Plan Year 2023

The actual certificate issued may vary from the samples provided based upon final plan selection or other factors. If there is any conflict between the samples provided and the certificate that is issued, the issued certificate will control.

If you are already a member, please sign in or register on www.humana.com to view your issued certificate.

COHJ67KEN 0123

Important

At Humana, it is important you are treated fairly.

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

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

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

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

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

ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call the number on your ID card **(TTY: 711)**... ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al número que figura en su tarjeta de identificación **(TTY: 711)**

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電會員卡上的電話號碼 **(TTY: 711)**

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số điện thoại ghi trên thẻ ID của quý vị **(TTY: 711)**

주의 : 한국어를 사용하시는 경우 , 언어 지원 서비스를 무료로 이용하실 수 있습니다 . ID 카드에 적혀 있는 번호로 전화해 주십시오 **(TTY: 711)**

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tawagan ang numero na nasa iyong ID card **(TTY: 711)**

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Наберите номер, указанный на вашей карточке-удостоверении **(телетайп: 711)**

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele nimewo ki sou kat idantite manm ou **(TTY: 711)**

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le numéro figurant sur votre carte de membre **(ATS: 711)**

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Proszę zadzwonić pod numer podany na karcie identyfikacyjnej **(TTY: 711)**

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para o número presente em seu cartão de identificação **(TTY: 711)**

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero che appare sulla tessera identificativa **(TTY: 711)**

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Wählen Sie die Nummer, die sich auf Ihrer Versicherungskarte befindet **(TTY: 711)**

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。お手持ちの ID カードに記載されている電話番号までご連絡ください **(TTY: 711)**

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

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

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

2. Title Page (Cover Page)

Humana.

Administrative Office:
500 West Main Street
Louisville, Kentucky 40202

Certificate of Coverage
Humana Health Plan, Inc.

Group Plan Sponsor:

Group Plan Number: **Plan:** **Option:**

Effective Date:

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

Bruce Broussard
President

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

This *certificate* does not provide any dental benefits to individuals age nineteen (19) or older. This *certificate* is being offered so the purchaser will have pediatric dental coverage as required by the Affordable Care Act. If *you* want adult dental benefits, *you* will need to buy a plan that has adult dental benefits. This *certificate* will not pay for any adult dental care, so *you* will have to pay the full price of any care *you* receive.

3. Contact Us

Contact us

You may call Humana Health Plan, Inc. toll free at telephone number: 1-866-427-7478.

Or *you* may write to Humana Health Plan, Inc. at:

Humana Health Plan, Inc.
500 West Main Street
Louisville, Kentucky 40202

Our website is www.humana.com.

Language access services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-866-4ASSIST (427-7478).
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-4ASSIST (427-7478).
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-866-4ASSIST (427-7478).
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-4ASSIST (427-7478).

HUMANA HEALTH PLAN, INC.

1. **The Health Maintenance Organization Networks maintain contracted Network Providers in the following counties in Colorado:**

   A. HMO X

   Adams
   Arapahoe
   Boulder
   Broomfield
   Denver
   Douglas
   El Paso
   Jefferson
   Larimer
   Teller
   Weld

   B. NPOS

   Adams
   Arapahoe
   Boulder
   Broomfield
   Denver
   Douglas
   Elbert
   El Paso
   Jefferson
   Larimer
   Teller
   Weld

2. ***Non-network providers*** **may balance bill** ***you*** **for the difference between the amount paid by** ***us*** **and the** ***non-network provider's*** **billed charges, if:**

   A. ***You*** **knowingly seek services from a** ***non-network provider*** **because** ***you*** **are required to travel a reasonable distance beyond the established geographic area requirements for an adequate network in order to receive services from a** ***network provider*****; and**

   B. The ***non-network provider*** **is reimbursed for an amount less than the billed charges.**

3. **To receive** ***our*** **reimbursement rate for specific covered services rendered by a** ***non-network provider,*** **please contact** ***our*** **claims department at 1-800-558-4444, or at Humana Correspondence Office P.O. Box 14610 Lexington, Kentucky 40512-4610.**

5. Eligibility

Eligibility date

Employee eligibility date

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

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

Dependent eligibility date

Each *dependent* is eligible for coverage on:

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

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

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

Enrollment

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

Employee enrollment

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

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

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

Dependent enrollment

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

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

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

Newborn and adopted dependent enrollment

A newborn *dependent* will be automatically covered from the date of birth to 31 days of age for *bodily injury* or *sickness* to include all *medically necessary* care and treatment of congenital defects and birth abnormalities. An adopted *dependent* will be covered automatically from the date of adoption or placement of the child for the purpose of adoption, whichever occurs first, for 31 days.

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

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

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

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

Special enrollment

Special enrollment is available if the following apply:

- *You* have a change in family status due to:
  - Marriage;
  - Partner in a *civil union*;
  - Divorce;
  - A Qualified Medical Child Support Order (QMCSO);
  - A National Medical Support Notice (NMSN);
  - The birth of a natural born child; or
  - The adoption of a child or placement of a child for the purpose of adoption or placement in foster care;
  - Entering into a designated beneficiary agreement, or a court order requires coverage for the individual to be covered; and
  - You enroll within 31 days after the *special enrollment date*; or

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

  Loss of eligibility of other coverage includes, but is not limited to:

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

- You had COBRA continuation coverage under another plan at the time of eligibility, and:
  - Such coverage has since been exhausted; and
  - You stated at the time of the initial enrollment that coverage under COBRA was your reason for declining enrollment; and
  - You enroll within 31 days after the *special enrollment date*; or
- You were covered under an alternate plan provided by the *employer* that terminates, and:
  - You are replacing coverage with the *master group contract*; and
  - You enroll within 31 days after the *special enrollment date*; or
- You are an *employee* or *dependent* eligible for coverage under the *master group contract,* and:
  - Your *Medicaid* coverage or your Children's Health Insurance Program (CHIP) coverage terminated as a result of loss of eligibility; and
  - You enroll within 60 days after the *special enrollment date*; or
- You are an *employee* or *dependent* eligible for coverage under the *master group contract,* and:
  - You become eligible for a premium assistance subsidy under *Medicaid* or CHIP; and
  - You enroll within 60 days after the *special enrollment date*, or
- You were covered under the "Colorado Medical Assistance Act" and you enroll within 60 days of the *special enrollment date*; or
- You are an *employee* or *dependent* eligible for coverage under the *master group contract,* and:
  - Your children's basic health plan coverage terminated as a result of loss of eligibility or disenrollment; and
  - You enroll within 60 days after the *special enrollment date*.

When *you* are notified or become aware of a special enrollment event that will occur in the future, *you* may apply for coverage during the 30 days prior to the *special enrollment date*. Coverage will begin no earlier than the *special enrollment date. You* must be able to provide written documentation to support the special enrollment.

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

Dependent special enrollment

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

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

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

Open enrollment

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

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

Effective date

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

Employee effective date

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

Dependent effective date

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

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

Newborn and adopted dependent effective date

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

The *effective date* of coverage for a newborn *dependent* is the date of birth if the newborn is not a *late applicant.* The newborn *dependent* will not be considered a *late applicant* if enrollment for coverage beyond the initial 31 days is requested within 31 days of the date of birth.

The *effective date* of coverage for an adopted *dependent* is the date of adoption or the date of placement for the purpose of adoption, whichever occurs first, if the *dependent* child is not a *late applicant*. The adopted *dependent* will not be considered a *late applicant* if enrollment for coverage beyond the initial 31 days is requested within 31 days of the date of adoption or date of placement for the purpose of adoption.

Premium is due within 31 days for *dependent* coverage to continue coverage beyond the first 31 days. Additional premium may not be required when *dependent* coverage is already in force.

Open enrollment effective date

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

Retired employee coverage

Retired employee eligibility date

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

Retired employee enrollment

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

Retired employee effective date

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

6. How to Access Your Services and Obtain Approval of Benefits (Applicable to managed care plans)

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

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

Covered and non-covered expenses

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

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

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

Refer to the "Schedule of Benefits (Who Pays What)," the "Benefits/Coverage (What is Covered)" and the "Limitations/Exclusions (What is Not Covered)" sections to see when services or supplies are *covered expenses* or are non-covered expenses.

Your choice of providers affects your benefits

We will pay benefits for *covered expenses* if *you* see a *network provider*. *You* must pay any *copayment, deductible* or *coinsurance* to the *network provider*. Be sure to check if *your qualified provider* is a *network provider* before seeing them.

We may designate certain *network providers* as preferred providers for specific services. If *you* do not see the *network provider* designated by *us* as a preferred provider for these services, *we* may pay less.

Some *non-network providers* work with *network facilities*. If possible, *you* may want to check if all health care providers working with *network facilities* are *network providers*.

We will apply the *network provider* benefit level and *you* will only be responsible to pay the *network provider copayment, deductible* and/or *coinsurance* for *covered expenses* when *you* receive the following services from *non-network providers*:

- *Ancillary services* at a *network facility*;
- Services that are not considered *ancillary services* at a *network facility* and *you* do not consent to the *non-network provider* to obtain such services;

- *Post-stabilization services* when:
  - The attending *qualified provider* determines *you* are not able to travel by non-medical transportation to obtain services from a *network provider*; and
  - *You* do not consent to the *non-network provider* to obtain such services; and
- When a *network provider* is not reasonably available to provide services and authorization is received from *us* to see a *non-network provider*.

For all other services *you* receive from *non-network providers*, no benefits will be provided including:

- Services that are not considered *ancillary services* when *you* are at a *network facility* and *you* consent to the *non-network provider* to obtain such services; and
- *Post-stabilization services* when:
  - The attending *qualified provider* determines *you* are able to travel by non-medical transportation to obtain services from a *network provider*; and
  - *You* consent to the *non-network provider* to obtain such services.

Non-network providers have not signed an agreement with *us* to accept discounted or negotiated fees for services and may bill *you* for charges in excess of the *maximum allowable fee*. *You* may be required to pay any amount not paid by *us* in addition to any applicable *deductible*, *coinsurance* and *copayment* for *covered expenses* received. Any amount *you* pay over the *maximum allowable fee* will not apply to *your deductible* or any *out-of-pocket limit.*

Refer to the "Schedule of Benefits (Who Pays What)" to see what *your* benefits are.

How to find a network provider

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

How to use your health maintenance organization (HMO) plan

You may receive services from a *network provider* with *your* HMO plan without a referral from *your primary care physician*. Refer to the "Schedule of Benefits (Who Pays What)" for any *preauthorization* requirements.

6. How to Access Your Services and Obtain Approval of Benefits (Applicable to managed care plans) (continued)

Access plan

The Network Access Plan, which describes an access plan specific to *your* network, is available at www.humana.com or by calling *our* customer service department and requesting a copy. This contains information that may be beneficial to *you* in utilizing *your* network. Some of the topics *you* will find include:

- Referral procedures;
- Description of the network;
- Accessible providers;
- Accessible facilities; and
- Grievance procedure.

Selecting your primary care physician

Each *covered person* on *your* plan must choose a *primary care physician*. If *you* do not choose a *primary care physician*, one will be chosen for *you.*

You may change *your primary care physician* at www.humana.com or *you* may call *us* at the customer service number listed on *your* ID card. *You* must contact *us* before receiving services from a new *primary care physician*. *We* will send *you* a new ID card with *your* new *primary care physician's* name.

Seeking emergency care

If *you* need *emergency care,* go to the nearest emergency facility.

You may call 911 or *your* local emergency telephone number if *you* are confronted with a life or limb threatening emergency.

You, or someone on *your* behalf, must call *us* within 48 hours after *your admission* to a *non-network hospital* for *emergency medical condition.* If *your* condition does not allow *you* to call *us* within 48 hours after *your admission,* contact *us* as soon as *your* condition allows. *We* may transfer *you* to a *network hospital* in the *service area* when *your* condition is stable.

Seeking urgent care

If *you* need *urgent care, you* must go to the nearest *urgent care center* or call an *urgent care qualified provider. You* must receive *urgent care* services from a *network provider* for the *network provider copayment, deductible* or *coinsurance* to apply.

Prospective review determination

For pre-service claims, *we* will provide notice of a favorable or *adverse benefit determination* within a reasonable time appropriate to the medical circumstances but no later than fifteen (15) days after the plan receives the claim.

Retrospective review determination

For post-service claims, *we* will provide notice of a favorable or *adverse benefit determination* within a reasonable time appropriate to the medical circumstances but no later than 30 days after the plan receives the claim.

Continuity of care

You may be eligible to elect continuity of care if *you* are a continuing care patient as of the date any of the following events occur:

- *Your qualified provider* terminates as a *network provider*;
- The terms of a *network provider's* participation in the network changes in a manner that terminates a benefit for a service *you* are receiving as a continuing care patient; or
- The *master group contract* terminates.

You must be in a course of treatment with the *qualified provider* as a continuing care patient the day before *you* are eligible to elect continuity of care.

