

CITY OF DALLAS

**PRESCRIPTION DRUG
STANDALONE PLAN FOR RETIREE 65 AND OVER
SUMMARY PLAN DESCRIPTION**

EFFECTIVE JANUARY 1, 2005

GROUP NUMBER: N6940

FOR CUSTOMER SERVICE PLEASE CALL 800-626-2694

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SCHEDULE OF PRESCRIPTION DRUG BENEFITS

NOTE: Additional drug information can be obtained by accessing the *Plan Manager's* website at www.humana.com.

| RETAIL COPAYMENT STRUCTURE PER PRESCRIPTION | |
|--|--|
| <i>Level 1 Drugs</i> | 10% with a \$5 minimum |
| <i>Level 2 Drugs</i> | 20% with a \$10 minimum |
| <i>Level 3 Drugs</i> | 30% with a \$25 minimum |
| Retail <i>Prescription Drug</i> Maximum Supply | 30 days or 100 units whichever is greater |
| MAIL ORDER COPAYMENT STRUCTURE PER PRESCRIPTION | |
| <i>Level 1 Drugs</i> | 10% with a \$10 minimum |
| <i>Level 2 Drugs</i> | 20% with a \$20 minimum |
| <i>Level 3 Drugs</i> | 30% with a \$30 minimum |
| Mail Order Drug Maximum Supply | 90 days |
| DEDUCTIBLE | |
| Individual | \$75 Combined Retail and Mail Order Deductible per individual |
| ANNUAL OUT-OF-POCKET-MAXIMUM | |
| Individual | \$2,500 Combined Retail and Mail Order Annual Out-of-Pocket Maximum per individual |
| SPECIALTY OFFICE MEDICATION AND INJECTABLE DRUGS PER PRESCRIPTION * | |
| For up to a 30 day supply | \$0 <i>copayment</i> |

*Specialty office medication and injectable drugs do not include *self-administered injectable drugs*.

ADDITIONAL PRESCRIPTION DRUG BENEFIT INFORMATION

If an *employee/eligible dependent* purchases a *brand name medication*, and an equivalent *generic medication* is available, the *employee/eligible dependent* must pay the difference between the *brand name medication* and the *generic medication* plus any applicable *Level 1* or *Level 3 generic medication copayment*. If the physician writes on the *prescription* "dispense as written", the drug will be dispensed as such, the *employee/eligible dependent* will only be responsible for the *brand name medication copayment*.

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

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

Schedule of Prescription Drugs Continued

Mail *pharmacy* receipts to:

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

PRIOR AUTHORIZATION

Some *prescription* drugs may be subject to *prior authorization*. To verify if a *prescription* drug requires *prior authorization*, call the toll free customer service phone number on the back of *your* ID card or visit the *Plan Manager's* website at www.humana.com.

DISPENSING LIMITS

Some *prescription* drugs may be subject to *dispensing limits*. To verify if a *prescription* drug has *dispensing limits*, call the toll free customer service phone number on the back of *your* ID card or visit the *Plan Manager's* website at www.humana.com.

PRESCRIPTION DRUG BENEFITS

RETAIL PHARMACY

Your Plan provisions include a retail *prescription* drug benefit. *You* will receive an identification (ID) card, which includes *your* name, medical group number, prescription drug plan numbers and *your* effective date.

Present *your* ID card at a *participating pharmacy* when purchasing a *prescription*. *Prescriptions* dispensed at a retail *pharmacy* are limited to a 30 day supply or 100 units whichever is greater per *prescription* or refill.

MAIL ORDER PHARMACY

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

Mail order pharmacy prescriptions will only be filled with the quantity prescribed by *your physician* and are limited to a maximum of a:

- 90 day supply per *prescription* or refill for a drug received from a *mail order pharmacy*; or
- 30 day supply per *prescription* or refill for *self-administered injectable medications* or specialty office medications and injectables.

Additional *mail order pharmacy* information can be obtained through *your* Human Resources Department or by calling the toll free customer service phone number on the back of *your* ID card or visit the *Plan Manager's* website at www.humana.com.

