



**Medical HMO Pricing**

| <b><u>Type of Coverage</u></b> | <b><u>Zoo Contribution<br/>(Monthly)</u></b> | <b><u>Employee<br/>Contribution<br/>(Monthly)</u></b> | <b><u>Total or COBRA<br/>Premium<br/>(Monthly)</u></b> |
|--------------------------------|--|---|--|
| Employee                       | \$385.77                                     | \$ 15.00  | \$400.77   |
| Employee plus 1                | \$771.54                                     | \$ 30.00  | \$801.54   |
| Employee plus 2+               | \$1,195.39                                   | \$ 47.00  | \$1,242.39   |

**Medical PPO (Coverage First) Pricing**

| <b><u>Type of Coverage</u></b> | <b><u>Zoo Contribution<br/>(Monthly)</u></b> | <b><u>Employee<br/>Contribution<br/>(Monthly)</u></b> | <b><u>Total or COBRA<br/>Premium<br/>(Monthly)</u></b> |
|--------------------------------|--|---|--|
| Employee                       | \$391.69                                     | \$ 40.00  | \$431.69   |
| Employee plus 1                | \$782.38                                     | \$ 81.00  | \$863.38   |
| Employee plus 2+               | \$1,212.23                                   | \$126.00  | \$1,338.23   |

**Dental PPO Pricing**

| <b><u>Type of Coverage</u></b> | <b><u>Zoo<br/>Contribution<br/>(Monthly)</u></b> | <b><u>Employee<br/>Contribution<br/>(Monthly)</u></b> | <b><u>Total or COBRA<br/>Premium<br/>(Monthly)</u></b> |
|--------------------------------|--|---|--|
| Employee                       | \$15.32  | \$9.00  | \$24.32  |
| Employee plus Spouse           | \$30.62  | \$18.00   | \$48.62  |
| Employee plus<br>Child(ren)    | \$37.50  | \$22.00   | \$59.50  |
| Employee plus Family           | \$52.79  | \$31.00   | \$83.79  |

**Life and Accidental Death & Dismemberment Insurance**

| <b><u>Type of Coverage</u></b> | <b><u>Zoo Contribution</u></b> | <b><u>Employee Contribution</u></b> |
|--------------------------------|--------------------------------|-------------------------------------|
| One times salary               | \$0.140 per \$1,000            | None                                |

1x salary with a Minimum \$10,000 and a Maximum of \$250,000

### Long Term Disability Insurance

| <u>Type of Coverage</u> | <u>Zoo Contribution</u> | <u>Employee Contribution</u> |
|-------------------------|-------------------------|------------------------------|
| 60% of your salary      | \$0.23 per \$100        | None                         |

Monthly benefit of 60% income replacement, to a monthly maximum amount of \$8,500 after 90 days of disability.

### Supplemental Group Term Life Insurance - Voluntary

Employee can purchase additional coverage in increments of \$10,000 to a maximum of \$500,000. Coverage for spouse is available in increments of \$10,000 up to 50% of the employee's coverage amount or \$250,000 whichever is less. Coverage for children is available in the amount of \$10,000 and covers all children living in the household for one low rate. See HR to obtain rate tables for this benefit.

### Short Term Disability - Voluntary

Monthly benefit of 60% income replacement, to a monthly maximum amount of \$3,000. 7 or 14 day elimination period available and benefit can last up to 3 months. See HR to obtain rate tables for this benefit.

### Accident Coverage - Voluntary

- \*Medical Expense up to \$1,000 less \$50 deductible for emergency room.
  - \*Ambulance up to \$500 Ground
  - \*Hospital Confinement up to \$150 a day for 30 days
  - \*AD&D up to \$10,000
- See HR to obtain rate tables for this benefit.

### Universal Life

- \*Guaranteed Issue based on premium of \$5.00 to \$20.00 weekly, up to \$150,000 coverage.
- \*Long Term Care (LTC) rider available.
- \*Family coverage available.
- \*Policy is 100% portable.

### Critical Illness

- \*Employee choice of \$10,000 or \$20,000 coverage.
- \*Provides a lump sum cash benefit to help cover out-of-pocket expenses associated with critical illness (example: heart attack, stroke, cancer, etc.).
- \*Family coverage available.
- \*Policy is 100% portable.

# HumanaHMO Summary of Benefits

## KANSAS/ MISSOURI Plan 75, Option 003

Plan pays for services provided or arranged by your **PARTICIPATING** primary care physician

|  |   |   |
|--|---|---|
| <b>Preventive Care</b>   | • Routine immunizations (except for travel)   | <b>100%</b>   |
|  | • Routine physical exams<br>• Well-child care<br>• Well-woman care (may self-refer to OB/GYN)<br>• Well-men care (Prostate exam) (1)  | <b>100%</b>   |
| <b>Physician Services</b><br>(most visits to specialists must be authorized by a primary care physician) | • Prenatal care (office visit copayment applies to first visit only)<br>• Physician office visits (office visits in conjunction with an illness or injury)<br>• Allergy test  | <b>100%</b> after \$20 copayment per visit to primary care physician or \$30 copayment per visit to specialist  |
|  | • Allergy serums and injections<br>• Emergency room physician   | <b>100%</b>   |
| <b>Hospital Services</b>   | • Inpatient care (semiprivate room, ancillary services, physician visits)   | <b>100%</b> after \$500 copayment per day for first three days, per admission   |
|  | • Preadmission testing  | <b>100%</b>   |
|  | • Outpatient surgical care (includes ambulatory surgical center)  | <b>100%</b> after \$300 copayment   |
|  | • Outpatient nonsurgical care   | <b>100%</b> after \$150 copayment   |
|  | • Emergency care (emergency room, emergency services)   | <b>100%</b> after \$100 copayment per visit (waived if admitted)  |
| <b>Prescription Drugs</b>  | • Please see attached pharmacy benefit information, if applicable.  |   |
| <b>Other Medical Services</b>  | • Skilled nursing facility (up to 100 days per calendar year)<br>• Home health care (up to 60 visits per calendar year)<br>• Ambulance<br>• Durable medical equipment<br>• Respiratory<br>• Radiation<br>• Hospice services | <b>100%</b>   |
|  | • Physical or speech (limited to 60 visits combined per calendar year)  | <b>100%</b> after \$30 copayment per visit  |
|  | • Diabetes services<br>– Diabetes education   | <b>100%</b> after \$20 copayment per visit to primary care physician or \$30 copayment per visit to specialist  |
|  | – Diabetes equipment  | <b>100%</b>   |
|  | – Diabetes supplies (30-day supply per copayment)   | Subject to the applicable prescription drug copayment. If drug rider is not available, then a \$5 generic/\$15 brand/\$30 not on the Drug List copayment per item |
|  | <b>Copayment Limits</b>   | • Individual  |
|  | • Family  | \$8,000   |
| <b>Lifetime Maximum</b>  |   | \$5,000,000   |
| <b>Kansas Mental Health, Alcohol and Chemical Dependency Services</b>                                    | • Inpatient (maximum of 30 days per calendar year) (2)  | <b>100%</b> after \$500 copayment per day for first three days  |
|  | • Outpatient<br>– First \$100   | <b>100%</b>   |
|  | – Next \$100  | <b>80%</b>  |
|  | – Thereafter  | <b>50%</b>  |

HumanaHMO is a health plan that enables you to take advantage of care arranged by the primary care physician you select from the network of participating providers. Your personal physician provides your primary care, referring you to specialists when appropriate.

**Plan 75, Option 003**

Plan pays for covered services received from **PARTICIPATING** providers

|  |   |   |
|--|---|---|
| <p><b>Missouri Mental Health</b></p>                   | <ul style="list-style-type: none"> <li>• Inpatient (<i>no limits</i>)</li> <li>• Outpatient (<i>no limits</i>)</li> </ul>   | <p><b>100%</b> after \$500 copayment per day for first three days</p> <p><b>100%</b> after \$30 copayment per visit</p> |
| <p><b>Missouri Alcohol and Chemical Dependency</b></p> | <ul style="list-style-type: none"> <li>• Inpatient (<i>limited to 30 days per calendar year</i>)</li> <li>• Outpatient (<i>limited to 20 visits per calendar year</i>)</li> </ul> | <p><b>100%</b> after \$500 copayment per day for first three days</p> <p><b>100%</b> after \$30 copayment per visit</p> |

**Prior authorization** - Humana sometimes requires preauthorization for some services and procedures your physician or other provider may recommend for you. Humana does this solely to determine whether the service or procedure qualifies for payment under your benefit plan. You and your health care provider decide whether you should have such services or procedures. Humana's preauthorization determination relates solely to payment by Humana. To find a list of services and supplies that require preauthorization for coverage, please visit our Website at [www.humana.com/members/home.asp](http://www.humana.com/members/home.asp) or call Customer Service.

