decisions related to patient care are the responsibility of the patient and the treating *health care practitioner*, regardless of any coverage determination(s) *we* have made or will make.

*H203400IL 11/05*

### **Our financial arrangements with providers**

*We have agreements with hospitals, health care practitioners (including, but not limited to, physicians and other health care professionals), and other health care providers in the provider network(s) that may contain different payment arrangements.*

- *Many health care practitioners and health care providers are paid on a discounted fee-for-services basis, meaning they are paid a mutually agreed upon amount for each covered expense rendered to covered persons. Most hospitals are paid on a specific Diagnosis Related Group (DRG) basis or flat fee per day basis for services provided to covered persons while hospital confined. Outpatient services rendered by hospitals and other facilities generally are reimbursed on a flat fee per service or procedure or a discount off charge basis.*
- *Some health care providers may have capitation agreements. This means the provider is prepaid a set dollar amount each month to care for each covered person regardless of how few or how many services a particular covered person may receive, or in some cases, whether services are provided by the primary care physician or a specialty care physician. Stop-loss insurance protects some providers from financial loss in case the actual costs incurred in caring for patients exceed certain sums.*
- *Some health care providers may participate in bonus programs which impact their payments for reaching mutually agreed upon standards.*

*H203500*

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## UNDERSTANDING YOUR COVERAGE (continued)

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### Privacy and confidentiality statement

We understand the importance of keeping *your* personal and health information (PHI) private. PHI includes both medical information and individually identifiable information, such as *your* name, address, telephone number or Social Security number. We are required by applicable federal and state law to maintain the privacy of *your* PHI.

Under both law and *our* policies, we have a responsibility to protect the privacy of *your* PHI. We:

- Protect *your* privacy by limiting who may see *your* PHI;
- Limit how we may use or disclose *your* PHI;
- Inform *you* of *your* legal duties with respect to *your* PHI;
- Explain *our* privacy policies; and
- Strictly adhere to the policies currently in effect.

We reserve the right to change *our* privacy practices at any time, as allowed by applicable law, rules and regulations. We reserve the right to make changes in *our* privacy practices for all PHI that we maintain, including information we created or received before we made the changes. When we make a significant change in *our* privacy practices, we will send notice to *our* health plan subscribers. For more information about *our* privacy practices, please contact us.

As a *covered person*, we may use and disclose *your* PHI, without *your* consent/authorization in the following ways:

- **Treatment** - we may disclose *your* PHI to a *health care practitioner*, a *hospital* or other entity which asks for it in order for *you* to receive medical treatment; and
- **Payment** - we may use and disclose *your* PHI to pay claims for *covered expenses* provided to *you* by *health care practitioners*, *hospitals* or other entities.

We may also use and disclose *your* PHI to conduct other health plan operational activities.

It has always been *our* goal to ensure the protection and integrity of *your* PHI. Therefore, we will notify *you* of any potential situations where *your* identification would be used for reasons other than treatment, payment and health plan operations.

H203600

### A note about this certificate - "benefit plan document"

This *certificate* is part of the *master group contract* and describes the benefits, provisions and limitations of the *master group contract*. Nothing in this *certificate* waives or alters any of the terms or conditions of the *master group contract*. The final interpretation of any specific provision in this *certificate* is governed by the terms of the *master group contract*. In the event of conflict between the *master group contract* and this *certificate*, the provisions of the *master group contract* will prevail. The benefits outlined in this *certificate* are effective only if *you* are eligible for coverage, become covered and remain covered in accordance with the terms of the *master group contract*.

H203700

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## SCHEDULE OF BENEFITS

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

- The level of benefits generally paid for *covered expenses*;
- The amounts of *copayments you* are required to pay; and
- *Preauthorization* requirements.

The benefits outlined in this "Schedule of Benefits" are a summary of coverage and limitations provided under the *master group contract*. A more detailed explanation of *your* coverage and its limitations and exclusions for these benefits are provided in the "Covered Expenses" and "Limitations and Exclusions" sections of this *certificate*. Please refer to any applicable riders for additional coverage and/or limitations.

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

The benefits outlined under the "Schedule of Benefits - Behavioral Health", "Schedule of Benefits - Serious Mental Illness", "Schedule of Benefits -Infertility", and "Schedule of Benefits - Transplant Services" sections are not payable under any other Schedule of Benefits of the *master group contract*. However, all other terms and provisions of the *master group contract*, including the *preauthorization* requirements, and *copayment limit(s)*, unless otherwise stated, are applicable.

### Network provider verification

This *certificate* contains multiple *network provider* benefit levels. The benefits are identified as "*primary care physician*" and "*specialty care physician*" in the Schedules of Benefits.

To know which benefit level is assigned to a *network provider*, please refer to the Online Physician Directory on *our* Website at [www.humana.com](http://www.humana.com). *You* may also contact *our* customer service department at the telephone number shown on *your* identification card. This list is subject to change.

### Preauthorization requirements

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

*You* or *your health care practitioner* must contact *us* by telephone, *electronic mail*, or in writing to request the appropriate authorization. *Your* identification card will show the *health care practitioner* the telephone number to call to request authorization.

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## SCHEDULE OF BENEFITS (continued)

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### Copayment limit

The *copayment limit* is the amount of *copayment* that must be paid by *you*, either individually or combined as a covered family, per *year* before *copayments* are no longer required for the remainder of that *year*. *Copayments* for prescription drugs do not apply towards any *copayment limit*.

<b>Copayment limit</b>	<b>Copayment limit amount</b>
Individual <i>network provider copayment limit</i>	\$3,000
Family <i>network provider copayment limit</i>	\$6,000

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## SCHEDULE OF BENEFITS (continued)

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No combination of *copayments* will exceed \$3000 for an individual or \$6000 for a family covered under this *master group contract*.

### Preventive services

#### Preventive services office visits

<b>Provider</b>	<b>Your copayment</b>
<i>Primary care physician</i>	Covered in full
<i>Specialty care physician</i>	Covered in full

#### Preventive screenings and immunizations

<b>Provider</b>	<b>Your copayment</b>
<i>Primary care physician</i>	Covered in full
<i>Specialty care physician</i>	Covered in full

#### Preventive endoscopic services

Includes colonoscopy, proctosigmoidoscopy and sigmoidoscopy.

<b>Provider</b>	<b>Your copayment</b>
<i>Primary care physician</i>	Covered in full
<i>Specialty care physician</i>	Covered in full

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## SCHEDULE OF BENEFITS (continued)

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### Routine pap smear or cervical smear

<b>Provider</b>	<b>Your copayment</b>
<i>Primary care physician</i>	Covered in full
<i>Specialty care physician</i>	Covered in full

### Routine mammogram

<b>Provider</b>	<b>Your copayment</b>
<i>Primary care physician</i>	Covered in full
<i>Specialty care physician</i>	Covered in full

### Prostate specific antigen (PSA) test

<b>Provider</b>	<b>Your copayment</b>
<i>Primary care physician</i>	Covered in full
<i>Specialty care physician</i>	Covered in full

### Immunizations against influenza (flu shots) and pneumonia

<b>Provider</b>	<b>Your copayment</b>
<i>Primary care physician</i>	Covered in full
<i>Specialty care physician</i>	Covered in full

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## SCHEDULE OF BENEFITS (continued)

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### Immunizations against human papillomavirus (HPV)

<b>Provider</b>	<b>Your copayment</b>
<i>Primary care physician</i>	Covered in full
<i>Specialty care physician</i>	Covered in full

### Immunizations against shingles

<b>Provider</b>	<b>Your copayment</b>
<i>Primary care physician</i>	Covered in full
<i>Specialty care physician</i>	Covered in full

### Routine hearing services

#### Routine hearing examination

<b>Provider</b>	<b>Your copayment</b>
<i>Primary care physician</i>	Covered in full
<i>Specialty care physician</i>	Covered in full

#### Routine hearing testing

<b>Provider</b>	<b>Your copayment</b>
<i>Primary care physician</i>	Covered in full
<i>Specialty care physician</i>	Covered in full

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## SCHEDULE OF BENEFITS (continued)

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### Health care practitioner office visit services

#### Health care practitioner office visit

Excludes diagnostic laboratory and radiology services, *advanced imaging* and *outpatient surgery*.

<b>Provider</b>	<b>Your copayment</b>
<i>Primary care physician</i>	\$30 <i>copayment</i> per visit
<i>Specialty care physician</i>	\$50 <i>copayment</i> per visit

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

Excludes *advanced imaging*.

<b>Provider</b>	<b>Your copayment</b>
<i>Primary care physician</i>	Covered in full
<i>Specialty care physician</i>	Covered in full

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

<b>Provider</b>	<b>Your copayment</b>
<i>Primary care physician</i>	Covered in full
<i>Specialty care physician</i>	Covered in full

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## SCHEDULE OF BENEFITS (continued)

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### Allergy serum when received in a health care practitioner's office

<b>Provider</b>	<b>Your copayment</b>
<i>Primary care physician</i>	Covered in full
<i>Specialty care physician</i>	Covered in full

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

<b>Provider</b>	<b>Your copayment</b>
<i>Primary care physician</i>	Covered in full
<i>Specialty care physician</i>	Covered in full

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

<i>Primary care physician</i>	Covered in full
<i>Specialty care physician</i>	Covered in full

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

<b>Provider</b>	<b>Your copayment</b>
<i>Primary care physician</i>	\$30 per visit
<i>Specialty care physician</i>	\$50 per visit

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## SCHEDULE OF BENEFITS (continued)

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### Hospital services

#### Hospital inpatient services

Provider	Your copayment
<i>Network hospital</i>	100% after \$200 copayment per day for the first 3 days per admission

#### Health care practitioner inpatient services when provided in a hospital

Provider	Your copayment
<i>Primary care physician</i>	Covered in full
<i>Specialty care physician</i>	Covered in full

#### Hospital outpatient surgical services

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

Provider	Your copayment
<i>Network hospital</i>	\$200

#### Health care practitioner outpatient services when provided in a hospital

Includes *outpatient surgery*.

Provider	Your copayment
<i>Primary care physician</i>	Covered in full
<i>Specialty care physician</i>	Covered in full

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## SCHEDULE OF BENEFITS (continued)

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### Hospital outpatient non-surgical services

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

Provider	Your copayment
<i>Network hospital</i>	Covered in full

### Hospital outpatient advanced imaging

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

Provider	Your copayment
<i>Network hospital</i>	Covered in full

### Pregnancy and newborn benefit

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

### Emergency services

#### Hospital emergency room services

Provider	Your copayment
<i>Network hospital</i>	\$200 <i>copayment</i> per visit

#### Hospital emergency room health care practitioner services

Provider	Your copayment
<i>Primary care physician</i>	Covered in full
<i>Specialty care physician</i>	Covered in full

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## SCHEDULE OF BENEFITS (continued)

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### Ambulance

<b>Provider</b>	<b>Your copayment</b>
<i>Network provider</i>	Covered in full

### Ambulatory surgical center services

#### Ambulatory surgical center for outpatient surgery

<b>Provider</b>	<b>Your copayment</b>
<i>Network provider</i>	\$200

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

Includes *outpatient surgery*.

<b>Provider</b>	<b>Your copayment</b>
<i>Primary care physician</i>	Covered in full
<i>Specialty care physician</i>	Covered in full

### Durable medical equipment and diabetes equipment

<b>Provider</b>	<b>Your copayment</b>
<i>Network provider</i>	Covered in full

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## SCHEDULE OF BENEFITS (continued)

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### Hearing aids and related services

Limited to a maximum benefit of 2 hearing aids every 36 months, limited to \$1,500 per hearing aid.

<b>Provider</b>	<b>Your copayment</b>
<i>Network provider</i>	Covered in full

### Prosthetic and orthotic devices and supplies

<b>Provider</b>	<b>Your copayment</b>
<i>Network provider</i>	Covered in full

### Custom compression stockings

Limited to a total of 6 stockings per year.

<b>Provider</b>	<b>Your copayment</b>
<i>Network provider</i>	Covered in full

### Free-standing facility services

#### Free-standing facility outpatient non-surgical services

(Excludes *advanced imaging*.)

<b>Provider</b>	<b>Your copayment</b>
<i>Network provider</i>	Covered in full

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## SCHEDULE OF BENEFITS (continued)

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### Free-standing facility outpatient advanced imaging

<b>Provider</b>	<b>Your copayment</b>
<i>Network provider</i>	Covered in full

### Health care practitioner outpatient non-surgical services provided in a free-standing facility

<b>Provider</b>	<b>Your copayment</b>
<i>Primary care physician</i>	Covered in full
<i>Specialty care physician</i>	Covered in full

### Home health care

<b>Provider</b>	<b>Your copayment</b>
<i>Network provider</i>	Covered in full

### Hospice

#### Hospice inpatient

Limited to a maximum benefit of \$3,000 per year.

<b>Provider</b>	<b>Your copayment</b>
<i>Network provider</i>	Covered in full

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## SCHEDULE OF BENEFITS (continued)

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### Hospice outpatient

Limited to a maximum benefit of \$2,000 per year.

<b>Provider</b>	<b>Your copayment</b>
<i>Network provider</i>	Covered in full

### Jaw joint benefit

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

### Physical medicine and rehabilitative services

Physical therapy, occupational therapy, speech therapy, and cognitive rehabilitation services are limited to a combined maximum total of 60 visits per year per condition.

<b>Provider</b>	<b>Your copayment</b>
<i>Network provider</i>	Covered in full

### Spinal manipulations and adjustments

Limited to 20 visits per year.

<b>Provider</b>	<b>Your copayment</b>
<i>Network provider</i>	\$50 per visit

### Other therapy

<b>Provider</b>	<b>Your copayment</b>
<i>Primary care physician</i>	Covered in full
<i>Specialty care physician</i>	Covered in full

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## SCHEDULE OF BENEFITS (continued)

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### Skilled nursing facility

Limited to 730 days per admittance. A new 730-day period begins when the member has not been in the hospital, a skilled nursing facility, a day or night care center, or residential substance abuse treatment facility for 60 consecutive days.

Provider	Your copayment
<i>Network provider</i>	Covered in full

### Urgent care services

Provider	Your copayment
<i>Network provider</i>	\$60 <i>copayment</i> per visit

### Autism spectrum disorders

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

### Additional covered expenses

Same as any other *sickness* based upon location of services and the type of provider.  
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## SCHEDULE OF BENEFITS - INFERTILITY

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Reading this "Schedule of Benefits - Infertility" section will help *you* understand:

- The level of benefits generally paid for the infertility services covered under the *master group contract*; and
- The amounts of *copayments you* are required to pay.

The benefits outlined in this "Schedule of Benefits - Infertility" section are a summary of coverage and limitations provided under the *master group contract*. A more detailed explanation of *your* coverage and exclusions for these benefits is provided in the "Covered Expenses - Infertility" and "Limitations and Exclusions" sections of this *certificate*. Please refer to this *certificate* and any applicable riders for additional coverage and/or limitations.

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

### **Infertility benefit**

<i>Network provider</i>	SAME AS ANY OTHER SICKNESS
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## SCHEDULE OF BENEFITS - BEHAVIORAL HEALTH

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Reading this "Schedule of Benefits - Behavioral Health" section will help *you* understand:

- The level of benefits generally paid for the *mental health services* and *chemical dependency services* under the *master group contract*; and,
- The amounts of *copayments you* are required to pay.

The benefits outlined in this "Schedule of Benefits - Behavioral Health" are a summary of coverage and limitations provided under the *master group contract*. A more detailed explanation of *your* coverage and its limitations and exclusions for these benefits are provided in the "Covered Expenses - Behavioral Health" and "Limitations and Exclusions" sections of this *certificate*. Please refer to this *certificate* and any applicable riders for additional coverage and/or limitations.

All services are subject to all the terms and provisions, limitations and exclusions of the *master group contract*. This schedule does not include services for *serious mental illness*.

### **Mental health acute inpatient services**

<b>Provider</b>	<b>Your copayment</b>
<i>Network provider</i>	Covered in full

### **Mental health partial hospitalization**

<b>Provider</b>	<b>Your copayment</b>
<i>Network provider</i>	Covered in full

### **Mental health skilled nursing facility**

<b>Provider</b>	<b>Your copayment</b>
<i>Network provider</i>	Covered in full

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**SCHEDULE OF BENEFITS - BEHAVIORAL HEALTH**  
**(continued)**

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**Mental health care practitioner services - inpatient**

<b>Provider</b>	<b>Your copayment</b>
<i>Network health care practitioner</i>	Covered in full

**Mental health outpatient therapy and office therapy**

<b>Provider</b>	<b>Your copayment</b>
<i>Network provider</i>	Covered in full

**Chemical dependency inpatient detoxification services**

<b>Provider</b>	<b>Your copayment</b>
<i>Network provider</i>	Covered in full

**Chemical dependency acute inpatient services**

<b>Provider</b>	<b>Your copayment</b>
<i>Network provider</i>	Covered in full

**Chemical dependency partial hospitalization**

<b>Provider</b>	<b>Your copayment</b>
<i>Network provider</i>	Covered in full

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**SCHEDULE OF BENEFITS - BEHAVIORAL HEALTH**  
**(continued)**

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**Chemical dependency skilled nursing facility**

<b>Provider</b>	<b>Your copayment</b>
<i>Network provider</i>	Covered in full

**Chemical dependency health care practitioner services - acute inpatient**

<b>Provider</b>	<b>Your copayment</b>
<i>Network health care practitioner</i>	Covered in full

**Chemical dependency outpatient detoxification services**

<b>Provider</b>	<b>Your copayment</b>
<i>Network provider</i>	Covered in full

**Chemical dependency outpatient therapy and office therapy**

<b>Provider</b>	<b>Your copayment</b>
<i>Network provider</i>	Covered in full

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## SCHEDULE OF BENEFITS - SERIOUS MENTAL ILLNESS

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Reading this "Schedule of Benefits - Serious Mental Illness" section will help *you* understand:

- The level of benefits generally paid for the treatment of *serious mental illness* covered under the *master group contract*; and
- The amounts of *copayments you* are required to pay.

The benefits outlined in this "Schedule of Benefits - Serious Mental Illness" section are a summary of coverage and limitations provided under the *master group contract*. A more detailed explanation of *your* coverage and its limitations and exclusions for these benefits is provided in the "Covered Expenses - Serious Mental Illness" and "Limitations and Exclusions" sections of this *certificate*. Please refer to this *certificate* and any applicable riders for additional coverage and/or limitations.

Benefits for *serious mental illness* are payable to the same extent as coverage for any other *sickness* under the *master group contract*, subject to the same limitations, *deductibles* or *copayments*, if any.

### Inpatient services

#### Inpatient facility services

Provider	Your copayment
<i>Network provider</i>	Covered in full

#### Inpatient health care practitioner services

Provider	Your copayment
<i>Network health care practitioner</i>	Covered in full

### Outpatient services

Provider	Your copayment
<i>Network provider</i>	Covered in full

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## SCHEDULE OF BENEFITS - TRANSPLANT SERVICES

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Reading this "Schedule of Benefits - Transplant Services" section will help *you* understand:

- The level of benefits generally paid for the transplant services covered under the *master group contract*; and
- The amounts of *copayments you* are required to pay.

The benefits outlined in this "Schedule of Benefits - Transplant Services" are a summary of coverage and limitations provided under the *master group contract*. A more detailed explanation of *your* coverage and its limitations and exclusions for these benefits are provided in the "Covered Expenses - Transplant Services" and "Limitations and Exclusions" sections of this *certificate*. Please refer to this *certificate* and any applicable riders for additional coverage and/or limitations.

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

### Organ transplant benefit

#### Medical Services

- *Hospital services*

*Hospital* benefits as shown in the "Schedule of Benefits" section under the "Hospital Services" provision of the *certificate* will be payable as follows:

<b>Provider</b>	<b>Your copayment</b>
<i>Network hospital</i> designated by <i>us</i> as an approved transplant facility	Same as any other <i>sickness</i> based on location of services and type of provider

- *Health care practitioner services*

*Health care practitioner* benefits as shown in the "Schedule of Benefits" section under the "Health Care Practitioner Services" provision of the *certificate* will be payable as follows:

<b>Provider</b>	<b>Your copayment</b>
<i>Network health care practitioner</i> designated by <i>us</i> as an approved transplant <i>health care practitioner</i>	Same as any other <i>sickness</i> based on location of services and type of provider

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## SCHEDULE OF BENEFITS - TRANSPLANT SERVICES (continued)

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### Direct, non-medical costs

Limited to a combined maximum of \$10,000 per covered *organ transplant*.

- Transportation

<b>Provider</b>	<b>Your copayment</b>
<i>Network hospital</i> designated by <i>us</i> as an approved transplant facility	Covered in full

- Temporary lodging

<b>Provider</b>	<b>Your copayment</b>
<i>Network hospital</i> designated by <i>us</i> as an approved transplant facility	Covered in full

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## SCHEDULE OF BENEFITS AND COVERED EXPENSES - BARIATRIC SERVICES (ONLY WHEN MEDICALLY NECESSARY)

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The "Schedule of Benefits and Covered Expenses - Bariatric Services" section describes the services that will be considered *covered expenses* for *bariatric services* under the *master group contract*. Benefits for *bariatric services* will be paid on a *usual and customary fee* basis subject to any applicable *copayment* and maximum benefit.

Refer to the "Limitations and Exclusions" section listed in this *certificate* for services not covered by the *master group contract*. All terms and provisions of the *master group contract*, including the *preauthorization* and referral requirements specified in this *certificate*, are applicable to *covered expenses*.

*Bariatric services* are subject to the terms, provisions, limitations and exclusions described below.  
H4000000IL

### Definitions

The following terms are used in this section:

***Bariatric services*** means the *bariatric surgery* and the post-discharge services and expenses related to complications following an approved *bariatric surgery*.

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

***Bariatric surgery treatment period*** means six months from the date of discharge from the *hospital* following an approved *bariatric surgery* received while *you* were covered by *us*.

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

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

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### Bariatric services benefit

Notwithstanding any exclusions or limitations contained in the *master group contract*, we will pay benefits for *covered expenses* incurred by *you* for *bariatric services* approved by *us*. Please contact *our* Bariatric Management Team or *our* designee when in need of *bariatric services* and to obtain a list of covered *bariatric surgeries*. The list is subject to change without notice.

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**SCHEDULE OF BENEFITS AND COVERED EXPENSES -  
BARIATRIC SERVICES (continued)  
(ONLY WHEN MEDICALLY NECESSARY)**

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*Preauthorization from us is required for bariatric services. You or your health care practitioner must notify us of your need for bariatric services in advance of receiving your initial evaluation for bariatric surgery. We must be given a reasonable opportunity to review the clinical results of the bariatric surgery evaluation before we determine if the bariatric surgery will be covered. We will advise your health care practitioner of our determination.*

Benefits are payable only if the *bariatric services* are approved by *us*. Coverage for post-discharge services and treatment of complications after an approved *bariatric surgery* are limited to the *bariatric surgery treatment period*.  
*H4000200IL*

**Covered expenses**

- The following are *covered expenses* for approved *bariatric services*:
- *Hospital services or ambulatory surgical center services.*
- *Health care practitioner services.*

Any expense incurred by *you* for *bariatric services* applies toward *your copayment limit*, if any.  
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**SCHEDULE OF BENEFITS AND COVERED EXPENSES -  
BARIATRIC SERVICES (continued)  
(ONLY WHEN MEDICALLY NECESSARY)**

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**Schedule of benefits - bariatric services**

**Hospital services**

**Hospital inpatient services**

<b>Provider</b>	<b>Your copayment</b>
<i>Network hospital</i> designated by us as an approved <i>bariatric services</i> facility	Same as any other <i>sickness</i> based upon location of services and the type of provider.