Prescription Drug Benefits Continued

SPECIALTY OFFICE MEDICATIONS AND INJECTABLES

Your qualified practitioner has access to specialty office medications and injectables used to treat chronic conditions. These medications can be ordered specifically for *you* for administration in his/her office setting. This allows *your* physician a cost effective and convenient way to obtain high cost, high tech specialty medications and injectables. Additional information can be obtained through *your* Human Resources Department or by calling the toll-free customer service phone number on the back of *your* ID card.

PRESCRIPTION DRUG COST SHARING

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

You are responsible for payment of:

- The drug deductible, if any;
- The *copayment*;
- The cost of medication not covered under the *prescription* drug benefit;
- The cost of any quantity of medication dispensed in excess of the day supply noted on the Schedule of Benefits.

Any *expense incurred* under the *prescription* drug benefit does not apply toward *your* medical out of pocket limits.

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

To verify whether a *prescription* is covered or not under the Plan, *you* may call the toll free customer service phone number on the back of *your* ID card or visit the *Plan Manager's* website at www.humana.com and follow the directions listed below:

1. Go to Humana's website (www.humana.com)
2. Click under ("Find a" and select Drug)
3. Review Step 1 for information on Humana's RX3 program; or
Type in name of drug under step 2 to obtain results from drug list; or
4. Call the toll free customer service number on the back of our ID card.

Prescription Drug Benefits Continued

Covered *prescription* drugs, medicine or medications must:

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

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

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

ELIGIBILITY AND EFFECTIVE DATE OF COVERAGE

MEMBER ELIGIBILITY

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

1. *You* are a *retired employee* who meets the eligibility requirements of the *employer* (see page 32 for retiree definition); and
2. All eligible *members* must reside in the United States.

Your eligibility date is the date immediately following *your* completion of any eligibility period.

MEMBER EFFECTIVE DATE OF COVERAGE

You must enroll by accessing the HRIS Self Evident Application (SEA) via the City of Dallas Intranet or City of Dallas Internet site at <http://cod.dtolawsonportal.com/lawson/portal/>. *You* must have an HRIS User ID and password which will be assigned within approximately two weeks of *your* eligibility date. Or, enroll by calling the Benefits Service Center at 1-888-873-7692 between 8:00 AM and 5:00 PM CST.

1. If *your* enrollment is completed before *your* eligibility date or within 31 days after *your* eligibility date, as determined by *your employer*, coverage is effective on *your* eligibility date.
2. If *your* enrollment is completed more than 31 days after *your* eligibility date, as determined by *your employer*, *you* are a *late applicant* and *you* will not be eligible for coverage under this Plan.

DEPENDENT ELIGIBILITY

Each *dependent* is eligible for coverage on:

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

The covered *member* may cover *dependents* only if the *member* is also covered. Check with *your employer* immediately on how to enroll for *dependent* coverage. Late enrollment will result in denial of *dependent* coverage until the next annual open enrollment period. *Your dependents'* coverage will be subject to the *pre-existing condition* limitation as defined within the Definitions section of this booklet

In any event, no person may be simultaneously covered as both a *member* and a *dependent*. If both parents are eligible for coverage, only one may enroll for *dependent* coverage.

Eligibility and Effective Date of Coverage Continued

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

If the *member* wishes to add a newborn *dependent* to the Plan and a change in the *member’s* level of coverage is not required, the newborn dependent must be added to the Plan by calling the Benefits Service Center at 1-888-873-7692 between 8:00 AM and 5:00 PM CST. Please see *your employer* for further details on the enrollment process.

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

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

1. If *your* enrollment is completed before the *dependent’s* eligibility date or within 31 days after the *dependent’s* eligibility date, that *dependent* is covered on the date he or she is eligible.
2. If *your* enrollment is completed more than 31 days after the *dependent’s* eligibility date, the *dependent* is a *late applicant*. The *dependent* will not be eligible for coverage under this Plan until the next annual open enrollment period. The *dependent’s* coverage will be subject to the *pre-existing condition* limitation as defined within the Definitions section of this booklet.

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

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

If the *member* wishes to add a *dependent* to the Plan and a change in the *member’s* level of coverage is required, *you* must enroll *your dependent* to the Plan by calling the Benefits Service Center at 1-888-873-7692 between 8:00 AM and 5:00 PM CST. Please see *your employer* for further details on the enrollment process.