If *you* elect continuity of care, *we* will apply the *network provider* benefit level to *covered expenses* related to *your* treatment as a continuing care patient. *You* will be responsible for the *network provider copayment, deductible* and/or *coinsurance* until the earlier of:

- 90 days from the date *we* notify *you* the *qualified provider* is no longer a *network provider*;
- 90 days from the date *we* notify *you* the terms of a *network provider's* participation in the network changes in a manner that terminates a benefit for a service *you* are receiving as a continuing care patient;
- 90 days from the date *we* notify *you* this *master group contract* terminates; or
- The date *you* are no longer a continuing care patient.

For the purposes of this "Continuity of care" provision, continuing care patient means at the time continuity of care becomes available, *you* are undergoing treatment from the *network provider* for:

- An acute *sickness* or *bodily injury* that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm;
- A chronic *sickness* or *bodily injury* that is a life-threatening condition, degenerative, potentially disabling, or is a *congenital anomaly*, and requires specialized medical care over a prolonged period of time;
- *Inpatient* care;
- A scheduled non-elective *surgery* and any related post-surgical care;

- A pregnancy; or
- A terminal illness.

For the purposes of this "Continuity of care" provision, a terminal illness means *you* have a medical prognosis with a life expectancy of 6 months or less.

Continuity of care is not available if:

- The *qualified provider's* participation in *our* network is terminated due to failure to meet applicable quality standards or fraud;
- *You* transition to another *qualified provider*;
- The services *you* receive are not related to *your* treatment as a continuing care patient;
- This "Continuity of care" provision is exhausted; or
- *Your* coverage terminates, however the *master group contract* remains in effect.

Our relationship with qualified providers

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

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

Our financial arrangements with network providers

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

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

The certificate

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

7. Benefits/Coverage (What is Covered)

This "Benefits/Coverage (What is Covered)" section describes the services that will be considered *covered expenses* under the *master group contract* for *preventive services* and medical services for a *bodily injury* and *sickness*. Benefits will be paid as specified in the "How your master group contract works" provision in the "Member Payment Responsibility" section and as shown on the "Schedules of Benefits (Who Pays What)," subject to any applicable:

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

Refer to the "Limitations/Exclusions (What is Not Covered)" section listed in this *certificate.* All terms and provisions of the *master group contract* apply.

Essential health benefits

Essential health benefits mean the items and services in the following 10 benefit categories defined by the United States Health and Human Services (HHS) as set forth by Section 1302(b)(1) of the Affordable Care Act. This is not an exhaustive listing of Essential Health Benefits. The complete listing can be found at the U.S. Preventive Task Force website at www.uspreventiveservicestaskforce.org:

- Ambulatory patient services;
- Emergency services;
- Hospitalization services;
- Maternity and newborn care services;
- Mental health, substance abuse disorders and *behavioral health* treatment services;
- *Prescription* drugs;
- Rehabilitative and *habilitative services* and devices;
- Laboratory and radiology services;
- Preventive and wellness services and chronic disease management; and
- Pediatric services, including oral and vision care.

Please note that the following categories are also required to be covered:

- Genetic evaluation;
- Sterilization;
- Oral anti-cancer medication;
- Hearing test (all ages); and
- Contraceptives. All FDA approved methods of contraception are covered under this *master group contract* without cost sharing as required by federal and state law.

Preventive services

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

- Services with an A or B rating in the current recommendations of the United States Preventive Services Task Force (USPSTF).

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

- Tobacco cessation services, including screening, counseling, cessation attempt services and the seven FDA approved tobacco cessation medications. Also refer to services available through the Colorado QuitLine at 1-800-QUIT-NOW or www.coquitline.org.

- *Behavioral health* wellness services, including:

  - An annual wellness examination to identify treatment needs and resources;
  - Screenings for unhealthy alcohol use, depression or other *behavioral health* conditions; and
  - Perinatal maternal counseling.

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

- Preventive care for women provided in the comprehensive guidelines supported by HRSA. This includes but is not limited to breast pumps.

- Preventive breast cancer screening study, within the guidelines by the American College of Radiology or The National Comprehensive Cancer Network, using noninvasive imaging modality appropriate for the *covered person* with at least one risk factor:

  - A family history of breast cancer;
  - Age 40 or older; or
  - Increased breast cancer risk determined by risk factor model.

  Covered expenses also include breast imaging, within the guidelines by the American College of Radiology or The National Comprehensive Cancer Network, performed after the breast cancer screening study for further evaluation or supplemental imaging within the same calendar *year*, based on factors including high lifetime risk for breast cancer or high breast density using noninvasive imaging modalities the same as or comparable to the modalities used for the breast cancer screening study. For additional breast imaging in the same *year*, refer to the "Additional covered expenses" provision of this section.

- An annual prostate specific antigen (PSA) test for a male *covered person* 40 years of age or older. The screening must be performed by a *health care practitioner*. The screening must consist of a:

  - PSA blood test; and
  - Digital rectal exam.

- Colorectal cancer screening in accordance with the A or B recommendations of the USPSTF. Coverage also includes screenings for *covered persons* at high risk who have:

  - A family history of colorectal cancer;
  - A prior occurrence of cancer or precursor neoplastic polyps;
  - A prior occurrence of chronic digestive disease, such as:

    - Inflammatory bowel disease;
    - Crohn's disease; or
    - Ulcerative colitis; or

- Other predisposing factors determined by the provider.

- Consistent with the USPSTF A or B recommendations, human immunodeficiency virus (HIV) Pre-exposure prophylaxix (PrEP) medications with a *prescription* from a *health care practitioner*. Refer to the Preventive Medication *drug list* for the covered *prescription* drugs. Coverage is also available for baseline and monitoring services, including office visits.

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

Health care practitioner office services

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

Health care practitioner office visit

Covered expenses include:

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

Virtual visit services

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

Health care practitioner services at a retail clinic

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

Hospital services

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

For *emergency care* benefits, refer to the "Emergency services" provision of this section.

Hospital inpatient services

Covered expenses include:

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

Health care practitioner inpatient services when provided in a hospital

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

Covered expenses include:

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

Hospital outpatient services

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

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

Hospital outpatient surgical services

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

Health care practitioner outpatient services when provided in a hospital

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

Covered expenses include:

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

Hospital outpatient non-surgical services

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

Hospital outpatient advanced imaging

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

Pregnancy and newborn benefit

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

Covered expenses include:

- A minimum stay in a *hospital* for 48 hours following an uncomplicated vaginal delivery (if the 48 hours falls after 8:00 p.m., coverage will continue until the following 8:00 a.m.) and 96 hours following an uncomplicated cesarean section (if the 96 hours falls after 8:00 p.m., coverage will continue until the following 8:00 a.m.). If an earlier discharge is consistent with the most current protocols and guidelines of the American College of Obstetricians and Gynecologists or the American Academy of Pediatrics and is consented to by the mother and the attending *health care practitioner*, a post-discharge office visit to the *health care practitioner* or a home health care visit during the first week of life if the newborn is released from the *hospital* less than 48 hours after delivery is also covered, subject to the terms of this *certificate.*

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

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

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

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

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

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

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

If determined by the *covered person* and *your health care practitioner*, coverage is available in a *birthing center*. *Covered expenses* in a *birthing center* include:

- An uncomplicated, vaginal delivery; and
- Immediate care after delivery for the *covered person* and the newborn.

Early intervention services

We will pay benefits for eligible *early intervention services* for an *eligible child* from birth up to the child's third birthday.

Emergency services

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

Emergency care provided by *non-network providers* will be covered at the *network provider* benefit level, as specified in the "Emergency services" benefit in the "Schedule of Benefits (Who Pays What)." *You* will only be responsible to pay the *network provider copayment, deductible* and/or *coinsurance* to the *non-network provider*. *You* will not have to pay any amount over the *maximum allowable fee* or the *qualified payment amount* for *emergency care* to a *non-network provider*.

Benefits under this "Emergency services" provision are not available if the services provided are not for an *emergency medical condition.*

Ambulance services

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

Ambulance and *air ambulance* services for an *emergency medical condition* provided by a *non-network provider* will be covered at the *network provider* benefit level, as specified in the "Ambulance services" benefit in the "Schedule of Benefits (Who Pays What)." *You* may be required to pay any amount not paid by *us* to the *non-network provider*, as follows:

- For *ambulance* services *you* received from a privately owned ambulance service in the state of Colorado, *you* will only be responsible to pay the *network provider copayment, deductible* and/or *coinsurance*. *You* will not have to pay any amount over the *maximum allowable fee.*
- For *ambulance* services *you* received from an ambulance service that is not privately owned in the state of Colorado and *ambulance* services received outside the state of Colorado, *you* will be responsible to pay the *network provider copayment, deductible* and/or *coinsurance*. *You* may also be responsible to pay any amount over the *maximum allowable fee* to a *non-network provider*. *Non-network providers* have not agreed to accept discounted or negotiated fees, and may bill *you* for charges in excess of the *maximum allowable fee.*
- For *air ambulance* services, *you* will only be responsible to pay the *network provider copayment, deductible* and/or *coinsurance* based on the *qualified payment amount.*

Ambulatory surgical center services

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

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

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

Covered expenses include:

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

Durable medical equipment

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

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

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

- Manufacturer's warranty is expired; and
- Repair cost is less than replacement cost.

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

- Manufacturer's warranty is expired; and
- Replacement cost is less than repair cost; and
- Replacement is required due to a change in *your* condition that makes the current equipment non-functional.

Hearing aids and services

We will pay benefits for *covered expenses* incurred by *you* for a hearing loss that has been verified by a *health care practitioner* and a licensed audiologist.

Covered expenses include the following:

- Initial *hearing aids* and replacement *hearing aids* not more frequently than every five years.
- A new *hearing aid* when alterations to the existing *hearing aid* can not adequately meet *your* needs.

- Services and supplies, including but not limited to, the initial assessment, fitting, adjustments and auditory training that is provided according to accepted professional standards.

Hearing aids must be medically appropriate to meet *your* needs.

Prosthetic devices and supplies

We will pay benefits for *covered expenses* incurred by *you* for prosthetic devices and supplies, including but not limited to limbs and eyes. Coverage will be provided for prosthetic devices for the most appropriate model that adequately meets the medical needs of the *covered person* as determined by the *covered person's* treating physician.

Covered expense for prosthetic devices includes repair or replacement, unless necessitated by misuse or loss.

Gender affirming services

We will pay benefits for *covered expenses* incurred by *you* for the treatment of gender dysphoria. Benefits include, but may not be limited to the following gender affirming services, as applicable, when *medically necessary*:

- Genital and non-genital surgical procedures;
- Blepharoplasty (eye and lid modification);
- Hormone therapy;
- Face, forehead or neck tightening;
- Facial bone remodeling for facial feminization;
- Genioplasty (chin width reduction);
- Rhytidectomy (cheek, chin and neck);
- Cheek, chin and nose implants;
- Lip lift (augmentation);
- Mandibular angle augmentation, creation or reduction (jaw);
- Orbital re-contouring;
- Rhinoplasty (nose reshaping);
- Laser or electrolysis hair removal; or
- Breast/chest augmentation, reduction or construction.

Free-standing facility services

Free-standing facility diagnostic laboratory and radiology services

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

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

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

Free-standing facility advanced imaging

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

Home health care services

We will pay benefits for *covered expenses* incurred by *you* in connection with a *home health care plan* provided by a *home health care agency.* All home health care services and supplies must be provided on a part-time or intermittent basis to *you* in conjunction with the approved *home health care plan*. Prior hospitalization is not required.

The "Schedule of Benefits (Who Pays What)" shows the maximum number of hours allowed by a representative of a *home health care agency,* if any. Home health care is provided at a minimum of 28 hours per week.

Home health care *covered expenses* are limited to:

- Care provided by a *nurse*;
- Certified nurse aide services under the supervision of a registered nurse (R.N.) or a qualified therapist;
- Physical, occupational, respiratory and inhalation therapy, speech therapy, and audiology services;
- Medical social work and nutrition services;
- Medical supplies, except for *durable medical equipment*; and
- Laboratory services.

Home health care *covered expenses* do not include:

- Charges for services or supplies for personal comfort or convenience, including homemaker services;
- Charges for mileage or travel time to and from the *covered person's* home;
- Wage or shift differentials for any representative of a *home health care agency*;
- Charges for supervision of *home health care agencies*;
- *Custodial care*;
- The provision or administration of *self-administered injectable drugs*, unless otherwise determined by *us*;
- Charges for services related to well-baby care; or
- Charges for food services or meals other than dietary counseling.

Hospice services

We will pay benefits for *covered expenses* incurred by *you* for a *hospice care program.* A *health care practitioner* must certify that the *covered person* is terminally ill.

If the above criteria is not met, no benefits will be payable under the *master group contract* for hospice care. *Covered expenses* incurred in connection with an unrelated illness will be covered in accordance with this plan's coverage provisions applicable to all other *sicknesses* or *bodily injuries*. *Covered expenses* will also include *inpatient hospice respite care* limited to periods of five (5) days or less.