Failure to obtain necessary preauthorization when required may result in a reduction of otherwise payable benefits. Your health care practitioner should call Customer Service to obtain preauthorization.

**Payments** - Participating providers agree to accept amounts negotiated with Humana as payment in full. The member is responsible for any required

deductible, coinsurance, or other copayments. Plan benefits paid to nonparticipating providers are based on maximum allowable fees, as defined in your Certificate of Insurance.

Nonparticipating providers may balance bill you for charges in excess of the maximum allowable fee. You will be responsible for charges in excess of the maximum allowable fee in addition to any applicable deductible, coinsurance, or copayment. Additionally, any amount you pay the provider in excess of the maximum allowable fee will not apply to your out-of-pocket limit or deductible.

**Participating primary care and specialist physicians and other providers in Humana's networks are not the agents, employees or partners of Humana or any of its affiliates or subsidiaries. They are independent contractors. Humana is not a provider of medical services. Humana does not endorse or control the clinical judgement or treatment recommendations made**

**by the physicians or other providers listed in network directories or otherwise selected by you.**

**To be covered, expenses must be medically necessary and specified as covered. Please see your Certificate for more information on medical necessity and other specific plan benefits.**

- (1) Coverage may be subject to specific age, frequency or medical history requirements.
- (2) Certain defined serious mental illness conditions may be covered beyond the 30-day limit. There may also be separate 30-day coverages for certain detoxification services. Please see your Certificate of Coverage.

*The amount of benefit provided depends upon the plan selected. Premiums will vary according to the selection made.*

*For general questions about the plan, contact your benefits administrator.*

## Limitations and Exclusions

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

1. 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 the Certificate.
2. A sickness or bodily injury arising out of, or in the course of, any employment for wage, gain or profit.
3. **(Kansas)** Any services or injuries or diseases related to your job to the extent you are covered or are required to be covered by the Worker's Compensation law. If you enter into a settlement giving up your right to recover future medical benefits under a Worker's Compensation law, the master group contract will not pay those medical benefits that would have been payable in absence of that settlement.
3. **(Missouri)** 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.
4. Services provided to you, if you do not comply with the master group contract's requirements. These include services:
  - a. not provided by a network provider, unless required for emergency care; (unless specifically stated on this benefit summary.)
  - b. received in an emergency room, unless required because of emergency care;
  - c. which require preauthorization if preauthorization was not obtained.
  - d. which require a primary care physician referral if a referral was not obtained. (unless specifically stated on this benefit summary.)
5. Any drug, biological product, device, medical treatment, or procedure which is experimental, or investigational or for research purposes.
6. Treatment of nicotine habit or addiction, including, but not limited to, nicotine patches, hypnosis, smoking cessation classes or tapes.
7. Prescription drugs and self-administered injectable drugs unless administered to you:
  - a. while an inpatient in a hospital, skilled nursing facility, or health care treatment facility;
  - b. by a health care practitioner during an office visit; or
  - c. by a home health care agency as part of a covered home health care plan when approved by us.
8. Hearing aids, the fitting of hearing aids or advice on their care; implantable hearing devices.
9. In-vitro fertilization; any medical or surgical treatment of infertility; infertility evaluations; infertility services; sex change services; or reversal of elective sterilization.
10. Cosmetic surgery and cosmetic services or devices, unless for reconstructive surgery:
  - a. resulting from a bodily injury, infection or other disease of the involved part, when functional impairment is present; or
  - b. resulting from congenital disease or anomaly of a covered dependent child which resulted in a functional impairment.

A functional impairment is defined as a direct measurable reduction of physical performance of an organ or body part. Expense 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.
11. 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 the Certificate.
12. Custodial care and maintenance care.
13. Any treatment, including but not limited to surgical procedures:
  - a. for obesity, which includes morbid obesity; or
  - b. for obesity, which includes morbid obesity, for the purpose of treating a sickness or bodily injury caused by, complicated by, or exacerbated by the obesity.
14. Alternative medicine.
15. Vision examinations or testing for the purposes of prescribing corrective lenses; orthoptic training (eye exercises); 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 the Certificate).
16. Expenses for treatment of complications of non-covered procedures or services.
17. **(Kansas)** Any care, treatment, services, equipment or supplies received outside of the service area:
  - a. if you could have reasonably foreseen or anticipated their need prior to departure from the service area; and
  - b. which are not authorized by us or to the extent they exceed the maximum allowable fee.
17. **(Missouri)** Any care, treatment, services, equipment or supplies received outside of the service area:
  - a. if you could have reasonably foreseen or anticipated their need prior to departure from the service area; and
  - b. which are not authorized by us as described in "Understanding Your Coverage" section under sub-section "Seeking Emergency Care" or to the extent they exceed the maximum allowable fee.

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.

**HUMANA**  
*Guidance* when you need it most

Offered by Humana Health Plan, Inc.

## How the Rx4 structure works

Covered prescription drugs are assigned to one of four different levels with corresponding copayment amounts. The levels are organized as follows:

- **Level One:** Lowest copayment for low cost generic and brand-name drugs.
- **Level Two:** Higher copayment for higher cost generic and brand-name drugs.
- **Level Three:** Higher copayment than Level Two for higher cost, brand-name drugs that may have generic or brand-name alternatives on Levels One or Two.
- **Level Four:** Highest copayment for high-technology drugs (certain brand-name drugs, and self-administered injectable medications).
- If you request a brand-name drug when a generic equivalent is available, you pay the applicable generic copayment, plus the cost difference between the brand-name and generic drugs. If your doctor indicates that a generic drug cannot be substituted by writing "Dispense as Written" on your prescription, you can only receive that specific drug, even if a generic equivalent is available. As a result, you will be charged the applicable brand-name copayment. In this case, you will not be responsible for the cost difference between the brand and generic. If you discover at the pharmacy that your doctor gave you a "Dispense as Written" prescription, you can ask the pharmacist to contact your doctor for approval of a generic equivalent.

Prescription drug products, or classes of certain prescription drug products, are generally reviewed on an ongoing basis by a Humana Pharmacy and Therapeutics committee, which is composed of physicians and pharmacists. Drugs are reviewed for safety, effectiveness and cost-effectiveness prior to assignment or a change in assignment to one of the levels. Coverage of a prescription drug or placement of the drug within a level are subject to change throughout the year. If drugs are moved to categories with higher member cost, advance notice is provided based on past usage. Always discuss prescription drugs with your doctor to determine appropriateness or clinical effectiveness.

Some drugs in all levels may be subject to dispensing limitations, based on age, gender, duration or quantity. Additionally, some drugs may need prior authorization in order to be covered. In these cases, your physician should contact Humana Clinical Pharmacy Review at 1-800-555-CLIN (2546).

Members can visit Humana's Website, **Humana.com**, to obtain information about their prescription drug and corresponding benefits and for possible lower cost alternatives, or they can call Humana's Customer Service with questions or to request a partial Humana Rx4 Drug List by mail.

## Coverage at participating pharmacies

When you present your ID card at a participating pharmacy, you are required to make a copayment for each prescription based on the current assigned level of the drug.

| Drugs assigned to: | Copayment per prescription or refill  |
|--------------------|---|
| Level One:         | \$15  |
| Level Two:         | \$30  |
| Level Three:       | \$50  |
| Level Four:        | 25%* of the total required payment to the dispensing pharmacy per prescription or refill. |

- \* The total maximum out-of-pocket copayment costs for drugs in Level Four is limited to \$2,500 per calendar year, per member.
- If the default rate is less than the corresponding copayment, you will only be responsible for the lower amount.
- Your copayments for covered prescription drugs are made on a per prescription or refill basis and will not change if Humana receives any retrospective volume discounts or prescription drug rebates.
- If you use a nonparticipating pharmacy, there is no coverage, except for prescriptions required during an emergency for treatment of an emergency medical condition.

There are no claim forms to file if you use a participating pharmacy and present your ID card with each prescription.

## Coverage specifics

Your coverage includes the following:

- A 30-day supply or the amount prescribed, whichever is less, for each prescription or refill.
- Contraceptives.
- For Arizona, coverage also includes FDA approved contraceptive devices.
- Certain self-administered injectable drugs and related supplies approved by Humana.
- Certain drugs, medicines or medications that, under federal or state law, may be dispensed only by prescription from a physician.