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

1. If *your* enrollment is completed before the *dependent’s* eligibility date or within 31 days after the *dependent’s* eligibility date, that *dependent* is covered on the date he or she is eligible.
2. If *your* enrollment is completed more than 31 days after the *dependent’s* eligibility date, the *dependent* is a *late applicant*. The *dependent* will not be eligible for coverage under this Plan until the next annual open enrollment period. The *dependent’s* coverage will be subject to the *pre-existing condition* limitation as defined within the Definitions section of this booklet.

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

Eligibility and Effective Date of Coverage Continued

DOMESTIC PARTNERS ELIGIBILITY

Benefits will be available to only one domestic same gender partner per employee.

The Plan defines the domestic partner of an employee as the only adult individual (age 18 or older) who:

1. Is the same gender; and;
2. Resides together in the same permanent residence and have lived together in a spouse-like relationship for at least six (6) consecutive months; and;
3. Is at least 18 years of age and are not related by blood and;
4. Is not legally married or the common-law spouse or Domestic Partner of any other person.

ELIGIBILITY CRITERIA

Meets at least two of the following requirements:

- a. Designation as a primary beneficiary for the employee's life insurance benefits or will, and or;
- b. Ownership of a joint bank account or credit card account for substantial assets, and, or;
- c. Demonstrating common ownership of real property by Joint Deed, Mortgage or Lease Agreement

ELIGIBILITY FOR CHILD OF DOMESTIC PARTNERS

The Plan may also provide benefits for the child of a domestic partner. For the child to be eligible for such benefits, all of the following conditions must apply:

1. The child is primarily dependent upon the employee and domestic partner for financial support, including debts incurred by the child, or the domestic partner is mandated by contract or legal ruling to provide financial support, and;
2. The child is unmarried, the domestic partner is the legal guardian and is less than age 25, or age 25 and is a regular full-time student in an accredited secondary school,
3. The employee and domestic partner assume parental responsibility for the child, including debts incurred by the child, and;
4. The child was claimed by the employee as a dependent on the employee's federal income tax return for the prior year and the employee intends to claim the child as a dependent for the current year and any subsequent years in which the child meets the above qualifications.

Domestic Partners have filled out and attested to the "[Affidavit of Domestic Partnership](#)" found on the City's web site <http://www.cod> / Publications / Affidavit of Domestic Partnership, or phone (214) 670-3120 for information.

Eligibility and Effective Date of Coverage Continued

MEDICAL CHILD SUPPORT ORDERS

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

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

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

RETIREE COVERAGE

Retired employees are eligible for the benefits as described below on the first of the month following their employment termination date and must enroll within thirty-one days after their date of retirement. Otherwise, the *retired employee* will be considered to have waived retiree coverage and will not be eligible for future coverage.

As a *retired employee*, benefits under this Plan are continued. The continued coverage will be the same coverage as for active *employees*, except as described below.

The continued benefits for *Medicare* eligibles are modified as shown in Special Rule Involving Employee's Entitlement to Medicare Benefits.

A surviving spouse and eligible *dependents* of a *retired employee* may remain in the Plan after the death of the *retired employee*:

- If the person was covered as a *dependent* spouse of the deceased *retired employee* at the time of the *retired employee's* death and is eligible to receive pension benefits;
- If carried as a *dependent* child, the person remains a *dependent* of the surviving spouse, but only if the spouse is receiving monthly survivor's benefits from one of the retirement funds.

Coverage for all surviving *dependents* ceases if coverage for the surviving spouse stops because of death, termination of monthly benefits, or any other reason.

A *retired employee*, or a surviving spouse or *dependent* who is eligible for *Medicare* participation by reason of age or disability or any other reason, must enroll and remain enrolled in *Medicare* Parts A and B in order to retain eligibility in the Plan.

The City will pay the *Medicare* Part A monthly premium on behalf of the *retired employees* and spouses of *retired employees* who are not otherwise qualified for *Medicare*. *Retired employees* are responsible for notifying the City, otherwise, they will be responsible for payment of the *Medicare* Part A premium. The *retired employee* and *retired employee's* spouse are responsible for payment of all *Medicare* Part B premiums.