Hospice care benefits are payable as shown in the "Schedule of Benefits (Who Pays What)" for the following hospice services:

- Bereavement support services for the hospice patient's immediate *family members*, the primary care giver and individuals with significant personal ties to the hospice patient, during the twelve month period following death;
- Short-term general *inpatient* acute hospice care or continuous home care during a period of crisis, for pain control, or symptom-management. Such care must be authorized in advance by the hospice care team and, except for emergencies, by *us*. Authorization for the transfer to the higher level of care must be received during *our* first business day following the emergency, weekend or holiday;
- Medical supplies;
- Drugs and biologicals;
- Prosthesis and orthopedic appliances;
- Oxygen and respiratory supplies;
- Diagnostic testing;
- Rental or purchase of *durable medical equipment*;
- Transportation;
- Physician services;
- Physical, speech and occupational therapy; and
- Nutritional counseling by a nutritionist or dietitian.

The following hospice services are considered *covered expenses:*

- Intermittent and 24 hour on-call professional nursing services provided by or under the supervision of a registered nurse (R.N.);
- Intermittent and 24 hour on-call social or counseling services; and
- Certified nurse aide services or nursing services delegated to other persons, permitted by Colorado revised statutes.

Jaw joint benefit

We will pay benefits for *covered expenses* incurred by *you* during a plan of treatment for any jaw joint problem, including temporomandibular joint disorder, craniomaxillary disorder, craniomandibular disorder, head and neck neuromuscular disorder or other conditions of the joint linking the jaw bone and the skull, subject to the maximum benefit shown in the "Schedule of Benefits (Who Pays What)," if any.

The following are *covered expenses*:

- A single examination including a history, physical examination, muscle testing, range of motion measurements, and psychological evaluation;
- Diagnostic x-rays;
- Physical therapy of necessary frequency and duration, limited to a multiple modality benefit when more than one therapeutic treatment is rendered on the same date of service;
- Therapeutic injections; and
- Surgical procedures.

Covered expenses do not include charges for:

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

Therapy services for congenital defects and birth abnormalities

We will pay benefits for *covered expenses* incurred by *you* for physical, occupational and speech therapy for the care and treatment of congenital defects and birth abnormalities for covered *dependent* children up to six years of age without regard to whether the purpose of the therapy is to maintain or improve functional capacity.

The "Schedule of Benefits (Who Pays What)" shows the maximum number of visits for therapy services for congenital defects and birth abnormalities, if any. The visit limit for therapy to treat congenital defects and birth abnormalities is not applicable if such therapy is *medically necessary* to treat autism spectrum disorders.

Physical medicine and rehabilitative services

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

- Physical therapy services;
- Occupational therapy services;
- Speech therapy or speech pathology services;
- Audiology services;
- Cognitive rehabilitation services;
- Acupuncture;
- Respiratory or pulmonary rehabilitation services; and
- Cardiac rehabilitation services.

The "Schedule of Benefits (Who Pays What)" shows the maximum number of visits for physical medicine and/or rehabilitative services, if any. The visit limit for therapy is not applicable if such therapy is *medically necessary* to treat autism spectrum disorders.

Habilitative services

We will pay benefits for *covered expenses* incurred by *you* for the following *habilitative services*, ordered and performed by a *health care practitioner*:

- Physical therapy services;
- Occupational therapy services;
- Speech therapy or speech pathology services; and
- Audiology services.

The "Schedule of Benefits (Who Pays What)" shows the maximum number of visits for *habilitative services*, if any. The visit limit for therapy is not applicable if such therapy is *medically necessary* to treat autism spectrum disorders.

Chiropractic care services

Office visit and diagnostic services

We will pay benefits for *covered expenses* incurred by *you* for the following chiropractic care performed by a *health care practitioner*:

- Diagnosis and evaluation; and
- Diagnostic laboratory and radiology, required for chiropractic care and musculoskeletal disorders.

Spinal manipulations/adjustments

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

The "Schedule of Benefits (Who Pays What)" shows the maximum number of visits for spinal manipulations/adjustments, if any.

Skilled nursing facility services

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

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

Health care practitioner services when provided in a skilled nursing facility

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

Covered expenses include:

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

Specialty drug medical benefit

We will pay benefits for *covered expenses* incurred by *you* for *specialty drugs* provided by or obtained from a *qualified provider* in the following locations:

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

Specialty drugs may be subject to *preauthorization* requirements. Refer to the "Schedule of Benefits (Who Pays What)" in this *certificate* for *preauthorization* requirements and contact *us* prior to receiving *specialty drugs.* Coverage for certain *specialty drugs* administered to *you* by a *qualified provider* in a *hospital's outpatient* department may only be granted as described in the "Access to non-formulary drugs" provision in the "Benefits/Coverage (What is Covered) – Pharmacy Services" section in this *certificate.*

Specialty drug benefits do not include the charge for the actual administration of the *specialty drug*. Benefits for the administration of *specialty drugs* are based on the location of the service and type of provider.

Transplant services and immune effector cell therapy

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

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

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

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

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

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

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

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

- Non-medical travel and lodging costs for:

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

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

  Non-medical travel and lodging costs include:

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

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

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

Urgent care services

We will pay benefits for *urgent care covered expenses* incurred by *you* for charges made by an *urgent care center* or an *urgent care qualified provider*. *Urgent care* services provided by a *non-network provider* will only be a *covered expense* for *emergency care*.

Additional covered expenses

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

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

- Oxygen and rental of equipment for its administration.

- Cochlear implants, when approved by *us*, for a *covered person* with bilateral severe to profound sensorineural deafness.

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

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

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

  Covered expense does not include:

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

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

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

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

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

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

- Certain oral surgical operations as follows:

  - Excision of partially or completely impacted teeth;

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

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

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

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

  - Reduction of fractures and dislocation of the jaw;

  - External incision and drainage of cellulitis and abscess;

- Incision and closure of accessory sinuses, salivary glands or ducts;
- Frenectomy (the cutting of the tissue in the midline of the tongue); and
- Orthognathic *surgery* for a *congenital anomaly*, *bodily injury* or *sickness* causing a *functional impairment*.

- Orthodontic treatment for a *congenital anomaly* related to or developed as a result of cleft palate, with or without cleft lip.
- Breast imaging in addition to the breast cancer screening study recommendations in the "Preventive services" provision in this section.
- For a *covered person*, who is receiving benefits in connection with a mastectomy, service for:
  - Reconstructive *surgery* of the breast on which the mastectomy has been performed;
  - *Surgery* and reconstruction on the non-diseased breast to achieve symmetrical appearance; and
  - Prostheses and treatment of physical complications for all stages of mastectomy, including lymphedemas.
- Reconstructive *surgery* resulting from:
  - A *bodily injury*, infection or other disease of the involved part, when a *functional impairment* is present; or
  - A *congenital anomaly* that resulted in a *functional impairment*.

  Expenses for reconstructive *surgery* due to a psychological condition are not considered a *covered expense*, unless the condition(s) described above are also met.
- Metabolic formulas and their modular counterparts, nutritional supplements, low protein modified foods and amino acid-based elemental formulas that are prescribed by a *health care practitioner* for consumption or administration enterally to a *covered person* to treat an inherited enzymatic disorder or severe protein allergic condition. Inherited enzymatic disorders and severe protein allergic conditions include the following diagnosed conditions:
  - Phenylketonuria (PKU), for a *dependent* child up to 21 years of age;
  - Maternal phenylketonuria, for a female *covered person* up to 35 years of age;
  - Maple syrup urine disease;
  - Tyrosinemia;
  - Homosystinuria;
  - Histidinemia;
  - Urea cycle disorders;
  - Hyperlysinemia;
  - Glutaric acidemias;
  - Methymalonic acidemia;
  - Propionic acidemia;
  - Immunoglobulin E and non-immunoglobulin E-mediated allergies to multiple food proteins;
  - Severe food protein induced enterocolitis syndrome;
  - Eosinophilic disorders as evidenced by the results of a biopsy; and

- Impaired absorption of nutrients caused by disorders affecting the absorptive surface, function, length, and motility of the gastrointestinal tract.

- Private duty nursing while *you* are *hospital confined*.

- *Palliative care*.

- Routine foot care for a *covered person* with diabetes as follows:

  - Hygienic care, and the treatment of superficial lesions of the feet, such as corns, calluses or hyperkeratosis;
  - Treatment of tarsalgia, metatarsalgia or bunion;
  - The cutting of toenails, including the removal of the nail matrix;
  - Heel wedges, lifts or shoe inserts; and
  - Arch supports (foot orthotics) or orthopedic shoes.

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

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

  Routine costs do not include services or items that are:

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

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

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

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

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

- *Covered expenses* for a newborn *dependent* child born with a cleft lip, cleft palate, or both, are payable the same as any other *sickness* with no age limit on benefits.

The following are *covered expenses*:

- Oral and facial surgery, surgical management and follow-up care by plastic surgeons and oral surgeons;
- Prosthetic treatment such as obturators, speech appliances and feeding appliances;
- Orthodontic treatment;
- Prosthodontic treatment;
- Habilitative speech therapy;
- Otolaryngology treatment; and
- Audiological assessments and treatment.

Benefits will not be payable under this section for dental or orthodontic treatment unrelated to the management of cleft lip and cleft palate.

- *Hospital*, free-standing surgical facility, or *health care treatment facility* and anesthesia charges associated with dental care provided by a licensed dentist to a *dependent* child meeting any of the following:

  - The *dependent* child has a physical, mental or medically compromising condition; or
  - The *dependent* child has dental needs for which local anesthesia is ineffective because of acute infection, anatomic variation or allergy; or
  - The *dependent* child is extremely uncooperative, unmanageable, anxious, or uncommunicative and the dental needs are deemed sufficiently important that the care cannot be deferred; or
  - The *dependent* child has sustained extensive orofacial and dental trauma.

- A second opinion for proposed treatment by a *health care practitioner*.

- *Covered expenses* to achieve pregnancy, including:

  - Diagnostic laboratory and radiology;
  - Diagnosis and treatment of involuntary infertility; and
  - Artificial insemination, except for donor semen, donor eggs and services related to their procurement and storage.

- *Medically necessary bariatric surgery.*

- Testing and treatment of COVID-19, as required under any applicable Federal or Colorado bulletins, laws or regulations.

Pediatric Dental

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

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

All terms used in this benefit have the same meaning given to them in the *certificate,* unless otherwise specifically defined in this benefit. Refer to the "Limitations and exclusions" provision in this section and the "Limitations/Exclusions (What is Not Covered)" section of this *certificate* for *pediatric dental services* not covered by the *master group contract.* All terms and provisions of the *master group contract* apply.

Definitions

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

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

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

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

Covered person under this "Benefits/Coverage (What is Covered) – Pediatric Dental" and "Schedule of Benefits (Who Pays What) – Pediatric Dental" sections means a person who is eligible and enrolled for benefits provided under the *master group contract* up to the end of the month following the date he or she attains age 19. An unmarried child of any age who is medically certified as disabled and dependent upon the parent is also a *covered person.*

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

Expense incurred date means the date on which:

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

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

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

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

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

- The actual cost for services;
- The fee most often charged in the geographical area where the service was performed;
- The fee most often charged by the provider;
- The fee determined by comparing charges for similar services to a national database adjusted to the geographical area where the services or procedures were performed;
- At *our* choice, the fee determined by using a national Relative Value Scale. Relative Value Scale means a methodology that values procedures and services relative to each other that includes, but is not limited to, a scale in terms of difficulty, work, risk, as well as the material and outside costs of providing the service, as adjusted to the geographic area where the services or procedures were performed;
- In the case of services rendered by providers with whom *we* have agreements, the fee that *we* have negotiated with that provider;
- The fee based on rates negotiated with one or more *network providers* in the geographic area for the same or similar services;
- The fee based on the provider's costs for providing the same or similar services as reported by the provider in the most recent, publicly available *Medicare* cost report submitted annually to the Centers for Medicare & Medicaid Services; or
- The fee based on a percentage of the fee *Medicare* allows for the same or similar services provided in the same geographic area.

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

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

Pediatric dental services benefit

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

Class I services

- Periodic and comprehensive oral evaluations. Limited to 2 per *year*.
- Limited, problem focused oral evaluations. Limited to 2 per *year*.
- Periodontal evaluations. Limited to 2 per *year*. Benefit allowed only for a *covered person* showing signs or symptoms of periodontal disease and for patients with risk factors such as smoking, diabetes or related health issues. No benefit is payable when performed with a cleaning (prophylaxis). Benefits are not available when a comprehensive oral evaluation is performed.
- Cleaning (prophylaxis), including all scaling and polishing procedures. Limited to 2 per *year*.
- Intra-oral complete series x-rays (at least 14 films, including bitewings) or panoramic x-ray. Limited to 1 every 5 *years*.
- Bitewing x-rays. Limited to 2 sets per *year*.
- Other x-rays, including intra-oral periapical and occlusal and extra-oral x-rays.
- Topical fluoride treatment. Limited to 2 per *year*.
- Application of sealants to the occlusal surface of permanent molars that are free of decay and restorations. Limited to 1 per tooth every 3 *years*.

- Installation of space maintainers (fixed unilateral, fixed bilateral, removable unilateral, and removable bilateral) for retaining space when a primary tooth is prematurely lost. *Pediatric dental services* do not include separate adjustment expenses.
- Recementation of space maintainers.
- Removal of fixed space maintainers.
- Distal shoe space maintainer – fixed – unilateral.