Some drugs may be subject to prior authorization requirements for coverage under the plan. Additionally, some drugs may have dispensing limitations, which limit coverage based on duration, age, gender or dosage criteria. To determine whether a drug prescribed for you may be affected by these coverage limitations, please contact Customer Service or visit our Website.

For a complete listing of participating pharmacies, please refer to your participating provider directory, or visit our Website at **Humana.com**.

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## Mail-order and 90-day Retail

For your convenience, you can receive a maximum 90-day supply per prescription or refill (maximum 30-day supply for self-administered injectable and specialty drugs\*) for certain maintenance drugs. In these cases, multiple copayments will usually apply. The same requirements apply whether purchasing medications through a participating mail-order pharmacy or purchasing in person at a retail pharmacy. Some retail pharmacies may not dispense on a 90-day basis. Members can call Customer Service or visit our Website for more information, including mail-order forms.

\* See Specialty Drug Benefit flyer where applicable

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## Definition of terms

- Brand-name medication (drug): a medication that is manufactured and distributed by only one pharmaceutical manufacturer or as defined by the national pricing standard used by Humana.
- Copayment: the amount to be paid by the member toward the cost of each separate prescription or refill of a covered drug when dispensed by a pharmacy.
- Default rate: the rate or amount equal to the Medicare reimbursement rate for the prescription or refill.
- Generic medication (drug): a medication 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 Humana.
- Nonparticipating pharmacy: a pharmacy that has not been designated by us to provide services to covered persons.
- Participating pharmacy: 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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Before applying for coverage, please refer to the Regulatory Pre-enrollment Disclosure Guide for a description of plan provisions which may exclude, limit, reduce, modify or terminate your coverage. Limitations and exclusions to coverage 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 any procedure, treatment or supply. This guide is available at [Humana.com/members/enrollment-center/pre-enrollment-disclosures](http://Humana.com/members/enrollment-center/pre-enrollment-disclosures) or through your sales representative.

# HUMANA®

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Statements in languages other than English contained in the advertisement do not necessarily reflect the exact contents of the policy written in English, because of possible linguistic differences. In the event of a dispute, the policy as written in English is considered the controlling authority.

For Arizona residents: offered by Humana Health Plan, Inc. or insured by Empheys Insurance Company or insured or administered by Humana Insurance Company

Please refer to your Benefit Plan Document (Certificate of Coverage/Insurance or Summary Plan Description) for more information on the company providing your benefits.

Our health benefit plans have limitations and exclusions

# Humana CoverageFirst<sup>ESM</sup> PPO Summary of Benefits

Friends of the Zoo - CoverageFirst PPO 08 100/70 \$1,500 Deductible

| MISSOURI   | Humana CoverageFirst PPO 08 100/70 Plan   | Plan pays for services at <b>PARTICIPATING</b> providers   | Plan pays for services at <b>NONPARTICIPATING</b> providers  |
|--|---|--|--|
| <b>Up-front Benefit Allowance</b>  | <ul style="list-style-type: none"> <li>Annual member benefit (Applies to medical services received from participating providers only. Preventive and pharmacy do not apply. Does not apply to member copayments.)</li> </ul>  | \$500 per calendar year per member   | Not applicable   |
| <b>Annual Deductible</b><br>(per calendar year; copayments do not apply) | <ul style="list-style-type: none"> <li>Individual</li> <li>Family (1)</li> </ul>  | <p>\$1,500</p> <p>Two times individual participating deductible</p>  | <p>Two times individual participating deductible</p> <p>Two times family participating deductible</p>  |
| <b>Preventive Care</b> (Does not reduce the benefit allowance)           | <ul style="list-style-type: none"> <li>Annual routine adult physical exam (18 years and above) (2)</li> <li>Routine child care (up to age 18)</li> <li>Routine immunizations (up to age 18)</li> <li>Routine mammography and Pap smears</li> <li>Routine outpatient laboratory tests/X-rays</li> <li>Preventive endoscopy (includes colonoscopy, proctosigmoidoscopy and sigmoidoscopy)</li> </ul>  | <p><b>100%</b></p> <p><b>100%</b></p>  | <p><b>70%</b> after deductible</p> <p><b>70%</b> after deductible</p>  |
| <b>Physician Services</b> (2)  | <ul style="list-style-type: none"> <li>Office visits (excludes diagnostic lab and X-ray)</li> <li>Prenatal benefit (office visit copayment applies to first visit only)</li> <li>Allergy testing (covered as part of office visit)</li> <li>Physician visits to emergency room (3)</li> <li>Diagnostic tests, lab and X-rays (when performed in office or clinic)</li> <li>Allergy serum</li> <li>Inpatient services</li> <li>Outpatient services</li> <li>Allergy injections and nonroutine injections other than allergy</li> </ul> | <p><b>100%</b> after \$15 primary care physician/<br/>\$30 specialist copayment per visit</p> <p><b>100%</b></p> <p><b>100%</b></p> <p><b>100%</b> after deductible</p> <p><b>100%</b> after deductible</p> <p><b>100%</b> after \$5 copayment per visit</p> | <p><b>70%</b> after deductible</p> <p><b>100%</b></p> <p><b>70%</b> after deductible</p> <p><b>70%</b> after deductible</p> <p><b>70%</b> after deductible</p> |
| <b>Hospital Services</b>   | <ul style="list-style-type: none"> <li>Inpatient care (semiprivate room and board, nursing care, ICU)</li> <li>Outpatient surgery</li> <li>Outpatient nonsurgical care</li> <li>Emergency room visit (copayment is waived if admitted) (3)</li> </ul>   | <p><b>100%</b> after deductible</p> <p><b>100%</b> after deductible</p> <p><b>100%</b> after deductible</p> <p><b>100%</b> after \$50 copayment per visit</p>  | <p><b>70%</b> after deductible</p> <p><b>70%</b> after deductible</p> <p><b>70%</b> after deductible</p> <p><b>100%</b> after \$50 copayment per visit</p>     |
| <b>Prescription Drugs</b>  | <ul style="list-style-type: none"> <li>Please see attached pharmacy benefit information, if applicable</li> </ul>   |  |  |
| <b>Other Medical Services</b><br>(4)                                     | <ul style="list-style-type: none"> <li>Skilled nursing facility (up to 60 days per calendar year)</li> <li>Home health care (up to 60 visits per calendar year)</li> <li>Durable medical equipment (unlimited)</li> <li>Physical, occupational, cognitive, speech and audiology therapy (subject to combined limit for all therapy services up to 60 visits per calendar year)</li> <li>Ambulance (3)</li> <li>Chiropractic (up to 26 visits per calendar year)</li> </ul>  | <p><b>100%</b> after deductible</p> <p><b>100%</b> after specialist copayment</p>                            | <p><b>70%</b> after deductible</p> <p><b>70%</b> after deductible</p> <p><b>100%</b> after participating deductible</p> <p><b>70%</b> after deductible</p>     |

Humana CoverageFirst combines the cost-saving incentives of a modern health plan with freedom of choice and an annual benefit allowance. When you see participating providers, you receive the highest level of benefits available under your plan. At the same time, you retain the flexibility to see any physician.

**Humana CoverageFirst PPO 08  
100/70 Plan**

Plan pays for services at  
**PARTICIPATING** providers

Plan pays for services at  
**NONPARTICIPATING** providers

|  |   |   |   |
|--|---|---|---|
| <p><b>Other Medical Services</b><br/>(4) (continued)</p>   | <ul style="list-style-type: none"> <li>Transplant services</li> </ul>   | <p>Same as any other covered condition<br/>(when services are received from a<br/>Humana Transplant Network Provider)</p> | <p>Same as any other covered condition<br/>(covered expenses are limited to a<br/>maximum benefit of \$35,000 per<br/>transplant)</p> |
| <p><b>Missouri Mental Health</b></p>   | <ul style="list-style-type: none"> <li>Individual (no limits)</li> <li>Outpatient (no limits)</li> </ul>  | <p>Same as any other covered condition<br/><br/><b>100%</b> after specialist copayment</p>                                | <p><b>70%</b> after deductible<br/><br/><b>70%</b> after deductible</p>   |
| <p><b>Missouri Alcohol and<br/>Chemical Dependency</b></p>   | <ul style="list-style-type: none"> <li>Inpatient (limited to 30 days per<br/>calendar year)</li> <li>Outpatient (limited to 20 visits per<br/>calendar year)</li> </ul> | <p>Same as any other covered condition<br/><br/><b>100%</b> after specialist copayment</p>                                | <p><b>70%</b> after deductible<br/><br/><b>70%</b> after deductible</p>   |
| <p><b>Maximum Out-Of-Pocket<br/>Expense Limit</b><br/>(per calendar year;<br/>excludes deductibles and<br/>copayments)</p> | <ul style="list-style-type: none"> <li>Individual</li> <li>Family</li> </ul>  | <p>N/A<br/><br/>N/A</p>   | <p>\$2,000<br/><br/>Two times individual nonparticipating<br/>maximum out-of-pocket</p>   |
| <p><b>Lifetime Maximum<br/>Benefit</b></p>   | <p>Unlimited<br/>(participating and nonparticipating combined)</p>  |   |   |

**Prior authorization** - Humana sometimes requires preauthorization for some services and procedures your physician or other provider may recommend for you. Humana does this solely to determine whether the service or procedure qualifies for payment under your benefit plan. You and your health care provider decide whether you should have such services or procedures. Humana's preauthorization determination relates solely to payment by Humana. To find a list of services and supplies that require preauthorization for coverage, please visit our Website at [Humana.com/members/tools/](http://Humana.com/members/tools/) or call Customer Service.