If a *retired employee* is enrolled in this Plan on January 1, and elects to discontinue coverage in this Plan, the *retired employee* will not be eligible to enroll at a later date or in a subsequent plan.

TERMINATION OF COVERAGE

Coverage terminates on the earliest of the following:

1. The date the Plan terminates;
2. The end of the period for which any required contribution was due and not paid;
3. The end of the calendar month *you* fail to be in an eligible class of persons according to the eligibility requirements of the *employer*; or
4. For any benefit, the date the benefit is removed from the Plan;
5. For *your dependents*, the date *your* coverage terminates;
6. For a *dependent*, the end of the calendar month such *covered person* no longer meets the definition of *dependent*; or
7. The end of the calendar month *you* request termination of coverage to be effective for yourself and/or *your dependents*.

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

CONTINUATION OF PRESCRIPTION DRUG BENEFITS

THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1986 (COBRA)

CONTINUATION OF BENEFITS

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

ELIGIBILITY

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

RETIRED EMPLOYEE: A *retired employee* covered by the *employer's* Plan has the right to elect continuation coverage if coverage is lost due to termination of retiree coverage when the former *employer* discontinues retiree coverage within one year before or one year after filing for Chapter 11 bankruptcy.

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

- The death of the *retired employee*;
- Divorce or legal separation from the *retired employee*; or
- Termination of a retiree spouse's coverage when the former *employer* discontinues retiree coverage within one year before or one year after filing for Chapter 11 bankruptcy.

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

- The death of the *retired employee* parent;
- Ceasing to be a "*dependent* child" under the Plan; or
- Termination of the retiree parent's coverage when the former *employer* discontinues retiree coverage within one year before or one year after filing for Chapter 11 bankruptcy.

LOSS OF COVERAGE

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

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

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

COBRA Continued

NOTICES AND ELECTION

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

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

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

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

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

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

COBRA Continued

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

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

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

MAXIMUM COVERAGE PERIOD

Coverage may continue up to:

- 36 months for a spouse whose coverage ended due to the death of the retiree or divorce from the retiree;
- 36 months for a *dependent* child whose coverage ended due to the divorce of the *retired employee* parent, the death of the *retired employee*, or the child ceasing to be a *dependent* under the Plan;
- For the retiree, until the date of death of the retiree who is on continuation due to loss of coverage within one year before or one year after the *employer* filed Chapter 11 bankruptcy;

DISABILITY

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

COBRA Continued

SECOND QUALIFYING EVENT

An 18-month extension of coverage will be available to spouses and dependent children who elect continuation coverage if a second qualifying event occurs during the first 18 months of continuation coverage. The maximum amount of continuation coverage available when a second qualifying event occurs is 36 months. Such second qualifying event may include the death of a covered *retired employee*, divorce or separation from the covered *retired employee*, the covered *retired employee's* becoming entitled to Medicare benefits (under Part A, Part B, or both), or a dependent child's ceasing to be eligible for coverage as a dependent under the Plan. These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred. You must notify the Plan within 60 days after the second qualifying event occurs if you want to extend your continuation coverage.

TERMINATION BEFORE THE END OF MAXIMUM COVERAGE PERIOD

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

- The *employer* no longer provides group health coverage to any of its *retired employees*;
- The premium for continuation is not paid timely;
- The individual on continuation becomes covered under another prescription drug plan (as a *retired employee* or otherwise);
- If there is a final determination under Title II or XVI of the Social Security Act that an individual is no longer disabled; however, continuation coverage will not end until the month that begins more than 30 days after the determination;
- The occurrence of any event (e.g. submission of a fraudulent claim) permitting termination of coverage for cause under the Plan.

TYPE OF COVERAGE; PREMIUM PAYMENT

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

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

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

The monthly premium payment to the Plan for continuing coverage must be submitted directly to the *COBRA Service Provider*. This monthly premium may include the *retired employee's* share and any portion previously paid by the *employer*. The monthly premium must be a reasonable estimate of the cost of providing coverage under the Plan for similarly situated non-COBRA beneficiaries. The premium for COBRA continuation coverage may include a 2% administration charge. Qualified beneficiaries who do not take the additional 11 months of special coverage will pay the up to 102% premium cost.