Class II services

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

Class III services

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

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

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

- Initial placement and replacement of crowns, implanted crowns and abutments. Limited to 1 per tooth every 24 months.

- Periodontic services as follows:

  - Periodontal scaling and root planing. Limited to 1 per quadrant every 2 *years*.

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

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

  - Periodontal and osseous surgical procedures, including bone replacement, tissue regeneration, gingivectomy, and gingivoplasty. Limited to 1 per quadrant every 3 *years*.

  - Occlusal adjustments when performed in conjunction with a periodontal surgical procedure. Limited to 1 per quadrant every 3 *years*.

  - Clinical crown lengthening – hard tissue.

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

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

- Endodontic procedures as follows:

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

  - Retreatment of previous root canal therapy. Any test, intraoperative x-rays, exam, laboratory, or any other follow-up care is considered integral to root canal therapy.

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

- Partial pulpotomy for apexogenesis for permanent teeth.
- Vital pulpotomy for primary teeth.
- Pulp debridement, pulpal therapy (resorbable) for permanent and primary teeth.
- Apexification/recalcification for permanent and primary teeth.

- Prosthodontics services as follows:
  - Denture adjustments when done by a *dentist*, other than the one providing the denture, or adjustments performed more than six months after initial installation.
  - Initial placement of bridges, complete dentures, and partial dentures. Limited to 1 every 5 *years*. *Pediatric dental services* include pontics, inlays and onlays. Limited to 1 per tooth every 5 *years.*
  - Initial placement of crowns. Limited to 1 per tooth every 24 months.
  - Replacement of bridges, complete dentures and partial dentures. *Pediatric dental services* include the replacement of the existing prosthesis if:
    - It has been 5 *years* since the prior insertion and is not, and cannot be made serviceable.
    - It is damaged beyond repair as a result of an *accidental dental injury* while in the oral cavity; or
    - Extraction of functioning teeth, excluding third molars or teeth not fully in occlusion with an opposing tooth or prostheses requires the replacement of the prosthesis.
  - Tissue conditioning.
  - Denture relines or rebases. Limited to 1 every 3 *years* after 6 months of installation.
  - Post and core build-up in addition to partial denture retainers with or without core build up. Limited to 1 per tooth every 5 *years*.

- The following simple oral surgical services as follows:
  - Extraction of coronal remnants of a primary tooth.
  - Extraction of an erupted tooth or exposed root for permanent and primary teeth.

- Implant services, subject to *clinical review*. Dental implants and related services, including implant supported bridges. Limited to 1 per tooth every 5 *years*. *Pediatric dental services* do not include an implant if it is determined a standard prosthesis or restoration will satisfy the dental need.
  - Implant supported crowns. Limited to 1 per tooth every 24 months.

  Implant supported removable denture for:
  - Edentulous arch – maxillary. Limited to 1 per tooth every 5 *years.*
  - Edentulous arch – mandibular. Limited to 1 per tooth every 5 *years.*

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

- Miscellaneous services as follows:

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

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

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

Class IV services

Orthodontic treatment, not as a result of a *congenital anomaly*, when *medically necessary*.

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

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

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

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

Integral service

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

- Local anesthetics.
- Bases.
- Pulp testing.
- Pulp caps.
- Study models/diagnostic casts.
- *Treatment plans*.

- Occlusal (biting or grinding surfaces of molar and bicuspid teeth) adjustments.
- Nitrous oxide.
- Irrigation.
- Tissue preparation associated with impression or placement of a restoration.

Pretreatment plan

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

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

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

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

Pretreatment plan process and timing

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

Alternate services

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

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

Limitations and exclusions

Refer to the "Limitations/Exclusions (What is Not Covered)" section of this *certificate* for additional exclusions. Unless specifically stated otherwise, no benefit will be provided for, or on account of, the following items:

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

  For the purposes of this exclusion, *covered person* means the *employee* and/or the *employee's dependents* enrolled for benefits under the *master group contract* and as defined in the "Definitions" section.
- Any service related to:
  - Altering vertical dimension of teeth or changing the spacing and/or shape of the teeth;
  - Restoration or maintenance of occlusion;
  - Splinting teeth, including multiple abutments, or any service to stabilize periodontally weakened teeth;
  - Replacing tooth structures lost as a result of abrasion, attrition, erosion, or abfraction; or
  - Bite registration or bite analysis.
- Infection control, including but not limited to, sterilization techniques.
- Expenses incurred for services performed by someone other than a *dentist*, except for scaling and teeth cleaning and the topical application of fluoride, which can be performed by a licensed dental hygienist. The treatment must be rendered under the supervision and guidance of the *dentist* in accordance with generally accepted dental standards.
- Any *hospital*, surgical or treatment facility, or for services of an anesthesiologist or anesthetist.
- *Prescription* drugs or pre-medications, whether dispensed or prescribed.

7. Benefits/Coverage (What is Covered) (continued)

- Any service that:
  - Is not eligible for benefits based on the *clinical review*;
  - Does not offer a favorable prognosis;
  - Does not have uniform professional acceptance; or
  - Is deemed to be experimental or investigational in nature.
- Preventive control programs including, but not limited to, oral hygiene instructions, plaque control, take-home items, prescriptions and dietary planning.
- Replacement of any lost, stolen, damaged, misplaced or duplicate major restoration, prosthesis or appliance.
- Any caries susceptibility testing, laboratory tests, saliva samples, anaerobic cultures, sensitivity testing or charges for oral pathology procedures.
- The following services when performed at the same time as a root canal:
  - Partial pulpotomy for apexogensis;
  - Vital pulpotomy; or
  - Pulp debridment or pulpal therapy.

Pediatric Vision Care

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

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

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

Definitions

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

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

Covered person under this "Benefits/Coverage (What is Covered) – Pediatric Vision Care" section and the "Schedule of Benefits (Who Pays What) – Pediatric Vision Care" section means a person who is eligible and enrolled for benefits provided under the *master group contract* up to the end of the month following the date he or she attains age 19 or anyone age 19 and older for comprehensive eye exams only.

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

Reimbursement limit means the maximum fee allowed for a *covered expense.* It is the lesser of:

- The actual cost for services or *materials*;
- The fee most often charged in the geographical area where the service was performed or *materials* provided;
- The fee most often charged by the provider;
- The fee determined by comparing charges for similar services or *materials* to a national database adjusted to the geographical area where the services or procedures were performed or *materials* provided;
- At *our* choice, the fee determined by using a national Relative Value Scale. Relative Value Scale means a methodology that values procedures and services relative to each other that includes, but is not limited to, a scale in terms of difficulty, work, risk, as well as the material and outside costs of providing the service, as adjusted to the geographic area where the services or procedures were performed or *materials* provided;
- In the case of services rendered by or *materials* obtained from providers with whom *we* have agreements, the fee that *we* have negotiated with that provider;
- The fee based on rates negotiated with one or more *network providers* for the same or similar services or *materials*;
- The fee based on the provider's costs for providing the same or similar services or *materials* as reported by the provider in the most recent, publicly available *Medicare* cost report submitted annually to the Centers for Medicare & Medicaid Services; or
- The fee based on a percentage of the fee *Medicare* allows for the same or similar services or *materials* provided in the same geographic area.

Severe vision problems mean the best-corrected acuity is:

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

Pediatric vision care benefit

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

- *Comprehensive eye exam.*

- Prescription lenses and standard lens options. If a *covered person* sees a *network provider*, the *network provider* of *materials* will show the *covered person* the selection of standard lens options covered by the *master group contract.* If a *covered person* selects a lens option that is not included in the standard lens option selection the *master group contract* covers, the *covered person* is responsible for the difference in cost between the *network provider* of *materials* reimbursement amount for covered standard lens options and the retail price of the lens options selected.

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

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

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

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

- *Low vision* services include the following:

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

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

Limitations and exclusions

In addition to the "Limitations/Exclusions (What is Not Covered)" section of this *certificate* and any limitations specified in the "Schedule of Benefits (Who Pays What) – Pediatric Vision Care," benefits for *pediatric vision care* are limited as follows:

- In no event will benefits exceed the lesser of the limits of the *master group contract*, shown in the "Schedule of Benefits (Who Pays What) – Pediatric Vision Care" or in the "Schedule of Benefits (Who Pays What)" of this *certificate.*

- *Materials* covered by the *master group contract* that are lost, stolen, broken or damaged will only be replaced at normal intervals as specified in the "Schedule of Benefits (Who Pays What) – Pediatric Vision Care."

Refer to the "Limitations/Exclusions (What is Not Covered)" section of this *certificate* for additional exclusions. Unless specifically stated otherwise, no benefits for *pediatric vision care* will be provided for, or on account of, the following items:

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

Behavioral Health

This "Benefits/Coverage (What is Covered) – Behavioral Health" section describes the services that will be considered *covered expenses* for *behavioral health* services under the *master group contract*, whether the services are voluntary or court-ordered as a result of contact with the criminal justice or juvenile justice system. Benefits will be paid as specified in the "How your policy works" provision of the "Member Payment Responsibility" section and as shown in the "Schedule of Benefits (Who Pays What) – Behavioral Health." Refer to the "Schedule of Benefits (Who Pays What)" for any service not specifically listed in the "Schedule of Benefits (Who Pays What) – Behavioral Health." Benefits are subject to any applicable:

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

Refer to the "Limitations/Exclusions (What is Not Covered)" section listed in this *certificate.* All terms and provisions of the *master group contract* apply.

Acute inpatient services

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

Acute inpatient health care practitioner services

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

Early intervention services

We will pay benefits for eligible *early intervention services* for an *eligible child* from birth up to the child's third birthday.

Emergency services

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

Emergency care provided by *non-network providers* will be covered at the *network provider* benefit level, as specified in the "Emergency services" benefit in the "Schedule of Benefits (Who Pays What)" or "Schedule of Benefits (Who Pays What) – Behavioral Health" sections of this *certificate*, subject to the *maximum allowable fee*. *You* will only be responsible to pay *network provider copayment, deductible* and/or *coinsurance* to the *non-network provider*. *You* will not have to pay any amount over the *maximum allowable fee* or the *qualified payment amount* for *emergency care* to a *non-network provider*.

Benefits under this "Emergency services" provision are not available if the services provided are not for an *emergency medical condition.*

Urgent care services

We will pay benefits for *urgent care covered expenses* incurred by *you* for charges made by an *urgent care center* or an *urgent care qualified provider* for *behavioral health* services.

Outpatient services

We will pay benefits for *covered expenses* incurred by *you* for *behavioral health* services, including services in a *health care practitioner* office, *retail clinic* or *health care treatment facility*. Coverage includes *outpatient* therapy, *intensive outpatient programs, partial hospitalization, virtual visits,* and other *outpatient* services.

Skilled nursing facility services

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

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

Home health care services

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

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

Home health care *covered expenses* do not include:

- Charges for services or supplies for personal comfort or convenience, including homemaker services;
- Charges for mileage or travel time to and from the *covered person's* home;
- Wage or shift differentials for any representative of a *home health care agency*;
- Charges for supervision of *home health care agencies*;
- *Custodial care*;
- The provision or administration of *self-administered injectable drugs*, unless otherwise determined by *us*;
- Charges for services related to well-baby care; or
- Charges for food services or meals other than dietary counseling.

Specialty drug benefit

We will pay benefits for *covered expenses* incurred by *you* for *behavioral health specialty drugs* provided by or obtained from a *qualified provider* in the following locations:

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

Specialty drugs may be subject to *preauthorization* requirements. Refer to the "Schedule of Benefits (Who Pays What)" in this *certificate* for *preauthorization* requirements and contact *us* prior to receiving *specialty drugs.* Coverage for certain *specialty drugs* administered to *you* by a *qualified provider* in a *hospital's outpatient* department may only be granted as described in the "Access to non-formulary drugs" provision in the "Benefits/Coverage (What is Covered) – Pharmacy Services" section in this *certificate.*

Specialty drug benefits do not include the charge for the actual administration of the *specialty drug*. Benefits for the administration of *specialty drugs* are based on the location of the service and type of provider.

Residential treatment facility services

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

Autism spectrum disorders

We will pay benefits for *covered expenses* incurred by a *covered person* for the treatment of autism spectrum disorders.

Covered expenses include:

- Evaluation and assessment services;
- Behavioral training and behavior management and applied behavior analysis;
- Habilitative or rehabilitative care;
- Pharmacy care and medication, if covered by the health benefit plan;
- Psychiatric care;
- Psychological care, including family counseling; and
- Therapeutic care.

Autism spectrum disorders are payable as shown in the "Schedule of Benefits (Who Pays What) – Behavioral Health."

Pharmacy Services

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

Refer to the "Limitations/Exclusions (What is Not Covered)," "Limitations/Exclusions (What is Not Covered) – Pharmacy Services," "Definitions" and "Definitions – Pharmacy Services" sections in this *certificate*. All terms and provisions of the *master group contract* apply, including *prior authorization* requirements specified in the "Schedule of Benefits (Who Pays What) – Pharmacy Services" of this *certificate*.