Failure to obtain necessary preauthorization when required may result in a reduction of otherwise payable benefits. Your health care practitioner should call Customer Service to obtain preauthorization.

**Payments** - Participating providers agree to accept amounts negotiated with Humana as payment in full. The member is responsible for any required deductible, coinsurance, or other copayments. Plan benefits paid to nonparticipating providers are based on maximum allowable fees, as defined in your Certificate of Insurance.

Nonparticipating providers may balance bill you for charges in excess of the maximum allowable fee. You will be responsible for charges in excess of the maximum allowable fee in addition to any applicable deductible, coinsurance, or copayment. Additionally, any amount you pay the provider in excess of the maximum allowable fee will not apply to your out-of-pocket limit or deductible.

**Participating primary care and specialist physicians and other providers in Humana's networks are not the agents, employees or partners of Humana or any of its affiliates or subsidiaries. They are independent contractors. Humana is not a provider of medical services. Humana does not endorse or control the clinical judgement or treatment recommendations made by the physicians or other providers listed in network directories or otherwise selected by you.**

**To be covered, expenses must be medically necessary and specified as covered. Please see your Certificate for more information on medical necessity and other specific plan benefits.**

- (1) You are not required to meet individual deductibles once the family deductible has been met.

- (2) Copayments for visits to primary care physicians, as defined in the plan, are generally lower than for visits to specialists. The following are generally defined as primary care physicians under your plan: general practitioner, family practitioner, pediatrician or internist.
- (3) Ambulance transportation and/or services received in an emergency room are not covered unless required because of emergency care, as defined in your Certificate.
- (4) Visit and day limits are combined for participating and nonparticipating providers.

**Before applying for coverage, please refer to the Regulatory Pre-enrollment Disclosure Guide for a description of plan provisions which may exclude, limit, reduce, modify or terminate your coverage. This guide is available at [Humana.com/members/enrollment-center/pre-enrollment-disclosures](http://Humana.com/members/enrollment-center/pre-enrollment-disclosures) or through your sales representative.**

*The amount of benefit provided depends upon the plan selected. Premiums will vary according to the selection made.*

*For general questions about the plan, contact your benefits administrator.*

## Limitations and Exclusions

The plan imposes a pre-existing condition exclusion. This means that if you have a medical condition before coming to our plan, you might have to wait a certain period of time before the plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within a 6-month period. Generally, this 6-month period ends the day before your coverage becomes effective. However, if you were in a waiting period for coverage, the 6-month period ends on the day before the waiting period begins. The pre-existing condition exclusion does not apply to pregnancy; genetic information in the absence of a diagnosis of the condition related to the information; or to a child who is enrolled in the plan within 31 days after birth, adoption, or placement for adoption.

This exclusion may last up to 12 months (18 months if you are a late enrollee) from your first day of coverage, or if you were in a waiting period, from the first day of your waiting period. However, you can reduce the length of this exclusion period by the number of days of your prior "creditable coverage". Most prior health coverage is creditable coverage and can be used to reduce the pre-existing condition exclusion if you have not experienced a break in coverage of at least 63 days. To reduce the 12-month (or 18-month) exclusion period by your creditable coverage, you should give us a copy of any certificates of creditable coverage you have. If you do not have a certificate, but you do have prior health coverage, we will help you obtain one from your prior plan or issuer. There are also other ways that you can show you have creditable coverage. Please contact us if you need help demonstrating creditable coverage.

All questions about the pre-existing condition exclusion and creditable coverage should be directed to Humana Enrollment at 2432 Fortune Drive, Lexington, KY 40509 or 1-800-872-7207.

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

1. Treatments, services, supplies or surgeries that are not medically necessary, except for the specified routine preventive services as outlined in the "Schedule of Benefits" and described in the "Covered Expenses" section of the certificate.
2. A sickness or bodily injury arising out of, or in the course of, any employment for wage, gain or profit.
3. A sickness or bodily injury, which 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.
4. Any drug, biological product, device, medical treatment, or procedure which is experimental, or investigational or for research purposes.
5. Treatment of nicotine habit or addiction, including, but not limited to, nicotine patches, hypnosis, smoking cessation classes or tapes.
6. Prescription drugs and self-administered injectable drugs, unless administered to you:
  - While an inpatient in a hospital, or skilled nursing facility, or health care treatment facility;
  - By a health care practitioner during an office visit; or
  - By a home health care agency as part of a covered home health care plan when approved by us.
7. Hearing aids, the fitting of hearing aids or advice on their care; implantable hearing devices.
8. In-vitro fertilization; any medical or surgical treatment of infertility; infertility evaluations; infertility services; sex change services; or reversal of elective sterilization.
9. Cosmetic surgery and cosmetic services or devices, unless for reconstructive surgery:
  - Resulting from a bodily injury, infection or other disease of the involved part, when functional impairment is present; or
  - Resulting from congenital disease or anomaly of a covered dependent child, which resulted in a functional impairment.

- A functional impairment is defined as a direct measurable reduction of physical performance of an organ or body part. Expense 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.
10. 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 the certificate.
  11. Custodial care and maintenance care.
  12. Any treatment, including but not limited to surgical procedures:
    - For obesity, which includes morbid obesity.
    - For obesity, which includes morbid obesity, for the purpose of treating a sickness or bodily injury caused by, complicated by, or exacerbated by the obesity.
  13. Alternative medicine.
  14. Vision examinations or testing for the purposes of prescribing corrective lenses; orthoptic training (eye exercises); radial keratotomy, refractive keratoplasty or any other surgery 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 the certificate).
  15. Expenses for treatment of complications of non-covered procedures or services.

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.

**HUMANA**  
Guidance when you need it most

## How the Rx4 structure works

Covered prescription drugs are assigned to one of four different levels with corresponding copayment amounts. The levels are organized as follows:

- **Level One:** Lowest copayment for low cost generic and brand-name drugs.
- **Level Two:** Higher copayment for higher cost generic and brand-name drugs.
- **Level Three:** Higher copayment than Level Two for higher cost, brand-name drugs that may have generic or brand-name alternatives on Levels One or Two.
- **Level Four:** Highest copayment for high-technology drugs (certain brand-name drugs, and self-administered injectable medications).
- If you request a brand-name drug when a generic equivalent is available, you pay the applicable generic copayment, plus the cost difference between the brand-name and generic drugs. If your doctor indicates that a generic drug cannot be substituted by writing "Dispense as Written" on your prescription, you can only receive that specific drug, even if a generic equivalent is available. As a result, you will be charged the applicable brand-name copayment. In this case, you will not be responsible for the cost difference between the brand and generic. If you discover at the pharmacy that your doctor gave you a "Dispense as Written" prescription, you can ask the pharmacist to contact your doctor for approval of a generic equivalent.

Prescription drug products, or classes of certain prescription drug products, are generally reviewed on an ongoing basis by a Humana Pharmacy and Therapeutics committee, which is composed of physicians and pharmacists. Drugs are reviewed for safety, effectiveness and cost-effectiveness prior to assignment or a change in assignment to one of the levels. Coverage of a prescription drug or placement of the drug within a level are subject to change throughout the year. If drugs are moved to categories with higher member cost, advance notice is provided based on past usage. Always discuss prescription drugs with your doctor to determine appropriateness or clinical effectiveness.