**Health care practitioner inpatient services**

<b>Provider</b>	<b>Your copayment</b>
<i>Network health care practitioner</i> designated by us as an approved <i>bariatric services health care practitioner</i>	Same as any other <i>sickness</i> based upon location of services and the type of provider.

**Hospital outpatient surgical services**

<b>Provider</b>	<b>Your copayment</b>
<i>Network hospital</i> designated by us as an approved <i>bariatric services</i> facility	Same as any other <i>sickness</i> based upon location of services and the type of provider.

**Health care practitioner outpatient services**

<b>Provider</b>	<b>Your copayment</b>
<i>Network health care practitioner</i> designated by us as an approved <i>bariatric services health care practitioner</i>	Same as any other <i>sickness</i> based upon location of services and the type of provider.

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**SCHEDULE OF BENEFITS AND COVERED EXPENSES -  
BARIATRIC SERVICES (continued)  
(ONLY WHEN MEDICALLY NECESSARY)**

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**Ambulatory surgical center services**

<b>Provider</b>	<b>Your copayment</b>
<i>Network provider</i> designated by <i>us</i> as an approved <i>bariatric services</i> facility	Same as any other <i>sickness</i> based upon location of services and the type of provider.

**Health care practitioner ambulatory surgical center services**

<b>Provider</b>	<b>Your copayment</b>
<i>Network health care practitioner</i> designated by <i>us</i> as an approved <i>bariatric services health care practitioner</i>	Same as any other <i>sickness</i> based upon location of services and the type of provider.

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**Limitations and exclusions**

No benefits will be provided for, or on account of, the following items:

- Expenses for a *bariatric surgery* which is *experimental, investigational, or for research purposes*.
- *Bariatric services* we do not approve based on *our* established criteria.
- *Bariatric services* for a *bariatric surgery* denied by *us*.
- *Bariatric services* for which *you* have not met criteria as established by *us*.
- Expenses for a *bariatric surgery* performed outside of the United States.
- Any care resulting from a non-covered *bariatric surgery*.

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## COVERED EXPENSES

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

- *Copayment*; and
- Maximum benefit.

Refer to the "Limitations and Exclusions" section listed in this *certificate*. All terms and provisions of the *master group contract*, including the *preauthorization* and referral requirements specified in this *certificate*, are applicable to *covered expenses*.

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### **Preventive services**

#### **Preventive services office visit**

*Covered expenses* include charges incurred for an office visit made to a *health care practitioner* for examinations and physicals to detect or prevent *sickness* as recommended by the U.S. Preventive Services Task Force.

#### **Preventive screenings and immunizations**

*Covered expenses* include charges incurred by *you* for the following *preventive services* as recommended by the United States Preventive Services Task Force:

- Laboratory, radiology and/or endoscopic services to detect or prevent *sickness*.
- Screening by *low-dose mammography* for the presence of occult breast cancer as follows:
  - A baseline mammogram for a female *covered person*.
  - Mammograms at the age and intervals considered *medically necessary* by the *health care practitioner*.
  - Coverage is also provided for a comprehensive ultrasound screening of an entire breast or breasts if a mammogram demonstrates heterogeneous or dense breast tissue, when *medically necessary* as determined by a *health care practitioner*.
- An annual thorough physical examination of the breast as *medically necessary*. This includes, but is not limited to, a comprehensive clinical breast examination performed by a *health care practitioner* to check for lumps and other changes.

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## COVERED EXPENSES (continued)

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- For female *covered persons*, coverage for surveillance tests for ovarian cancer if at risk for ovarian cancer. For the purposes of this coverage, a female *covered person* is at risk if:
  - She has a family history of one or more first-degree relatives with ovarian cancer; or
  - She has clusters of female relatives with breast cancer; or
  - She has clusters of female relatives with nonpolyposis colorectal cancer.
  - She tests/has tested positive for BRCA1 or BRCA2 mutations.

Surveillance tests may include annual screening using the CA-125 serum tumor marker testing, a transvaginal ultrasound, and/or a pelvic exam.

- An annual routine pap smear or cervical smear.
- Human papillomavirus (HPV) vaccine for *covered persons* 9 years of age through 26 years of age that is approved by the FDA.
- Shingles vaccine for *covered persons* 60 years of age or older that is approved by the FDA
- Meningitis vaccine for *covered persons* under 26 years of age that is approved by the FDA
- An annual prostate specific antigen (PSA) test and/or digital rectal examination for a male *covered*.
- Routine immunizations. TB tine tests and allergy desensitization injections are not considered routine immunizations.
- Immunizations against influenza and pneumonia, as determined by *us*.
- Routine hearing examination and testing.
- Routine hearing screening.
- Routine vision screening through age 17 (not including refractions).

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H204200IL 03/09

### Health care practitioner office services

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

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## COVERED EXPENSES (continued)

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### Health care practitioner office visit

*Covered expenses include:*

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

H204400 03/09

### Hospital services

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

For *emergency care* benefits provided in a *hospital*, refer to the "Emergency Services" provisions of the "Covered Expenses" section.

### Hospital inpatient services

*Covered expenses include:*

- Daily semi-private, ward, intensive care or coronary care *room and board* charges for each day of *confinement*.
- Services and supplies, other than *room and board*, provided by a *hospital* to a registered bed patient.

### Health care practitioner inpatient services

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

*Covered expenses include:*

- Medical services furnished by an attending *health care practitioner* to you while you are *hospital confined*.
- *Surgery* performed on an *inpatient* basis.
- Services of a surgical assistant and/or assistant surgeon when *medically necessary*.

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## COVERED EXPENSES (continued)

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- Services of a physician assistant (P.A.), registered nurse (R.N.) or a certified operating room technician when *medically necessary*.
- Anesthesia administered by a *health care practitioner* or certified registered anesthetist attendant for a *surgery*.
- Consultation charges requested by the attending *health care practitioner* during a *hospital confinement*.
- Services of a pathologist.
- Services of a radiologist.
- Services performed on an emergency basis in a *hospital* if the *sickness* or *bodily injury* being treated results in a *hospital confinement*.

### **Hospital outpatient services**

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

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

### **Hospital outpatient surgical services**

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

### **Health care practitioner outpatient services**

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

*Covered expenses* include:

- Surgery performed on an *outpatient* basis.
- Services of a surgical assistant and/or assistant surgeon when *medically necessary*.
- Services of a physician assistant (P.A.), registered nurse (R.N.) or a certified operating room technician when *medically necessary*.
- Anesthesia administered by a *health care practitioner* or certified registered anesthetist attendant for a *surgery*.
- Services of a pathologist.
- Services of a radiologist.

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## COVERED EXPENSES (continued)

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### Hospital outpatient non-surgical services

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

*Covered expenses* for *hospital* non-surgical services do not include *advanced imaging*.

### Hospital outpatient advanced imaging

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

H205400IL 07/07

### Pregnancy and newborn benefit

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

*Covered expenses* include:

- A minimum stay of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated cesarean section. If an earlier discharge is consistent with the most current protocols and guidelines of the American College of Obstetricians and Gynecologists or the American Academy of Pediatrics and is consented to by the mother and the attending *health care practitioner*, a post-discharge office visit to the *health care practitioner* or a home health care visit within the first 48 hours after discharge is also covered, subject to the terms of this *certificate*.
- For a newborn, *hospital confinement* during the first 48 hours or 96 hours following birth, as applicable and listed above for:
  - *Hospital* charges for *routine nursery care*;
  - The *health care practitioner's* charges for circumcision of the newborn child; and
  - The *health care practitioner's* charges for routine examination of the newborn before release from the *hospital*.
- If the covered newborn must remain in the *hospital* past the mother's *confinement*, services and supplies received for:
  - A *bodily injury* or *sickness*;
  - Care and treatment for premature birth; and
  - Medically diagnosed birth defects and abnormalities.

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## COVERED EXPENSES (continued)

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

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

The newborn will not be required to satisfy a separate *copayment* for *hospital* facility charges for the *confinement* period immediately following birth. A *copayment*, if applicable, will be required for any subsequent *hospital admission*.

H205500IL 03/09

### Emergency services

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

*Emergency care* provided by a *non-network hospital* or a *non-network health care practitioner* will be covered.

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

H205700IL 07/07

### Ambulance

We will pay benefits for *covered expenses* incurred by you for professional *ambulance* service to, from or between medical facilities for *emergency care*.

*Ambulance* service for *emergency care* provided by a *non-network provider* will be covered at the *network provider* benefit percentage.

H205800IL 03/11

### Ambulatory surgical center

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

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## COVERED EXPENSES (continued)

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

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

*Covered expenses* include:

- *Surgery* performed on an *outpatient* basis.
- Services of a surgical assistant and/or assistant surgeon when *medically necessary*.
- Services of a physician assistant (P.A.), registered nurse (R.N.) or a certified operating room technician when *medically necessary*.
- Anesthesia administered by a *health care practitioner* or certified registered anesthetist attendant for a *surgery*.
- Services of a pathologist.
- Services of a radiologist.

H206000IL 07/07

### **Durable medical equipment and diabetes equipment**

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

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

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

- Manufacturer's warranty is expired;
- Repair or maintenance is not a result of misuse or abuse;
- Maintenance is not more frequent than every six months; and
- Repair cost is less than replacement cost;

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

- Manufacturer's warranty is expired;
- Replacement cost is less than repair cost; and
- Replacement is not due to lost or stolen equipment, or misuse or abuse of the equipment; or

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## COVERED EXPENSES (continued)

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

We do not pay for equipment or devices not specifically designed and intended for the care and treatment of a *sickness* or *bodily injury*.

The following are not considered *covered expenses*:

- Duplicate or similar rentals or purchases of *durable medical equipment* or *diabetes equipment* as determined by *us*.  
H206100 05/05

### **Prosthetic and orthotic devices and supplies**

We will pay benefits for *covered expenses* incurred by *you* for prosthetic and orthotic devices and supplies, including limbs and eyes. Replacement is a *covered expense* if due to pathological changes or growth. *Covered expense* includes repair of the device if not covered by the manufacturer.

*Covered expense* includes casts, splints, trusses, crutches, orthotics and braces. Orthotics must be custom made of rigid or semi-rigid material.

Regardless of indication, no coverage is provided for:

- Fabric supports, except for compression stockings as stated elsewhere in this *certificate*;
- Oral splints and appliances, except as stated elsewhere in this *certificate*;
- Dental splints and dental braces; or
- Orthotics prescribed for flat feet.

IL248490.2 01/11

H206200

### **Free-standing facility services**

#### **Free-standing outpatient non-surgical services**

We will pay benefits for *covered expenses* for services provided in a *free-standing facility* for the utilization of the facility and ancillary services.

*Covered expenses* for *outpatient* non-surgical services do not include *advanced imaging*.

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## COVERED EXPENSES (continued)

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

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

### Free-standing outpatient advanced imaging

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

H206600 07/07

### Home health care

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

The "Schedule of Benefits" shows the maximum number of visits allowed by a representative of a *home health care agency*, if any. A visit by any representative of a *home health care agency* of two hours or less will be counted as one visit.

Home health care *covered expenses* include:

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

Home health care *covered expenses* do not include:

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

H206700 03/09

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## COVERED EXPENSES (continued)

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### Hospice

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

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

Hospice care benefits are payable as shown on the "Schedule of Benefits" for the following hospice services, subject to the *individual lifetime maximum benefit* and any other maximum(s):

- *Room and board* at a hospice, when it is for management of acute pain or for an acute phase of chronic symptom management;
- Part-time nursing care provided by or supervised by a registered nurse (R.N.) for up to eight hours in any one day;
- Counseling for the terminally ill covered person and his/her immediate covered family members by a licensed:
  - Clinical social worker; or
  - Pastoral counselor.
- Medical social services provided to the terminally ill *covered person* or his/her immediate covered *family members* under the direction of a *health care practitioner*, including:
  - Assessment of social, emotional and medical needs, and the home and family situation; and
  - Identification of the community resources available;
- Psychological and dietary counseling;
- Physical therapy;
- Part-time home health aid services for up to eight hours in any one day; and
- Medical supplies, drugs, and medicines prescribed by a *health care practitioner* for *palliative care*.

Hospice care *covered expenses* do not include:

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

H206800 05/05

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## COVERED EXPENSES (continued)

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### Jaw joint benefit

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

The following are *covered expenses*:

- A single examination including a history, physical examination, muscle testing, range of motion measurements, and psychological evaluation;
- Diagnostic x-rays;
- Physical therapy of necessary frequency and duration, limited to a multiple modality benefit when more than one therapeutic treatment is rendered on the same date of service;
- Therapeutic injections;
- Appliance therapy utilizing an appliance which does not permanently alter tooth position, jaw position or bite. Benefits for reversible appliance therapy will be based on the *usual and customary fee* for use of a single appliance, regardless of the number of appliances used in treatment. The benefit for the appliance therapy will include an allowance for all jaw relation and position diagnostic services, office visits, adjustments, training, repair, and replacement of the appliance; and
- Surgical procedures.

*Covered expenses* do not include charges for:

- Computed Tomography (CT) scans or magnetic resonance imaging except in conjunction with surgical management;
- Electronic diagnostic modalities;
- Occlusal analysis; or
- Any irreversible procedure, including, but not limited to: orthodontics, occlusal adjustment, crowns, onlays, fixed or removable partial dentures, full dentures.

H206900IL 05/05

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## COVERED EXPENSES (continued)

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### Physical medicine and rehabilitative services benefit

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

- Physical therapy services;
- Occupational therapy services;
- Spinal manipulations/adjustments and modalities performed in a *health care practitioner's* office or on an *inpatient* or *outpatient* basis or in a *rehabilitation facility*;
- Speech therapy or speech pathology services;
- Audiology services;
- Cognitive rehabilitation services;
- Vision therapy services;
- Acupuncture services;
- Respiratory or pulmonary therapy services; and
- Cardiac rehabilitation services.

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

*H207000 03/09*

### Skilled nursing facility

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

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

*H207100 05/05*

### Urgent care center

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

*H207200*

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## COVERED EXPENSES (continued)

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### Sexual assault services

Examination and testing provided to a *covered person* who is a victim of sexual assault or abuse will be covered in full and will not be subject to any *copayments* or *deductibles*.

*H207250IL 05/05*

### Autism spectrum disorders

We will pay benefits for the diagnosis and treatment of *medically necessary autism spectrum disorders*.

*Covered expenses* include:

- Psychiatric care;
- Psychological care;
- Habilitative or rehabilitative care (counseling and treatment programs intended to develop, maintain, and restore the functioning of an individual); and
- Therapeutic care (including behavioral, speech, occupational, and physical therapies) addressing the following areas:
  - Self-care and feeding;
  - Pragmatic, receptive, and expressive language;
  - Cognitive functioning;
  - Applied behavioral analysis, intervention, and modification;
  - Motor planning; and
  - Sensory processing
- Respite care for *dependents* 2 through 21 years of age for *autism spectrum disorder* provided by a *health care practitioner*.

*Autism spectrum disorders* are payable as shown on the "Schedule of Benefits".

*H207267IL 03/09*

### Additional covered expenses

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

- Blood and blood plasma which is not replaced by donation; administration of the blood and blood products including blood extracts or derivatives.
- Oxygen and rental of equipment for its administration.
- Wigs due to hair loss resulting from chemotherapy or radiation.

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## COVERED EXPENSES (continued)

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- Cochlear implants, when approved by *us*, for a *covered person*:
  - 18 years of age or older with bilateral severe to profound sensorineural deafness; or
  - 12 months to 17 years of age with profound bilateral sensorineural deafness.

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

  - The existing device malfunctions and cannot be repaired;
  - Replacement is due to a change in the *covered person's* condition that makes the present device non-functional; or
  - The replacement or upgrade is not for cosmetic purposes.
- The following special supplies, dispensed up to a 30-day supply, when prescribed by *your* attending *health care practitioner*:
  - Surgical dressings;
  - Catheters;
  - Colostomy bags, rings and belts; and
  - Flotation pads.
- The initial pair of eyeglasses or contacts needed due to cataract *surgery* or an *accident* if the eyeglasses or contacts were not needed prior to the *accident*.
- Dental treatment only if:
  - The charges are incurred for treatment of a *dental injury* to a *sound natural tooth*; and
  - The *pre-existing condition* exclusion period, if applicable, has been satisfied; and
  - The treatment begins within 12 months after the date of the *dental injury*; and
  - The treatment is completed within 12 months after the date of the *dental injury*.
- Certain oral surgical operations as follows:
  - Excision of partially or completely impacted teeth;
  - Excisions of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth when such conditions require pathological examinations;
  - Surgical procedures required to correct accidental injuries of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
  - Reduction of fractures and dislocation of the jaw;
  - External incision and drainage of cellulitis;
  - Incision of accessory sinuses, salivary glands or ducts; and
  - Cosmetic bonding.
- Elective vasectomy or tubal ligation.

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## COVERED EXPENSES (continued)

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- For a *covered person*, who is receiving benefits in connection with a mastectomy, service for:
  - Reconstructive *surgery* of the breast on which the mastectomy has been performed;
  - *Surgery* and reconstruction on the non-diseased breast to achieve symmetrical appearance; and
  - Prostheses and treatment of physical complications for all stages of mastectomy, including lymphedema.
- Amino-acid based elemental formulas, regardless of delivery method, for the diagnosis and treatment of an inherited metabolic disease, e.g. phenylketonuria (PKU), eosinophilic disorders, or short bowel syndrome when *medically necessary* and prescribed by a *health care practitioner*, unless otherwise covered in the Prescription Drug Benefit Rider, if any, attached to this *master group contract*.
- Private duty nursing while you are *hospital confined*.
- Following a mastectomy, *medically necessary* length of stay for *inpatient* care and post-discharge office visit to the physician or in home nurse visit provided in the first 48 hours after discharge. For the purposes of this provision, mastectomy means the removal of all or a part of the breast for *medically necessary* reasons, as determined by the *health care practitioner*.
- Colorectal cancer examination and laboratory tests for colorectal cancer as prescribed by a physician and in accordance with the American Cancer Society guidelines on colorectal cancer screening or other colorectal cancer screening guidelines issued by nationally recognized professional medical societies or federal government agencies, including the National Cancer Institute, the Centers for Disease Control and Prevention, and the American College of Gastroenterology.
- Anesthesia charges associated with dental procedures at a *hospital* or *ambulatory surgical center* are a *covered expense* for the following *covered persons*:
  - A child age six or under;
  - An individual who has a medical condition that requires hospitalization or general anesthesia for dental care; or
  - An individual who is disabled.
- If *medically necessary*, coverage for bone mass measurement and treatment for osteoporosis.
- If *medically necessary*, pain medication and pain therapy related to the treatment of breast cancer. Pain therapy means pain therapy that is medically based and includes reasonably defined goals, including, but not limited to, stabilizing or reducing pain, with periodic evaluations of the efficacy of the pain therapy against these goals.

IL248490.4 01/11

H207420IL 03/09

- Coverage for prenatal HIV testing.  
H207436IL

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## COVERED EXPENSES - INFERTILITY

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The "Covered Expenses - Infertility" section describes the infertility services that will be considered *covered expenses* under the *master group contract*. Benefits will be paid on a *usual and customary fee* basis and as shown in the "Schedule of Benefits - Infertility" subject to any applicable:

- Copayment; and
- Maximum benefit.

Refer to the "Limitations and Exclusions" section listed in this *certificate*. All terms and provisions of the *master group contract*, including the *preauthorization* and referral requirements specified in this *certificate*, are applicable to *covered expenses*.

### Definitions

**Donor** means an oocyte donor or sperm donor who is covered under this *master group contract*.

**Infertility** means the inability to conceive after one year of *unprotected sexual intercourse* or the inability to sustain a successful pregnancy. If a physician determines a medical condition exists that renders conception impossible through *unprotected sexual intercourse*, the one year requirement will be waived.

**Surrogate** means a woman who carries a pregnancy for a woman who has infertility coverage as specified in this *master group contract*.

**Unprotected sexual intercourse** means sexual union between a male and a female without the use of any process, device or method that prevents conception, including but not limited to oral contraceptives, chemicals, physical or barrier contraceptives, natural abstinence or voluntary permanent surgical procedures.

### Coverage

Coverage is provided for the following:

- Diagnosis and treatment of infertility including uterine embryo lavage, embryo transfer, artificial insemination, low tubal ovum transfer, injectable medication and infertility drugs.
- In vitro fertilization, gamete intrafallopian tube transfer, or zygote intrafallopian tube transfer if the following conditions have been met:
  - *You* are unable to attain or sustain a pregnancy though less costly infertility treatments covered by this *master group contract*. This requirement will be waived in the event that *your* physician determines that *you* have a medical condition that renders less costly infertility treatments useless.
  - *You* have not undergone four complete oocyte retrievals; except, if a live birth follows a completed oocyte retrieval, two more completed oocyte retrievals will be covered. *We* will cover one attempt at fertilized egg implantation per oocyte harvest procedure. If an oocyte *donor* is used, then the completed oocyte retrieval performed on the *donor* will count against *you* as one completed oocyte retrieval. In no event will more than six oocyte retrievals be covered by this *master group contract* during *your* lifetime.

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## COVERED EXPENSES - INFERTILITY (continued)

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- The procedures are performed at medical facilities that conform to the American Society for Reproductive Medicine guidelines for in vitro fertilization clinics or minimum standards for programs of in vitro fertilization.
- Medical expenses of a *donor* for procedures utilized to retrieve oocytes or sperm, as well as a subsequent procedure to transfer the oocytes or sperm to *you*.

### Exclusions

- Reversal of voluntary sterilization;
- Payment for medical services rendered to a *surrogate* for purposes of childbirth;
- Costs associated with cryo preservation and storage of sperm, eggs, and embryos; provided, subsequent procedures of a medical nature necessary to make use of the cryo preserved substance will not be similarly excluded if deemed non-experimental and non-investigational;
- Selected termination of an embryo; provided that where the life of the mother would be in danger were all embryos to be carried to full term, the termination is covered;
- Non-medical costs of an egg or sperm *donor*;
- Travel costs for travel within one hundred (100) miles of *your* home address as filed with *us*. Travel costs not *medically necessary*, not mandated or required by *us*.
- Infertility treatments deemed experimental in nature as determined by the written determination of the American Society for Reproductive Medicine. Except, where infertility treatment includes elements which are not experimental in nature along with those which are, to the extent services may be delineated and separately charged, those services which are not experimental in nature will be covered.
- Infertility treatments rendered to *dependents* under the age of 18.