Coverage description

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

Covered *prescription* drugs are:

- Drugs, medicines or medications and *specialty drugs* that under federal or state law may be dispensed only by *prescription* from a *health care practitioner*.
- Drugs, medicines or medications and *specialty drugs* included on *our drug list*.
- Insulin and *diabetes supplies*.
- *Self-administered injectable drugs* approved by *us*.
- Hypodermic needles, syringes or other methods of delivery when prescribed by a *health care practitioner* for use with insulin or *self-administered injectable drugs*. (Hypodermic needles, syringes or other methods of delivery used in conjunction with covered drugs may be available at no cost to *you*).
- Eye drops, as identified on the *drug list*, including one additional bottle every three months when the initial *prescription* includes the request for the additional bottle and states it is needed for use in a day care center, school, or adult day program.
- Metabolic formulas and their modular counterparts, nutritional supplements and amino acid-based elemental formulas that are prescribed by a *health care practitioner* for consumption or administration enterally to a *covered person* to treat an inherited enzymatic disorder or severe protein allergic condition.

- Spacers and/or peak flow meters for the treatment of asthma.
- Drugs, medicines or medications on the Preventive Medication Coverage *drug list* with a *prescription* from a *health care practitioner*. All FDA approved methods of contraception are covered under the *policy* without cost sharing as required by federal and state law.
- Drugs, medicines or medications used for to treat opioid dependence and included on *our drug list*.

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

Restrictions on choice of providers

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

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

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

About our drug list

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

Prescription drug assistance program

The *prescription drug* assistance program, which may be administered by a third party, is available to provide direct support toward the cost of certain *prescriptions* and *specialty drugs*. If *you* are prescribed a drug or *specialty drug* that is part of the prescription drug assistance program, *you* will be contacted to enroll in the program. *Your copayment* and/or *coinsurance* may vary depending on the direct support, if any, available for the *prescription* or *specialty drug*.

Access to medically necessary contraceptives

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

Access to non-formulary drugs

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

Non-formulary drug standard exception request

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

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

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

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

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

Non-formulary drug expedited exception request

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

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

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

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

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

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

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

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

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

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

Non-formulary drug exception request external review

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

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

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

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

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

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

Step therapy requirement exception request

When step therapy is required for a *prescription* drug, an exception for any clinically appropriate *prescription* drug included on the *drug list* can be requested by *you* or *your* appointed representative. The *step therapy* exception request should be made using the *prior authorization* form available on *our* website at www.humana.com or call the customer service telephone number on *your* ID card.

A drug approved by the U.S. Food and Drug Administration and included on *our drug list* will not be subject to *step therapy* for a *covered person* with stage four advanced metastatic cancer if the use of the drug is consistent with:

- The U.S. Food and Drug Administration approved indication or the National Comprehensive Cancer Network Drugs and Biologics Compendium indication for the treatment of stage four advanced metastatic cancer; or
- Peer-reviewed medical literature.

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

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

We will approve a step therapy requirement exception request if:

- The required *prescription* drug is contraindicated; or
- *You* have tried the required *prescription* drug and the *health care practitioner* submits evidence of failure or intolerance;

If *we* deny an exception request, *we* will provide to *you, your authorized representative* or *your* prescribing *health care practitioner* the reason for the denial, an alternative covered medication, and *your* right to appeal *our* decision as outlined in the "Appeals and Complaints" section in this *certificate*.

8. Limitations/Exclusions (What is Not Covered)

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.* Services for *covered expenses* resulting from self-harm or suicide attempt or completion will not be denied.

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

- Treatments, services, supplies, or *surgeries* that are not *medically necessary*, except *preventive services*.
- A *sickness* or *bodily injury* arising out of, or in the course of, any employment for wage, gain or profit. This exclusion applies whether or not *you* have Workers' Compensation coverage. This exclusion does not apply to *employees* of entities that are not legally required to obtain and have not obtained Workers' Compensation coverage and does not apply to an *employee* that is sole proprietor, partner, or corporate officer if the sole proprietor, partner or corporate officer is not eligible to receive Workers' Compensation benefits.
- Care and treatment given in a *hospital* owned or run by any government entity, unless *you* are legally required to pay for such care and treatment. However, care and treatment provided by military *hospitals* to *covered persons* who are armed services retirees and their *dependents* are not excluded.
- Any service furnished while *you* are *confined* in a *hospital* or institution owned or operated by the United States government or any of its agencies for any military service-connected *sickness* or *bodily injury*.
- Services, or any portion of a service, for which no charge is made.
- Services, or any portion of a service, *you* would not be required to pay for, or would not have been charged for, in the absence of this coverage.
- Any portion of the amount *we* determine *you* owe for a services that the provider waives, rebates or discounts, including *your copayment, deductible* or *coinsurance*.
- *Sickness* or *bodily injury* for which *you* are in any way paid or entitled to payment or care and treatment by or through a government program.
- Any service not ordered by a *health care practitioner*.
- Services provided to *you*, if *you* do not comply with the *master group contract's* requirements. These include services:
  - Not provided by a *network provider*, unless required for *emergency care* or as otherwise specified in this *certificate*; and
  - Received in an emergency room, unless required because of *emergency care*.

8. Limitations/Exclusions (What is Not Covered) (continued)

- Services rendered by a standby physician, *surgical assistant* or *assistant surgeon*, unless *medically necessary*.
- Any service not rendered by the billing provider.
- Any service not substantiated in the medical records of the billing provider.
- Any amount billed for a professional component of an automated:
  - Laboratory service; or
  - Pathology service.
- Education or training, except for *diabetes self-management training* and *habilitative services.*
- Educational or vocational therapy, testing, services or schools, including therapeutic boarding schools and other therapeutic environments. Educational or vocational videos, tapes, books, and similar materials are also excluded.
- Services provided by a *covered person's family member*, unless the *covered expense* is performed by a *family member* who is a licensed provider.
- *Ambulance* and *air ambulance* services for routine transportation to, from or between medical facilities and/or a *health care practitioner's* office.
- Any drug, biological product, device, medical treatment, or procedure which is *experimental, investigational or for research purposes.*
- Vitamins, except for *preventive services* with a *prescription* from a *health care practitioner*, dietary supplements, and dietary formulas, except metabolic formulas and their modular counterparts, amino acid based elemental formulas, nutritional supplements or low protein modified food products for the treatment of inherited enzymatic disorders and severe protein allergic conditions as specified in the "Benefits/Coverage (What is Covered)" section.
- Over-the-counter, non-prescription medications, unless for drugs, medicines or medications or supplies on the Preventive Medication Coverage *drug list* with a *prescription* from a *health care practitioner*.
- Over-the-counter medical items or supplies that can be provided or prescribed by a *health care practitioner* but are also available without a written order or *prescription*, except for *preventive services*.
- Growth hormones, except as otherwise specified in the pharmacy services sections of this *certificate.*
- Certain *specialty drugs* administered by a *qualified provider* in a *hospital's outpatient* department, except as specified in the "Access to non-formulary drugs" provision in the "Benefits/Coverage (What is Covered) - Pharmacy Services" section of this *certificate.*
- Hearing aids, the fitting of hearing aids or advice on their care; implantable hearing devices, except for cochlear implants as otherwise stated in this *certificate.*

8. Limitations/Exclusions (What is Not Covered) (continued)

- Services received in an emergency room, unless required because of *emergency care* or non-*emergency care* if *you* were referred by *your health care practitioner* or *us*.

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

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

- Any treatment, supply, medication, or service provided to achieve pregnancy or to achieve or maintain ovulation. *Infertility services* includes but is not limited to, in vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), tubal ovum transfer, embryo freezing or transfer, sperm storage or banking, ovum storage or banking; embryo or zygote banking, and any other assisted reproductive techniques or cloning methods, except as otherwise covered under the "Benefits/Coverage (What is Covered)" section.

- Reversal of elective sterilization.

- In vitro fertilization regardless of the reason for treatment.

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

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

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

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

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

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

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

- Services provided for:

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

8. Limitations/Exclusions (What is Not Covered) (continued)

- *Cosmetic surgery* and cosmetic services or devices.
- Hair prosthesis, hair transplants or implants and wigs.
- Dental services, appliances or supplies for treatment of the teeth, gums, jaws, or alveolar processes, including but not limited to, any *oral surgery*, *endodontic services* or *periodontics*, implants and related procedures, orthodontic procedures, and any dental services related to a *bodily injury* or *sickness* unless otherwise stated in this *certificate.*
- The following types of care of the feet:
  - Shock wave therapy of the feet;
  - The treatment of weak, strained, flat, unstable, or unbalanced feet; and
  - Arch supports (foot orthotics) or orthopedic shoes, except for diabetes or hammer toe.
- The following types of care of the feet, unless *you* have diabetes:
  - Hygienic care, and the treatment of superficial lesions of the feet, such as corns, calluses or hyperkeratosis;
  - Non-surgical treatment of tarsalgia, metatarsalgia or bunion;
  - The cutting of toenails, except the removal of the nail matrix; and
  - Heel wedges, lifts or shoe inserts.
- *Custodial care* and *maintenance care*.
- Any loss contributed to, or caused by:
  - War or any act of war, whether declared or not;
  - Insurrection; or
  - Any conflict involving armed forces of any authority.
- Services relating to a *sickness* or *bodily injury* as a result of:
  - Engagement in an illegal profession or occupation; or
  - Commission of or an attempt to commit a criminal act.

  This exclusion does not apply to any *sickness* or *bodily injury* resulting from an act of domestic violence or a medical condition (including both physical and mental health conditions).
- Expenses for any membership fees or program fees, including but not limited to, health clubs, health spas, aerobic and strength conditioning, work-hardening programs and weight loss or surgical programs, and any materials or products related to these programs.
- Surgical procedures for the removal of excess skin and/or fat in conjunction with or resulting from weight loss or a weight loss *surgery.*

8. Limitations/Exclusions (What is Not Covered) (continued)

- Expenses for services that are primarily and customarily used for environmental control or enhancement (whether or not prescribed by a *health care practitioner*) and certain medical devices including, but not limited to:
  - Common household items including air conditioners, air purifiers, water purifiers, vacuum cleaners, waterbeds, hypoallergenic mattresses or pillows, or exercise equipment;
  - Motorized transportation equipment (e.g. scooters), escalators, elevators, ramps, or modifications or additions to living/working quarters or transportation vehicles;
  - Personal hygiene equipment including bath/shower chairs, transfer equipment or supplies or bed side commodes;
  - Personal comfort items including cervical pillows, gravity lumbar reduction chairs, swimming pools, whirlpools, spas, or saunas;
  - Medical equipment including:
    - Blood pressure monitoring devices, unless prescribed by a *health care practitioner* for *preventive services* and ambulatory blood pressure monitoring is not available to confirm diagnosis of hypertension;
    - PUVA lights; and
    - Stethoscopes;
  - Communication systems, telephone, television, or computer systems and related equipment or similar items or equipment;
  - Communication devices, except after surgical removal of the larynx or a diagnosis of permanent lack of function of the larynx.
- Duplicate or similar rentals or purchases of *durable medical equipment* or *diabetes equipment.*
- Therapy and testing for treatment of allergies including, but not limited to, services related to clinical ecology, environmental allergy and allergic immune system dysregulation and sublingual antigen(s), extracts, neutralization tests and/or treatment unless such therapy or testing is approved by:
  - The American Academy of Allergy and Immunology; or
  - The Department of Health and Human Services or any of its offices or agencies.
- Lodging accommodations, unless provided in connection with a pre-approved transplant.
- Transportation, unless provided as part of a *hospice care program* or in connection with a pre-approved transplant.
- Communications or travel time.
- *Sickness* or *bodily injury* for which no-fault medical payment or expense coverage benefits are paid or payable under any homeowners, premises or any other similar coverage.
- Elective medical or surgical abortion unless:
  - The pregnancy would endanger the life of the mother;
  - The pregnancy is a result of rape or incest; or
  - The fetus has been diagnosed with a lethal or otherwise significant abnormality.