Some drugs in all levels may be subject to dispensing limitations, based on age, gender, duration or quantity. Additionally, some drugs may need prior authorization in order to be covered. In these cases, your physician should contact Humana Clinical Pharmacy Review at 1-800-555-CLIN (2546).

Members can visit Humana's Website, **Humana.com**, to obtain information about their prescription drug and corresponding benefits and for possible lower cost alternatives, or they can call Humana's Customer Service with questions or to request a partial Humana Rx4 Drug List by mail.

## Coverage at participating pharmacies

When you present your ID card at a participating pharmacy, you are required to make a copayment for each prescription based on the current assigned level of the drug.

| Drugs assigned to: | Copayment per prescription or refill  |
|--------------------|---|
| Level One:         | \$15  |
| Level Two:         | \$30  |
| Level Three:       | \$50  |
| Level Four:        | 25%* of the total required payment to the dispensing pharmacy per prescription or refill. |

\* The total maximum out-of-pocket copayment costs for drugs in Level Four is limited to \$2,500 per calendar year, per member.

- If the default rate is less than the corresponding copayment, you will only be responsible for the lower amount.
- Your copayments for covered prescription drugs are made on a per prescription or refill basis and will not change if Humana receives any retrospective volume discounts or prescription drug rebates.

There are no claim forms to file if you use a participating pharmacy and present your ID card with each prescription.

## Nonparticipating pharmacy coverage\*

You may also purchase prescribed medications from a nonparticipating pharmacy. You will be required to pay for your prescriptions according to the following rule.

- You pay 100 percent of the dispensing pharmacy's charges.
  - You file a claim form with Humana (address is on the back of ID card).
  - Claim is paid at 70 percent of the default rate, after it is first reduced by the applicable copayment.
- Your copayments for covered prescription drugs are made on a per prescription or refill basis and will not change if Humana receives any retrospective volume discounts or prescription drug rebates.

\* In Georgia, the nonparticipating benefits are paid the same as the participating benefits, per state regulation.

## Coverage specifics

Your coverage includes the following:

- A 30-day supply or the amount prescribed, whichever is less, for each prescription or refill.
- Contraceptives.
- For Arizona, coverage also includes FDA approved contraceptive devices.
- Certain self-administered injectable drugs and related supplies approved by Humana.
- Certain drugs, medicines or medications that, under federal or state law, may be dispensed only by prescription from a physician.

Some drugs may be subject to prior authorization requirements for coverage under the plan. Additionally, some drugs may have dispensing limitations, which limit coverage based on duration, age, gender or dosage criteria. To determine whether a drug prescribed for you may be affected by these coverage limitations, please contact Customer Service or visit our Website.

For a complete listing of participating pharmacies, please refer to your participating provider directory, or visit our Website at **Humana.com**

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## Mail-order and 90-day Retail

For your convenience, you can receive a maximum 90-day supply per prescription or refill (maximum 30-day supply for self-administered injectable or specialty drugs\*) for certain maintenance drugs. In these cases, multiple copayments will usually apply. The same requirements apply whether purchasing medications through a participating mail-order pharmacy or purchasing in person at a retail pharmacy. Some retail pharmacies may not dispense on a 90-day basis. Members can call Customer Service or visit our Website for more information, including mail-order forms.

\* See Specialty Drug Benefit flyer where applicable.

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## Definition of terms

- Brand-name medication (drug): a medication that is manufactured and distributed by only one pharmaceutical manufacturer or as defined by the national pricing standard used by Humana.
- Default rate: the rate or amount equal to the Medicare reimbursement rate for the prescription or refill.
- Copayment: the amount to be paid by the member toward the cost of each separate prescription or refill of a covered drug when dispensed by a pharmacy.
- Generic medication (drug): a medication 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 Humana.
- Nonparticipating pharmacy: a pharmacy that has not been designated by us to provide services to covered persons.
- Participating pharmacy: 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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Before applying for coverage, please refer to the Regulatory Pre-enrollment Disclosure Guide for a description of plan provisions which may exclude, limit, reduce, modify or terminate your coverage. Limitations and exclusions to coverage 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 any procedure, treatment or supply. This guide is available at [Humana.com/members/enrollment-center/pre-enrollment-disclosures](http://Humana.com/members/enrollment-center/pre-enrollment-disclosures) or through your sales representative.

# HUMANA®

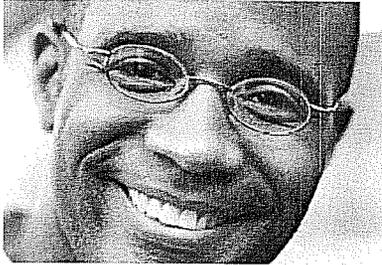
Humana plans are offered by Humana Medical Plan, Inc., Humana Employers Health Plan of Georgia, Inc., Humana Health Plan, Inc., Humana Health Benefit Plan of Louisiana, Inc., Humana Health Plan of Ohio, Inc., Humana Health Plans of Puerto Rico, Inc. License # 00235-0008, Humana Wisconsin Health Organization Insurance Corporation, or Humana Health Plan of Texas, Inc. - A Health Maintenance Organization, or Insured by Humana Health Insurance Company of Florida, Inc., Humana Health Plan, Inc., Humana Health Benefit of Louisiana, Inc., Humana Insurance Company, Humana Insurance Company of Kentucky, Emphesys Insurance Company, or Humana, or Humana Insurance of Puerto Rico, Inc. License # 00187-0009, or administered by Humana Insurance Company or Humana Health Plan, Inc.

Statements in languages other than English contained in the advertisement do not necessarily reflect the exact contents of the policy written in English, because of possible linguistic differences. In the event of a dispute, the policy as written in English is considered the controlling authority.

For Arizona residents: offered by Humana Health Plan, Inc. or insured by Emphesys Insurance Company or insured or administered by Humana Insurance Company

Please refer to your Benefit Plan Document (Certificate of Coverage/Insurance or Summary Plan Description) for more information on the company providing your benefits.

Our health benefit plans have limitations and exclusions



## — Vision Discount Program—

**Eligibility:** All eligible Full Time Employees

**Effective:** First of the month following 30 days after date of hire.

### Vision

Humana offers an additional benefit for vision care, as part of your medical plan election, so you can access vision care when you need it. Please keep in mind the benefits are different depending on which medical plan you select and the premiums for these plans are included in with your medical premiums. Please see the following summary for more details to the plan.

### If you are on the HMO Plan:

| Type of Service        | Amount You Pay                   |
|------------------------|----------------------------------|
| Eye Exam               | \$10 co-pay                      |
| Single Vision Lenses   | \$35 Copay                       |
| Bifocal Vision Lenses  | \$55 Copay                       |
| Trifocal Vision Lenses | \$90 Copay                       |
| Frames                 | 45% off retail price up to \$130 |
| Contacts               | 15% off retail price             |

### If you are on the PPO plan:

| Type of Service        | Amount You Pay  |
|------------------------|---|
| Eye Exam               | Routine Eye - \$5 discount<br>Contact Lens Exam - \$10 discount |
| Single Vision Lenses   | \$50 Copay  |
| Bifocal Vision Lenses  | \$70 Copay  |
| Trifocal Vision Lenses | \$105 Copay   |
| Frames                 | 35% off retail price  |
| Contacts               | 15% off retail price  |

diseases including heart disease, diabetes, anemia, stomach ulcers, osteoporosis and kidney disease. Regular check ups and cleanings can save you the pain and expense of future problems. Using your dental insurance for regular dental check- ups can improve your health. Your dental insurance can also help save you money if more serious dental treatments are needed.