H207700IL 05/05

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## COVERED EXPENSES - BEHAVIORAL HEALTH

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The "Covered Expenses - Behavioral Health" section describes the services that will be considered *covered expenses* for *mental health services* and *chemical dependency services* under the *master group contract*. Benefits for *mental health services* and *chemical dependency services* will be paid on a *usual and customary fee* basis and as shown in the "Schedule of Benefits - Behavioral Health" subject to any applicable:

- *Copayment*; and
- Maximum benefit.

Refer to the "Limitations and Exclusions" section listed in this *certificate*. All terms and provisions of the *master group contract*, including the *preauthorization* and referral requirements specified in this *certificate*, are applicable to *covered expenses*

This "Covered Expenses-Behavioral Health" section does not include services for *serious mental illness*.  
H208000IL 05/05

### **Mental health acute inpatient services**

We will pay benefits for *covered expenses* incurred by you for *acute inpatient services* for *mental health services* provided in a *hospital*.

H208100IL

### **Mental health acute inpatient facility services**

We will pay benefits for *covered expenses* incurred by you for a *confinement* or *partial hospitalization* in a *hospital*, *health care treatment facility*, *halfway house* or *residential treatment facility* for *mental health services*.

H208200IL

### **Mental health acute inpatient health care practitioner services**

We will pay benefits for *covered expenses* incurred by you for *mental health services* provided by a *health care practitioner* in a *hospital*, *health care treatment facility*, *halfway house* or *residential treatment facility*.

H208300IL

### **Mental health outpatient care and office therapy services**

We will pay benefits for *covered expense* incurred by you for *mental health services* while not *confined* in a *hospital*, *health care treatment facility*, *halfway house* or *residential treatment facility* for *outpatient services*, including *outpatient services* provided as part of an *intensive outpatient program*.

H208500IL

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## **COVERED EXPENSES - BEHAVIORAL HEALTH (continued)**

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### **Chemical dependency detoxification services**

We will pay benefits for *inpatient* or *outpatient* detoxification services as *medically necessary* for the treatment of the medical complications of the abuse of or addiction to alcohol or drugs.

*H208510IL*

### **Chemical dependency rehabilitation services, including health care practitioner services**

We will pay benefits for *covered expenses* incurred by you for *acute inpatient services* for *chemical dependency* services provided in a *hospital*.

*H208520IL*

### **Chemical dependency acute inpatient services**

We will pay benefits for *covered expenses* incurred by you for a *confinement* or *partial hospitalization* in a *hospital*, *health care treatment facility*, *halfway house* or *residential treatment center* for *chemical dependency* services.

*H208530IL*

### **Chemical dependency acute inpatient health care practitioner services**

We will pay benefits for *covered expenses* incurred by you for *chemical dependency* services provided by a *health care practitioner* in a *hospital*, *health care treatment facility*, *halfway house* or *residential treatment facility*.

*H208540IL*

### **Chemical dependency partial hospitalization**

We will pay benefits for *covered expenses* incurred by you for *partial hospitalization* in a *hospital*, *health care treatment facility*, *halfway house* or *residential treatment facility* for *chemical dependency* services.

*H208550IL*

### **Chemical dependency outpatient care and office therapy**

We will pay benefits for *covered expense* incurred by you for *chemical dependency* services while not *confined* in a *hospital*, *health care treatment facility*, *halfway house* or *residential treatment facility* for *outpatient* services, including *outpatient* services provided as part of an *intensive outpatient program*.

*H208560IL*

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## COVERED EXPENSES - SERIOUS MENTAL ILLNESS

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The "Covered Expenses - Serious Mental Illness" section describes the services that will be considered *covered expenses* for *serious mental illness* under the *master group contract*. Benefits for *serious mental illness* will be paid as any other *sickness* subject to any applicable:

- *Copayment*; and
- Maximum benefit.

Refer to the "Limitations and Exclusions" section listed in this *certificate*. All terms and provisions of the *master group contract*, including the *preauthorization* and referral requirements specified in this *certificate*, are applicable to *covered expenses*.

### **Inpatient services**

We will pay benefits for *inpatient* care for the treatment of *serious mental illness* provided in a *hospital*, *health care treatment facility*, *residential treatment facility* or halfway house.

### **Inpatient facility services**

We will pay benefits for *covered expenses* incurred by you while *confined* in a *hospital*, *health care treatment facility*, *residential treatment facility* or halfway house for the treatment of *serious mental illness*.

### **Inpatient health care practitioner services**

We will pay benefits for *covered expenses* incurred by you for the treatment of *serious mental illness* provided by a *health care practitioner* in a *hospital*, *health care treatment facility*, *residential treatment facility* or halfway house.

### **Outpatient services**

#### **Serious mental illness**

We will pay benefits for *covered expenses* incurred by you for the treatment of *serious mental illness* while not *confined* in a *hospital*, *health care treatment facility*, *residential treatment facility* or halfway house for *outpatient* services.

#### **Pervasive developmental disorder**

We will pay benefits for *outpatient* speech therapy visits for treatment of Pervasive Developmental Disorders (PDD), as defined in this *certificate*.

H209400IL 10/06

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## COVERED EXPENSES - TRANSPLANT SERVICES

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The "Covered Expenses - Transplant Services" section describes the services that will be considered *covered expenses* for transplant services under the *master group contract*. Benefits for transplant services will be paid on a *usual and customary fee* basis and as shown in the "Schedule of Benefits - Transplant Services" subject to any applicable:

- *Copayment*; and
- Maximum benefit.

Refer to the "Exclusions" provision in this section and the "Limitations and Exclusions" section listed in this *certificate* for transplant services not covered by the *master group contract*. All terms and provisions of the *master group contract*, including the *preauthorization* and referral requirements specified in this *certificate*, are applicable to *covered expenses*.

### Organ transplant benefit

We will pay benefits for *covered expenses* incurred by you for an *organ transplant*. The *organ transplant* must be approved in advance by us, and is subject to the terms, conditions and limitations described below and contained in the *master group contract*. Please contact our Transplant Management Department or our designee when in need of these services.

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

Once coverage for the *organ transplant* is approved, we will advise your *health care practitioner*. Benefits are payable only if the pre-transplant services, the *organ transplant* and post-discharge services are approved by us. Coverage for post-discharge services and treatment of complications after transplantation are limited to the *organ transplant treatment period*.

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

### Covered expenses

*Covered expense* for an *organ transplant* includes pre-transplant services, transplant inclusive of any chemotherapy and associated services, post-discharge services, and treatment of complications after transplantation of the following organs or procedures only:

- Heart;
- Lung(s);
- Liver;

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## COVERED EXPENSES - TRANSPLANT SERVICES (continued)

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- Kidney;
- *Bone marrow*;
- Intestine;
- Pancreas;
- Auto islet cell;
- Any combination of the above listed organs; and
- Any organ not listed above required by state or federal law.

The following are *covered expenses* for approved *organ transplants* and all related complications:

- *Hospital* and *health care practitioner* services.
- Organ acquisition and donor costs, including pre-transplant services, the acquisition procedure, and any complications resulting from the acquisition. Donor costs will not exceed the *organ transplant treatment period* and are not payable under the *master group contract* if they are payable in whole or in part by any other group plan, insurance company organization or person other than the donor's family or estate.
- Direct, non-medical costs:
  - The *covered person* receiving the *organ transplant*, if he or she lives more than 100 miles from the transplant facility; and
  - One designated caregiver or support person (two, if the *covered person* receiving the *organ transplant* is under 18 years of age), if they live more than 100 miles from the transplant facility.

Direct non-medical costs include:

- Transportation to and from the *hospital* where the *organ transplant* is performed; and
- Temporary lodging at a prearranged location when requested by the *hospital* and approved by *us*.

All direct, non-medical costs for the *covered person* receiving the *organ transplant* and the designated caregivers(s) or support person(s) are limited to a combined maximum coverage per *organ transplant* as specified in the "Schedule of Benefits - Transplant Services" section in this *certificate*.

### Exclusions

No benefit is payable for or in connection with an *organ transplant* if:

- It is *experimental* or *investigational*, or for *research purposes* as defined elsewhere in this *certificate*, and
  - The Office of Health Care Technology Assessment, within the Agency for Health Care Policy and Research within the federal Department of Health and Human Services, deems the procedure to be either experimental or investigational; or
  - There is insufficient data or experience to determine whether the procedure is clinically acceptable.

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## COVERED EXPENSES - TRANSPLANT SERVICES (continued)

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- The expense relates to storage of cord blood and stem cells, unless it is an integral part of an *organ transplant* approved by *us*.
- *We* do not approve coverage for the *organ transplant*, based on *our* established criteria.
- Expenses are eligible to be paid under any private or public research fund, government program except *Medicaid*, or another funding program, whether or not such funding was applied for or received.
- The expense relates to the transplantation of any non-human organ or tissue, unless otherwise stated in the *master group contract*.
- The expense relates to the donation or acquisition of an organ for a recipient who is not covered by *us*.
- The expense relates to an *organ transplant* performed outside of the United States and any care resulting from that *organ transplant*.
- A denied transplant is performed; this includes the pre-transplant evaluation, the transplant procedure, follow-up care, immunosuppressive drugs, and expenses related to complications of such transplant.
- *You* have not met pre-transplant criteria as established by *us*.

H210300IL 10/06

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## LIMITATIONS AND EXCLUSIONS

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### Limitations and exclusions

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

*H211200*

- Treatments, services, supplies or *surgeries* that are not *medically necessary*, except for the specified *preventive services* as outlined in the "Schedule of Benefits" and described in the "Covered Expenses" section of this *certificate*.
- A *sickness* or *bodily injury* arising out of, or in the course of, any employment for wage, gain or profit.
- A *sickness* or *bodily injury* that is covered under any Workers' Compensation or similar law. This limitation also applies to a *covered person* who is not covered by Workers' Compensation and lawfully chose not to be.
- Care and treatment given in a *hospital* owned, or run, by any government entity, unless *you* are legally required to pay for such care and treatment. However, care and treatment provided by military *hospitals* to *covered persons* who are armed services retirees and their *dependents* are not excluded.

*H211600 07/07*

- Any service furnished while *you* are *confined* in a *hospital* or institution owned or operated by the United States government or any of its agencies for any military service-connected *sickness* or *bodily injury*.
- Any service *you* would not be legally required to pay for in the absence of this coverage.
- *Sickness* or *bodily injury* for which *you* are in any way paid or entitled to payment or care and treatment by or through a government program.
- Any service not ordered by a *health care practitioner*.
- Services provided to *you*, if *you* do not comply with the *master group contract's* requirements. These include services:
  - Not provided by a *network provider*, unless required for *emergency care*;
  - Received in an emergency room, unless required because of *emergency care*;
  - Which require *preauthorization* if *preauthorization* was not obtained.
  - Which require a *primary care physician* referral if a referral was not obtained.

*H212100 07/07*

- Services rendered by a standby physician, surgical assistant, assistant surgeon, physician assistant, registered nurse or certified operating room technician unless *medically necessary*.
- Any service that is not rendered or not substantiated in the medical records.

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## LIMITATIONS AND EXCLUSIONS (continued)

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- Education, or training, except for *diabetes self-management training*.
- Educational or vocational, therapy, testing, services or schools, including therapeutic boarding schools and other therapeutic environments. Educational or vocational videos, tapes, books and similar materials are also excluded.

H212600 07/07

- Medical services provided by a *covered person's family member*.
- *Ambulance* services for routine transportation to, from or between medical facilities and/or a *health care practitioner's* office.
- Any drug, biological product, device, medical treatment, or procedure which is *experimental* or *investigational* or *for research purposes*.
- Vitamins, dietary supplements, and dietary formulas, except enteral formulas, nutritional supplements or low protein modified food products for the treatment of an inherited metabolic disease, e.g. phenylketonuria (PKU).
- Over the counter, non-prescription medications.

H213100 03/09

- Immunizations required for foreign travel for a *covered person* of any age.
- Growth hormones (medication, drugs or hormones to stimulate growth) unless there is a laboratory confirmed diagnosis of growth hormone deficiency, or as otherwise determined by *us*.
- Treatment of nicotine habit or addiction, including, but not limited to, nicotine patches, hypnosis, smoking cessation classes or tapes.
- Prescription drugs and *self-administered injectable* drugs unless administered to *you*:
  - While an *inpatient* in a *hospital, skilled nursing facility, or health care treatment facility*; or
  - By the following, when deemed appropriate by *us*:
    - A *health care practitioner*:
      - During an office visit; or
      - While an *outpatient*; or
    - A *home health care agency* as part of a covered *home health care plan*.

H213600 03/09

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## LIMITATIONS AND EXCLUSIONS (continued)

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- Implantable hearing devices, except for cochlear implants as otherwise stated in this *certificate*.
- Weekend non-emergency *hospital admissions*, specifically *admissions* to a *hospital* on a Friday or Saturday at the convenience of the *covered person* or his or her *health care practitioner* when there is no cause for an emergency *admission* and the *covered person* receives no *surgery* or therapeutic treatment until the following Monday.
- *Hospital inpatient* services when you are in *observation status*.
- Reversal of elective sterilization.  
*H214000IL 07/07*
- Sex change services, regardless of any diagnosis of gender role or psychosexual orientation disorders.
- No benefits will be provided for:
  - Immunotherapy for recurrent abortion;
  - Chemonucleolysis;
  - Biliary lithotripsy;
  - Home uterine activity monitoring;
  - Sleep therapy;
  - Light treatments for Seasonal Affective Disorder (S.A.D.);
  - Immunotherapy for food allergy;
  - Prolotherapy;
  - Cranial banding, unless otherwise determined by *us*;
  - Hyperhydrosis *surgery*;
  - Lactation therapy; or
  - Sensory integration therapy.
- *Cosmetic surgery* and cosmetic services or devices, unless for reconstructive *surgery*:
  - Resulting from a *bodily injury*, infection or other disease of the involved part, when a *functional impairment* is present; or
  - Resulting from congenital disease or anomaly of a covered *dependent* child.

Expenses incurred for reconstructive *surgery* performed due to the presence of a psychological condition are not covered, unless the condition(s) described above are also met.
- Removal of breast implants, regardless of medical necessity, if breast implants were implanted solely for cosmetic reasons.
- Hair prosthesis, hair transplants or implants, and wigs, except as otherwise stated in this *certificate*.  
*H214300IL 03/09*

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## LIMITATIONS AND EXCLUSIONS (continued)

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- Dental services, appliances or supplies for treatment of the teeth, gums, jaws or alveolar processes, including but not limited to, any *oral surgery* or *periodontic surgery* and preoperative and postoperative care, implants and related procedures, orthodontic procedures, and any dental services related to a *bodily injury* or *sickness* unless otherwise stated in this *certificate*.
- The following types of care of the feet:
  - Shock wave therapy of the feet;
  - The treatment of weak, strained, flat, unstable or unbalanced feet;
  - Hygienic care, and the treatment of superficial lesions of the feet, such as corns, calluses, or hyperkeratoses;
  - The treatment of tarsalgia, metatarsalgia, or bunion, except surgically;
  - The cutting of toenails, except the removal of the nail matrix;
  - The provision of heel wedges, lifts, or shoe inserts; and
  - The provision of arch supports or orthopedic shoes, unless *medically necessary* because of diabetes or hammer toe.
- *Custodial care* and *maintenance care*.
- Any loss contributed to, caused by:
  - War or any act of war, whether declared or not;
  - Insurrection; or
  - Any act of armed conflict or any conflict involving armed forces of any authority.
- *Sickness* or *bodily injury* caused by the *covered person's*:
  - Engaging in an illegal occupation; or
  - Commission of or an attempt to commit a felony.

H214800IL 07/07

- Expenses for any membership fees or program fees paid by *you*, including but not limited to, health clubs, health spas, aerobic and strength conditioning, work-hardening programs, and weight loss or surgical programs, and any materials or products related to these programs.
- Surgical procedures for the removal of excess skin and/or fat in conjunction with or resulting from weight loss or a weight loss surgery.
- Expenses for services that are primarily and customarily used for environmental control or enhancement (whether or not prescribed by a *health care practitioner*) and certain medical devices including, but not limited to:

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## LIMITATIONS AND EXCLUSIONS (continued)

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- Common household items including air conditioners, air purifiers, water purifiers, vacuum cleaners, waterbeds, hypoallergenic mattresses or pillows or exercise equipment;
  - Motorized transportation equipment (e.g. scooters), escalators, elevators, ramps or modifications or additions to living/working quarters or transportation vehicles;
  - Personal hygiene equipment including bath/shower chairs, transfer equipment or supplies or bed side commodes;
  - Personal comfort items including cervical pillows, gravity lumbar reduction chairs, swimming pools, whirlpools, spas or saunas;
  - Medical equipment including blood pressure monitoring devices, breast pumps, PUVA lights and stethoscopes;
  - Communication systems, telephone, television or computer systems and related equipment or similar items or equipment;
  - Communication devices, except after surgical removal of the larynx or a diagnosis of permanent lack of function of the larynx.
- 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 tests and/or treatment unless such therapy or testing is approved by:
    - The American Academy of Allergy and Immunology; or
    - The Department of Health and Human Services or any of its offices or agencies.
  - Lodging accommodations or transportation.  
*H215200 07/07*
  - Communications or travel time.
  - Any treatment, including but not limited to surgical procedures, for obesity, unless qualified as *morbid obesity* and *medically necessary*.
  - *Sickness* or *bodily injury* for which medical payment or expense coverage benefits are paid or payable under any homeowners, premises or any other similar coverage.
  - Elective medical or surgical abortion unless:
    - The pregnancy would endanger the life of the mother; or
    - The pregnancy is a result of rape or incest; or
    - The fetus has been diagnosed with a lethal or otherwise significant abnormality.
  - *Alternative medicine*.  
*H215700IL 07/07*

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## LIMITATIONS AND EXCLUSIONS (continued)

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- Acupuncture, unless:
  - The treatment is *medically necessary* and appropriate and is provided within the scope of the acupuncturist's license; and
  - *You* are directed to the acupuncturist for treatment by a licensed physician.
- Services rendered in a premenstrual syndrome clinic or holistic medicine clinic.
- Chiropractic services or spinal manipulations, unless *medically necessary*.
- Services of a midwife, unless provided by a Certified Nurse Midwife.
- Vision testing for the purposes of prescribing corrective lenses; radial keratotomy, refractive keratoplasty or any other *surgery* or procedure to correct myopia, hyperopia or stigmatic error; or, the purchase or fitting of eyeglasses or contact lenses (except as the result of an *accident* or following cataract *surgery* as stated in this *certificate*).

*H216100IL 07/07*

- Services and supplies which are:
  - Rendered in connection with mental illnesses not classified in the International Classification of Diseases of the U.S. Department of Health and Human Services; or
  - Extended beyond the period necessary for evaluation and diagnosis of learning and behavioral disabilities or for mental retardation.
- Marriage counseling.
- *Court-ordered behavioral health services*.
- Expenses for employment, school, sport or camp physical examinations or for the purposes of obtaining insurance.
- Expenses for care and treatment of non-covered procedures or services.

*H216500IL 07/07*

- Expenses for treatment of complications of non-covered procedures or services.
- Expenses incurred for services prior to the *effective date* or after the termination date of *your* coverage under the *master group contract*. Coverage will be extended as described in the "Extension of Benefits" section, if such coverage is required by state law.
- Any care, treatment, services, equipment or supplies received outside of the *service area*:

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## LIMITATIONS AND EXCLUSIONS (continued)

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- If *you* could have reasonably foreseen or anticipated their need prior to departure from the *service area*; and
  - Which are not authorized by *us* or to the extent they exceed the *usual and customary fee*
- *Pre-surgical/procedural testing duplicated during a hospital confinement.*  
*H216925IL 03/09*

These limitations and exclusions apply even if a *health care practitioner* has performed or prescribed a medically appropriate procedure, treatment or supply. This does not prevent *your health care practitioner* from providing or performing the procedure, treatment or supply; however, the procedure, treatment or supply will not be a *covered expense*.  
*H216950*

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## ELIGIBILITY AND EFFECTIVE DATES

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### Eligibility date

#### Employee eligibility date

The *employee* who lives or works in the *service area* is eligible for coverage on the date:

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

#### Dependent eligibility date

Each *dependent* is eligible for coverage on:

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

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

A *dependent* child who enrolls for other group coverage through any employment is no longer eligible for *group* coverage under the *master group contract*. If a *dependent* child becomes an *employee* of the *employer*, he or she is no longer eligible as a *dependent* and must make application as an eligible *employee*.

**Note:** A *dependent* child who resides outside of the *service area* is eligible for coverage as a *dependent*. Out-of-area coverage, however, is limited to *emergency care* and *urgent care* services unless additional coverage is provided by addenda. To be covered, all other care, including follow-up care for *emergency care* and *urgent care* services, must be obtained in the *service area* under the direction of a *network health care practitioner*.

### Enrollment

#### Open enrollment period

The *open enrollment period* is the annual period during which eligible *employees* may apply for coverage for themselves and for their eligible *dependents*.

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## ELIGIBILITY AND EFFECTIVE DATES (continued)

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### How to enroll

To enroll, the *employee* must complete the enrollment/change form provided by *us*, carefully listing each person to be covered. The *employee* must submit the completed enrollment/change form to their *employer* within the time periods indicated below:

- To enroll during an *open enrollment period*, the *employee* must submit an enrollment/change form during the *open enrollment period*.
- To enroll outside of an *open enrollment period*, the *employee* must submit an enrollment/change form within thirty-one (31) days of their *eligibility date* or *special enrollment date*.
- To enroll a newly eligible *dependent* that becomes eligible to enroll outside of an *open enrollment period*, the *employee* must submit an enrollment/change form within thirty-one (31) days from the *dependent's* first date of eligibility or *special enrollment date*.
- If the *employee* or their eligible *dependents* do not enroll within 31 days of the *eligibility date* or *special enrollment date*, they are a *late applicant* and must wait until the *group's* next *open enrollment period* to enroll.

### Employee enrollment

The *employee* must enroll as agreed by the *group plan sponsor* and *us*.

If the *employee* enrolls more than 31 days after the *employee's eligibility date* or more than 31 days after the *employee's special enrollment date*, the *employee* is a *late applicant* and must wait until the *group's* next *open enrollment period* to enroll.

### Dependent enrollment

Check with the *employer* immediately on how to enroll for *dependent* coverage. The *employee* must enroll for *dependent* coverage and enroll additional *dependents* as agreed by the *group plan sponsor* and *us*.

A *dependent* enrolled more than 31 days after the *dependent's eligibility date* or the *special enrollment date* will be a *late applicant* and must wait until the *group's* next *open enrollment period* to enroll.

### Newborn dependent enrollment

A *dependent* child born to *you* will become covered from the moment of birth. However, in order to continue that coverage beyond 31 days, *you* must notify *us* as follows:

- An *employee* who already has *dependent* child coverage in force prior to the newborn's date of birth is not required to complete an enrollment form for the newborn child. However, the *employee* must notify *us* of the birth within 31 days after the date of birth.
- An *employee* who does not have *dependent* child coverage must enroll the newborn *dependent*, as agreed by the *group plan sponsor* and *us*, within 31 days after the date of birth. A newborn *dependent* enrolled more than 31 days after the date of birth will be a *late applicant* and must wait until the *group's* next *open enrollment period* to enroll.