8. Limitations/Exclusions (What is Not Covered) (continued)

- *Alternative medicine*.
- Acupuncture, unless:
  - The treatment is *medically necessary*, appropriate and is provided within the scope of the acupuncturist's license; and
  - *You* are directed to the acupuncturist for treatment by a licensed physician.
- Services rendered in a premenstrual syndrome clinic or holistic medicine clinic.
- Services of a midwife, unless the midwife is licensed.
- Vision examinations or testing for the purposes of prescribing corrective lenses, except *comprehensive eye exams* provided under the "Benefits/Coverage (What is Covered) – Pediatric Vision Care" section in this *certificate.*
- Orthoptic/vision training (eye exercises).
- Radial keratotomy, refractive keratoplasty or any other *surgery* or procedure to correct myopia, hyperopia or stigmatic error.
- The purchase or fitting of eyeglasses or contact lenses, except as:
  - The result of an *accident* or following cataract *surgery* as stated in this *certificate*.
  - Otherwise specified in the "Benefits/Coverage (What is Covered) – Pediatric Vision Care" section in this *certificate.*
- Services and supplies which are:
  - Rendered in connection with mental illnesses not classified in the International Classification of Diseases of the U.S. Department of Health and Human Services; or
  - Educational services for learning and behavioral disabilities or for mental retardation.
- Marriage counseling.
- Expenses for:
  - Employment;
  - School;
  - Sport;
  - Camp;
  - Travel; or
  - The purposes of obtaining insurance.
- Expenses for care and treatment of non-covered procedures or services.
- Expenses for treatment of complications of non-covered procedures or services.
- Expenses incurred for services prior to the *effective date* or after the termination date of *your* coverage under the *master group contract.*

8. Limitations/Exclusions (What is Not Covered) (continued)

- Any care, treatment, services, equipment, or supplies received outside of the *service area*:
  - If *you* could have reasonably foreseen or anticipated their need prior to departure from the *service area*; and
  - Which are not authorized by *us* or to the extent they exceed the *maximum allowable fee.*
- *Pre-surgical/procedural testing* duplicated during a *hospital confinement.*

8. Limitations/Exclusions (What is Not Covered) (continued)

Pharmacy Services

This "Limitations/Exclusions (What is Not Covered) – Pharmacy Services" section describes the limitations and exclusions under the *master group contract* that apply to *prescription* drugs, including *specialty drugs*, dispensed by a *pharmacy*. Please refer to the "Limitations/Exclusions (What is Not Covered)" section of this *certificate* for additional limitations.

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

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

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

  even though a charge is made to *you*.
- Allergen extracts.
- Therapeutic devices or appliances, including, but not limited to:
  - Hypodermic needles and syringes (except when prescribed by a *health care practitioner* for use with insulin and *self-administered injectable drugs*, whose coverage is approved by *us*);
  - Support garments;
  - Test reagents;
  - Mechanical pumps for delivery of medications; and
  - Other non-medical substances.

8. Limitations/Exclusions (What is Not Covered) (continued)

- Dietary supplements and nutritional products, except metabolic formulas and their modular counterparts, amino acid-based elemental formulas and nutritional supplements for the treatment of inherited enzymatic disorders and severe protein allergic conditions. Refer to the "Benefits/Coverage (What is Covered)" section of the *certificate* for coverage of low protein modified foods.

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

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

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

- Any drug used for the purpose of weight loss.

- Any drug used for cosmetic purposes, including, but not limited to:

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

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

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

- Compounded drugs that:

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

- Abortifacients (drugs used to induce abortions).

- Any medications provided to achieve pregnancy or to achieve or maintain ovulation. *Infertility services* includes but is not limited to, in vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), tubal ovum transfer, embryo freezing or transfer, sperm storage or banking, ovum storage or banking; embryo or zygote banking, and any other assisted reproductive techniques or cloning methods, except as otherwise covered under the "Benefits/Coverage (What is Covered)" section.

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

8. Limitations/Exclusions (What is Not Covered) (continued)

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

- The administration of covered medication(s).

- *Prescriptions* that are to be taken by or administered to *you*, in whole or in part, while *you* are a patient in a facility where drugs are ordinarily provided on an *inpatient* basis by the facility. *Inpatient* facilities include, but are not limited to:

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

- Injectable drugs, including, but not limited to:

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

- *Prescription* fills or refills:

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

- Any portion of a *prescription* fill or refill that exceeds a 90-day supply when received from a *mail order pharmacy* or a retail *pharmacy* that participates in *our* program, which allows *you* to receive a 90-day supply of a *prescription* fill or refill. This exclusion does not apply to a *prescription* fill or refill for up to a 12-month supply of contraceptives.

- Any portion of a *prescription* fill or refill that exceeds a 30-day supply when received from a retail *pharmacy* that does not participate in *our* program, which allows *you* to receive a 90-day supply of a *prescription* fill or refill. This exclusion does not apply to a *prescription* fill or refill for up to a 12-month supply of contraceptives.

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

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

  - Exceeds *our* drug-specific *dispensing limit*;
  - Is dispensed to a *covered person*, whose age is outside the drug-specific age limits defined by *us*;
  - Is refilled early, as defined by *us*, except for *prescription* refills of a topical ophthalmic product when the product is written for additional fills; or
  - Exceeds the duration-specific *dispensing limit*.

8. Limitations/Exclusions (What is Not Covered) (continued)

- Any drug for which *we* require *prior authorization* or *step therapy* and it is not obtained by the prescribing *health care practitioner*.
- Any drug for which a charge is customarily not made.
- Any drug, medicine or medication received by *you*:
  - Before becoming covered; or
  - After the date *your* coverage has ended.
- Any costs related to the mailing, sending or delivery of *prescription* drugs.
- Any intentional misuse of this benefit, including *prescriptions* purchased for consumption by someone other than *you.*
- Any *prescription* fill or refill for drugs, medicines or medications that are lost, stolen, spilled, spoiled, or damaged.
- Drug delivery implants and other implant systems or devices.
- Any amount *you* paid for a *prescription* that has been filled, regardless of whether the *prescription* is revoked or changed due to adverse reaction or change in dosage or *prescription*.
- *Prescriptions* filled at a *non-network pharmacy*, except for *prescriptions* required during an emergency.

9. Member Payment Responsibility

How your master group contract works

We may apply a *copayment* or *deductible* before *we* pay for certain *covered expenses*. If a *deductible* applies, and it is met, *we* will pay *covered expenses* at the *coinsurance* amount. Refer to the "Schedule of Benefits (Who Pays What)" to see when a *copayment, deductible* and/or *coinsurance* may apply.

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

Covered expenses are subject to the *maximum allowable fee*. *We* will apply the applicable *network provider* benefit level to the total amount billed by the *qualified provider*, less any amounts such as:

- Those in excess of the negotiated amount by contract, directly or indirectly, between *us* and the *qualified provider*; or
- Those in excess of the *maximum allowable fee*; and
- Adjustments related to *our* claims processing procedures. Refer to the "Claims Procedure (How to File a Claim)" section of this *certificate* for more information on *our* claims processing procedures.

Unless stated otherwise in this *certificate, you* will be responsible to pay:

- The applicable *network provider copayment, deductible* and/or *coinsurance*;
- Any amount over the *maximum allowable fee* to a *non-network provider*; and
- Any amount not paid by *us*.

However, *we* will apply the *network provider* benefit level and *you* will only be responsible to pay the *network provider copayment, deductible* and/or *coinsurance*, based on the *maximum allowable fee* for *covered expenses* when *you* receive the following services from *non-network providers* in the state of Colorado:

- *Ambulance* services for *emergency care* received from a privately owned ambulance service;
- *Emergency care*;
- *Ancillary services* while *you* are at a *network facility*;
- Services that are not considered *ancillary services* while *you* are at a *network facility*, and *you* do not consent to the *non-network provider* to obtain such services; and
- *Post-stabilization services* when:
    - The attending *qualified provider* determines *you* are not able to travel by non-medical transportation to obtain services from a *network provider*; and
    - *You* do not consent to the *non-network provider* to obtain such services; and
- When a *network provider* is not reasonably available to provide services and authorization is received from *us* to see a *non-network provider*.

HOW TO ACCESS YOUR SERVICE AND OBTAIN APPROVAL OF BENEFITS (Applicable to manage care plans) (continued)

We will apply the *network provider* benefit level and *you* will only be responsible to pay the *network provider copayment, deductible* and/or *coinsurance* based on the *qualified payment amount* for *covered expenses* when *you* receive the following services from *non-network providers*:

- *Air ambulance* services;
- *Emergency care* outside the state of Colorado;
- *Ancillary services* while *you* are at a *network facility* outside the state of Colorado;
- Services that are not considered *ancillary services* while *you* are at a *network facility* outside the state of Colorado, and *you* do not consent to the *non-network provider* to obtain such services; and
- *Post-stabilization services* received outside the state of Colorado when:

    - The attending *qualified provider* determines *you* are not able to travel by non-medical transportation to obtain services from a *network provider*; and
    - *You* do not consent to the *non-network provider* to obtain such services.

Any *network provider copayment, deductible* and/or *coinsurance you* pay a *non-network provider* for the specific *covered expenses* listed above will be applied to the *network provider out-of-pocket limit*.

If an *out-of-pocket limit* applies and it is met, *we* will pay *covered expenses* at 100% the rest of the *year*, subject to any maximum benefit and all other terms, provisions, limitations, and exclusions of the *master group contract.*

10. Claims Procedure (How to File a Claim)

Notice of claim

Network providers will submit claims to *us* on *your* behalf. If *you* utilize a *non-network provider* for *covered expenses*, *you* may have to submit a notice of claim to *us.* Notice of claim must be given to *us* in writing or by *electronic mail* within 20 days or as soon as is reasonably possible thereafter. Notice must be sent to *us* at *our* mailing address shown on *your* ID card or at *our* website at www.humana.com.

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

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

If *you* receive services outside the United States or from a foreign provider, *you* must also submit the following information along with *your* complete claim:

- *Your* proof of payment to the provider for the services received outside the United States or from a foreign provider;
- Complete medical information and medical records;
- *Your* proof of travel outside of the United States, such as airline tickets or passport stamps, if *you* traveled to receive the services; and
- The foreign provider's fee schedule if the provider uses a billing agency.

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

Proof of loss

You must give written or *electronic* proof of loss within 90 days after the date *you* incur such loss. *Your* claims will not be reduced or denied if it was not reasonably possible to give such proof within that time period.

Your claims may be reduced or denied if written or *electronic* proof of loss is not provided to *us* within one year after the date proof of loss is required, unless *your* failure to timely provide that proof of loss is due to *your* legal incapacity as determined by an appropriate court of law.

Other programs and procedures

We may introduce new programs and procedures that apply to *your* coverage under the *master group contract*. *We* may also introduce limited pilot or test programs including, but not limited to, disease management, care management, expanded accessibility, or wellness initiatives.

We reserve the right to discontinue or modify a program or procedure at any time.

Right to require medical examinations

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

To whom benefits are payable

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

Benefit payments for *covered expenses* when *you* received services from a *non-network provider* are due and owing solely to *you*. *You* are responsible for all payments to the *non-network provider*. However, *we* will pay the *non-network provider* directly for the amount *we* owe if:

- *You* direct *us* to pay all or any part of the medical benefits to the health care provider on whose charge the claim is based; or

- The services are for the specific *covered expenses* payable to a *non-network provider* at the *network provider* benefit level specified in the "How your policy works" provision in the "Member Payment Responsibility" section of this *certificate*.

Any payment made directly to the *non-network provider* will not constitute the assignment of any legal obligation to the *non-network provider*.

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

Time of payment of claims

- Clean claims will be paid, denied or settled within 30 calendar days after receipt by *us electronically* or within 45 calendar days after receipt by *us* by any means other than *electronically*.
- If a claim requires additional information, *we* must request such information within 30 calendar days.
- Absent fraud, all claims except clean claims will be paid, denied or settled within 90 calendar days after receipt by *us*.

Right to request overpayments

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

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

We reserve the right to adjust any amount applied in error to the *deductible*, *out-of-pocket limit* or *copayment limit*, if any.

Right to collect needed information

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

- Authorizing the release of medical information including the names of all providers from whom *you* received medical attention;
- Obtaining medical information or records from any provider as requested by *us*;
- Providing information regarding the circumstances of *your sickness*, *bodily injury* or *accident*;
- Providing information about other insurance coverage and benefits, including information related to any *bodily injury* or *sickness* for which another party may be liable to pay compensation or benefits;
- Providing copies of claims and settlement demands submitted to third parties in relation to a *bodily injury* or *sickness*;
- Disclosing details of liability settlement agreements reached with third parties in relation to a *bodily injury* or *sickness*; and
- Providing information *we* request to administer the *master group contract.*

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

Recovery rights

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

Duty to cooperate in good faith

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

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

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

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

Workers' compensation

This *master group contract* excludes coverage for *sickness* or *bodily injury* for which Workers' Compensation or similar coverage is available.

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

We shall have first priority to recover amounts *we* have paid and the reasonable value of services and benefits provided under a managed care agreement from any funds that are paid or payable by Workers' Compensation or similar coverage as a result of any *sickness* or *bodily injury*, and *we* shall not be required to contribute to attorney fees or recovery expenses under a Common Fund or similar doctrine.

Our right to recover from funds that are paid or payable by Workers' Compensation or similar coverage will apply even though:

- The Workers' Compensation carrier does not accept responsibility to provide benefits;
- There is no final determination that *bodily injury* or *sickness* was sustained in the course of, or resulted from, *your* employment;
- The amount of Workers' Compensation due to medical or health care is not agreed upon or defined by *you* or the Workers' Compensation carrier; or
- Medical or health care benefits are specifically excluded from the Workers' Compensation settlement or compromise.

As a condition to receiving benefits from *us*, *you* hereby agree, in consideration for the coverage provided by the *master group contract*, *you* will notify *us* of any Workers' Compensation claim *you* make, and *you* agree to reimburse *us* as described above. If *we* are precluded from exercising *our* recovery rights to recover from funds that are paid by Workers' Compensation or similar coverage *we* will exercise *our* right to recover against *you.*

This provision does not apply to *employees* of the *employer* that are or may be eligible for coverage under any Workers' Compensation Act or similar law when the *employer* is given the option to apply for such coverage by such Act or law and the *employer* did not apply for such coverage.