With your **PPO** plan, you can visit any dentist; but you pay less out-of-pocket when you choose a PPO dentist. Out-of-network benefits are limited to our PPO fee schedule.

|  | <b>PPO</b>            |                       |
|--|-----------------------|-----------------------|
| <b>Network</b>                                   | DentalGuard Preferred |                       |
| <b>Calendar year deductible</b>                  | <i>In-Network</i>     | <i>Out-of-Network</i> |
| Individual                                       | \$50                  | \$50                  |
| Family limit                                     | 3 per family          |                       |
| Waived for                                       | Preventive            | Preventive            |
| <b>Charges covered for you (co-insurance)</b>    | <i>In-Network</i>     | <i>Out-of-Network</i> |
| Preventive Care (e.g. cleanings)                 | 100%                  | 100%                  |
| Basic Care (e.g. fillings)                       | 90%                   | 80%                   |
| Major Care (e.g. crowns, dentures)               | 60%                   | 50%                   |
| Orthodontia                                      | 50%                   | 50%                   |
| <b>Annual Maximum Benefit</b>                    | \$1000                | \$1000                |
| <b>Maximum Rollover</b>                          | Yes                   |                       |
| Rollover Threshold                               | \$500                 |                       |
| Rollover Amount                                  | \$250                 |                       |
| Rollover In-network Amount                       | \$350                 |                       |
| Rollover Account Limit                           | \$1000                |                       |
| <b>Lifetime Orthodontia Maximum</b>              | \$1000                |                       |
| <b>Dependent Age Limits(Non-Student/Student)</b> | 25/26                 |                       |

|             | Frequency:  | Once Every 3 Months<br>(Enhanced) |            |
|-------------|---|-----------------------------------|------------|
|             | Root Canal  | 90%                               | 80%        |
|             | Scaling & Root Planing (per quadrant)                 | 90%                               | 80%        |
|             | Simple Extractions                                    | 90%                               | 80%        |
|             | Surgical Extractions                                  | 90%                               | 80%        |
| Major Care  | Bridges and Dentures                                  | 60%                               | 50%        |
|             | Inlays, Onlays, Veneers**                             | 60%                               | 50%        |
|             | Repair & Maintenance of<br>Crowns, Bridges & Dentures | 60%                               | 50%        |
|             | Single Crowns   | 60%                               | 50%        |
| Orthodontia | Orthodontia   | 50%                               | 50%        |
|             | Limits:   |                                   | Child(ren) |

This is only a partial list of dental services. Your certificate of benefits will show exactly what is covered and excluded. \*\*For PPO and or Indemnity members, Crowns, Inlays, Onlays and Labial Veneers are covered only when needed because of decay or injury or other pathology when the tooth cannot be restored with amalgam or composite filling material. When Orthodontia coverage is for "Child(ren)" only, the orthodontic appliance must be placed prior to the age limit set by your plan; If full-time status is required by your plan in order to remain insured after a certain age; then orthodontic maintenance may continue as long as full-time student status is maintained. If Orthodontia coverage is for "Adults and Child(ren)" this limitation does not apply. The total number of cleanings and periodontal maintenance procedures are combined in a 12 month period. \*General Anesthesia – restrictions apply. ‡For PPO and or Indemnity members, Fillings – restrictions may apply to composite fillings.

### Manage Your Benefits:

Enrolled members and their dependents can access helpful, secure information about their Guardian benefits at [www.guardiananytime.com](http://www.guardiananytime.com)

### Find A Dentist:

Visit [www.GuardianAnytime.com](http://www.GuardianAnytime.com)  
Click on "Find A Provider"

### Questions?

Call the Guardian Helpline (888) 600-1600  
Call weekdays, 7:00 AM to 8:30 PM, EST. And refer to your plan number: 00454698

## EXCLUSIONS AND LIMITATIONS

- Important Information about Guardian's DentalGuard Indemnity and DentalGuard Preferred PPO plans: This policy provides dental insurance only. Coverage is limited to those charges that are necessary to prevent, diagnose or treat dental disease, defect, or injury. Deductibles apply. The plan does not pay for: oral hygiene services (except as covered under preventive services), orthodontia (unless expressly provided for), cosmetic or experimental treatments (unless they are expressly provided for), any treatments to the extent benefits are payable by any other payor or for which no charge is made, prosthetic devices unless certain conditions are met, and services ancillary to surgical treatment. The plan limits benefits for diagnostic consultations and for

preventive, restorative, endodontic, periodontic, and prosthodontic services. The services, exclusions and limitations listed above do not constitute a contract and are a summary only. The Guardian plan documents are the final arbiter of coverage. Contract # GP-1-DG2000 et al.

- **PPO and or Indemnity Special Limitation:** Teeth lost or missing before a covered person becomes insured by this plan. A covered person may have one or more congenitally missing teeth or have lost one or more teeth before he became insured by this plan. We won't pay for a prosthetic device which replaces such teeth unless the device also replaces one or more natural teeth lost or extracted after the covered person became insured by this plan. R3 – DG2000

|             | Frequency:  | Once Every 3 Months<br>(Enhanced) |            |
|-------------|---|-----------------------------------|------------|
|             | Root Canal  | 90%                               | 80%        |
|             | Scaling & Root Planing (per quadrant)                 | 90%                               | 80%        |
|             | Simple Extractions                                    | 90%                               | 80%        |
|             | Surgical Extractions                                  | 90%                               | 80%        |
| Major Care  | Bridges and Dentures                                  | 60%                               | 50%        |
|             | Inlays, Onlays, Veneers**                             | 60%                               | 50%        |
|             | Repair & Maintenance of<br>Crowns, Bridges & Dentures | 60%                               | 50%        |
|             | Single Crowns   | 60%                               | 50%        |
| Orthodontia | Orthodontia   | 50%                               | 50%        |
|             | Limits:   |                                   | Child(ren) |

This is only a partial list of dental services. Your certificate of benefits will show exactly what is covered and excluded. \*\*For PPO and or Indemnity members, Crowns, Inlays, Onlays and Labial Veneers are covered only when needed because of decay or injury or other pathology when the tooth cannot be restored with amalgam or composite filling material. When Orthodontia coverage is for "Child(ren)" only, the orthodontic appliance must be placed prior to the age limit set by your plan; If full-time status is required by your plan in order to remain insured after a certain age; then orthodontic maintenance may continue as long as full-time student status is maintained. If Orthodontia coverage is for "Adults and Child(ren)" this limitation does not apply. The total number of cleanings and periodontal maintenance procedures are combined in a 12 month period. \*General Anesthesia – restrictions apply. ‡For PPO and or Indemnity members, Fillings – restrictions may apply to composite fillings.

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preventive, restorative, endodontic, periodontic, and prosthodontic services. The services, exclusions and limitations listed above do not constitute a contract and are a summary only. The Guardian plan documents are the final arbiter of coverage. Contract # GP-1-DG2000 et al.

■ **PPO and or Indemnity Special Limitation:** Teeth lost or missing before a covered person becomes insured by this plan. A covered person may have one or more congenitally missing teeth or have lost one or more teeth before he became insured by this plan. We won't pay for a prosthetic device which replaces such teeth unless the device also replaces one or more natural teeth lost or extracted after the covered person became insured by this plan. R3 – DG2000



## — Life & AD&D Insurance —

**Eligibility:** All eligible Full Time Employees

**Effective:** First of the month following 30 days after date of hire.

### **Basic Life & AD&D Insurance**

Friends of the Zoo provides a Group Term Life and Accidental Death and Dismemberment insurance benefit for regular full-time employees at no cost to the employee after the new hire waiting period. This coverage is one times your annual salary to a maximum of \$250,000. To activate your policy, you must fill out the Guardian Enrollment / Change Request form. If you need to change your beneficiary information through out the year please see Human Resources.

### **Voluntary Life Insurance**

Employees who want to supplement their group life insurance benefit may purchase additional coverage on yourself and/or your dependents. With this benefit, you pay the full cost through payroll deductions.

- You can purchase additional coverage on yourself in \$10,000 increments up to \$500,000.
- Coverage for your spouse is available in \$10,000 increments up to 50% of the employee's elected coverage amount or \$250,000, whichever is less.
- Employees may also elect voluntary life coverage for their children - to 19 years old (25 years old if a full time student) in the amount of \$10,000. An election into the child voluntary life plan will allow you to cover any legal dependent children living in your household for one rate. You do not need to take out separate policies for each child.

**Life Benefit Summary**

**Group Number:** 00454698

**About Your Benefits:**

Your family depends on you in many ways and you've worked hard to ensure their financial security. But if something happened to you, will your family be protected? Will your loved ones be able to stay in their home, pay bills, and prepare for the future. Life insurance provides a financial benefit that your family can depend on. And getting it at work is easier, more convenient and more affordable than doing it on your own. If you have financial dependents- a spouse, children or aging parents, having life insurance is a responsible and a smart decision. Enroll today to secure their future!