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## ELIGIBILITY AND EFFECTIVE DATES (continued)

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### Special enrollment

#### Loss of other coverage

If you are an *employee* or *dependent* who was previously eligible for coverage under the *master group contract* and had waived coverage, you may be eligible for the "Special Enrollment" provision.

You will not be considered a *late applicant*, if the following applies:

- You declined enrollment under the *master group contract* at the time of initial enrollment because:
  - You were covered under a group health plan or other *health insurance coverage* at the time of eligibility and your coverage terminated as a result of:
    - Termination of employment or eligibility;
    - Reduction in number of hours of employment;
    - Divorce, legal separation or death of a spouse; or
    - Termination of your employer's contribution for the coverage; or
  - You had COBRA continuation coverage under another plan at the time of eligibility and such coverage has since been exhausted; and
  - You stated, at the time of the initial enrollment, that coverage under another group health plan, other *health insurance coverage* or COBRA continuation was your reason for declining enrollment; and
  - You were covered under an alternate plan provided by the *employer* and you are replacing coverage with the *master group contract*;
- You apply for coverage within 31 days after termination of coverage under another group health plan or other *health insurance coverage* or COBRA.

#### Dependent special enrollment period

The *dependent* Special Enrollment Period is a 31-day period from the *special enrollment date*.

If *dependent* coverage is available under the *employer's master group contract* or added to the *master group contract*, an *employee* who is a *covered person* can enroll eligible *dependents* during the Special Enrollment Period. An *employee*, who is otherwise eligible for coverage and had waived coverage under the *master group contract* when eligible, can enroll himself/herself and eligible *dependents* during the Special Enrollment Period. The *employee* or *dependent* enrolling within 31 days from the *special enrollment date* will not be considered a *late applicant*.

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## ELIGIBILITY AND EFFECTIVE DATES (continued)

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### Effective date

#### Employee effective date

The *employee's effective date* provision is stated in the Employer Group Application. It may be the date immediately following, or the first of the month following, completion of the *waiting period* or the *special enrollment date*.

For *employees* who enroll during an *open enrollment period*, coverage will become effective on the date specified by the *employer*.

If the *employee* enrolls more than 31 days after his or her *eligibility date* or *special enrollment date*, he or she is a *late applicant*.

#### Dependent effective date

The *dependent's effective date* will be determined as follows:

- If we receive enrollment on, prior to, or within 31 days of the *dependent's eligibility date* that *dependent* is covered on the date he or she is eligible.
- If we receive enrollment on, prior to, or within 31 days of the *dependent's special enrollment date*, that *dependent's* coverage is effective on the *special enrollment date*.
- If we receive enrollment more than 31 days after the *dependent's eligibility date*, or the *special enrollment date*, that *dependent* is considered a *late applicant*.

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

#### Newborn dependent effective date

- If we receive enrollment on, prior to, or within 31 days of the newborn's date of birth, *dependent* coverage is effective on the newborn's date of birth.
- If we receive enrollment more than 31 days after the newborn's date of birth, the newborn is considered a *late applicant*.
- If the *employee* already has *dependent* child coverage, and enrollment is not required, *dependent* coverage is effective on the newborn's date of birth provided the *employee* notify us of the birth within 31 days.

**Note:** Premium is due for any period of newborn *dependent* coverage whether or not the newborn *dependent* is subsequently enrolled, unless specifically not allowed by applicable law.

### Benefit changes

Benefit changes will become effective on the date specified by us.

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## ELIGIBILITY AND EFFECTIVE DATES (continued)

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### Retired employee coverage

#### Retired employee eligibility date

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

#### Retired employee enrollment

The *employer* must submit notification of the *employee's* retirement to us within 31 days of the date of retirement. If *we* receive the notification more than 31 days after the date of retirement, the retiree will be considered a *late applicant*.

#### Retired employee effective date

The *effective date* of coverage for an eligible retired *employee* is the date of retirement for an *employee* who retires after the date *we* approve the *employer's* request for a retiree classification, provided *we* receive notice of the retirement within 31 days.

#### Retired employee benefit changes

Additional or increased coverage or a decrease in coverage will become effective on the approved date of change.

H218600IL 10/06

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## REPLACEMENT OF COVERAGE

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### Applicability -

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

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

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

*H221000*

### Waiting period credit

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

*H221200*

### Out-of-pocket limit

Any amount applied to the Prior Plan's *out-of-pocket limit* or stop-loss limit will not be credited toward the satisfaction of any *out-of-pocket limit* or *copayment limit*, if any, of the *master group contract*.

*H221300*

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## TERMINATION PROVISIONS

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### Termination of coverage

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

When *we* receive notification of a change in eligibility status in advance of the effective date of the change, coverage will terminate on the actual date specified by the *employer* and/or *employee* or at the end of that month, as selected by *your employer* on the Employer Group Application.

H222000

Otherwise, coverage terminates on the earliest of the following:

- The date the *master group contract* terminates;
- The end of the period for which required premiums were due to *us* and not received by *us*;
- For the *employee*, the date that he or she has terminated employment with the *employer*;
- For the *employee*, the date that he or she is no longer qualified as an *employee*;
- For the *employee*, the date that he or she no longer lives or works in the *service area*;
- The date *you* fail to be in an eligible class of persons as stated in the Employer Group Application;
- The date *you* entered full-time military, naval or air service;
- The date the *employee* retired, except if the Employer Group Application provides coverage for a retiree class of *employees* and the retiree is in an eligible class of retirees, selected by the *employer*;
- For a *dependent*, the date the *employee's* coverage terminates;
- For a *dependent*, the date the *employee* ceases to be in a class of *employees* eligible for *dependent* coverage;
- For a *dependent*, the date he or she no longer qualifies as a *dependent*;
- For any benefit, the date the benefit is deleted from the *master group contract*; or
- The date *we* determine that fraud or an intentional misrepresentation of a material fact has been committed by *you*.

H222100IL

*You and the employer are responsible to notify us of any change in eligibility, including the lack of eligibility, of any covered person.*

H222200

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## TERMINATION PROVISIONS (continued)

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### Termination for cause

We will terminate *your* coverage for cause under the following circumstances:

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

*H222300IL 05/05*

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## EXTENSION OF BENEFITS

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### Extension of coverage for total disability

We extend limited coverage if:

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

H223000

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

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

No insurance is extended to a child born as a result of a *covered person's* pregnancy.

The "Extension of Coverage for Total Disability" provision does not apply to covered retired persons.

H223100IL

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## CONTINUATION

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### Continuation options in the event of termination

If coverage terminates:

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

A complete description of the "State Continuation of Coverage", "Continuation of Coverage for Dependents", and "Continuation for Dependent Children" provisions follow.

*H224000IL 03/09*

### State continuation of coverage

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

If *your* medical coverage under the *master group contract* terminates due to loss of employment, or reduction in normal working hours, *you* may continue medical coverage for *you* and *your* covered *dependents* if:

- *You* were covered under the *master group contract* for at least three consecutive months immediately prior to termination; and
- *You* are not eligible for *Medicare* or other group coverage.

However, *you* and *your dependents* are NOT eligible for continuation of medical coverage if *you* were discharged from *your* employment due to commission of a felony or a theft in connection with *your* work and for which the *employer* was in no way responsible, provided that *you* have admitted to commission of the felony or theft or have been convicted or received an order of supervision by a court of competent jurisdiction for such act.

### Enrollment

The *group plan sponsor* will notify *you* in writing of *your* right to continue coverage. If *you* elect to continue coverage *you* must notify the *group plan sponsor* in writing within 30 days following:

- The date *your* coverage would otherwise terminate; or
- The date *you* received written notification of *your* right to continue coverage.

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## CONTINUATION (continued)

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Under no circumstances will *you* be eligible to elect continuation of coverage more than 60 days after the date *your* coverage would have otherwise terminated.

If *you* elect to continue coverage *you* must pay the total monthly premium in advance to the *group plan sponsor*. The premium for continuing *your* coverage will be the rate that would have been applicable to the *group plan sponsor* for *your* group coverage during the continuation period.

If *you* do not choose to continue *your* group medical coverage, or if *you* do and it terminates, *you* have the right to exercise the Medical Conversion Privilege described in this *certificate*. However, if *you* do not elect to continue coverage and instead utilize the Medical Conversion Privilege, *you* thereby waive the right to continue coverage. The Medical Conversion Privilege is available to *your* covered dependents while *you* are insured under this continuation privilege.

### Termination

Medical coverage may be continued until the earliest of the following:

- 12 months after the date *your* coverage would otherwise have terminated;
- The end of any month for which *you* fail to make timely payment of premiums, or timely payment of premiums is not made on *your* behalf by the *group plan sponsor*. The *group plan sponsor* is responsible for sending *us* the premium payments for those individuals who choose to continue their coverage. If the *group plan sponsor* fails to make proper payment of the premiums to *us*, *we* are relieved of all liability for any coverage that was continued and the liability will rest with the *group plan sponsor*;
- The date the *group* coverage terminates in its entirety. If group coverage is replaced, coverage will continue under the new master group contract;
- The date on which the *covered person* is, or could be, covered under *Medicare*;
- The date on which the *covered person* is eligible or is covered for similar benefits under another group plan;
- For *your dependent*, the date he or she no longer meets the definition of *dependent*.

If the *employee* returns to *active status* while insured under this continuation privilege, he or she must reenroll for *employee* coverage.

H224100IL 03/09

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## CONTINUATION (continued)

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### **Continuation of coverage for dependents due to divorce, death or retirement of the employee**

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

- The death of the covered *employee*;
- The retirement of the covered *employee*; or
- The severance of the family relationship through legal annulment, dissolution of marriage or divorce.

*You* may continue medical coverage for *you* and *your* covered *dependents* if *you*:

- Give the *group plan sponsor* written notice within 30 days after the date *your* coverage would have otherwise terminated;
- Elect to continue group medical coverage within 30 days after receipt of written notice of *your* right to continue coverage; and
- Pay the total monthly premium in advance to the *group plan sponsor*. The premium for continuing *your* coverage will be the rate that would have been applicable to the *group plan sponsor* for *your* group coverage during the continuation period.

### **Termination**

If the former spouse has not attained the age of 55 at the time the continued coverage begins, coverage may be continued until the earliest of the following:

- Two years after the date the continued coverage began;
- The date the former spouse remarries;
- The end of any month for which *you* fail to make timely payment of premiums, or timely payment of premiums is not made on *your* behalf by the *group plan sponsor*;
- The date coverage would have terminated under the terms of the existing *master group contract*, if the *employee* and former spouse were still married to each other; except that the continued coverage shall not be modified or terminated during the first 120 days following the divorce or death of the *employee* unless the *master group contract* is modified or terminated as to all *employees*;
- The date the *group* coverage terminates in its entirety. If group coverage is replaced, coverage will continue under the new master group contract;

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## CONTINUATION (continued)

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- The date the former spouse first becomes an insured employee under any other group health plan after the date of election of continued coverage; or
- For a dependent child, the date no longer qualified as a dependent.

If the former spouse or retiree's spouse has attained the age of 55 at the time the continued coverage begins, coverage may be continued until the earliest of the following:

- The date the former spouse or retiree's spouse remarries;
- The end of any month for which *you* fail to make timely payment of premiums, or timely payment of premiums is not made on *your* behalf by the *group plan sponsor*;
- The date coverage would have terminated, except due to the retirement of an *employee*, under the terms of the existing *master group contract*, if the *employee* and former spouse were still married to each other; except that the continued coverage shall not be modified or terminated during the first 120 days following the divorce, death or retirement of the *employee* unless the *master group contract* is modified or terminated as to all *employees*.
- The date the *group* coverage terminates in its entirety. If group coverage is replaced, coverage will continue under the new master group contract;
- The date the former spouse or retiree's spouse first becomes an insured employee under any other group health plan after the date of election of continued coverage;
- For a dependent child, the date no longer qualified as a *dependent*; or
- The date the former spouse or retiree's spouse reaches the qualifying age or otherwise becomes eligible for *Medicare*.

H224200IL 03/09

### Continuation for dependent children

If *your* (the covered *dependent child*'s) medical coverage under this *master group contract* terminates, either due to death of the *employee* or due to attaining the limiting age as stated in this *certificate*, *you* may continue medical coverage if *you* (or the responsible adult acting on *your* behalf):

- Give the *group plan sponsor* written notice within 30 days after the date *your* coverage would otherwise terminate;

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## CONTINUATION (continued)

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- Elect to continue group medical coverage within 30 days after receipt of written notice of *your* right to continue coverage; and
- Pay the total monthly premium in advance to the *group plan sponsor*. The premium for continuing *your* coverage will be the rate that would have been applicable to the *group plan sponsor* for *your* group coverage during the continuation period.

### **Termination**

Coverage may be continued until the earliest of the following:

- Two years after the date the continued coverage began;
- The end of any month for which *you* fail to make timely payment of premiums, or timely payment of premiums is not made on *your* behalf by the *group plan sponsor*;
- The date coverage would have terminated under the terms of the existing *master group contract* if *you* were still an eligible *dependent* of the *employee*; or
- The date *you* first become an insured employee under any other group health plan after the date of election of continued coverage.

*H224210IL 03/09*

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# MEDICAL CONVERSION PRIVILEGE

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## Eligibility

Subject to the terms below, if *your* medical coverage under the *master group contract* terminates, a Medical Conversion Plan is available without medical examination. *You* must have been continuously covered under the *master group contractor* or any group health plan it replaced for at least 3 months and:

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

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

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

This privilege does not apply when the *employer's* participation in the *master group contract* terminates and medical coverage is replaced within 31 days by another group coverage plan.

A state pool plan may be available in lieu of a medical conversion policy. Please contact *us* for details.

## Notice

Election of conversion coverage would eliminate *your* federal eligibility for coverage under Illinois Comprehensive Health Insurance Plan (CHIP).

## Overinsurance - duplication of coverage

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

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## MEDICAL CONVERSION PRIVILEGE (continued)

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### Medical conversion plan

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

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

### Effective date and premium

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

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

*H225300IL 06/06*

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# COORDINATION OF BENEFITS

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## Applicability

This coordination of benefits (COB) provision applies to *this plan* when a *covered person* has health care coverage under more than one *plan*. *Plan* and *this plan* are defined herein.

If this COB provision applies, the order of benefits determination rules should be looked at first. Those rules determine whether the benefits of *this plan* are determined before or after those of another *plan*. The benefits of *this plan*:

- Shall not be reduced when, under the order of benefits determination rules, *this plan* determines its benefits before another *plan*; but
- May be reduced when, under the order of benefits determination rules, another *plan* determines its benefits first. This reduction is described in the "Effect on the benefits of this plan" provision.

## Definitions

The following definitions are used exclusively in this provision.

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

*Plan* includes:

- Group insurance, closed panel or other forms of group or group-type coverage (whether insured or uninsured);
- Hospital indemnity benefits in excess of \$200 per day;
- Medical care components of group long-term care contracts, such as skilled nursing care;
- Medical benefits under group or individual automobile contracts, including "No Fault" and Medical Payments coverages; and
- *Medicare* or other governmental benefits, as permitted by law.

*Plan* does not include:

- Individual or family insurance;
- Closed panel or other individual coverage (except for group-type coverage);
- Hospital indemnity benefits of \$200 or less per day;
- School accident type coverage;
- Benefits for non-medical care components of group long-term care contracts;
- Medicare supplement policies;
- A state plan under Medicaid; and
- Coverage under other governmental plans, unless permitted by law.

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

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## COORDINATION OF BENEFITS (continued)

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

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

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

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

- If a *covered person* is confined in a private *hospital* room, the difference between the cost of a semi-private room in the *hospital* and the private room, (unless the patient's stay in a private *hospital* room is medically necessary in terms of generally accepted medical practice, or one of the *plans* routinely provides coverage for *hospital* private rooms) is not an *allowable expense*.
- If a person is covered by two or more *plans* that compute their benefits payments on the basis of usual and customary fees, any amount in excess of the highest usual and customary fees for a specific benefit is not an *allowable expense*.
- If a person is covered by two or more *plans* that provide benefits or services on the basis of negotiated fees, any amount in excess of the highest of the fees is not an *allowable expense*.
- If a person covered by one *plan* that calculates its benefits or services on the basis of usual and customary fees and another *plan* that provides its benefits or services on the basis of negotiated fees, the *primary plan's* payment arrangement shall be the *allowable expense* for all *plans*.
- The amount a benefit is reduced by the *primary plan* because a *covered person* does not comply with the *plan* provisions. Examples of these provisions are second surgical opinions and preferred provider arrangements.

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

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

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

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## COORDINATION OF BENEFITS (continued)

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### Order of determination rules

#### General

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

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

#### Rules

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

- **Non-dependent or dependent.** The *plan* that covers the person other than as a *dependent*, for example as an *employee*, member, subscriber or retiree is *primary* and the *plan* that covers the person as a *dependent* is *secondary*. However, if the person is a *Medicare* beneficiary and, as a result of federal law, *Medicare* is *secondary* to the *plan* covering the person as a *dependent*; and *primary* to the *plan* covering the person as other than a *dependent* (e.g. retired *employee*); then the order of benefits between the two *plans* is reversed so that the *plan* covering the person as an *employee*, member, subscriber or retiree is *secondary* and the other *plan* is *primary*.
- **Child covered under more than one plan.** The order of benefits when a child is covered by more than one *plan* is:
  - The *primary plan* is the *plan* of the parent whose birthday is the earlier in the year if:
    - The parents are married;
    - The parents are not separated (whether or not they have been married); or
    - A court decree awards joint custody without specifying that one part has the responsibility to provide health care coverage.
  - If both the parents have the same birthday, the *plan* that covered either of the parents longer is *primary*.
    - If the specific terms of a court decree state that one parent is responsible for the child's health care expenses or health care coverage and the *plan* of that parent has actual knowledge of those terms, that *plan* is *primary*. This rule applies to *claim determination periods* or plan years commencing after the *plan* is given notice of the court decree.

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## COORDINATION OF BENEFITS (continued)

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- If the parents are not married, or are separated (whether or not they ever have been married) or are divorced, the order of benefits is:
  - The plan of the custodial parent;
  - The plan of the spouse of the custodial parent;
  - The plan of the non-custodial parent; and then
  - The plan of the spouse of the non-custodial parent.
- **Active or inactive employee.** The *plan* that covers a person as an *employee* who is neither laid off nor retired, is *primary*. The same would hold true if a person is a *dependent* of a person covered as a retiree and an *employee*. If the other *plan* does not have this rule, and if, as a result, the *plans* do not agree on the order of benefits, this rule is ignored.
- **Continuation coverage.** If a person whose coverage is provided under a right of continuation provided by federal or state law also is covered under another *plan*, the *plan* covering the person as an *employee*, member, subscriber or retiree (or as that person's *dependent*) is *primary*, and the continuation coverage is *secondary*. If the other *plan* does not have this rule, and if, as a result, the *plans* do not agree on the order of benefits, this rule is ignored.
- **Longer or shorter length of coverage.** The *plan* that covered the person as an *employee*, member, subscriber or retiree longer is *primary*.

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

### Effects on the benefits of this plan

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

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

### Right to receive and release needed information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this *plan* and other *plans*. We may get the facts we need from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under this *plan* and other *plans* covering the person claiming benefits. We need not tell, or get the consent of, any person to do this. Each person claiming benefits under this *plan* must give us any facts we need to apply those rules and determine benefits payable.

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## COORDINATION OF BENEFITS (continued)

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### **Facility of payment**

A payment made under another *plan* may include an amount that should have been paid under this *plan*. If it does, *we* may pay that amount to the organization that made the payment. That amount will then be treated as though it were a benefit paid under this *plan*. *We* will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means a reasonable cash value of the benefits provided in the form of services.

### **Right of recovery**

If the amount of the payments made by *us* is more than *we* should have paid under this COB provision, *we* may recover the excess from one or more of the persons *we* have paid or for whom *we* have paid; or any other person or organization that may be responsible for the benefits or services provided for the *covered person*. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

*H226700IL 06/06*

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# COORDINATION OF BENEFITS FOR MEDICARE ELIGIBLES

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## Definitions

*Medicare Part B* means the Social Security program which provides medical insurance benefits.  
H227000

## Coordination of benefits with Medicare

If *you* are covered under both *Medicare* and this *certificate*, federal law mandates that *Medicare* is the secondary plan in most situations. But when permitted by law, this plan is the secondary plan. In all cases, coordination of benefits with *Medicare* will conform to federal statutes and regulations. If *you* are enrolled in *Medicare*, *your* benefits under this *certificate* will be coordinated to the extent benefits are payable under *Medicare*, as allowed by federal statutes and regulations.

If *you* are eligible for *Medicare Part B*, but are not enrolled, *your* benefits under the *master group contract* will be coordinated as if *you* were enrolled in *Medicare Part B*. We will not pay benefits to the extent that benefits would have been payable under *Medicare Part B*, if *you* had enrolled. Therefore, it is important that *you* enroll in *Medicare Part B* if *you* are eligible to do so.

*You* are considered to be eligible for *Medicare* on the earliest date coverage under *Medicare* could have become effective for *you*.  
H227100IL

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## CLAIMS

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### Notice of claim

*Network providers* will submit claims to *us* on *your* behalf. If *you* utilize a *non-network provider* for *covered expenses*, *you* must submit a notice of claim to *us*. Notice of claim must be given to *us* in writing or by electronic mail as required by *your* plan, or as soon as is reasonably possible thereafter. Notice must be sent to *us* at *our* mailing address shown on *your* identification documentation or at *our* Website at [www.humana.com](http://www.humana.com).

H228000 05/05

Claims must be complete. At a minimum a claim must contain:

- Name of the *covered person* who incurred the *covered expenses*;
- Name and address of the provider;
- Diagnosis;
- Procedure or nature of the treatment;
- Place of service;
- Date of service; and
- Billed amount.

The forms necessary for filing proof of loss are available via the internet at *our* Website. *When* requested by *you*, *we* will send *you* the forms for filing proof of loss. If the requested forms are not sent to *you* within 15 days, *you* will have met the proof of loss requirements by sending *us* a written or *electronic* statement of the nature and extent of the loss containing the above elements within the time limit stated in the "Proof of Loss" provision.

H228100

### Proof of loss

*You* must give written or electronic proof of loss within 90 days after the date of loss. *Your* claims will not be reduced or denied if it was not reasonably possible to give such proof. In any event, written or electronic notice must be given within one year after the date proof of loss is otherwise required, except if *you* were legally incapacitated.

H228200

### Right to require medical examinations

*We* have the right to require a medical examination on any *covered person* as often as *we* may reasonably require. If *we* require a medical examination, it will be performed at *our* expense. *We* also have a right to request an autopsy in the case of death, if state law so allows.