10. Claims Procedure (How to File a Claim) (continued)

Right of subrogation

As a condition to receiving benefits from *us*, *you* agree to transfer to *us* any rights *you* may have to make a claim, take legal action or recover any expenses paid under the *master group contract.* *We* will be subrogated to *your* rights to recover from any funds paid or payable as a result of a personal injury claim or any reimbursement of expenses by:

- Any legally liable person or their carrier, including self-insured entities;
- Any uninsured motorist or underinsured motorist coverage;
- Medical payments/expense coverage under any automobile, homeowners, premises, or similar coverages;
- Workers' Compensation or other similar coverage; and
- No-fault or other similar coverage.

We may enforce *our* subrogation rights by asserting a claim to any coverage to which *you* may be entitled. *We* shall have first priority to recover amounts *we* have paid and the reasonable value of services and benefits provided under a managed care agreement from any funds that are paid or payable as a result of any *sickness* or *bodily injury*, regardless of whether available funds are sufficient to fully compensate *you* for *your sickness* or *bodily injury.*

If *we* are precluded from exercising *our* rights of subrogation, *we* may exercise *our* right of reimbursement.

Right of reimbursement

If benefits are paid under the *master group contract*, and *you* recover from any legally responsible person, their insurer, or any uninsured motorist, underinsured motorist, medical payment/expense, Workers' Compensation, no-fault, or other similar coverage, *we* have the right to recover from *you* an amount equal to the amount *we* paid and for the reasonable value of services and benefits provided under a managed care agreement.

You shall notify *us*, in writing or by *electronic mail*, within 31 days of any settlement, compromise or judgment. Any *covered person* who waives, abrogates or impairs *our* right of reimbursement or fails to comply with these obligations, relieves *us* from any obligation to pay past or future benefits or expenses until all outstanding lien(s) are resolved.

If, after the inception of coverage with *us*, *you* recover payment from and release any legally responsible person, their insurer, or any uninsured motorist, underinsured motorist, medical payment/expense, Workers' Compensation, no-fault, or other similar insurer from liability for future medical expenses relating to a *sickness* or *bodily injury*, *we* shall have a continuing right to reimbursement from *you* to the extent of the benefits *we* provided with respect to that *sickness* or *bodily injury.* This right, however, shall apply only to the extent of such payment.

The obligation to reimburse *us* in full exists, regardless of whether the settlement, compromise or judgment designates the recovery as including or excluding medical expenses.

Assignment of recovery rights

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

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

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

Cost of legal representation

The costs of *our* legal representation in matters related to *our* recovery rights shall be borne solely by *us.*

The costs of legal representation incurred by *you* shall be borne solely by *you.* *We* shall not be responsible to contribute to the cost of legal fees or expenses incurred by *you* under any Common Fund or similar doctrine unless *we* were given timely notice of the claim and an opportunity to protect *our* own interests and *we* failed or declined to do so.

11. General Policy Provisions

Entire contract

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

Additional group plan sponsor responsibilities

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

- Collection of premium; and
- Distributing:

  - Benefit plan documents and the Summary of Benefits and Coverage (SBC);
  - Renewal notices and *master group contract* modification information;
  - Discontinuance notices; and
  - Information regarding continuation rights.

No *group plan sponsor* may change or waive any provision of the *master group contract.*

Certificates

A *certificate* setting forth the benefits available to the *employee* and the *employee's* covered *dependents* will be available at www.humana.com or in writing when requested. The *employer* is responsible for providing *employees* access to the *certificate.*

No document inconsistent with the *master group contract* shall take precedence over it. This is true, also, when this *certificate* is incorporated by reference into a summary description of plan benefits by the administrator of a group plan subject to ERISA. If the terms of a summary plan description differ with the terms of this *certificate,* the terms of this *certificate* will control.

Incontestability

After two years from the effective date of the *master group contract, we* cannot contest the validity of the *master group contract* except for non-payment of premium.

No statement made for the purpose of effecting insurance coverage under the *master group contract* with respect to *you* shall be used to avoid the insurance with respect to which such statement was made or to reduce benefits under such *master group contract* after such insurance has been in force for a period of two years during *your* lifetime unless such statement is contained in a written form signed by *you* making such statement and a copy of that instrument is or has been furnished to *you* or to *your* beneficiary.

Fraud

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

If *you* commit fraud against *us* or *your employer* commits fraud pertaining to *you* against *us*, as determined by *us*, *we* reserve the right to *rescind your* coverage after *we* provide *you* a 30 calendar day advance written notice that coverage will be *rescinded*. *You* have the right to appeal the *rescission*.

Clerical error or misstatement

If it is determined that information about a *covered person* was omitted or misstated in error, an adjustment may be made in premiums and/or coverage in effect. This provision applies to *you* and to *us*.

Assignment

The *master group contract* and its benefits may not be assigned by the *group plan sponsor*; however, *we* will pay the *non-network provider* directly when the *covered person* makes this request.

Emergency declarations

We may alter or waive the requirements of the *master group contract* as a result of a state or federal emergency declaration including, but not limited to:

- *Prior authorization* or *preauthorization* requirements;
- *Prescription* quantity limits; and
- *Your copayment*, *deductible* and/or *coinsurance*.

We have the sole authority to waive any *master group contract* requirements in response to an emergency declaration.

Conformity with statutes

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

Replacement of coverage

Applicability

This "Replacement of Coverage" section applies when an *employer's* previous group health plan not offered by *us* or *our* affiliates (Prior Plan) is terminated and replaced by coverage under the *master group contract* within 31 days of termination and:

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

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

Deductible credit

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

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

Waiting period credit

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

Out-of-pocket limit

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

Coordination of benefits

This "Coordination of Benefits" (COB) provision applies when a *covered person* has health care coverage under more than one *plan*. *Plan* is defined below.

The *order of benefit determination* rules below determine which *plan* will pay as the *primary plan.* The *primary plan* pays first without regard to the possibility another *plan* may cover some expenses. A *secondary plan* pays after the *primary plan* and may reduce the benefits it pays so that payments from all *plans* do not exceed 100% of the total *allowable expense*.

Definitions

The following definitions are used exclusively in this provision.

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

Plan includes:

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

Plan does not include:

- Individual or family insurance;
- Closed panel or other individual coverage (except for group-type coverage);
- Hospital indemnity or other fixed indemnity;
- Accident only coverage;
- Specified disease or specified accident coverage;
- Limited benefit health coverage, as defined by state law;
- School accident-type coverage;
- Benefits for non-medical care components of group long-term care contracts;
- Medicare supplement policies;
- A state plan under *Medicaid*; and
- Coverage under other governmental plans, unless permitted by law.

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

11. General Policy Provisions (continued)

Order of benefit determination rules determine whether this *plan* is a *primary plan* or *secondary plan* when compared to another *plan* covering the person.

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

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

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

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

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

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

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

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

- Dental care.

- Vision care.

- Prescription drugs.

Claim determination period is usually a calendar year, but a *plan* may use some other period of time that fits the coverage of the group contract. A person is covered by a *plan* during a portion of a *claim determination period* if that person's coverage starts or ends during the *claim determination period*. However, it does not include any part of a *year* during which a person has no coverage under this *plan*, or before the date this COB provision or a similar provision takes effect.

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

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

Order of benefit determination rules

General

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

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

Rules

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

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

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

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

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

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

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

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

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

- **Active or inactive *employee***. The *plan* that covers a person as an *employee* who is neither laid off nor retired is *primary*. The same would hold true if a person is a *dependent* of a person covered as a retiree and an *employee*. If the other *plan* does not have this rule, and if, as a result, the *plans* do not agree on the order of benefits, this rule is ignored. Coverage provided an individual as a retired worker and as a *dependent* of an actively working spouse will be determined under the first rule listed above.

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

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

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

Effects on the benefits of this plan

- When this *plan* is *secondary,* it may reduce its benefits so that the total benefits paid or provided by all *plans* during a *year* are not more than the total *allowable expenses*. In determining the amount to be paid for any claim, the *secondary plan* will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any *allowable expense* under its *plan* that is unpaid by the *primary plan.* The *secondary plan* may then reduce its payment by the amount so that, when combined with the amount paid by the *primary plan,* the total benefits paid or provided by all *plans* for the claim do not exceed the total *allowable expense* for that claim. In addition, the *secondary plan* shall credit to its plan *deductible* any amounts it would have credited to its *deductible* in the absence of other health care coverage.

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

Right to receive and release needed information

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

Facility of payment

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

Right of recovery

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

General coordination of benefits with Medicare

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

Disclosure provisions

Employee assistance program

We may provide *you* access to an employee assistance program (EAP). The EAP may include confidential, telephonic consultations and work-life services. The EAP provides *you* with short-term, problem solving services for issues that may otherwise affect *your* work, personal life or health. The EAP is designed to provide *you* with information and assistance regarding *your* issue and may also assist *you* with finding a medical provider or local community resource.

The services provided by the EAP are not *covered expenses* or insured benefits under the *master group contract,* therefore the *copayments*, *deductible* or *coinsurance* do not apply. However, there may be additional costs to *you,* if *you* obtain services from a professional or organization the EAP has recommended or has referred *you* to. The EAP does not provide medical care. *You* are not required to participate in the EAP before using *your* insured benefits under the *master group contract,* and the EAP services are not coordinated with *covered expenses* under the *master group contract.* The decision to participate in the EAP is voluntary, and *you* may participate at any time during the *year*. Refer to the marketing literature for additional information.

Discount programs

From time to time, *we* may offer or provide access to discount programs to *you.* In addition, *we* may arrange for third party service providers such as pharmacies, optometrists, dentists and alternative medicine providers to provide discounts on goods and services to *you.* Some of these third party service providers may make payments to *us* when *covered persons* take advantage of these discount programs. These payments offset the cost to *us* of making these programs available and may help reduce the costs of *your* plan administration. Although *we* have arranged for third parties to offer discounts on these goods and services, these discount programs are not covered services under the *master group contract.* The third party service providers are solely responsible to *you* for the provision of any such goods and/or services. *We* are not responsible for any such goods and/or services, nor are *we* liable if vendors refuse to honor such discounts. Further, *we* are not liable to *covered persons* for the negligent provision of such goods and/or services by third party service providers. Discount programs may not be available to persons who "opt out" of marketing communications and where otherwise restricted by law.

Wellness programs

From time to time *we* may offer directly, or enter into agreements with third parties who administer participatory or health-contingent wellness programs to *you.*

"Participatory" wellness programs do not require *you* to meet a standard related to a health factor. Examples of participatory wellness programs may include, but are not limited to, membership in a fitness center, certain preventive testing or attending a no-cost health education seminar.

"Health-contingent" wellness programs require *you* to attain certain wellness goals that are related to a health factor. Examples of health contingent wellness programs may include, but are not limited to completing a 5k event, lowering blood pressure or ceasing the use of tobacco.

The rewards may include, but are not limited to, payment for all or a portion of a participatory wellness program, merchandise, gift cards, debit cards, discounts or contributions to *your* health spending account. *We* are not responsible for any rewards provided by third parties that are non-insurance benefits or for *your* receipt of such reward(s).

The rewards may also include, but are not limited to, discounts or credits toward premium or a reduction in *copayments*, *deductibles* or *coinsurance*, as permitted under applicable state and federal laws. Such insurance premium or benefit rewards may be made available at the individual or *group* health plan level.

The rewards may be taxable income. *You* may consult a tax advisor for further guidance.

Our agreement with any third party does not eliminate any of *your* obligations under this *master group contract* or change any of the terms of this *master group contract.* *Our* agreement with the third parties and the program may be terminated at any time, although insurance benefits will be subject to applicable state and federal laws.

We are committed to helping *you* achieve *your* best health. Some wellness programs may be offered only to *covered persons* with particular health factors. If *you* think *you* might be unable to meet a standard for a reward under a health-contingent wellness program, *you* might qualify for an opportunity to earn the same reward by different means. Contact *us* at the number listed on *your* ID card or in the marketing literature issued by the wellness program administrator for more information.

The wellness program administrator or *we* may require proof in writing from *your health care practitioner* that *your* medical condition prevents *you* from taking part in the available activities.

The decision to participate in wellness program activities is voluntary if eligible, and *you* may decide to participate anytime during the *year*. Refer to the marketing literature issued by the wellness program administrator for their program's eligibility, rules and limitations.

Shared savings program

As a *covered person* under the health benefit plan, coverage is limited to *network providers*, unless for *emergency care.* For coverage to be available for *non-network providers* other than *emergency care*, *you* must receive a referral from *us.*

If *you* choose to obtain services from a *non-network provider*, the services may be eligible for a discount to *you* under the Shared Savings Program. It is not necessary for *you* to inquire in advance about services that may be discounted. When processing *your* claim, *we* will automatically determine if the services are subject to the Shared Savings Program and calculate *your deductible* and *coinsurance* on the discounted amount. Whether services are subject to the Shared Savings Program is at *our* discretion, and *we* apply the discounts in a non-discriminatory manner. *Your* Explanation of Benefits statement will reflect any savings with a remark code that the services have been discounted. *We* cannot guarantee that services rendered by *non-network providers* will be discounted. The *non-network provider* discounts in the Shared Savings Program may not be as favorable as *network provider* discounts.