**What Your Benefits Cover:**

|   | <b>BASIC LIFE</b>  | <b>VOLUNTARY TERM LIFE</b>   |
|---|--|--|
| <b>Employee Benefit</b>   | Your employer provides Basic Life Coverage for all full time employees in the amount of 100% of your annual salary, to a maximum of \$250,000 with a minimum amount of \$10,000. | \$10,000 increments to a maximum of \$500,000. See Cost Illustration page for details.   |
| <b>Accidental Death and Dismemberment</b>   | Your Basic Life coverage includes Accidental Death and Dismemberment coverage equal to one times the employee's life benefits.   | Not available  |
| <b>Spouse ‡ Benefit</b>   | N/A  | Up to 50% of employee coverage to a max of \$250,000   |
| <b>Child Benefit</b>  | N/A  | Your dependent children age 14 days to 23 years (25 if full time student). Up to 10% of employee coverage to a max of \$10,000. Subject to state limits. |
| <b>Guarantee Issue:</b> The 'guarantee' means you are not required to answer health questions to qualify for coverage up to and including the specified amount, when you sign up for coverage during the initial enrollment period. | Underwriting may be required, depending on amount and/or age   | We Guarantee Issue coverage up to \$140,000 per employee, \$30,000 for a spouse and \$10,000 for dependent children                                      |
| <b>Premiums</b>   | Covered by your company if you meet eligibility requirements   | Increase on plan anniversary after you enter next five-year age group  |
| <b>Portability:</b> Allows you to take your coverage with you if you terminate employment.  | Yes, with age and other restrictions, including evidence of insurability   | Yes, with age and other restrictions, including evidence of insurability   |
| <b>Conversion:</b> Allows you to continue your coverage after your group plan has terminated.   | Yes, with restrictions; see certificate of benefits  | Yes, with restrictions; see certificate of benefits  |
| <b>Accelerated Life Benefit:</b> A lump sum benefit is paid to you if you are diagnosed with a terminal condition, as defined by the plan.  | Yes  | Yes  |

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## Long-Term Disability Insurance

### SUMMARY OF BENEFITS

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**Sponsored by:** Friends of the Zoo

**Effective date:** January 1, 2014

**All Other Active Full-time Employees**

Long-term disability is intended to protect your income for a long duration after you have depleted short-term disability or any sick leave your company may offer.

|   |   |
|---|---|
| <b>Eligibility</b>                      | All full-time active employees working 30 or more hours per week in an eligible class are eligible for coverage on the policy effective date.   |
| <b>Maximum Monthly Benefit</b>          | 60% of salary up to \$8,500 per month   |
| <b>Maximum Benefit Duration</b>         | Later of Age 65 or Social Security Normal Retirement Age  |
| <b>Own Occupation Period</b>            | 24 months   |
| <b>Elimination Period</b>               | 90 days<br>The number of days you must be disabled prior to collecting disability benefits.   |
| <b>Accumulation of Elimination Days</b> | You can satisfy the days of your elimination period with either total (off work entirely) or partial (working some hours at your current job) disability. If you are working on a partial basis, you will have 2x the elimination period days to satisfy the total of 90 days.                      |
| <b>Pre-Existing Condition</b>           | No treatment for 3 months prior to the coverage effective date unless it begins after you have performed your regular occupation on a full-time basis for 12 months following the coverage effective date and no treatment was received for 6 consecutive months after the coverage effective date. |
| <b>Enrollment</b>                       | You are able to take advantage of this coverage now without a health examination. You may not be offered this opportunity again, or may be responsible for the cost of required examinations.   |
| <b>Waiver of Premium</b>                | You will not be required to pay premium during any time of approved total or partial disability.  |
| <b>Survivor Income Benefit</b>          | A survivor benefit may be paid to your beneficiary if you should die while receiving qualifying disability payments.  |
| <b>EmployeeConnect<sup>SM</sup></b>     | Access to an employee assistance program for the employee or an immediate household family member who may be experiencing personal or workplace issues.   |
| <b>Benefit Limitations</b>              | Mental Illness: 24 Months<br>Substance Abuse: 24 Months<br>Specified Illness: 24 Months   |
| <b>Progressive Income Benefit</b>       | If you are disabled and have a loss of two or more Activities of Daily Living, you will receive an additional benefit of 10% to a maximum of \$5000.  |
| <b>Family Care Expense</b>              | If you have a qualified disability and incur Family Care Expenses, you will be reimbursed for expenses up to \$350 for a maximum of 12 months.  |

## Understanding Your Benefits

|                                   |   |
|-----------------------------------|---|
| <b>Own Occupation</b>             | The occupation trade or profession you were employed in prior to your disability as defined by the US DOL Dictionary of Occupational Titles.  |
| <b>Total Disability</b>           | You are considered totally disabled if, due to an injury or illness, you are unable to perform each of the main duties of your own occupation. Your "own" occupation is covered for a specific period of time. Following this, the definition of total disability becomes the inability to perform any occupation for which you are reasonably suited based on your experience, education, or training.   |
| <b>Partial Disability</b>         | You are considered partially disabled if you are unable, due to an injury or illness, to perform the main duties of your regular occupation on a full-time basis. Partial Disability benefits may be payable if you are earning at least 20% of the income you earned prior to becoming disabled, but not more than 99%. Partial disability benefits allow you to work and earn income from your employer as well as continue to receive benefits, which may enable you to receive 100% of your income during your time of disability.  |
| <b>Continuation of Disability</b> | If you return to work full-time but become disabled from the same disability within six months of returning to work, you will begin receiving benefits again immediately.   |
| <b>Benefit Duration Reduction</b> | Your benefit duration may be reduced if you become disabled after age 65.   |
| <b>Pre-Existing Condition</b>     | Any sickness or injury for which you have received medical treatment, consultation, care, or services (including diagnostic measures or the taking of prescribed medications) during the specified months prior to the coverage effective date. A disability arising from any such sickness or injury will be covered only if it begins after you have performed your regular occupation on a full-time basis for the specified months following the coverage effective date, unless no treatment was received for the specified consecutive months after the coverage effective date, unless no treatment was received for the specified consecutive months after the coverage effective date. |
| <b>Benefit Exclusions</b>         | You will not receive benefits in the following circumstances: <ul style="list-style-type: none"><li>• Your disability is the result of a self-inflicted injury.</li><li>• You are not under the regular care of a doctor when requesting disability benefits.</li><li>• You were involved in a felony commission, act of war, or participation in a riot.</li></ul>   |
| <b>Benefit Reductions</b>         | Your benefits may be reduced if you are receiving benefits from any of the following sources: <ul style="list-style-type: none"><li>• Any compulsory benefit act or law (such as state disability plans);</li><li>• Any governmental retirement system earned as a result of working for the current policyholder;</li><li>• Any disability or retirement benefit received under a retirement plan;</li><li>• Any Social Security, or similar plan or act, benefits;</li><li>• Earnings the insured earns or receives from any form of employment.</li><li>• Workers compensation;</li><li>• Salary continuance or employer contributions to an employer sponsored retirement plan.</li></ul>   |
| <b>Benefit Termination</b>        | This coverage will terminate when you terminate employment with this policyholder, or at your retirement.   |

### For assistance or additional information

Contact Lincoln Financial Group at (800) 423-2765 or log on to [www.LincolnFinancial.com](http://www.LincolnFinancial.com)

NOTE: This is not intended as a complete description of the insurance coverage offered. Controlling provisions are provided in the policy, and this summary does not modify those provisions or the insurance in any way. This is not a binding contract. A certificate of coverage will be made available to you that describes the benefits in greater details. Should there be a difference between this summary and the contract, the contract will govern.

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**DISABILITY INCOME PLUS** is a group disability income insurance policy designed to provide disability income benefits to eligible Employees of the Employer. Coverage is provided for accident only or, if selected by the Employer, for accident and sickness.

- Covers off-the-job injuries after 7 days of total disability
- Covers off-the-job sicknesses after 7 days of total disability
- Benefits are paid for a maximum of 90 days per disability
- You can protect up to 60% of your pay

**MONTHLY DEDUCTIONS**

| Ages  | Monthly Benefit |         |         |         |         |         |         |         |         |         |         |
|-------|-----------------|---------|---------|---------|---------|---------|---------|---------|---------|---------|---------|
|       | \$400           | \$500   | \$600   | \$700   | \$800   | \$900   | \$1,000 | \$1,100 | \$1,200 | \$1,300 | \$1,400 |
| 18-50 | 10.16           | 12.70   | 15.24   | 17.78   | 20.32   | 22.86   | 25.40   | 27.94   | 30.48   | 33.02   | 35.56   |
| 51-64 | 11.52           | 14.40   | 17.28   | 20.16   | 23.04   | 25.92   | 28.80   | 31.68   | 34.56   | 37.44   | 40.32   |
| 65+   | 13.84           | 17.30   | 20.76   | 24.22   | 27.68   | 31.14   | 34.60   | 38.06   | 41.52   | 44.98   | 48.44   |
| Ages  | \$1,500         | \$1,600 | \$1,700 | \$1,800 | \$1,900 | \$2,000 | \$2,100 | \$2,200 | \$2,300 | \$2,400 | \$2,500 |
| 18-50 | 38.10           | 40.64   | 43.18   | 45.72   | 48.26   | 50.80   | 53.34   | 55.88   | 58.42   | 60.96   | 63.50   |
| 51-64 | 43.20           | 46.08   | 48.96   | 51.84   | 54.72   | 57.60   | 60.48   | 63.36   | 66.24   | 69.12   | 72.00   |
| 65+   | 51.90           | 55.36   | 58.82   | 62.28   | 65.74   | 69.20   | 72.66   | 76.12   | 79.58   | 83.04   | 86.50   |

**PLAN FEATURES**

- Pre-existing conditions covered after 12 months
- Includes coverage for pregnancy as any other sickness
- Non-occupational coverage
- Contingent Guarantee Issue is available for a benefit of up to \$3000 per month
- Three rate bands: Ages 18-50, 51-64, 65+
- Waiver of premium included after 90 days of total disability
- Unisex Rates
- Ease of payroll deductions
- Benefits are paid directly to the insured

Presented by:  
Power Benefits Group

**DISABILITY INCOME PLUS** is a group disability income insurance policy designed to provide disability income benefits to eligible Employees of the Employer. Coverage is provided for accident only or, if selected by the Employer, for accident and sickness.