H228300

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## CLAIMS (continued)

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### To whom benefits are payable

If *you* receive services from a *network provider*, we will pay the provider directly for all *covered expenses*. *You* will not have to submit a claim for payment.

All benefit payments for services rendered by a *non-network provider* are due and owing solely to the *covered person*. However, *you* may request that *we* direct a payment of selected medical benefits to the health care provider on whose charge the claim is based. If such a request is made, *we* will pay the health care provider directly. Such payments will not constitute the assignment of any legal obligation to the *non-network provider*. If such a request for direct payment to the health care provider is not made, *we* will pay *you* directly, and *you* are then responsible for all payments to the *non-network provider(s)*.

If any *covered person* to whom benefits are payable is a minor or, in *our* opinion, not able to give a valid receipt for any payment due him or her, such payment will be made to his or her parent or legal guardian. However, if no request for payment has been made by the parent or legal guardian, *we* may, at *our* option, make payment to the person or institution appearing to have assumed his or her custody and support.  
H228400IL 05/05

### Time of payment of claims

Payments due under the *master group contract* will be paid no more than 30 days after receipt of written or electronic proof of loss.  
H228500

### Right to request overpayments

*We* reserve the right to recover any payments made by *us* that were:

- Made in error; or
- Made to *you* and/or any party on *your* behalf, where *we* determine such payment made is greater than the amount payable under the *master group contract*; or
- Made to *you* and/or any party on *your* behalf, based on fraudulent or misrepresented information; or
- Made to *you* and/or any party on *your* behalf for charges that were discounted, waived or rebated.

*We* reserve the right to adjust any amount applied in error to the *deductible* or *copayment limit*, if any.  
H228700IL 05/05

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## CLAIMS (continued)

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### Right to collect needed information

*You* must cooperate with *us* and when asked, assist *us* by:

- Authorizing the release of medical information including the names of all providers from whom *you* received medical attention;
- Obtaining medical information and/or records from any provider as requested by *us*;
- Providing information regarding the circumstances of *your sickness, bodily injury or accident*;
- Providing information about other insurance coverage and benefits, including information related to any *bodily injury or sickness* for which another party may be liable to pay compensation or benefits; and
- Providing information *we* request to administer the *master group contract*.

If *you* fail to cooperate or provide the necessary information, *we* may recover payments made by *us* and deny any pending or subsequent claims for which the information is requested.

H228800

### Exhaustion of time limits

If *we* fail to complete a claim determination or appeal within the time limits set forth in the *master group contract*, the claim shall be deemed to have been denied and *you* may proceed to the next level in the review process outlined under the "Complaints and Appeals Procedures" section of this *certificate* or as required by law.

H228900

### Recovery rights

*You* as well as *your dependents* agree to the following, as a condition of receiving benefits under the *master group contract*.

H229000

### Duty to cooperate in good faith

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

*You* will do whatever is necessary to enable *us* to enforce *our* recovery rights and will do nothing after loss to prejudice *our* recovery rights.

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## CLAIMS (continued)

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

In the event that *you* fail to cooperate with *us*, *we* shall be entitled to recover from *you* any payments made by *us*.

H229100

### **Duplication of benefits/other insurance**

*We* will not provide duplicate coverage for benefits under the *master group contract* when a person is covered by *us* and has, or is entitled to, benefits as a result of their injuries from any other coverage including, but not limited to, first party uninsured or underinsured motorist coverage, any no-fault insurance, medical payment coverage (auto, homeowners or otherwise), workers compensation settlement or awards, other group coverage (including student plans), direct recoveries from liable parties, premises medical pay or any other insurer providing coverage that would apply to pay *your* medical expenses, except another "plan," as defined in the "Coordination of Benefits" section (e.g., group health coverage), in which case coverage will be determined as described in the "Coordination of Benefits" section.

Where there is such coverage, *we* will not duplicate other coverage available to *you* and shall be considered secondary, except where specifically prohibited. Where double coverage exists, *we* shall have the right to be repaid from whomever has received the overpayment from *us* to the extent of the duplicate coverage.

*We* will not duplicate coverage under the *master group contract* whether or not *you* have made a claim under the other applicable coverage.

When applicable, *you* are required to provide *us* with authorization to obtain information about the other coverage available, and to cooperate in the recovery of overpayments from the other coverage, including executing any assignment of rights necessary to obtain payment directly from the other coverage available.

H229200

### **Workers' Compensation**

If benefits are paid by *us* and *we* determine that the benefits were for treatment of *bodily injury* or *sickness* that arose from or was sustained in the course of, any occupation or employment for compensation, profit or gain, *we* have the right to recover as described below. *We* will exercise *our* right to recover against *you*.

The recovery rights will be applied even though:

- The Workers' Compensation benefits are in dispute or are made by means of settlement or compromise;
- No final determination is made that *bodily injury* or *sickness* was sustained in the course of or resulted from *your* employment;

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## CLAIMS (continued)

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- The amount of Workers' Compensation due to medical or health care is not agreed upon or defined by *you* or the Workers' Compensation carrier; or
- Medical or health care benefits are specifically excluded from the Workers' Compensation settlement or compromise.

*You* hereby agree, in consideration for the coverage provided by the *master group contract*, *you* will notify *us* of any Workers' Compensation claim *you* make, and *you* agree to reimburse *us* as described above.  
H229300

### Right of subrogation

*We* are assigned the right to recover from the negligent third party, or his or her insurer, to the extent of the benefits *we* paid for that *sickness* or *bodily injury*. *You* are required to furnish any information or assistance, or provide any documents that *we* may reasonably require in order to exercise *our* rights under this provision. This provision applies whether or not the third party admits liability.  
H229400IL 04/08

### Right of reimbursement

If a *covered person* recovers expenses for a *sickness* or *bodily injury* that occurred due to the negligence of a third party, *we* have the right to first reimbursement for all benefits *we* paid from any and all damages collected from the negligent third party for those same expenses whether by action at law, settlement, or compromise, by the *covered person* (or the *covered person's* parents if the *covered person* is a minor), or the *covered person's* legal representative as a result of that *sickness* or *bodily injury*. *You* are required to furnish any information or assistance, or provide any documents that *we* may reasonably require in order to exercise *our* rights under this provision. This provision applies whether or not the third party admits liability.  
H229500IL 04/08

### Assignment of recovery rights

The *master group contract* contains an exclusion for *sickness* or *bodily injury* for which there is medical payment/expenses coverage provided under any automobile, homeowner's, premises or other similar coverage.

If *your* claim against the other insurer is denied or partially paid, *we* will process *your* claim according to the terms and conditions of the *master group contract*. If payment is made by *us* on *your* behalf, *you* agree to assign to *us* the right *you* have against the other insurer for medical expenses *we* pay.

If benefits are paid under the *master group contract* and *you* recover under any automobile, homeowner's, premises or similar coverage, *we* have the right to recover from *you* an amount equal to the amount *we* paid.  
H229600

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## CLAIMS (continued)

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### Cost of legal representation

The costs of *our* legal representation in matters related to *our* recovery rights shall be borne solely by *us*. The costs of legal representation incurred by *you* shall be borne solely by *you*, unless *we* were given timely notice of the claim and an opportunity to protect *our* own interests and *we* failed or declined to do so.

*H229700*

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# COMPLAINT AND APPEAL PROCEDURES

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We make every effort to resolve customer dissatisfaction issues at an informal level. *Our* customer service representatives are available to assist *you* with any issue relating to *your* coverage. *Our* customer service representatives may be reached at 1 (800) 4 HUMANA. If the customer service representatives are unable to resolve *your* dissatisfaction, *you* can file an appeal with the group plan by documenting *your* concerns in writing.

## Definitions

The following definitions are used exclusively in this provision:

**Adverse determination** - means a determination by *us* or by an *external independent reviewer* that a health care service is not medically necessary.

**External independent reviewer** - means a clinical peer who has no direct financial interest in the case.

## Internal review

In the event *your* problem has not been resolved at the informal level, *you* or an authorized person, *health care practitioner* or *health care treatment facility* acting on *your* behalf, may initiate an appeal. The appeal may relate to any dissatisfaction with *us*, including but not limited to:

- A complaint regarding the availability, access, delivery or quality of health care services;
- An *adverse determination*;
- Claims payment, handling or reimbursement for health care services; or
- Matters pertaining to the contractual relationship between *you* and *us*.

An appeal must be submitted within 90 days of the occurrence, unless good cause for delay can be shown.

Once an appeal is filed, *we* will investigate *your* appeal. The person or persons appointed to review an appeal involving a clinical issue will include at least one clinical peer physician or other provider in the same or similar specialty that typically manages the medical condition, procedure or treatment.

*We* will acknowledge the appeal to *you* within three working days of the receipt of the written appeal, or of the documents and/or records necessary for the resolution of the appeal. *We*, upon receipt of the required documentation and/or records, will notify *you*, within fifteen working days, orally of its resolution, followed up by a written resolution letter. The resolution letter will clearly explain *our* decision and *your* right to request an external independent review.

## Filing complaints with the Illinois Division of Insurance

*You* have the right to file a complaint with the Illinois Division of Insurance, Consumer Services Unit, at:

320 West Washington Street  
Springfield, Illinois 62767

OR

100 West Randolph Street, Suite 15-100  
Chicago, Illinois 60601

*You* may also contact the Office of Consumer Health Insurance at 1-877-527-9431.

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## COMPLAINT AND APPEAL PROCEDURES (continued)

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### Expedited appeal review

An expedited review may be requested, orally or in writing, when review time frames could significantly increase risk to *your* health, or ability to regain maximum function, or when *your* prescribed ongoing course of treatment is at issue. *We* will notify *you* within twenty-four hours, of the receipt of the appeal, or of the documents and/or records necessary for the resolution of the appeal. Upon receipt of the required documentation and/or records, *we* will notify *you* within twenty-four hours, orally of its resolution followed up by written resolution letter. The resolution letter will clearly explain *our* decision and the right to request an external independent review.

### External review of an adverse determination

If *you* are not satisfied with the resolution of *our* internal appeals process concerning an appeal denial, *you* may make a written request for an external review to *us*. The request must be made within 30 working days after receipt of the written notice of an adverse resolution and shall include all necessary documents and/or records.

The review will be conducted by an *external independent reviewer* selected jointly by *you*, *your health care practitioner* and *us* within 30 working days of the receipt of the request for the external independent review. *We* will forward to the *external independent reviewer* all document and/or records including a statement of *our* decision.

The *external independent reviewer* will review the initial appeals determination and all supporting documents and/or records and render a decision within five working days of receipt. The decision made by the *external independent reviewer* is final. If the *external independent reviewer* determines the health care service to be medically appropriate, *we* will provide the coverage. Any coverage provided is subject to the terms, limitations, and conditions of the *master group contract*. In addition, if *you* are not satisfied with the final decision made by the *external independent reviewer*, *you* may appeal with the Illinois Division of Insurance.

*We* will pay any fees associated with the external independent review.

### Expedited external review

*You*, an authorized person, provider, or health care facility acting on *your* behalf, may request an expedited review when review time frames would significantly jeopardize risk to *your* health or ability to regain maximum function, or when *your* prescribed ongoing course of treatment is at issue. If the expedited external review criteria are met and after all necessary documents and/or records are received, *we* will notify *you* with resolution within twenty-four hours.

H230000IL

### Exhaustion of remedies

*You* must complete all levels of the appeal process available to *you* under state or federal law, including external review, before filing a law suit. This assures that both *you* and *we* have a full and fair opportunity to complete the record and resolve the dispute. Contact *us* if *you* believe *your* condition requires the use of the shorter time lines applicable to emergency health conditions.

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## COMPLAINT AND APPEAL PROCEDURES (continued)

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The appeal process, however, does not preclude *you* from pursuing other appropriate remedies, including seeking injunctive relief or equitable relief, if the requirement of exhausting the process for appeals, including the emergency appeal process, would place *your* health in serious jeopardy.

A coverage denial does not mean that *your* provider cannot provide the service or supply. *Our* denial only means *we* will not pay for the service or supply, unless *our* decision is reversed on appeal or in a subsequent lawsuit.

*H230100 05/05*

### **Legal actions and limitations**

No lawsuit with respect to plan benefits may be brought after the expiration of three years after the time written proof of loss is required to be furnished.

*H230200IL 05/05*

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## MISCELLANEOUS PROVISIONS

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### Entire contract

The entire contract is made up of the *master group contract*, the Employer Group Application of the *group plan sponsor*, incorporated by reference herein, and the applications of the *employees*, if any. All statements made by the *group plan sponsor* or by an *employee* are considered to be representations, not warranties. This means that the statements are made in good faith. No statement will void the *master group contract*, reduce the benefits it provides or be used in defense to a claim unless it is contained in a written or *electronic* application and a copy is furnished to the person making such statement or his or her beneficiary.

### Additional group plan sponsor responsibilities

In addition to responsibilities outlined in the *master group contract*, the *group plan sponsor* is responsible for:

- Collection of premium, and
- Providing access to:
  - Benefit plan documents;
  - Renewal notices and policy modification information;
  - Product discontinuance notices; and
  - Information regarding continuation rights.

No *group plan sponsor* has the power to change or waive any provision of the *master group contract*.

### Certificates

A *certificate* setting forth a statement of benefits the *employee* and the *employee's* covered *dependents* are entitled will be available via the Internet or in writing when requested. The *employer* is responsible for providing *employees* access to the *certificate*.

This *certificate* is part of the *master group contract* that controls our obligations regarding coverage. No document that is viewed as being not consistent with the *master group contract* shall take precedence over it. This is true, also, when the *certificate* is incorporated by reference into a summary description of plan benefits prepared and distributed by the administrator of a group plan subject to ERISA. This *certificate* is not subject to the ERISA style and content conventions that apply to summary plan descriptions. So if the terms of a summary plan description appear to differ with the terms of this *certificate* respecting coverage, the terms of this *certificate* will control.

### Incontestability

After two years from the effective date of the *master group contract*, no misstatement made by the *group plan sponsor*, except a fraudulent misstatement made in the application may be used to void the *master group contract*.

After *you* are covered without interruption for two years, *we* cannot contest the validity of *your* coverage except for:

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## MISCELLANEOUS PROVISIONS (continued)

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- Nonpayment of premiums; or
- Any fraudulent misrepresentation made by *you*.

At any time, *we* may assert defenses based upon provisions in the *master group contract* which relate to *your* eligibility for coverage under the *master group contract*.

No statement made by *you* can be contested unless it is in a written or *electronic* form signed by *you*. A copy of the form must be given to *you* or *your* beneficiary.

An independent incontestability period begins for each type of change in coverage or when a new Employee Enrollment Form is completed.

### **Fraud**

Health insurance fraud is a criminal offense that can be prosecuted. Any person(s) who willingly and knowingly engages in an activity intended to defraud *us* by filing a claim or form that contains a false or deceptive statement may be guilty of insurance fraud.

If *you* commit fraud against *us* or *your employer* commits fraud pertaining to *you* against *us*, as determined by *us*, *your* coverage ends automatically, without notice, as of the date fraud is committed or as of the date otherwise determined by *us*.

### **Clerical error, misstatement of age or gender**

If it is determined that information about the age or gender of *you* or *your dependents* was omitted or misstated in error, the amount of coverage for which *you* are properly eligible will be in effect. An equitable premium adjustment will be made. This provision applies equally to *you* and to *us*.

### **Modification of master group contract**

The *master group contract* may be modified at any time by agreement between *us* and the *group plan sponsor* without the consent of any *covered person* or any beneficiary. No modification will be valid unless approved by *our* President, Secretary or Vice-President. The approval must be endorsed on or attached to the *master group contract*. No agent has authority to modify the *master group contract*, or waive any of the *master group contract* provisions, to extend the time of premium payment, or bind *us* by making any promise or representation.

The *master group contract* may be modified by *us* at anytime without prior consent of, or notice to, the *group plan sponsor* when the changes are:

- Allowed by state or federal law or regulation;
- Directed by the state agency that regulates insurance;
- Benefit increases that do not impact premium; or
- Corrections of clerical errors or clarifications that do not reduce benefits.

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## MISCELLANEOUS PROVISIONS (continued)

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Modifications due to reasons other than those listed above, may be made by *us*, upon renewal of the *master group contract*, in accordance with state and federal law. The *group plan sponsor* will be notified in writing or *electronically* at least 31 days prior to the effective date of such changes.

### **Premium contributions**

*Your employer* must pay the required premium to *us* as they become due. *Your employer* may require *you* to contribute toward the cost of *your* coverage. Failure of *your employer* to pay any required premium to *us* when due may result in the termination of *your* coverage.

### **Premium rate change**

*We* reserve the right to change any premium rates in accordance with applicable law upon notice to the *employer*. *We* will provide notice to the *employer* of any such premium changes. Questions regarding changes to premium rates should be addressed to the *employer*.

### **Assignment**

The *master group contract* and its benefits may not be assigned by the *group plan sponsor*.

### **Conformity with statutes**

Any provision of the *master group contract* which is not in conformity with applicable state law(s) or other applicable law(s) shall not be rendered invalid, but shall be construed and applied as if it were in full compliance with the applicable state law(s) and other applicable law(s).

*H233200IL 06/06*

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## GLOSSARY

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Terms printed in italic type in this *certificate* have the meaning indicated below. Defined terms are printed in italic type wherever found in this *certificate*.

H234000

### A

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

**Active status** means the *employee* is performing all of his or her customary duties whether performed at the *employer's* business establishment, some other location which is usual for the *employee's* particular duties or another location when required to travel on the job:

- On a regular full-time basis or for the number of hours per week shown on the Employer Group Application; and
- For 48 weeks a year; and
- Is maintaining a bona fide *employer-employee* relationship with the *group plan sponsor* of the *master group contract* on a regular basis.

Each day of a regular vacation and any regular non-working holiday is deemed *active status*, if the *employee* was in *active status* on his or her last regular working day prior to the vacation or holiday. An *employee* is deemed to be in *active status* if an absence from work is due to a *sickness* or *bodily injury*, provided the individual otherwise meets the definition of *employee*.

**Acute inpatient services** means care given in a *hospital* or *health care treatment facility* which:

- Maintains permanent full-time facilities for *room and board* of resident patients;
- Provides emergency, diagnostic and therapeutic services with a capability to provide life-saving medical and psychiatric interventions;
- Has physician services, appropriately licensed behavioral health practitioners and skilled nursing services available 24-hours a day;
- Provides direct daily involvement of the physician; and
- Is licensed and legally operated in the jurisdiction where located.

*Acute inpatient services* are utilized when there is an immediate risk to engage in actions which would result in death or harm to self or others or there is a deteriorating condition in which an alternative treatment setting is not appropriate.

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

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

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## GLOSSARY (continued)

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**Alternative medicine**, for the purposes of this definition, includes, but is not limited to: acupressure, aromatherapy, ayurveda, biofeedback, faith healing, guided mental imagery, herbal medicine, holistic medicine, homeopathy, hypnosis, macrobiotics, massage therapy, naturopathy, ozone therapy, reflexotherapy, relaxation response, rolfing, shiatsu and yoga.

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

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

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

**Autism spectrum disorders** means pervasive development disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, including:

- Autism,
- Asperger's disorder, and
- Pervasive developmental disorder.

H234800IL 03/09

## B

**Behavioral health** means *mental health services*, *chemical dependency services* and *serious mental illness*.

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

**Bone marrow** means the transplant of human blood precursor cells which are administered to a patient following high-dose, ablative or myelosuppressive chemotherapy. Such cells may be derived from bone marrow, circulating blood, or a combination of bone marrow and circulating blood obtained from the patient in an autologous transplant or from a matched related or unrelated donor or cord blood. If chemotherapy is an integral part of the treatment involving an *organ transplant of bone marrow*, the term *bone marrow* includes the harvesting, the transplantation and the chemotherapy components.

H235100 07/07

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## GLOSSARY (continued)

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### C

**Certificate** means this benefit plan document which outlines the benefits, provisions and limitations of the *master group contract*.

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

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

**Copayment** means the specified amount that *you* must pay to a provider for certain *covered expenses* regardless of any amounts that may be paid by *us*.

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

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

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

**Covered expense** means *medically necessary* services or routine *preventive services* which are:

- Ordered by a *health care practitioner*;
- For the benefits described herein, subject to any maximum benefit and all other terms, provisions limitations and exclusions of the *master group contract*; and
- Incurred when *you* are insured for that benefit under the *master group contract* on the date that the service is rendered.

**Covered person** means the *employee* and/or the *employee's dependents* who are enrolled for benefits provided under the *master group contract*.

**Creditable coverage** means a *covered person's* prior coverage under any of the following:

- A group health plan, including church and governmental plans;
- *Health insurance coverage*;
- *Medicare* or *Medicaid*;
- The health plan for active military personnel, including TRICARE;
- The Indian Health Services or other tribal organization program;
- A state health benefits risk pool;
- The Federal Employees Health Benefits Program;

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## GLOSSARY (continued)

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- A non-federal, public health plan;
- A health benefit plan under section 5(e) of the Peace Corps Act;
- The Illinois Children's Health Insurance Program; or
- Foreign health care.

*Creditable coverage* does not include any of the following:

- Accident only coverage, disability income insurance, or any combination thereof;
- Supplemental coverage to liability insurance;
- Liability insurance, including general liability insurance and automobile liability insurance;
- Workers' compensation or similar insurance;
- Automobile medical payment insurance;
- Credit-only insurance;
- Coverage for on site medical clinics;
- Benefits if offered separately:
  - Limited scope dental and vision;
  - Long-term care, nursing home care, home health care, community based care, or any combination thereof; and
  - Other similar, limited benefits;
- Benefits if offered as independent, non-coordinated benefits:
  - Specified disease or illness coverage; and
  - Hospital indemnity or other fixed indemnity insurance;
- Benefits offered as a separate policy:
  - *Medicare* supplement insurance;
  - Supplemental coverage to the health plan for active military personnel, including TRICARE; and
  - Similar supplemental coverage provided to group health plan coverage;
- A health Flexible Spending Account (FSA), if it meets the Internal Revenue Service definition of a health FSA, and:
  - *You* have other coverage available under a group health plan; and
  - *Your* maximum benefit payable under the FSA does not exceed two times *your* salary election. If *your* maximum benefit payable under the FSA is greater than two times *your* salary election, it must not exceed more than \$500 plus *your* salary election.

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## GLOSSARY (continued)

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**Custodial care** means services given to *you* if:

- *You* need services including, but not limited to, assistance with dressing, bathing, preparation and feeding of special diets, walking, supervision of medication which is ordinarily self administered, getting in and out of bed, maintaining continence; or
- The services *you* require are primarily to maintain, and not likely to improve, *your* condition; or
- The services involve the use of skills which can be taught to a layperson and do not require the technical skills of a *nurse*.

Services may still be considered *custodial care* by *us* even if:

- *You* are under the care of a *health care practitioner*;
- The *health care practitioner* prescribed services are to support or maintain *your* condition; or
- Services are being provided by a *nurse*.

H236100IL 07/07

## D

**Deductible** means the amount of *covered expenses* that *you*, either individually or combined as a covered family, must pay per *year* before *we* pay benefits for certain specified services.