COBRA Continued

OTHER INFORMATION

Additional information regarding rights and obligations under the Plan and under federal law may be obtained by contacting the Plan Administrator.

It is important for the *covered person* or qualified beneficiary to keep the Plan Administrator informed of any changes in address.

PLAN CONTACT INFORMATION

Retired employees should contact the *COBRA Service Provider* for any question regarding continuation coverage.

COBRA Service Provider
3201 34th Street South
St. Petersburg, Florida 33711-3828
1-800-877-7994

REIMBURSEMENT/SUBROGATION

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

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

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

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

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

AGREEMENT AND COOPERATION REQUIRED

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

The *covered person* shall cooperate by providing information and executing any documents to preserve the Plan's right and shall have the affirmative obligation of notifying the Plan that claims are being made against responsible parties to recover for injuries for which the Plan has paid. If the *covered person* enters into litigation or settlement negotiations regarding the obligations of the other party, the *covered person* must not prejudice, in any way, rights to recover an amount equal to any benefits that have provided or paid for the *bodily injury* or *sickness*. Failure of the *covered person* to provide such notice or cooperation, or any action by the *covered person* resulting in prejudice to the Plan's rights will be a material breach of this Plan and will result in the *covered person* being personally responsible to make repayment. In such an event, the *Plan Manager* may deduct from any pending or subsequent claim made under the Plan any amounts the *covered person* owes the Plan until such time as cooperation is provided and the prejudice ceases.

Reimbursement/Subrogation Continued

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

GENERAL PROVISIONS

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

CONTESTABILITY

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

RIGHT TO REQUEST OVERPAYMENTS

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

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

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

WORKERS' COMPENSATION NOT AFFECTED

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

WORKERS' COMPENSATION

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

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

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

General Provisions Continued

MEDICAID

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

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

CONSTRUCTION OF PLAN TERMS

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

PRIVACY OF PROTECTED HEALTH INFORMATION

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

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

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

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

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

General Provisions Continued

The *Plan Manager* will afford access to *protected health information* as reasonably directed in writing by the Plan Administrator, which shall only be made with due regard for confidentiality. In that regard, the *Plan Manager* has been directed that disclosure of *protected health information* may be made to a designated representative of the *Employer*.

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

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

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

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

CLAIMS PROCEDURES

SUBMITTING A CLAIM

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

- A claim must be filed with the *Plan Manager* by mail or courier.
- Claims must be submitted to the *Plan Manager* at the address indicated in the documents describing the Plan or *claimant's* identification card. Claims will not be deemed submitted for purposes of these procedures unless and until received at the correct address.
- Also, claims submissions must be in a format acceptable to the *Plan Manager* and compliant with any applicable legal requirements. Claims that are not submitted in accordance with the requirements of applicable federal law respecting privacy of protected health information and/or electronic claims standards will not be accepted by the Plan.
- Claims submissions must be timely. Claims must be filed as soon as reasonably possible after they are incurred, and in no event later than 12 months after the date of loss, except if *you* were legally incapacitated. Plan benefits are only available for claims that are incurred by a *covered person* during the period that he or she is covered under the Plan.
- Claims submissions must be complete. They must contain, at a minimum:
 - ◆ The name of the *covered person* who incurred the *covered expense*;
 - ◆ The name and address of the health care provider;
 - ◆ The diagnosis of the condition;
 - ◆ The procedure or nature of the treatment;
 - ◆ The date of and place where the procedure or treatment has been or will be provided;
 - ◆ The amount billed and the amount of the covered expense not paid through coverage other than Plan coverage, as appropriate;
 - ◆ Evidence that substantiates the nature, amount, and timeliness of each *covered expense* in a format that is acceptable according to industry standards and in compliance with applicable law.