- Covers off-the-job injuries after 14 days of total disability
- Covers off-the-job sicknesses after 14 days of total disability
- Benefits are paid for a maximum of 90 days per disability
- You can protect up to 60% of your pay

**MONTHLY DEDUCTIONS**

| Ages  | Monthly Benefit |         |         |         |         |         |         |         |         |         |         |
|-------|-----------------|---------|---------|---------|---------|---------|---------|---------|---------|---------|---------|
|       | \$400           | \$500   | \$600   | \$700   | \$800   | \$900   | \$1,000 | \$1,100 | \$1,200 | \$1,300 | \$1,400 |
| 18-50 | 7.96            | 9.95    | 11.94   | 13.93   | 15.92   | 17.91   | 19.90   | 21.89   | 23.88   | 25.87   | 27.86   |
| 51-64 | 9.64            | 12.05   | 14.46   | 16.87   | 19.28   | 21.69   | 24.10   | 26.51   | 28.92   | 31.33   | 33.74   |
| 65+   | 12.40           | 15.50   | 18.60   | 21.70   | 24.80   | 27.90   | 31.00   | 34.10   | 37.20   | 40.30   | 43.40   |
| Ages  | \$1,500         | \$1,600 | \$1,700 | \$1,800 | \$1,900 | \$2,000 | \$2,100 | \$2,200 | \$2,300 | \$2,400 | \$2,500 |
| 18-50 | 29.85           | 31.84   | 33.83   | 35.82   | 37.81   | 39.80   | 41.79   | 43.78   | 45.77   | 47.76   | 49.75   |
| 51-64 | 36.15           | 38.56   | 40.97   | 43.38   | 45.79   | 48.20   | 50.61   | 53.02   | 55.43   | 57.84   | 60.25   |
| 65+   | 46.50           | 49.60   | 52.70   | 55.80   | 58.90   | 62.00   | 65.10   | 68.20   | 71.30   | 74.40   | 77.50   |

**PLAN FEATURES**

- Pre-existing conditions covered after 12 months
- Includes coverage for pregnancy as any other sickness
- Non-occupational coverage
- Contingent Guarantee Issue is available for a benefit of up to \$3000 per month
- Three rate bands: Ages 18-50, 51-64, 65+
- Waiver of premium included after 90 days of total disability
- Unisex Rates
- Ease of payroll deductions
- Benefits are paid directly to the insured

Presented by:  
Power Benefits Group

## Designed for the Employees of Friends of the Zoo

Form 7006 1/04

Axiom provides off-the-job coverage for accidental injuries, ambulance, hospital care and accidental death benefits. There is no coverage for sickness.

### Base Plan Benefits per covered person:

|  | Level 2  | Level 4  |
|--|----------|----------|
| <b>ACCIDENT MEDICAL EXPENSE BENEFIT</b> Pays the actual expenses up to the amount selected for diagnosis or treatment by a Physician or in an Emergency Room. Emergency Room service subject to a \$50 deductible. | \$1,000  | \$2,000  |
| <b>AMBULANCE BENEFIT</b> Pays actual charges up to the amount selected if injury requires ground or air ambulance transportation.  | \$500    | \$1,000  |
| <b>HOSPITAL INDEMNITY BENEFIT</b> Pays a benefit up to the amount selected if an injury requires inpatient hospital confinement for a maximum of 30 days per accident.   | \$150    | \$300    |
| <b>ACCIDENTAL DEATH AND DISMEMBERMENT</b>  | \$10,000 | \$20,000 |

### OPTIONAL BENEFITS:

**Bone Fracture and Dislocation Optional Benefit Rider** Pays a benefit when a covered person suffers one of the fractures or dislocations listed. One unit, \$750, or two units, \$1,500 may be selected. The benefit payable will equal the percentage shown, of the unit selected, for the injury.

### Monthly Deductions & Monthly Premium - Rider(s) shown inclusively: \$1500 Bone Fracture & Dislocation

| Benefit     | Employee |         | Employee & Spouse |         | Employee & Children |         | Family  |         |
|-------------|----------|---------|-------------------|---------|---------------------|---------|---------|---------|
|             | 18-50    | 51-60   | 18-50             | 51-60   | 18-50               | 51-60   | 18-50   | 51-60   |
| <b>Two</b>  | \$14.04  | \$15.90 | \$28.08           | \$31.80 | \$32.94             | \$34.80 | \$46.98 | \$50.70 |
| <b>Four</b> | \$17.94  | \$19.80 | \$35.88           | \$39.60 | \$44.44             | \$46.30 | \$62.38 | \$66.10 |

### PLAN FEATURES

|  |   |
|--|---|
| <ul style="list-style-type: none"> <li>- No waiting period</li> <li>- No Pre-existing condition limitations</li> <li>- Unisex rates for ages 18 to 60</li> <li>- Provides benefits beginning with the first day</li> <li>- Coverage fully portable</li> <li>- If you have family coverage, newborn children are covered from birth provided they are added to the policy within 31 days</li> </ul> | <ul style="list-style-type: none"> <li>- Benefits are paid directly to the insured</li> </ul> |
|--|---|

Presented by: Power Benefits Group



## How the AmeriFlex Plan Works

If you participate in the AmeriFlex FSA plan, you will elect to have a specified amount of "pre-tax" money deducted from your paycheck each pay period. These funds are subtracted from your gross earnings before taxes and put into an FSA that you can then use to pay for eligible out-of-pocket expenses.

...Increase your take-home pay with an FSA plan!

The following table illustrates how you save by participating in a Flexible Spending Account:

### Without This Plan

|                             |                    |                                    |  |
|-----------------------------|--------------------|------------------------------------|--|
| Gross pay (annual)          | <b>\$30,000.00</b> | Gross pay (annual)                 |  |
| Tax Withholding (est. @25%) | <b>\$ 7,500.00</b> | • Eligible expense                 |  |
| Take-home pay               | <b>\$22,500.00</b> | Taxable income                     |  |
| • Eligible expense          | <b>\$ 1,000.00</b> | Tax Withholding (est. @25%)        |  |
| New take-home pay           | <b>\$21,500.00</b> | New take-home pay                  |  |
|                             |                    | • Result (increased take-home pay) |  |

The information in this table is for descriptive purposes only and is not intended to reflect your own personal tax situation.



## Eligible Expenses

### Medical FSA Eligible Expenses

A medical FSA (also referred to as a "Health FSA") is used to pay for healthcare expenses that are not covered under your medical or other insurance plan. The IRS determines what expenses are eligible for reimbursement under a medical FSA. IRS-qualified expenses may include:

- Co-pays, deductibles, and other payments that you are responsible for under your health plan
- Expenses that may not be covered under your health plan, such as:
  - Routine exams
  - Dental care
  - Prescription drugs
  - Orthodontia (check with your employer to determine if orthodontia is allowed under your plan and what reimbursement method is used)
  - Eye care (including Lasik, glasses, and contact lenses)
  - Hearing aids
  - Well-baby care
- Miscellaneous expenses such as:
  - Certain over-the-counter healthcare expenses\* (Band-Aids, First Aid supplies)
  - Transportation, tolls and parking to receive medical care
  - Individual psychiatric or psychological counseling
  - Diabetic equipment and supplies
  - Durable medical equipment
  - Qualified medical products or services prescribed by a doctor