**Dental injury** means an injury to a *sound natural tooth* caused by a sudden and external force that could not be predicted in advance and could not be avoided. It does not include biting or chewing injuries.

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

- Legally recognized spouse or common law spouse;
- Unmarried natural born child, step-child, foster child, child of common law spouse, legally adopted child, child placed for adoption, regardless of whether a final order granting adoption is ultimately issued, or any child for which *you* are a court appointed legal guardian, whose age is less than the limiting age, or child of common law spouse; or
- Unmarried child whose age is less than the limiting age and for whom the *employee* has received a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN) to provide coverage, if the *employee* is eligible for family coverage until:

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## GLOSSARY (continued)

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- Such QMCSO or NMSN is no longer in effect; or
- The child is enrolled for comparable health coverage, which is effective no later than the termination of the child's coverage under the *master group contract*; or
- Child of a covered *dependent* child. Coverage for such child terminates as determined in the Employer Group Application; or
- Unmarried natural born child, step-child, legally adopted child whose age is less than the limiting age if he or she:
  - Is an Illinois resident; and
  - Served as a member of the active or reserve components of the U.S. Armed Forces, including the National Guard; and
  - Received a release or discharge other than a dishonorable discharge; and
  - Submits proof of service using a DD2-14 (Member 4 or 6) form, otherwise known as a "Certificate of Release or Discharge from Active Duty." This form is issued by the federal government to all veterans. For more information on how to obtain a copy of a DD2-14, the veteran can call the Illinois Department of Veterans' Affairs at 1-800-437-9824 or the U.S. Department of Veterans' Affairs at 1-800-827-1000.

Under no circumstances shall *dependent* mean a great grandchild or *emancipated minor*, unless the child meets all of the qualifications of a dependent as determined by the Internal Revenue Service.

The coverage for each *dependent* child is subject to the following limiting age(s):

- The end of the *year* that he or she attains the age of 26; or
- The end of the *year* that he or she attains the age of 26, if such child has met the eligibility criteria for a military veteran as specified above.

We shall continue to provide coverage for a *dependent* college student who takes a medical leave of absence or reduces his or her course load to part-time status because of a catastrophic *sickness* or *bodily injury*. Continuation of insurance under the *master group contract* shall terminate 12 months after notice of the *sickness* or *bodily injury* or until the coverage would have otherwise terminated pursuant to the terms and conditions of the *master group contract*, whichever comes first. The need for part-time status or medical leave of absence must be supported by a clinical certification of need from a *health care practitioner*.

A covered *dependent* child who becomes an employee eligible for other group coverage through employment is no longer eligible as a *dependent* for coverage under the *master group contract*.

A covered *dependent* child who attains the limiting age while covered under the *master group contract* remains eligible if the covered *dependent* child is:

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## GLOSSARY (continued)

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- Permanently mentally or physically handicapped; and
- Incapable of self-sustaining employment; and
- Unmarried.

In order for the covered *dependent* child to remain eligible as specified above, *we* must receive notification within 31 days prior to the covered *dependent* child attaining the limiting age.

A handicapped *dependent* child, as defined in the bulleted items above, who attained the limiting age while covered under the *employer's* previous group medical plan (Prior Plan) is eligible for coverage under this plan. Please refer to the "Replacement of Coverage" section of this *certificate*.

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

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

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

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

***Durable medical equipment*** means equipment, defined by *Medicare* Part B, that meets all of the following criteria:

- It can stand repeated use;
- It is primarily and customarily used to serve a medical purpose rather than being primarily for comfort or convenience;
- It is usually not useful to *you* in the absence of *sickness* or *bodily injury*;
- It is appropriate for home use;
- It is related to *your* physical disorder;
- It is not typically furnished by a *hospital* or *skilled nursing facility*;
- It is *medically necessary* and necessitated by *your bodily injury* or *sickness*; and
- It is provided in the most cost effective manner required by *your* condition, including, at *our* discretion, rental or purchase.

H236800IL 03/09

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## GLOSSARY (continued)

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### E

**Effective date** means the date *your* coverage begins under the *master group contract*.

**Electronic or Electronically** means relating to technology having electrical, digital, magnetic, wireless, optical, electromagnetic, or similar capabilities.

**Electronic mail** means a computerized system that allows a user of a network computer system and/or computer system to send and receive messages and documents among other users on the network and/or with a computer system.

**Electronic signature** means an electronic sound, symbol, or process attached to or logically associated with a record and executed or adopted by a person with the intent to sign the record.

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

**Emancipated minor** means a child who has not yet attained full legal age, but who has been declared by a court to be emancipated.

**Emergency care** means services provided in a *hospital* emergency facility for a *bodily injury* or *sickness* manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of that individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment of bodily functions; or
- Serious dysfunction of any bodily organ or part.

**Emergency care** does not mean services for the convenience of the *covered person* or the provider of treatment or services.

**Employee** means a person who is in *active status* for the *employer* on a *full-time* basis. The *employee* must be paid a salary or wage by the *employer* that meets the minimum wage requirements of *your* state or federal minimum wage law for work done at the *employer's* usual place of business or some other location which is usual for the *employee's* particular duties.

**Employee** also includes a sole proprietor, partner or corporate officer where:

- The *employer* is a sole proprietorship, partnership or corporation; and
- The sole proprietor, partner or corporate officer is actively performing activities relating to the business, and gains their livelihood from the sole proprietorship, partnership or corporation and is in an *active status* at the *employer's* usual place of business or some other location which is usual for the sole proprietor's, partner's or corporate officer's particular duties.

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## GLOSSARY (continued)

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**Employer** means the sponsor of this *group* plan, or any subsidiary or affiliate described in the Employer Group Application.

**Enrollment date** means:

- If you are not a *late applicant*, your *enrollment date* is the earlier of the following:
  - The first day your coverage is effective under the *master group contract*; or
  - The first day of the *waiting period* for enrollment, if any *waiting period* is applicable.
- Your *enrollment date* is the first day your coverage is effective under the *master group contract*, if:
  - You are a *late applicant*; or
  - You are enrolled on a *special enrollment date*.

The term *enrollment date* in this *certificate* is used for the determination and application of the *pre-existing condition* limitation and/or *creditable coverage*.

**Experimental, or investigational or for research purposes** means a drug, biological product, device, treatment or procedure that meets any one of the following criteria, as determined by *us*:

- Cannot be lawfully marketed without the final approval of the United States Food and Drug Administration (FDA) and which lacks such final FDA approval for the use or proposed use, unless (a) found to be accepted for that use in the most recently published edition of the United States Pharmacopeia-Drug Information for Healthcare Professional (USP-DI) or in the most recently published edition of the American Hospital Formulary Service (AHFS) Drug Information, or (b) identified as safe, widely used and generally accepted as effective for that use as reported in nationally recognized peer reviewed medical literature published in the English language as of the date of service; or (c) is mandated by state law;
- Is a device required to receive Premarket Approval (PMA) or 510K approval by the FDA but has not received a PMA or 510K approval;
- Is not identified as safe, widely used and generally accepted as effective for the proposed use as reported in nationally recognized peer reviewed medical literature published in the English language as of the date of service;
- Is the subject of a National Cancer Institute (NCI) Phase I, II or III trial or a treatment protocol comparable to a NCI Phase I, II or III trial, or any trial not recognized by NCI regardless of phase; or
- Is identified as not covered by the Centers for Medicare and Medicaid Services (CMS) Medicare Coverage Issues Manual, a CMS Operational Policy Letter or a CMS National Coverage Decision, except as required by state or federal law.

*H238000 07/07*

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## GLOSSARY (continued)

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### F

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

**Free-standing facility** means any licensed public or private establishment other than a *hospital* which has permanent facilities equipped and operated to provide laboratory and diagnostic laboratory, *outpatient* radiology, *advanced imaging*, chemotherapy, inhalation therapy, radiation therapy, lithotripsy, physical, cardiac, speech and occupational therapy, or renal dialysis services. An appropriately licensed birthing center is also considered a *free-standing facility*.

**Full-time**, for an *employee*, means a work week of the number of hours shown on the Employer Group Application.

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

H238300 03/09

### G

**Group** means the persons for whom this health coverage has been arranged to be provided.

**Group plan sponsor** means the legal entity identified as the *group plan sponsor* on the face page of the *master group contract* who establishes, sponsors and endorses an employee benefit plan for health care coverage.

H238450 07/07

### H

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

**Health care treatment facility** means a facility, institution or clinic, duly licensed by the appropriate state agency to provide medical services, *behavioral health* services, and is primarily established and operating within the scope of its license. *Health care treatment facility* does not include a *residential treatment facility*.

**Health insurance coverage** means medical coverage under any hospital or medical service policy or certificate, hospital or medical service plan contract or health maintenance organization (HMO) contract offered by a health insurance issuer. "Health insurance issuer" means an insurance company, insurance service, or insurance organization (including an HMO) that is required to be licensed to engage in the business of insurance in a state and that is subject to the state law that regulates insurance.

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## GLOSSARY (continued)

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***Health status-related factor*** means any of the following:

- Health status or medical history;
- Medical condition, either physical or mental;
- Claims experience;
- Receipt of health care;
- Genetic information;
- Disability; or
- Evidence of insurability, including conditions arising out of acts of domestic violence.

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

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

***Home health care plan*** means a plan of care and treatment for *you* to be provided in *your* home. To qualify, the *home health care plan* must be established and approved by a *health care practitioner*. The services to be provided by the plan must require the skills of a *nurse*, or another *health care practitioner* and must not be for *custodial care*.

***Hospice care program*** means a coordinated, interdisciplinary program provided by a hospice designed to meet the special physical, psychological, spiritual and social needs of a terminally ill *covered person* and his or her immediate covered family members, by providing *palliative care* and supportive medical, nursing and other services through at-home or *inpatient* care. A hospice must be licensed by the laws of the jurisdiction where it is located and must be operated as a hospice as defined by those laws. It must provide a program of treatment for at least two unrelated individuals who have been medically diagnosed as having no reasonable prospect for cure for their *sickness* and, as estimated by their physicians, are expected to live 18 months or less as a result of that *sickness*.

***Hospital*** means an institution that meets all of the following requirements:

- It must provide, for a fee, medical care and treatment of sick or injured patients on an *inpatient* basis;
- It must provide or operate, either on its premises or in facilities available to the *hospital* on a pre-arranged basis, medical, diagnostic and surgical facilities;
- Care and treatment must be given by and supervised by physicians. Nursing services must be provided on a 24-hour basis and must be given by or supervised by registered nurses;

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## GLOSSARY (continued)

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- It must be licensed by the laws of the jurisdiction where it is located. It must be operated as a hospital as defined by those laws;
- It must not be primarily a:
  - Convalescent, rest or nursing home; or
  - Facility providing custodial, educational or rehabilitative care.

The *hospital* must be accredited by one of the following:

- The Joint Commission on the Accreditation of Hospitals;
- The American Osteopathic Hospital Association; or
- The Commission on the Accreditation of Rehabilitative Facilities.

H239200 07/07

### I

***Individual lifetime maximum benefit*** means the maximum amount of benefits payable by *us* for all *covered expenses* incurred by *you*. Once the *individual lifetime maximum benefit* is reached, benefits are not payable and will not be reinstated.

***Infertility services*** means any diagnostic evaluation, treatment, supply, medication, or service provided to achieve pregnancy or to achieve or maintain ovulation. This includes, but is not limited to:

- Artificial insemination;
- In vitro fertilization;
- Gamete Intrafallopian Transfer (GIFT);
- Zygote Intrafallopian Transfer (ZIFT);
- Tubal ovum transfer;
- Embryo freezing or transfer;
- Sperm storage or banking;
- Ovum storage or banking;
- Embryo or zygote banking;
- Diagnostic and/or therapeutic laparoscopy;
- Hysterosalpingography;
- Ultrasonography;
- Endometrial biopsy; and
- Any other assisted reproductive techniques or cloning methods.

***Inpatient*** means *you* are *confined* as a registered bed patient.

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## GLOSSARY (continued)

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

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

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

- *Custodial care*; or
- Day care.

H239600 07/07

### J

### K

### L

**Late applicant** means an *employee* or *dependent* who applies for coverage more than 31 days after his/her *eligibility date*, or more than 31 days after the *special enrollment date*.

**Low-dose mammography** means the x-ray examination of the breast using equipment dedicated specifically for mammography, including the x-ray tube, filter, compression device, and image receptor, with radiation exposure delivery of less than 1 rad per breast for 2 views of an average size breast. The term also includes digital mammography.

H239700IL 03/09

### M

**Maintenance care** means services and supplies furnished mainly to:

- Maintain, rather than improve, a level of physical or mental function; or
- Provide a protected environment free from exposure that can worsen the *covered person's* physical or mental condition.

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## GLOSSARY (continued)

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**Master group contract** means the document describing the benefits *we* provide as agreed to by *us* and the *group plan sponsor*.

**Medicaid** means a state program of medical care for needy persons, as established under Title 19 of the Social Security Act of 1965, as amended.

**Medically necessary** means the required extent of health care service, treatment or product that a *health care practitioner* would provide to his or her patient for the purpose of diagnosing, palliating or treating a *sickness* or *bodily injury*, or its symptoms. Such health care service, treatment or product must be:

- In accordance with nationally recognized standards of medical practice and identified as safe, widely used and generally accepted as effective for the proposed use;
- Clinically appropriate in terms of type, frequency, intensity, toxicity, extent, setting, and duration;
- Not primarily for the convenience of the patient, physician or other health care provider;
- Clearly substantiated and supported by the medical records and documentation concerning the patient's condition;
- Performed in the most cost effective setting required by the patient's condition; and
- Supported by the preponderance of nationally recognized peer review medical literature, if any, published in the English language as of the date of service.

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

**Mental health services** means those diagnoses and treatments related to the care of a *covered person* who exhibits a mental, nervous or emotional condition classified in the Diagnostic and Statistical Manual of Mental Disorders.

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

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

H240300IL 07/07

## N

**Network health care practitioner** means a *health care practitioner* who has signed a direct agreement with *us* as an independent contractor or who has been designated by *us* as an independent contractor to provide services to all *covered persons*. *Network health care practitioner* designation by *us* may be limited to specified services.

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## GLOSSARY (continued)

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**Network hospital** means a *hospital* which has signed a direct agreement with *us* as an independent contractor or has been designated by *us* as an independent contractor to provide services to all *covered persons*. *Network hospital* designation by *us* may be limited to specified services.

**Network provider** means a *hospital, health care treatment facility, physician, or any other health services provider* who has signed an agreement with *us* as an independent contractor or who has been designated by *us* as an independent contractor to provide services to all *covered persons*. *Network provider* designation by *us* may be limited to specified services.

**Non-network health care practitioner** means a *health care practitioner* who has not been designated as a *network health care practitioner* by *us*.

**Non-network hospital** means a *hospital* which has not been designated as a *network hospital* by *us*.

**Non-network provider** means a *hospital, health care treatment facility, physician, or any other health services provider* who has not been designated as a *network provider* by *us*.

**Nurse** means a Registered Nurse (R.N.), a Licensed Practical Nurse (L.P.N.), or a Licensed Vocational Nurse (L.V.N.).

H241000 07/07

## O

**Observation status** means a stay in a *hospital* or *health care treatment facility* for less than 24 hours if:

- *You* have not been admitted as a resident *inpatient*;
- *You* are physically detained in an emergency room, treatment room, observation room or other such area; or
- *You* are being observed to determine whether *confinement* will be required.

**Ongoing course of treatment** means the treatment of a condition or disease that requires repeated health care services pursuant to a plan of treatment by a *health care practitioner* because of the potential for changes in the *covered person's* therapeutic regimen.

**Open enrollment period** means the period of time, set by *us* and the *group plan sponsor*, for eligible persons to enroll under the *master group contract*.

**Oral surgery** means procedures to correct diseases, injuries and defects of the jaw and mouth structures. These procedures include, but are not limited to, the following:

- Surgical removal of full bony impactions;
- Mandibular or maxillary implant;
- Maxillary or mandibular frenectomy;
- Alveolectomy and alveoplasty;

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## GLOSSARY (continued)

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- Orthognathic surgery;
- Surgery for treatment of temporomandibular joint syndrome/dysfunction; and
- Periodontal surgery, including gingivectomies.

**Organ transplant** means only the services, care, and treatment received for or in connection with the pre-approved transplant of the organs identified in the "Covered Expenses - Transplant Services" section, which are determined by *us* to be *medically necessary* services and which are not *experimental*, or *investigational*, or *for research purposes*. Transplantation of multiple organs, when performed simultaneously, is considered one organ transplant.

**Organ transplant treatment period** means 365 days from the date of discharge from the *hospital* following an *organ transplant* received while *you* were covered by *us*.

**Outpatient** means *you* are not *confined* as a registered bed patient.

**Outpatient surgery** means *surgery* performed in a *health care practitioner's* office, *ambulatory surgical center*, or the *outpatient* department of a *hospital*.

H241600IL 07/07

## P

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

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

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

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

Licensed drug abuse rehabilitation programs and alcohol rehabilitation programs accredited by the Joint Commission on the Accreditation of Health Care Organizations or approved by the appropriate state agency are also considered *partial hospitalization* services.

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## GLOSSARY (continued)

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*Partial hospitalization* does not include services that are for:

- *Custodial care*; or
- Day care.

***Periodontics*** means the branch of dentistry concerned with the study, prevention, and treatment of diseases of the tissues and bones supporting the teeth.

***Pre-surgical/procedural testing*** means:

- Laboratory tests or radiological examinations done on an *outpatient* basis in a *hospital* or other facility accepted by the *hospital* before *hospital confinement* or *outpatient surgery* or procedure;
- The tests must be accepted by the *hospital* or *health care practitioner* in place of like tests made during *confinement*; and
- The tests must be for the same *bodily injury* or *sickness* causing you to be *hospital confined* or to have the *outpatient surgery* or procedure.

*Pre-surgical/procedural testing* billed as *inpatient* will be paid at the *inpatient hospital* benefit percentage.

***Preauthorization*** means approval by *us*, or *our* designee, of a service prior to it being provided. Certain services require medical review by *us* in order to determine eligibility for coverage.

*Preauthorization* is granted when such a review determines that a given service is a *covered expense* according to the terms and provisions of the *master group contract*.

***Preventive services*** means services determined to be effective and accepted for the detection and prevention of disease in persons with no symptoms as recommended by the U.S. Preventive Services Task Force.

***Primary care physician*** means a *network health care practitioner* with a specialty of internal medicine, pediatrics or family medicine/general practice who provides initial and primary care services to *covered persons*, maintains the continuity of *covered persons* medical care and helps direct *covered persons* to *specialty care physicians* and other providers.

H242550 07/07

## Q

## R

***Rehabilitation facility*** means any licensed public or private establishment which has permanent facilities that are equipped and operated primarily to render physical and occupational therapies, diagnostic services and other therapeutic services.

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## GLOSSARY (continued)

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

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

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

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

**Routine nursery care** means the charges made by a *hospital* or licensed birthing center for the use of the nursery. It includes normal services and supplies given to well newborn children following birth. *Health care practitioner* visits are not considered *routine nursery care*. Treatment of a *bodily injury, sickness, birth abnormality, congenital defect* following birth and care resulting from prematurity is not considered *routine nursery care*.

H242900IL 07/07

## S

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

**Serious mental illness** means the following psychiatric illnesses as defined by the American Psychiatric Association in the Diagnostic and Statistical Manual (DSM):

- Schizophrenia;
- Paranoid and other psychotic disorders;
- Bipolar disorders (hypomanic, manic, depressive and mixed);
- Major depressive disorders (single episode or recurrent);
- Schizo-affective disorders (bipolar or depressive);
- Pervasive development disorders;
- Obsessive-compulsive disorders;
- Depression in childhood and adolescence;
- Panic disorders;
- Post-traumatic stress disorders (acute, chronic, or with delayed onset); or
- Anorexia nervosa; and
- Bulimia nervosa.

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## GLOSSARY (continued)

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**Service area** means the geographic area designated by *us*, or as otherwise agreed upon between the *group plan sponsor* and *us* and approved by the Department of Insurance of the state in which the *master group contract* is issued, if such approval is required. The *service area* is the geographic area where the *network provider* services are available to *you*. A description of the *service area* is provided in the provider directories.

**Sickness** means a disturbance in function or structure of the body which causes physical signs or physical symptoms and which, if left untreated, will result in a deterioration of the health state of the structure or system(s) of the body. The term also includes: (a) pregnancy; (b) any medical complications of pregnancy; and (c) *behavioral health*.

**Skilled nursing facility** means a licensed institution (other than a *hospital*, as defined) which meets all of the following requirements:

- It must provide permanent and full-time bed care facilities for resident patients;
- It must maintain, on the premises and under arrangements, all facilities necessary for medical care and treatment;
- It must provide such services under the supervision of physicians at all times;
- It must provide 24-hours-a-day nursing services by or under the supervision of a registered nurse; and
- It must maintain a daily record for each patient.

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

**Small employer** means an *employer* who employed an average of two but not more than 50 *employees* on business days during the preceding calendar year and who employs at least two *employees* on the first day of the *year*, unless otherwise provided under state law. All entities that are affiliated or that are eligible to file combined tax return are considered one employer.

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

- Is organic and formed by the natural development of the body (not manufactured, capped, crowned or bonded);
- Has not been extensively restored;
- Has not become extensively decayed or involved in periodontal disease; and
- Is not more susceptible to injury than a whole natural tooth, (for example a tooth that has not been previously broken, chipped, filled, cracked or fractured).

**Special enrollment date** means:

- The date of change in family status after the initial *eligibility date* as follows:
  - Date of marriage;
  - Date of divorce;
  - Date specified in a Qualified Medical Child Support Order (QMCSO);
  - Date specified in a National Medical Support Notice (NMSN);

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## GLOSSARY (continued)

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- Date of birth of a natural born child; or
- Date of adoption of a child or date of placement of a child with the *employee* for the purpose of adoption; or
- The date of termination of coverage under a group health plan or other *health insurance coverage*, as specified under the "Special Enrollment" provision.

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

**Standing referral** means a written referral from the *primary care physician* for an *ongoing course of treatment* pursuant to a treatment plan specifying needed services and time frames developed by a *specialty care physician* in consultation with the *primary care physician*.

**Surgery** means services categorized as Surgery in the Current Procedural Terminology (CPT) Manuals published by the American Medical Association. The term *surgery* includes, but is not limited to: excision or incision of the skin or mucosal tissues or insertion for exploratory purposes into a natural body opening; insertion of instruments into any body opening, natural or otherwise, done for diagnostic or other therapeutic purposes; and treatment of fractures.

H243800IL 03/09

### T

**Total disability or totally disabled** means *your* continuing inability, as a result of a *bodily injury* or *sickness*, to perform the material and substantial duties of any job for which *you* are or become qualified by reason of education, training or experience.

The term also means a *dependent's* inability to engage in the normal activities of a person of like age. If the *dependent* is employed, the *dependent* must be unable to perform his or her job.