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

Prescription claims and correspondence should be mailed to:

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

Claims Procedures Continued

MISCELLANEOUS PRESCRIPTION DRUGS CHARGES

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

PROCEDURAL DEFECTS

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

ASSIGNMENTS AND REPRESENTATIVES

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

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

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

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

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

Claims Procedures Continued

CLAIMS DECISIONS

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

PRE-SERVICE CLAIMS

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

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

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

URGENT CARE CLAIMS

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

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

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

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

Claims Procedures Continued

CONCURRENT CARE DECISIONS

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

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

POST-SERVICE CLAIMS

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

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

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

TIMES FOR DECISIONS

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

PAYMENT OF CLAIMS

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

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

Claims Procedures Continued

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

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

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

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

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

INITIAL DENIAL NOTICES

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

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

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

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

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

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

Claims Procedures Continued

APPEALS OF ADVERSE DETERMINATIONS

A *claimant* must appeal an adverse determination within 180 days after receiving written notice of the denial (or partial denial). With the exception of *urgent care claims* and *concurrent care decisions*, the Plan uses a two level appeals process for all adverse determinations. The *Plan Manager* will make the determination on the first level of appeal. If the *claimant* is dissatisfied with the decision on this first level of appeal, or if the *Plan Manager* fails to make a decision within the time frame indicated below, the *claimant* may appeal to the Plan Administrator. *Urgent care claims* and *concurrent care decisions* are subject to a single level appeal process only, with the *Plan Manager* making the determination.

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

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

Humana – G&A
P.O. Box 14546
Lexington, KY 40512 - 4546

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

Humana – G&A
P.O. Box 14546
Lexington, KY 40512 - 4546

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.

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

Claims Procedures Continued

Time Periods for Decisions on Appeal -- First Level

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

| | |
|----------------------------------|--|
| <i>Urgent Care Claims</i> | As soon as possible, but not later than 72 hours after the <i>Plan Manager</i> receives the appeal request (if oral notification is given, written notification will follow in hard copy or electronic format within the next 3 days). |
| <i>Pre-Service Claims</i> | Within a reasonable period, but not later than 15 days after the <i>Plan Manager</i> receives the appeal request. |
| <i>Post-Service Claims</i> | Within a reasonable period but no later than 30 after days after the <i>Plan Manager</i> receives the appeal request. |
| <i>Concurrent Care Decisions</i> | Within the time periods specified above, depending upon the type of claim involved. |

Time Periods for Decisions on Appeal -- Second Level

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

| | |
|----------------------------|---|
| <i>Pre-Service Claims</i> | Within a reasonable period, but not later than 15 days after the <i>Plan Manager</i> receives the appeal request. |
| <i>Post-Service Claims</i> | Within a reasonable period but no later than 30 days after the <i>Plan Manager</i> receives the appeal request. |

APPEAL DENIAL NOTICES

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

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

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

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

Claims Procedures Continued

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

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

RIGHT TO REQUIRE MEDICAL EXAMS

(Applies only to medical Plans)

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

EXHAUSTION

Upon completion of the appeals process under this section, a *claimant* will have exhausted his or her administrative remedies under the Plan. If the *Plan Manager* or Plan Administrator fails to complete a claim determination or appeal within the time limits set forth above, the *claimant* may treat the claim or appeal as having been denied, and the *claimant* may proceed to the next level in the review process.

LEGAL ACTIONS AND LIMITATIONS

A civil action may not be brought with respect to Plan benefits until all remedies under the Plan have been exhausted.

DEFINITIONS

Active status means performing on a regular, full-time or part-time basis all customary occupational duties, for not less than 20 hours per week, at the *employer's* business locations or when required to travel for the *employer's* business purposes. Each day of a regular paid vacation and any regular non-working holiday will be deemed *active status* if you were in an *active status* on your last regular working day prior to the vacation or holiday.

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

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

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

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

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

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

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

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

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

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

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

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

Covered person means the *retired employee*, or any of their covered *dependents*.

Definitions Continued

Dependent means a covered *member's*:

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

The limiting age for each *dependent* child is 25 years if such child is dependent upon the *member* for support and in regular full-time attendance at an accredited secondary school, college or university. The *dependent* child must be enrolled for sufficient course credits to maintain full-time status as defined by that school. A *dependent* child continues to be eligible for coverage for up to four months following the close of a school term only if enrolled as a full-time student for the following school term.

Adopted children and children placed for adoption are subject to all terms and provisions of the Plan.

3. A covered *member's* child whose age is less than the limiting age and is entitled to coverage under the provisions of this Plan because of a medical child support order;
4. Grandchild, as long as the *member's* covered *dependent*, who is the parent of the grandchild, is not yet age 18.