H244050IL 07/07

### U

**Urgent care** means those health care services that are appropriately provided for an unforeseen condition of a kind that usually requires attention without delay but that does not pose a threat to life, limb or permanent health of the *covered person*.

**Urgent care center** means any licensed public or private non-hospital *free-standing facility* which has permanent facilities equipped to provide *urgent care services*.

**Usual and customary fee** for a *covered expense* is the fee as reasonably determined by *us* that is based on the fee which the provider who renders the service usually charges its patients for the same service and the fee is within the range of usual fees other providers of similar type, training and experience in a similar geographic area charge their patients for the same service, under similar or comparable circumstances.

H244200IL 07/07

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## GLOSSARY (continued)

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### V

### W

**Waiting period** means the period of time, elected by the *group plan sponsor*, which must pass before an *employee* is eligible for coverage under the *master group contract*.

**We, us or our** means the offering company as shown on the cover page of this *master group contract* and *certificate*.

**Woman's principal health care provider** means a *health care practitioner* specializing in obstetrics, gynecology or family practice.

H244400IL 07/07

### X

### Y

**Year** means the period of time which begins on any January 1st and ends on the following December 31st. When *you* first become covered by the *master group contract*, the first *year* begins for *you* on the effective date of *your* coverage and ends on the following December 31st.

**You or your** means any *covered person*.

### Z

H244600 07/07

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## PRESCRIPTION DRUG BENEFIT RIDER

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This rider is made part of the *master group contract* to which it is attached. The effective date of this change is the latter of the effective date of the *certificate* or the date this benefit is added to the *master group contract*.

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

Any expenses incurred by *you* under provisions of this rider do not apply toward *your copayment limit*, if any.

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

All terms used in this benefit rider have the same meaning given to them in the *certificate* unless otherwise specifically defined in this benefit rider.

### Prescription drug cost sharing

*You* are responsible for any and all payments of the following, when applicable, according to the "Schedule of benefits-prescription drugs" provision of this benefit rider:

- The *drug deductible*, if any; and
- The *copayment*\*.

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

The amount paid by *us* to the dispensing *pharmacy* may not reflect the ultimate cost to *us* for the drug. *Your copayments* are made on a per *prescription* or refill basis and will not be adjusted if *we* receive any retrospective volume discounts or prescription drug rebates.

### Definitions

The following terms are used in this benefit rider:

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

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## PRESCRIPTION DRUG BENEFIT RIDER (continued)

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

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

**Drug deductible** means a specified amount of *prescription* drug expenses *you* must incur per *year* before benefits will be paid under this benefit rider. These expenses do not apply toward any other *deductible*, if any, stated in the *master group contract*.

**Drug list** means a list of *prescription* drugs, medicines, medications and supplies specified by *us*. The *drug list* identifies drugs as *level 1* or *level 2* and indicates applicable *dispensing limits* and/or any *prior authorization* or *step therapy* requirements. Visit *our* Website at [www.humana.com](http://www.humana.com) or call the customer service telephone number on *your* identification card to obtain the *drug list*. The *drug list* is subject to change without notice.

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

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

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

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

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

**Network pharmacy** means a *pharmacy* that has signed a direct agreement with *us* or has been designated by *us* to provide:

- Covered *pharmacy* services;
- Covered *specialty pharmacy* services; or
- Covered *mail order pharmacy* services,

as defined by *us*, to *covered persons*, including covered *prescriptions* or refills delivered through the mail.

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## PRESCRIPTION DRUG BENEFIT RIDER (continued)

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**Non-network pharmacy** means a *pharmacy* that has not signed a direct agreement with *us* or has not been designated by *us* to provide:

- Covered *pharmacy* services;
- Covered *specialty pharmacy* services; or
- Covered *mail order pharmacy* services,

as defined by *us*, to *covered persons*, including covered *prescriptions* or refills delivered through the mail.

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

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

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

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

**Prescription** means a direct order for the preparation and use of a drug, medicine or medication. The *prescription* must be given by a *health care practitioner* to a *pharmacist* for *your* benefit and used for the treatment of a *sickness* or *bodily injury* which is covered under this plan. The drug, medicine or medication must be obtainable only by *prescription*. The *prescription* may be given to the *pharmacist* verbally, *electronically* or in writing by the *health care practitioner*. The *prescription* must include at least:

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

**Prior authorization** means the required prior approval from *us* for the coverage of *prescription* drugs, medicines and medications, including the dosage, quantity and duration, as appropriate for *your* diagnosis, age and sex. Certain *prescription* drugs, medicines or medications may require *prior authorization*. Visit *our* Website at [www.humana.com](http://www.humana.com) or call the customer service telephone number on *your* identification card to obtain a list of *prescription* drugs, medicines and medications that require *prior authorization*.

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## PRESCRIPTION DRUG BENEFIT RIDER (continued)

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

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

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

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

**Year** means the period of time which begins on any January 1<sup>st</sup> and ends on the following December 31<sup>st</sup>. When *you* first become covered by the *master group plan*, the first *year* begins for *you* on the effective date of *your* insurance and ends on the following December 31<sup>st</sup>.

### Coverage description

*We* will cover *prescription* drugs that are received by *you* from a *network pharmacy* while *you* are covered under this Prescription Drug Benefit Rider. Benefits may be subject to *dispensing limits*, *prior authorization* and *step therapy* requirements, if any.

Covered *prescription* drugs are:

- Drugs, medicines or medications that under federal or state law may be dispensed only by *prescription* from a *health care practitioner*.
- Drugs, medicines or medications that are included on the *drug list*.
- Insulin and *diabetes supplies*.
- Hypodermic needles or syringes when prescribed by a *health care practitioner* for use with insulin or *self-administered injectable drugs*. (Hypodermic needles and syringes used in conjunction with covered drugs may be available at no cost to *you*).
- *Specialty drugs* and *self-administered injectable drugs* approved by *us*.
- Formulas and nutritional supplements necessary for the treatment of phenylketonuria (PKU) or other inherited metabolic disease, or as otherwise determined by *us*.

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## PRESCRIPTION DRUG BENEFIT RIDER (continued)

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- Spacers and/or peak flow meters for the treatment of asthma.
- Drugs prescribed for infertility.
- Drugs prescribed for erectile dysfunction.

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

### Schedule of benefits - prescription drugs

*You* are responsible for the following:

#### Retail Pharmacy / specialty pharmacy

#### Up to 30-day supply

<i>Level 1 drugs</i>	\$10 <i>copayment</i> per <i>prescription</i> or refill
<i>Level 2 drugs</i>	\$22 <i>copayment</i> per <i>prescription</i> or refill
Erectile dysfunction drugs	\$32 <i>copayment</i> per <i>prescription</i> or refill

#### Mail order pharmacy

#### Up to 90-day supply

<i>Level 1 drugs, level 2 drugs</i> and erectile dysfunction drugs	2 times the applicable <i>copayment</i> , as outlined above under <b>Retail Pharmacy / Specialty Pharmacy</b> per <i>prescription</i> or refill
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If *you* request a *brand-name medication* when a *generic medication* is available, *your* cost share is greater. *You* are responsible for the applicable *generic medication copayment* and 100% of the difference between the amount *we* would have paid the dispensing *pharmacy* for the *brand-name medication* and the amount *we* would have paid the dispensing *pharmacy* for the *generic medication*, unless, the prescribing *health care practitioner* determines that the *brand-name medication* is *medically necessary*. Then *you* are only responsible for the applicable *copayment* of a *brand-name medication*.

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## PRESCRIPTION DRUG BENEFIT RIDER (continued)

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### Mandatory mail

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

For up to a 90-day supply of a medication received from a *mail order pharmacy*, you must pay 2 time(s) the applicable *copayment*, subject to one *copayment* for up to a 30-day supply.

### Limitations and exclusions

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

- *Legend drugs*, which are not deemed *medically necessary* by us.
- Any drug prescribed for intended use other than for:
  - Indications approved by the FDA; or
  - Off-label indications recognized through peer-reviewed medical literature.

However, drugs for the treatment of cancer will not be excluded on the basis that the drug has been prescribed for the treatment of a type of cancer for which the drug has not been approved by the FDA. The drug must be approved by the FDA and must be recognized for the treatment of the specific cancer for which the drug has been prescribed in any one of the following established reference compendia:

- The American Medical Association Drug Evaluations,
  - The American Hospital Formulary Service Drug Information
  - The United States Pharmacopeia Drug Information; or
  - If not in the compendia, the drug must be recommended for that particular type of cancer in formal clinical studies for which results have been published in at least two peer reviewed professional medical journals published in the United States or Great Britain.
- Any drug prescribed for a *sickness* or *bodily injury* not covered under the *master group contract*.
  - Any drug, medicine or medication that is either:
    - Labeled "Caution-limited by federal law to investigational use"; or
    - *Experimental* or *investigational* or *for research purposes*,

even though a charge is made to you.

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## PRESCRIPTION DRUG BENEFIT RIDER (continued)

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- Allergen extracts.
- Therapeutic devices or appliances including, but not limited to:
  - Hypodermic needles and syringes (except needles and syringes for use with insulin and *self-administered injectable drugs* whose coverage is approved by *us*);
  - Support garments;
  - Test reagents;
  - Mechanical pumps for delivery of medications; and
  - Other non-medical substances.
- Dietary supplements, except enteral formulas and nutritional supplements for the treatment of phenylketonuria (PKU) or other inherited metabolic disease. Refer to the "Covered Expenses" section of the *certificate* for coverage of low protein modified foods.
- Nutritional products.
- Fluoride supplements.
- Minerals.
- Growth hormones (medications, drugs or hormones to stimulate growth) for idiopathic short stature.
- Growth hormones (medications, drugs or hormones to stimulate growth), unless there is a laboratory confirmed diagnosis of growth hormone deficiency, or as otherwise determined by *us*.
- Herbs and vitamins, except prenatal (including greater than one milligram of folic acid) and pediatric multi-vitamins with fluoride.
- Anabolic steroids.
- Anorectic or any drug used for the purpose of weight control.
- Any drug used for cosmetic purposes, including but not limited to:
  - Tretinoin, e.g. Retin A, except if *you* are under the age of 45 or are diagnosed as having adult acne;
  - Dermatologicals or hair growth stimulants; or
  - Pigmenting or de-pigmenting agents, e.g. Solaquin.

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## PRESCRIPTION DRUG BENEFIT RIDER (continued)

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- Any drug or medicine that is:
  - Lawfully obtainable without *prescription* (over the counter drugs), except insulin; or
  - Available in prescription strength without a *prescription*.
- Compounded drugs in any dosage form.
- Progesterone crystals or powder in any compounded dosage form, unless otherwise determined by *us*.
- Abortifacients (drugs used to induce abortions).
- Any drug, medicine or medication that is consumed or injected at the place where the *prescription* is given, or dispensed by the *health care practitioner*.
- The administration of covered medication(s).
- *Prescriptions* that are to be taken by or administered to *you*, in whole or in part, while *you* are a patient in a facility where drugs are ordinarily provided by the facility on an inpatient basis. *Inpatient* facilities include, but are not limited to:
  - *Hospital*;
  - *Skilled nursing facility*; or
  - *Hospice facility*.
- Injectable drugs, including but not limited to:
  - Immunizing agents;
  - Biological sera;
  - Blood;
  - Blood plasma; or
  - *Self-administered injectable drugs* or *specialty drugs* for which coverage is not approved by *us*.
- *Prescription* refills:
  - In excess of the number specified by the *health care practitioner*; or
  - Dispensed more than one year from the date of the original order.
- Any portion of a *prescription* or refill that exceeds a 90-day supply when received from a *mail order pharmacy* or a retail *pharmacy* that participates in *our* program which allows *you* to receive a 90-day supply of a *prescription* or refill.
- Any portion of a *prescription* or refill that exceeds a 30-day supply when received from a retail *pharmacy* that does not participate in *our* program which allows *you* to receive a 90-day supply of a *prescription* or refill.

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## PRESCRIPTION DRUG BENEFIT RIDER

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- Any portion of a *specialty drug* or *self-administered injectable drug* that exceeds a 30-day supply, unless otherwise determined by *us*.
- Any portion of a *prescription* or refill that:
  - Exceeds *our* drug specific *dispensing limit*, e.g. IMITREX;
  - Is dispensed to a *covered person* whose age is outside the drug specific age limits defined by *us*; or
  - Exceeds the duration-specific *dispensing limit*.
- Any drug for which *prior authorization* or *step therapy* is required, as determined by *us*, and not obtained.
- Any drug for which a charge is customarily not made.
- Any drug, medicine or medication received by *you*:
  - Before becoming covered under this rider; or
  - After the date *your* coverage under this rider has ended.
- Any costs related to the mailing, sending or delivery of *prescription* drugs.
- Any intentional misuse of this benefit, including *prescriptions* purchased for consumption by someone other than *you*.
- Any *prescription* or refill for drugs, medicines or medications that are lost, stolen, spilled, spoiled or damaged.
- Any service, supply or therapy to eliminate or reduce a dependency on, or addiction to tobacco and tobacco products, including but not limited to nicotine withdrawal therapies, programs, services or medications.
- Drug delivery implants.
- Treatment for onychomycosis (nail fungus).
- More than one *prescription* or refill for the same drug or therapeutic equivalent medication prescribed by one or more *health care practitioners* and dispensed by one or more *pharmacies* until *you* have used, or should have used, at least 75% of the previous *prescription* or refill, unless the drug or therapeutic equivalent medication is purchased through a *mail order pharmacy*, or a retail *pharmacy* that participates in *our* program which allows *you* to receive a 90-day supply of a *prescription* or refill, in which case *you* have used, or should have used 66% of the previous *prescription*. (Based on the dosage schedule prescribed by the *health care practitioner*).

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## PRESCRIPTION DRUG BENEFIT RIDER (continued)

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- Any drug or biological that has received designation as an *orphan drug*, unless approved by *us*.
- Any amount *you* paid for a *prescription* that has been filled, regardless of whether the *prescription* is revoked or changed due to adverse reaction or change in dosage or *prescription*.
- *Prescriptions* filled at a *non-network pharmacy* except for *prescriptions* required during an emergency.

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

### HUMANA HEALTH PLAN, INC.



Michael B. McCallister  
President

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## DOMESTIC PARTNER BENEFIT RIDER

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This rider is made part of the *master group contract* to which it is attached. The effective date of this change is the latter of the effective date of the *certificate* or the date this benefit is added to the *master group contract*.

All terms used in this rider have the same meaning given to them in the *certificate* unless otherwise specifically defined in this rider.

This rider modifies the *master group contract* as follows:

- By adding the definition of *domestic partner* to the "Glossary" section of the *certificate* as follows:

***Domestic partner*** means an individual of the same or opposite gender who resides with the covered *employee* in a long-term relationship of indefinite duration; and, there is an exclusive mutual commitment in which the partners agree to be jointly responsible for each other's common welfare and share financial obligations. The *domestic partner* must be more than 18 years of age, competent to contract, and may not be related by blood to a degree of closeness which would prohibit legal marriage in the state in which they legally reside. We reserve the right to require an affidavit from the *domestic partners* attesting that the domestic partnership has existed for a minimum period of 12 months and, periodically thereafter, to require proof that the *domestic partner* relationship continues to exist.

- By deleting the definition of *dependent* in the "Glossary" section of the *certificate* and replacing it with the following:

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

- Legally recognized spouse, common law spouse or *domestic partner*;
- Unmarried natural born child, step-child, foster child, child of common law spouse, legally adopted child, child placed for adoption, regardless of whether a final order granting adoption is ultimately issued, or any child for which the insured is a court appointed guardian whose age is less than the limiting age;
- Unmarried child whose age is less than the limiting age and for whom the *employee* has received a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN) to provide coverage, if the *employee* is eligible for family coverage until:
  - Such QMCSO or NMSN is no longer in effect; or
  - The child is enrolled for comparable health coverage, which is effective no later than the termination of the child's coverage under the *master group contract*;

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## DOMESTIC PARTNER BENEFIT RIDER (continued)

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- *Domestic partner's* unmarried natural born child, step-child, foster child, legally adopted child, child placed for adoption, or any child for which the insured is a court appointed guardian whose age is less than the limiting age, subject to the following conditions:
  - The domestic partner's child must live in the employee's household;
  - The *domestic partner's* child is not covered by any other medical plan; and
  - The *domestic partner's* child is not entitled to coverage through another medical plan because of a QMCSO or NMSN.

**Note:** The *domestic partner's* child cannot qualify as a *dependent* prior to the *employee's* *domestic partner* becoming a qualified *dependent*.

- Child of a covered *dependent* child. Coverage for such child terminates as determined in the Employer Group Application; or
- Unmarried natural born child, step-child, legally adopted child whose age is less than the limiting age if he or she:
  - Is an Illinois resident; and
  - Served as a member of the active or reserve components of the U.S. Armed Forces, including the National Guard; and
  - Received a release or discharge other than a dishonorable discharge; and
  - Submits proof of service using a DD2-14 (Member 4 or 6) form, otherwise known as a "Certificate of Release or Discharge from Active Duty." This form is issued by the federal government to all veterans. For more information on how to obtain a copy of a DD2-14, the veteran can call the Illinois Department of Veterans' Affairs at 1-800-437-9824 or the U.S. Department of Veterans' Affairs at 1-800-827-1000.

Under no circumstances shall *dependent* mean a great-grandchild or *emancipated minor*, unless the child meets all of the qualifications of a dependent as determined by the Internal Revenue Service.

The coverage for each *dependent* child is subject to the following limiting age(s):

- The end of the *year* that he or she attains the age of 26; or
- The end of the *year* that he or she attains the age of 26, if such child has met the eligibility criteria for a military veteran as specified above.

We shall continue to provide coverage for a *dependent* college student who takes a medical leave of absence or reduces his or her course load to part-time status because of a catastrophic *sickness* or *bodily injury*. Continuation of insurance under the *master group contract* shall terminate 12 months after notice of the *sickness* or *bodily injury* or until the coverage would have otherwise terminated pursuant to the terms and conditions of the *master group contract*, whichever comes first. The need for part-time status or medical leave of absence must be supported by a clinical certification of need from a *health care practitioner*.

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## DOMESTIC PARTNER BENEFIT RIDER (continued)

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A covered *dependent* child who becomes an employee eligible for other group coverage through employment is no longer eligible as a *dependent* for coverage under the *master group contract*.

A covered *dependent* child who attains the limiting age while covered under the *master group contract* remains eligible if the covered *dependent* child is:

- Permanently mentally or physically handicapped; and
- Incapable of self-sustaining employment; and
- Unmarried.

In order for the covered *dependent* child to remain eligible as specified above, *we* must receive notification within 31 days prior to the covered *dependent* child attaining the limiting age.

A handicapped *dependent* child, as defined in the bulleted items above, who attained the limiting age while covered under the *employer's* previous group medical plan (Prior Plan) is eligible for coverage under the *master group contract*. Please refer to the "Replacement of Coverage" section of this *certificate*.

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

- By deleting the definition of *family member* in the "Glossary" section of the *certificate* and replacing it with the following:

***Family member*** means *you*, *your* legally recognized spouse or *domestic partner*. It also means *your* or *your* legally recognized spouse's, *domestic partner's*, or common law spouse's child, brother, sister or parent.

### HUMANA HEALTH PLAN, INC.



Michael B. McCallister  
President

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## DISCLOSURE

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### Discount programs

From time to time, we may offer or provide access to discount programs to you. In addition, we may arrange for third party service providers such as pharmacies, optometrists, dentists and alternative medicine providers to provide discounts on goods and services to you. Some of these third party service providers may make payments to us when covered persons take advantage of these discount programs. These payments offset the cost to us of making these programs available and may help reduce the costs of your plan administration. Although we have arranged for third parties to offer discounts on these goods and services, these discount programs are not covered services under the master group contract. The third party service providers are solely responsible to you for the provision of any such goods and/or services. We are not responsible for any such goods and/or services, nor are we liable if vendors refuse to honor such discounts. Further, we are not liable to covered persons for the negligent provision of such goods and/or services by third party service providers. Discount programs may not be available to persons who "opt out" of marketing communications and where otherwise restricted by law.

### Rewards

From time to time we may enter into agreements with third parties who administer Rewards programs that may be available to you. Through these programs, you may earn rewards by:

- Completing certain activities such as wellness, educational or informational programs; or
- Reaching certain goals such as lowering blood pressure or becoming smoke free.

The rewards may include non-insurance benefits such as merchandise, gift cards, debit cards, discounts or contributions to your health spending account. We are not responsible for any rewards that are non-insurance benefits or for your receipt of such reward.

The rewards may be taxable income. You may consult a tax advisor for further guidance.

Our agreement with any third party does not eliminate any of your obligations under this master group contract or change any of the terms of this master group contract. Our agreement with the third parties and the program may be terminated at any time, although insurance benefits will be subject to applicable State and Federal laws.

Please call the telephone number listed on your identification card or in the marketing literature issued by the Rewards program administrator for a possible alternative activity if:

- It is unreasonably difficult for you to reach certain goals due to your medical condition; or
- Your health care practitioner advises you not to take part in the activities needed to reach certain goals.

The Rewards program administrator or we may require proof in writing from your health care practitioner that your medical condition prevents you from taking part in the available activities.

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## **DISCLOSURE (continued)**

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The decision to participate in these programs or activities is voluntary and you may decide to participate anytime during the year. Refer to the marketing literature issued by the Rewards program administrator for their program s eligibility, rules and limitations.

# NOTICE OF PROTECTION PROVIDED BY ILLINOIS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

This notice provides a **brief summary** description of the Illinois Life and Health Insurance Guaranty Association ("the Association") and the protection it provides for policyholders. This safety net was created under Illinois law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your member life, annuity or health insurance company becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Illinois law, with funding from assessments paid by other insurance companies.

The basic protections provided by the Association per insolvency are:

- Life Insurance
  - \$300,000 in death benefits
  - \$100,000 in cash surrender or withdrawal values
  
- Health Insurance
  - \$500,000 in hospital, medical and surgical insurance benefits \*
  - \$300,000 in disability insurance benefits
  - \$300,000 in long-term care insurance benefits
  - \$100,000 in other types of health insurance benefits
  
- Annuities
  - \$250,000 in withdrawal and cash values

\*The maximum amount of protection for each individual, regardless of the number of policies or contracts, is \$500,000, except special rules apply with regard to hospital, medical and surgical insurance benefits for which the maximum amount of protection is \$500,000.

**Note: Certain policies and contracts may not be covered or fully covered.** For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also residency requirements and other limitations under Illinois law.

**NOTICE OF PROTECTION PROVIDED BY  
ILLINOIS LIFE AND HEALTH INSURANCE  
GUARANTY ASSOCIATION (continued)**

To learn more about the above protections, as well as protections relating to group contracts or retirement plans, please visit the Association's website at [www.ilhiga.org](http://www.ilhiga.org) or contact:

Illinois Life and Health  
Insurance Guaranty Association  
8420 West Bryn Mawr Avenue, Suite 550  
Chicago, Illinois 60631-3404  
(773) 714-8050

Illinois Department of Insurance  
4th Floor  
320 West Washington Street  
Springfield, Illinois 62767  
(217) 782-4515

**Insurance companies and agents are not allowed by Illinois law to use the existence of the Association or its coverage to encourage you to purchase any form of insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and Illinois law, then Illinois law will control.**

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## **NOTICES**

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**The following pages contain important information about Humana's claims procedures and certain federal laws. There may be differences between the Certificate of Insurance and this Notice packet. There may also be differences between this notice packet and state law. The Plan participant is eligible for the rights more beneficial to the participant.**

**This section includes notices about:**

**Claims and Appeal Procedures**

**Federal Legislation**

**Women's Health and Cancer Rights Act**

**Statement of Rights Under the Newborns' and Mothers' Health Protection Act**

**Medical Child Support Orders**

**General Notice of COBRA Continuation of Coverage Rights**

**Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA)**

**Family And Medical Leave Act (FMLA)**

**Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)  
Your Rights Under ERISA**

**Certificate of Creditable Coverage**

**Privacy and Confidentiality Statement**

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## NOTICES (continued)

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### Claims and appeals procedures

#### Federal standards

The Employee Retirement Income Security Act of 1974 (ERISA) established minimum requirements for claims procedures, Humana complies with these standards. Covered persons in insured plans subject to ERISA should also consult their insurance benefit plan documents (e.g., the Certificate of Insurance or Evidence of Coverage). Humana complies with the requirements set forth in any such benefit plan document issued by it with respect to the plan unless doing so would prevent compliance with the requirements of the federal ERISA statute and the regulations issued thereunder. The following claims procedures are intended to comply with the ERISA claims regulation, and should be interpreted consistent with the minimum requirements of that regulation. Covered persons in plans not subject to ERISA, should consult their benefit plan documents for the applicable claims and appeals procedures.

#### Discretionary authority

With respect to paying claims for benefits or determining eligibility for coverage under a policy issued by Humana, Humana as administrator for claims determinations and as ERISA claims review fiduciary, shall have full and exclusive discretionary authority to:

- Interpret plan provisions;
- Make decisions regarding eligibility for coverage and benefits; and
- Resolve factual questions relating to coverage and benefits.

#### Definitions

**Adverse determination** means a decision to deny benefits for a *pre-service claim* or a *post-service claim* under a *group health plan*.

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

**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.

**Group health plan** means an employee welfare benefit plan to the extent the plan provides medical care to employees or their dependents directly (self insured) or through insurance (including HMO plans), reimbursement or otherwise.

**Health insurance issuer** means the offering company listed on the face page of your Certificate of Insurance and referred to in this document as "Humana".

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

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## NOTICES (continued)

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**Pre-service claim** means a request for authorization of a benefit for which the plan conditions receipt of the benefit, in whole or in part, on advance approval.

**Urgent-care claim (expedited review)** means a claim for covered services to which the application of the time periods for making non-urgent care determinations:

- Could seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function; or
- In the opinion of a physician with knowledge of the covered person's medical condition, would subject the covered person to severe pain that cannot be adequately managed without the service that is the subject of the claim.

Humana will make a determination of whether a claim is an *urgent-care claim*. However, any claim a physician, with knowledge of a covered person's medical condition, determines is an "*urgent-care claim*" will be treated as a "claim involving urgent care".

### Submitting a claim

This section describes how a *claimant* files a claim for plan benefits. A claim must be filed in writing and delivered by mail, postage prepaid, by FAX or e-mail. A request for pre-authorization may be filed by telephone. The claim or request for pre-authorization must be submitted to Humana or to Humana's designee at the address indicated in the covered person's benefit plan document or identification card. This is particularly important with respect to mental health coordinators and other providers to whom Humana has delegated responsibility for claims administration. Claims will not be deemed submitted for purposes of these procedures unless and until received at the correct address.

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

Claims submissions must be timely. Claims must be filed as soon as reasonably possible after they are incurred, and in no event later than the period of time described in the benefit plan document.

Claims submissions must be complete and delivered to the designated address. At a minimum they must include:

- Name of the covered person who incurred the covered expense;
- Name and address of the provider;
- Diagnosis;
- Procedure or nature of the treatment;
- Place of service;
- Date of service ; and
- Billed amount.

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## NOTICES (continued)

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Presentation of a prescription to a pharmacy does not constitute a claim for benefits under the plan. If a covered person is required to pay the cost of a covered prescription drug, he or she may submit a written claim for plan benefits to Humana.

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

### **Failure to provide necessary information**

If a *pre-service claim* submission is not made in accordance with the plan's requirements, Humana will notify the *claimant* of the problem and how it may be remedied within five (5) days (or within 24 hours, in the case of an *urgent-care claim*). If a *post-service claim* is not made in accordance with the plan's requirement, it will be returned to the submitter.

### **Authorized representatives**

A covered person may designate an authorized representative to act on his or her behalf in pursuing a benefit claim or appeal. The authorization must be in writing and authorize disclosure of health information. If a document is not sufficient to constitute designation of an authorized representative, as determined by Humana, 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 Humana in advance or at the time an authorized representative commences a course of action on behalf of the covered person. Humana may verify the designation with the covered person prior to recognizing authorized representative status.

In any event, a health care provider with knowledge of a covered person's medical condition acting in connection with an *urgent-care claim* will be recognized by the plan as the covered person's authorized representative.

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

### **Claims decisions**

After a determination on a claim is made, Humana will notify the *claimant* within a reasonable time, as follows:

- ***Pre-service claims*** - Humana will provide notice of a favorable or *adverse determination* within a reasonable time appropriate to the medical circumstances but no later than 15 days after the plan receives the claim.

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## NOTICES (continued)

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

If the reason for the extension is because Humana does not have enough information to decide the claim, the notice of extension will describe the required information, and the *claimant* will have at least 45 days from the date the notice is received to provide the necessary information.

- ***Urgent-care claims (expedited review)*** - Humana will determine whether a particular claim is an *urgent-care claim*. This determination will be based on information furnished by or on behalf of a covered person. Humana will exercise its judgment when making the determination with deference to the judgment of a physician with knowledge of the covered person's condition. Humana may require a *claimant* to clarify the medical urgency and circumstances supporting the *urgent-care claim* for expedited decision-making.

Notice of a favorable or *adverse determination* will be made by Humana as soon as possible, taking into account the medical urgency particular to the covered person's situation, but not later than 72 hours after receiving the *urgent-care claim*.

If a claim does not provide sufficient information to determine whether, or to what extent, services are covered under the plan, Humana will notify the *claimant* as soon as possible, but not more than 24 hours after receiving the *urgent-care claim*. The notice will describe the specific information necessary to complete the claim. The *claimant* will have a reasonable amount of time, taking into account the covered person's circumstances, to provide the necessary information but not less than 48 hours.

Humana will provide notice of the plan's *urgent-care claim* determination as soon as possible but no more than 48 hours after the earlier of:

- The plan receives the specified information; or
- The end of the period afforded the *claimant* to provide the specified additional information.

- ***Concurrent-care decisions*** - Humana will notify a *claimant* of a *concurrent-care decision* involving a reduction or termination of pre-authorized benefits sufficiently in advance of the reduction or termination to allow the *claimant* to appeal and obtain a determination.

Humana will decide *urgent-care claims* involving an extension of a course of treatment as soon as possible taking into account medical circumstances. Humana will notify a *claimant* of the benefit determination, whether adverse or not, within 24 hours after the plan receives the claim, provided the claim is submitted to the plan 24 hours prior to the expiration of the prescribed period of time or number of treatments.

- ***Post-service claims*** - Humana will provide notice of a favorable or *adverse determination* within a reasonable time appropriate to the medical circumstances but no later than 30 days after the plan receives the claim.

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## NOTICES (continued)

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

If the reason for the extension is because Humana does not have enough information to decide the claim, the notice of extension will describe the required information, and the *claimant* will have at least 45 days from the date the notice is received to provide the specified information. Humana will make a decision on the earlier of the date on which the *claimant* responds or the expiration of the time allowed for submission of the requested information.

### Initial denial notices

Notice of a claim denial (including a partial denial) will be provided to *claimants* by mail, postage prepaid, by FAX or by e-mail, as appropriate, within the time frames noted above. With respect to adverse decisions involving *urgent-care claims*, notice may be provided to *claimants* orally within the time frames noted above. If oral notice is given, written notification must be provided no later than 3 days after oral notification.

A claims denial notice will convey the specific reason for the *adverse determination* and the specific plan provisions upon which the determination is based. The notice will also include a description of any additional information necessary to perfect the claim and an explanation of why such information is necessary. The notice will disclose if any internal plan rule, protocol or similar criterion was relied upon to deny the claim. A copy of the rule, protocol or similar criterion will be provided to *claimants*, free of charge, upon request.

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.

If an *adverse determination* is based on medical necessity, experimental treatment or similar exclusion or limitation, the notice will state that an explanation of the scientific or clinical basis for the determination will be provided, free of charge, upon request. The explanation will apply the terms of the plan to the covered person's medical circumstances.

In the case of an adverse decision of an *urgent-care claim*, the notice will provide a description of the plan's expedited review procedures.

### 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 Humana, in person, or by mail, postage prepaid.

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## NOTICES (continued)

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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, FAX, or other available similarly expeditious method, to the extent permitted by applicable law.

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

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

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

### **Time periods for decisions on appeal**

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

- ***Urgent-care claims*** - As soon as possible but not later than 72 hours after Humana receives the appeal request;
- ***Pre-service claims*** - Within a reasonable period but not later than 30 days after Humana received the appeal request;
- ***Post-service claims*** - Within a reasonable period but not later than 60 days after Humana receives the appeal request;
- ***Concurrent-care decisions*** - Within the time periods specified above depending on the type of claim involved.

### **Appeals denial notices**

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

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## NOTICES (continued)

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A notice that a claim appeal has been denied will include:

- The specific reason or reasons for the *adverse determination*;
- Reference to the specific plan provision upon which the determination is based;
- If any internal plan rule, protocol or similar criterion was relied upon to deny the claim. A copy of the rule, protocol or similar criterion will be provided to the claimant, free of charge, upon request;
- A statement describing any voluntary appeal procedures offered by the plan and the claimant's right to obtain the information about such procedures, and a statement about the claimant's right to bring an action under §502(a) of ERISA;
- If an *adverse determination* is based on medical necessity, experimental treatment or similar exclusion or limitation, the notice will state that an explanation of the scientific or clinical basis for the determination will be provided, free of charge, upon request. The explanation will apply the terms of the plan to the covered person's medical circumstances.

In the event an appealed claim is denied, the claimant will be entitled to receive without charge reasonable access to, and copies of, any documents, records or other information that:

- Was relied upon in making the determination;
- Was submitted, considered or generated in the course of making the benefit determination, without regard to whether such document, record or other information was relied upon in making the benefit determination;
- Demonstrates compliance with the administrative processes and safeguards required in making the determination;
- Constitutes a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit for the claimant's diagnosis, without regard to whether the statement was relied on in making the benefit determination.

### **Exhaustion of remedies**

Upon completion of the appeals process under this section, a claimant will have exhausted his or her administrative remedies under the plan. If Humana fails to complete a claim determination or appeal within the time limits set forth above, the claim shall be deemed to have been denied and the claimant may proceed to the next level in the review process.

After exhaustion of remedies, a claimant may pursue any other legal remedies available, which may include bringing civil action under ERISA section 502(a) for judicial review of the plan's determination. Additional information may be available from the local U.S. Department of Labor Office.

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## **NOTICES (continued)**

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### **Legal actions and limitations**

No lawsuit may be brought with respect to plan benefits until all remedies under the plan have been exhausted.

No lawsuit with respect to plan benefits may be brought after the expiration of the applicable limitations period stated in the benefit plan document. If no limitation is stated in the benefit plan document, then no such suit may be brought after the expiration of the applicable limitations under applicable law.

### **Federal legislation**

#### **Women's health and cancer rights act of 1998**

##### **Required coverage for reconstructive surgery following mastectomies**

Under federal law, group health plans and health insurance issuers offering group health insurance providing medical and surgical benefits with respect to mastectomy shall provide, in a case of a participant or beneficiary who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with such mastectomy, coverage for:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce symmetrical appearance; and
- Prostheses and physical complications of all stages of mastectomy, including lymphedemas;

in a manner determined in consultation with the attending physician and the patient. Such coverage may be subject to annual deductibles and coinsurance provisions as may be deemed appropriate and as are consistent with those established for other benefits under the plan.

#### **Statement of rights under the newborns' and mothers' health protection act (NMHPA)**

##### **If your plan covers normal pregnancy benefits, the following notice applies to you.**

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, group health plans and health insurance issuers may not set the level of benefits or out-of-pocket costs so any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

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## **NOTICES (continued)**

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In addition, a group health plan or health insurance issuer may not, under federal law, require a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain pre-authorization. For information on pre-authorization, contact your plan administrator.

### **Medical child support orders**

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

A QMCSO is a state-court order or judgment, including approval of a settlement agreement that:

- Provides for support of a covered employee's child;
- Provides for health care coverage for that child;
- Is made under state domestic relations law (including a community property law);
- Relates to benefits under the group health plan; and
- Is "qualified," i.e., it meets the technical requirements of ERISA or applicable state law.

QMCSO also means a state court order or judgment enforcing state Medicaid law regarding medical child support required by the Social Security Act §1908 (as added by Omnibus Budget Reconciliation Act of 1993).

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

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

### **General notice of COBRA continuation coverage rights**

#### **Introduction**

You are receiving this notice because you have recently become covered under a group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

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## NOTICES (continued)

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The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

### **What is COBRA continuation coverage?**

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event". Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary". You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, the qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced; or
- Your employment ends for any reason other than gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a "dependent child".

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## NOTICES (continued)

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### When is COBRA coverage available?

The plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or commencement of a proceeding in bankruptcy with respect to the employer, the employer must notify the Plan Administrator of the qualifying event.

### You must give notice of some qualifying events

**For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child) you must notify the Plan Administrator within 60 days after the qualifying event occurs.**

### How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children. Once the Plan Administrator offers COBRA continuation coverage, the qualified beneficiaries must elect such coverage within 60 days.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction in the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee last until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which the employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended:

- ***Disability extension of 18-month period of continuation coverage*** - If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator within 60 days of such determination, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total of 29 months. The disability would have to have started at some time before the 60<sup>th</sup> day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage;

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## NOTICES (continued)

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- **Second qualifying event extension of 18-month period of continuation coverage** - If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is given to the Plan within 60 days of the event. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

### **If you have questions**

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting your group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at <http://www.dol.gov/ebsa/>. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

### **Keep your plan informed of address changes**

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

### **Plan contact information:**

Humana  
Billing/Enrollment Department  
101 E Main Street  
Louisville, KY 40201  
1-800-872-7207

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## NOTICES (continued)

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### **Important notice for individuals entitled to Medicare tax equity and fiscal responsibility act of 1982 (TEFRA) options**

Where an employer employs more than 20 people, the Tax Equity And Fiscal Responsibility Act of 1982 (TEFRA) allows covered employees in active service who are age 65 or older and their covered spouses who are eligible for Medicare to choose one of the following options:

- **Option 1** - The benefits of their group health plan will be payable first and the benefits of Medicare will be payable second.
- **Option 2** - Medicare benefits only. The employee and his or her dependents, if any, will not be insured by the group health plan.

The employer must provide each covered employee and each covered spouse with the choice to elect one of these options at least one month before the covered employee or the insured spouse becomes age 65. All new covered employees and newly covered spouses age 65 or older must be offered these options. If Option 1 is chosen, its issue is subject to the same requirements as for an employee or dependent that is under age 65.

Under TEFRA regulations, there are two categories of persons eligible for Medicare. The calculation and payment of benefits by the group health plan differs for each category.

- **Category 1** Medicare eligibles are:
  - Covered employees in active service who are age 65 or older who choose Option 1;
  - Age 65 or older covered spouses; and
  - Age 65 or older covered spouses of employees in active service who are either under age 65 or age 70 or older;
- **Category 2** Medicare eligibles are any other covered persons entitled to Medicare, whether or not they enrolled. This category includes, but is not limited to:
  - Retired employees and their spouses; or
  - Covered dependents of a covered employee, other than his or her spouse.

### **Calculation and payment of benefits**

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

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

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## **NOTICES (continued)**

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### **Family and Medical Leave Act (FMLA)**

If an employee is granted a leave of absence (Leave) by the employer as required by the Federal Family and Medical Leave Act, s/he may continue to be covered under the plan for the duration of the Leave under the same conditions as other employees who are currently employed and covered by the plan. If the employee chooses to terminate coverage during the Leave, or if coverage terminates as a result of nonpayment of any required contribution, coverage may be reinstated on the date the employee returns to work immediately following the end of the Leave. Charges incurred after the date of reinstatement will be paid as if the employee had been continuously covered.

### **Uniformed services employment and reemployment rights act of 1994 (USERRA)**

#### **Continuation of benefits**

Effective October 13, 1994, federal law requires health plans offer to continue coverage for employees that are absent due to service in the uniformed services and/or dependents.

#### **Eligibility**

An employee is eligible for continuation under USERRA if he or she is absent from employment because of voluntary or involuntary performance of duty in the Armed Forces, Army National Guard, Air National Guard, or commissioned corps of the Public Health Service. Duty includes absence for active duty, active duty for training, initial active duty for training, inactive duty training and for the purpose of an examination to determine fitness for duty.

An employee's dependents that have coverage under the plan immediately prior to the date of the employee's covered absence are eligible to elect continuation under USERRA.

If continuation of Plan coverage is elected under USERRA, the employee or dependent is responsible for payment of the applicable cost of coverage. If the employee is absent for not longer than 31 days, the cost will be the amount the employee would otherwise pay for coverage. For absences exceeding 30 days, the cost may be up to 102% of the cost of coverage under the plan. This includes the employee's share and any portion previously paid by the employer.

#### **Duration of coverage**

If elected, continuation coverage under USERRA will continue until the earlier of:

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

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

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## **NOTICES (continued)**

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### **Other information**

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

### **Your rights under the Employee Retirement Income Security Act of 1974 (ERISA)**

Under ERISA, all plan participants covered by ERISA are entitled to certain rights and protections, as described below. Notwithstanding anything in the group health plan or group insurance policy, following are a covered person's minimum rights under ERISA. ERISA requirements do not apply to plans maintained by governmental agencies or churches.

### **Information about the plan and benefits**

Plan participants may:

- Examine, free of charge, all documents governing the plan. These documents are available in the plan administrator's office;
- Obtain, at a reasonable charge, copies of documents governing the plan, including a copy of any updated summary plan description and a copy of the latest annual report for the plan (Form 5500), if any, by writing to the plan administrator;
- Obtain, at a reasonable charge, a copy of the latest annual report (Form 5500) for the plan, if any, by writing to the plan administrator.

As a plan participant, you will receive a summary of any material changes made in the plan within 210 days after the end of the plan year in which the changes are made unless the change is a material reduction in covered services or benefits, in which case you will receive a summary of the material reduction within 60 days after the date of its adoption.

If the plan is required to file a summary annual financial report, you will receive a copy from the plan administrator.

### **Responsibilities of plan fiduciaries**

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the plan. These people, called "fiduciaries" of the plan, have a duty to act prudently and in the interest of plan participants and beneficiaries.

No one, including an employer, may discharge or otherwise discriminate against a plan participant in any way to prevent the participant from obtaining a benefit to which the participant is otherwise entitled under the plan or from exercising ERISA rights.

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## **NOTICES (continued)**

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### **Continue group health plan coverage**

Participants may be eligible to continue health care coverage for themselves, their spouse or dependents if there is a loss of coverage under the group health plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review the COBRA notice in this document regarding the rules governing COBRA continuation coverage rights.

Participants should review their group health plan document regarding reduction or elimination of exclusionary periods for preexisting conditions due to creditable coverage from another plan. The group health plan or health insurance issuer should provide a certificate of creditable coverage when coverage ends under the plan, the participant becomes entitled to elect COBRA continuation coverage, COBRA continuation coverage ceases (if COBRA is requested before losing coverage) or, if requested, up to 24 months after losing coverage. Without evidence of creditable coverage, a participant may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after the coverage enrollment date.

### **Claims determinations**

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

### **Enforce your rights**

Under ERISA, there are steps participants may take to enforce the above rights. For instance:

- If a participant requests a copy of plan documents and does not receive them within 30 days, the participant may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to \$110 a day until the participant receives the materials, unless the materials were not sent because of reasons beyond the control of the plan administrator;
- If a claim for benefits is denied or disregarded, in whole or in part, the participant may file suit in a state or Federal court;
- If the participant disagrees with the plan's decision, or lack thereof, concerning the qualified status of a domestic relations order or a medical child support order, the participant may file suit in Federal court;
- If plan fiduciaries misuse the plan's money, or if participants are discriminated against for asserting their rights, they may seek assistance from the U.S. Department of Labor, or may file suit in a Federal court.

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## NOTICES (continued)

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The court will decide who should pay court costs and legal fees. If the participant is successful, the court may order the person sued to pay costs and fees. If the participant loses, the court may order the participant to pay the costs and fees.

### Assistance with questions

- Contact the group health plan human resources department or the plan administrator with questions about the plan;
- For questions about ERISA rights, contact the nearest area office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or:

The Division of Technical Assistance and Inquiries  
Employee Benefits Security Administration  
U.S. Department of Labor  
200 Constitution Avenue N.W.  
Washington, D.C. 20210;

- Call the publications hotline of the Employee Benefits Security Administration to obtain publications about ERISA rights.

### Certificate of Creditable Coverage

Upon termination of this group health plan, you will receive a certificate of creditable coverage. You may also call the Customer Service number on the back of your Humana identification card to request a copy.

### Privacy and confidentiality statement

We understand the importance of keeping your personal and health information private (PHI). PHI includes both medical information and individually identifiable information, such as your name, address, telephone number or social security number. We are required by applicable federal and state law to maintain the privacy of your PHI.

Under both law and our policies, we have a responsibility to protect the privacy of your PHI. We:

- Protect your privacy by limiting who may see your PHI;
- Limit how we may use or disclose your PHI;
- Inform you of our legal duties with respect to your PHI;
- Explain our privacy policies; and
- Strictly adhere to the policies currently in effect.

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## NOTICES (continued)

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We reserve the right to change our privacy practices at any time, as allowed by applicable law, rules and regulations. We reserve the right to make changes in our privacy practices for all PHI that we maintain, including information we created or received before we made the changes. When we make a significant change in our privacy practices, we will send notice to our health plan subscribers. For more information about our privacy practices, please contact us.

As a covered person, we may use and disclose your PHI, without your consent/authorization, in the following ways:

- **Treatment:** We may disclose your PHI to a health care practitioner, a hospital or other entity which asks for it in order for you to receive medical treatment.
- **Payment:** We may use and disclose your PHI to pay claims for covered services provided to you by health care practitioners, hospitals or other entities.

We may use and disclose your PHI to conduct other health care operations activities.

It has always been our goal to ensure the protection and integrity of your personal and health information. Therefore, we will notify you of any potential situations where your identification would be used for reasons other than treatment, payment and health plan operations.