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

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

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

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

Definitions Continued

Dispensing limit means the monthly drug dosage limit and or the number of months the drug usage is needed to treat a particular condition.

Drug list means a list of *prescription* drug, medicines, medications and supplies approved by the *Plan Manager*. This list is subject to change.

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

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

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

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

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

Hospital means an institution which:

1. Maintains permanent full-time facilities for bed care of resident patients;
2. Has a physician and surgeon in regular attendance;
3. Provides continuous 24 hour a day nursing *services*;
4. Is primarily engaged in providing diagnostic and therapeutic facilities for medical or surgical care of sick or injured persons;
5. Is legally operated in the jurisdiction where located; and
6. Has surgical facilities on its premises or has a contractual agreement for surgical *services* with an institution having a valid license to provide such surgical *services*; or
7. Is a lawfully operated *qualified treatment facility* certified by the First Church of Christ Scientist, Boston, Massachusetts.

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

Late applicant means a *retired employee* and/or a *retired employee's* eligible *dependent* who applies for prescription coverage more than 31 days after the eligibility date.

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

Definitions Continued

Level 1 drugs means a category of generic drugs, medicines or medications on the *Plan Manager's drug list*.

Level 2 drugs means a category of brand name drugs, medicines or medications on the *Plan Manager's drug list*.

Level 3 drugs means a category of generic or brand name drugs, medicines or medications not on the *Plan Manager's drug list*.

Mail order pharmacy means a pharmaceutical vendor designated by the *Plan Manager*, properly licensed to dispense and deliver covered *prescriptions* through the mail.

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

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

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

Member means retiree covered by this plan.

Non-participating pharmacy means a *pharmacy*, which has not entered into an agreement with the *Plan Manager* or has not been designated by the *Plan Manager* to provide *services* to *covered persons*.

Participating pharmacy means a *pharmacy* which has entered into an agreement with or has been designated by the *Plan Manager* to provide *services* to *covered persons*.

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

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

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

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

Definitions Continued

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

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

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

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

Prior authorization means the required prior approval from the *Plan Manager* for the coverage of *prescription* drugs, medicines, medications, including the dosage, quantity and duration, as appropriate for the *covered person's* age and sex.

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

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

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

Retired employee means an eligible *employee* who meets all of the following:

- A former *employee* who has retired and is either (a) drawing benefits under either the Employees Retirement Fund of the City of Dallas or the Dallas Police and Fire Pension System; or (b) contributing to Deferred Retirement Option Plan ("DROP"). An *employee* who terminates with the vested interest in one of these retirement plans but who is not yet eligible for pension benefits is not classified as a retiree under the plan; **and**
- The *employee* was covered under this Plan or a continuation of this Plan (COBRA) on the day before the date of retirement.

Retired employee also means:

- A former *employee* who was within two years of reaching pension eligibility and was terminated through Reduction in Force ("RIF") as defined under the City of Dallas Civil Service rules; **or**
- A former *employee* who had earned 30 years' pension service credit but did not have sufficient age to qualify as a retiree;

Definitions Retired Employee Continued

And (in either of the above)

- Was covered under this Plan on the day before the “RIF” or termination, who subsequently becomes eligible, because of age, to receive retirement benefits from the Employees’ Retirement Fund or the City of Dallas (“ERF”) or the Dallas Police and Fire Pension System (“DPFP”), or elects to defer the pension benefit payment to a Deferred Retirement Option Plan (“DROP”) account established by DPFP.

In order to be eligible for retiree prescription coverage, a *retired employee* must have been enrolled on this plan or a previous City of Dallas Health Benefits Plan on December 31, 2003.

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

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

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

Timely applicant means a *retired employee* and/or a *retired employee's* eligible *dependent* who applies for prescription coverage within 31 days of the eligibility date.

Urgent care claim means a claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations:

- Could seriously jeopardize the life or health of the *claimant* or the ability of the *claimant* to regain maximum function; or
- In the opinion of a physician with knowledge of the *claimant's* medical condition, would subject the *claimant* to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.
- Generally, whether a claim is a claim involving urgent care will be determined by the *Plan Manager*. However, any claim that a physician with knowledge of a *claimant's* medical condition determines is a “claim involving urgent care” will be treated as a “claim involving urgent care.”

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