However, if *you* would like to inquire in advance to determine if services rendered by a *non-network provider* may be subject to the Shared Savings Program, please contact *our* customer service department at the telephone number shown on *your* ID card. Provider arrangements in the Shared Savings Program are subject to change without notice. *We* cannot guarantee that the services *you* receive from a *non-network provider* are still subject to the Shared Savings Program at the time services are received. Discounts are dependent upon availability and cannot be guaranteed.

We reserve the right to modify, amend or discontinue the Shared Savings Program at any time.

12. Termination/Nonrenewal/Continuation

Termination of coverage

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

You and *your employer* must notify *us* as soon as possible if *you* or *your dependent* no longer meets the eligibility requirements of the *master group contract.* Notice must be provided to *us* within 14 days of the change.

When *we* receive notification of a change in eligibility status in advance of the effective date of the change, coverage will terminate on the actual date specified by the *employer* or *employee* or at the end of that month, as selected by *your employer* on the EGA. *We* will send *you* notice of termination of *your* coverage at least 30 days prior to termination including the reason for termination.

When *we* receive the *employer's* request to terminate coverage retroactively, the *employer's* termination request is their representation to *us* that *you* did not pay any premium or make contribution for coverage past the requested termination date.

Otherwise, coverage terminates on the earliest of the following:

- The date the *master group contract* terminates;
- The end of the period for which required premiums were paid to *us*;
- The date the *employee* terminated employment with the *employer*;
- The date the *employee* no longer qualified as an *employee*;
- The date the *employee* no longer lives or works in the *service area*;
- The date *you* fail to be in an eligible class of persons as stated in the EGA;
- The date the *employee* retired, except if the EGA provides coverage for a retiree class of *employees* and the retiree is in an eligible class of retirees, selected by the *employer*;
- The date of an *employee* request for termination of coverage for the *employee* or *dependents*;
- For a *dependent,* the date the *employee's* coverage terminates;
- For a *dependent,* the date the *employee* ceases to be in a class of *employees* eligible for *dependent* coverage;
- The date *your dependent* no longer qualifies as a *dependent*;
- For any benefit, the date the benefit is deleted from the *master group contract*; or
- The date fraud or an intentional misrepresentation of a material fact has been committed by *you.* For more information on fraud and intentional misrepresentation, refer to the "Fraud" provision in the "General Policy Provisions" section of this *certificate.*

Termination for cause

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

- If *you* allow an unauthorized person to use *your* identification card or if *you* use the identification card of another *covered person.* Under these circumstances, the person who receives the services provided by use of the identification card will be responsible for paying *us* any amount *we* paid for those services. *We* will send *you* notice of termination of *your* coverage at least 30 days prior to termination including the reason for termination.

- If *you* or the *group plan sponsor* perpetrate fraud or intentional misrepresentation of a material fact on claims, identification cards or other identification in order to obtain services or a higher level of benefits. This includes, but is not limited to, the fabrication or alteration of a claim, identification card or other identification.

Continuation options in the event of termination

If health insurance terminates:

- It may be continued under the continuation provisions as provided by the Consolidated Omnibus Budget Reconciliation Act (COBRA), if applicable; or
- It may be continued as described under the "State continuation of health insurance" provision below, provided *your employer* has:

  - Less than 20 *employees*; or
  - More than 20 *employees* and *you* are not a qualified beneficiary under the Consolidated Omnibus Budget Reconciliation Act (COBRA).

State continuation of health insurance

Subject to the terms below, if the *employee* or covered *dependent* is no longer eligible for medical coverage under the *master group contract* he or she has the right to continue medical coverage, unless loss of eligibility is due to:

- Discontinuance of the *master group contract* in its entirety;
- Discontinuance of the *employer*'s participation under the *master group contract*; or
- Termination of the insured class to which the *employee* belongs.

Coverage may be continued for the *employee* and any of the *employee's* covered *dependents.*

Continuation is available only if *you* have been continuously covered under the *master group contract,* or under any group contract providing similar benefits which it replaces, for at least six (6) months immediately prior to termination, and:

- All premiums required from or on behalf of the *employee* have been paid to the termination date; and
- *You* are NOT covered by *Medicare* or *Medicaid,* unless *your employer* offers continuation coverage regardless of *Medicare* or *Medicaid* coverage.

You may elect this option if:

- *You* are an *employee* whose eligibility for group coverage terminates;
- *You* are the former spouse of an *employee*, and *your* marriage ended due to divorce or annulment while *you* were covered under the group plan, and the *employee* continues to be covered under the group plan; or
- *You* are a surviving *dependent* spouse or child of an *employee* who died while *you* were covered under the group plan.

When *your* coverage terminates the *employer* will notify *you* in writing of *your* right to continue medical coverage.

If *you* elect to continue coverage, *you* have thirty-one (31) days after the date *your* coverage terminates to notify the *employer* in writing and pay the first premium. Subsequent premiums are due monthly to the *employer*.

If the *employer* fails to notify *you* of *your* right to continue coverage, *you* have sixty (60) days after the date *your* coverage terminates to make payment of the first premium to the *employer*.

Your premium will be the sum of *your* normal contribution for medical coverage, if any, and the *employer's* normal contribution.

Continuation of coverage will end on the earliest of the following:

- 18 months after the date *your* eligibility for coverage would otherwise end;
- The end of any period for which *you* fail to make timely payment of premium when due; or
- The date *you* become eligible for other group coverage unless the replacing group coverage excludes a condition covered under the continued plan. Coverage under the *master group contract* may be continued for the excluded condition only for the remainder of the 18 months or until the new plan covers the excluded condition, whichever is less.

Extension of coverage

If *your* coverage terminates for any reason other than nonpayment of premium, fraud, or abuse while *you* are an *inpatient*, benefits will be provided for *covered expenses* until *you* are discharged.

13. Appeals and Complaints

Definitions

Adverse benefit determination means a denial, reduction, or termination of, or a failure to provide or make a payment (in whole or in part) for a benefit, including:

- A determination that an item or service is experimental or investigational or not *medically necessary*;
- A determination of *your* eligibility for group coverage under the *master group contract*;
- A determination that the benefit is not covered;
- Any rescission of coverage or cancellation of coverage applied retroactively that is not attributed to a failure to pay premiums.

An *adverse benefit determination* also includes claims protected under the Federal No Surprises Act.

Appeal is a request for reconsideration of an *adverse benefit determination.*

Business day means, for purposes of this section for Appeals and Complaints, the days of the week between and including Monday through Friday, not including public holidays and weekends.

Commissioner means the Commissioner of the Colorado Division of Insurance.

Complaint means a written communication primarily expressing a *grievance*.

De minimis means any minor error or omission that does not substantively impact the rights of a *covered person* to request an external review of an *adverse benefit determination.*

Designated representative means:

- *Your health care practitioner* or a person *you* have given written consent to represent *you*;
- A person authorized by law to provide substituted consent for *you*, including a guardian, agent under power of attorney or a proxy; or a designee of the Colorado Department of Health Care Policy and Financing; and/or
- A *health care practitioner* with knowledge of *your* medical condition in urgent care situations.

Expedited (external) review means a review following completion of procedures for expedited internal review of an *adverse benefit determination* involving a situation where the timeframe of the standard independent external review procedures would seriously jeopardize the life or health of the *covered person* or would jeopardize the *covered person's* ability to regain maximum function. *Expedited review* is available if the *adverse benefit determination* concerns an admission, availability of care, continued stay or health care services for which the *covered person* received *emergency care* has not been discharged from the *health care treatment facility*.

Final adverse benefit determination means an *adverse benefit determination* that has been upheld by *us* at the completion of the internal appeals process or in when the internal appeals process has been exhausted.

Grievance means a circumstance regarded as a cause for protest, including the protest of an *adverse benefit determination.*

Independent Review Entity (IRE) means an entity assigned by the *commissioner* to conduct an independent external review of an *adverse benefit determination* and a *final adverse benefit determination.*

Prospective review means *utilization review* conducted prior to an *admission* or course of treatment. Also known as a "pre-service review."

Retrospective review means *utilization review* conducted after services have been provided to the *covered person,* but does not include the review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding or adjudication for payment. Also known as a "post-service review."

Urgent-care claim means a claim for covered services to which the application of the time periods for making non-urgent care determinations:

- Could seriously jeopardize the life or health of the *covered person* or the ability of the *covered person* to regain maximum function; or
- In the opinion of a physician with knowledge of the *covered person's* medical condition, would subject the *covered person* to severe pain that cannot be adequately managed without the service that is the subject of the claim; or
- For a *covered person* with a disability, creates an imminent and substantial limitation of his or her existing ability to live independently.

We will make a determination of whether a claim is an *urgent-care claim.* However, any claim a physician, with knowledge of a *covered person's* medical condition, determines is an "*urgent-care claim*" will be treated as a "claim involving urgent care."

Utilization review means a set of formal techniques designed to monitor the use of, or evaluate the clinical medical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures, or settings.

Contact information

You may contact the *commissioner* for assistance at any time using the contact information below:

Colorado Division of Insurance
1560 Broadway, Suite 850
Denver, CO 80202

Telephone Numbers:
303-894-7490 - Consumer Information
800-930-3745 - Toll Free outside Denver

13. Appeals and Complaints (continued)

Internal appeals

First level review

You or *your designated representative* must *appeal* an *adverse benefit determination* within 180 days or next *business day* following the 180 days after receiving written notice of the denial (or partial denial). A request for a first level review of an *adverse benefit determination* may be made by *you* or *your designated representative* by means of written application to *us* or by mail, postage prepaid to the address below:

HUMANA INSURANCE COMPANY
GRIEVANCE AND APPEAL DEPARTMENT
P.O. BOX 14546
LEXINGTON, KY 40512-4546

The first level review is for medical necessity, experimental or investigational service or contractual determination when *you* or *your designated representative* have provided evidence from a medical professional that there is a reasonable medical basis that the contractual determination does apply to the denied benefit. The first level review will be evaluated by a *health care practitioner* who shall consult with an appropriate clinical peer or peers. The *health care practitioner* and clinical peer(s) shall not have been involved in the initial *adverse benefit determination*; however, a person previously involved may answer questions.

We will notify *you* or *your designated representative* of the decision no later than:

- 30 calendar days after the date *we* received the request for the first level review; or
- 60 calendar days after the date *we* received the request for the post service review of a post service contractual determination when *you* or *your designated representative* have not provided evidence from a medical professional that there is a reasonable medical basis that the contractual determination does not apply to the denied benefit.

You or *your designated representative* may request an expedited internal appeal of an adverse *urgent-care claim* decision orally or in writing. In such case, all necessary documents, including the plan's benefit determination on review, will be transmitted between the plan and *you* or *your designated representative* by telephone, FAX, or other available similarly expeditious method.

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

You or *your designated representative* may submit written comments, documents, records and other material relating to the *adverse benefit determination* for consideration and may receive, upon request and free or charge, reasonable access to, and copies of all documents, records and other relevant information.

If new or additional evidence is relied upon or if new or additional rationale is used during the internal appeal process, *we* will provide *you* or *your designated representative*, free of charge, the evidence or rationale as soon as possible and in advance of the appeals decision in order to provide *you* or *your designated representative* a reasonable opportunity to respond.

Expedited internal appeal

We will establish written procedures for the expedited review of *urgent care claim* of grievances involving an *adverse benefit determination. We* will also provide an *expedited review* for a request for a benefit for a *covered person* who has received *emergency care* but has not been discharged from a *health care treatment facility*. The procedures shall allow a *covered person* to request an *expedited review* under this section orally or in writing. The procedures shall also allow the *covered person* to identify health care providers to whom *we* will send a copy of the review decision. A *covered person* requesting an expedited external review may request such review concurrently with a request for an expedited internal review.

An *expedited review* shall be available to, and may be initiated by, *you* or *your designated representative.*

In an *expedited review,* all necessary information, including *our* decision, shall be transmitted between *us* and *you* or *your designated representative* by telephone, facsimile or similar expeditious method available.

Expedited appeal evaluations:

- Expedited appeals shall be evaluated by an appropriate clinical peer(s) in the same or similar specialty as would typically manage the case under review. For the purposes of this section, the clinical peer(s) shall be called "the reviewer(s)." The clinical peer(s) shall not have been involved in the initial *adverse benefit determination.*

- In conducting a review under this section, the reviewer(s) shall take into consideration all comments, documents, records and other information regarding the request for services submitted by, or on behalf of, the *covered person* without regard to whether the information was submitted or considered in making the initial *adverse benefit determination.*

In an *expedited review, we* will make a decision and notify *you* or *your designated representative* as expeditiously as the *covered person's* medical condition requires, but in no event more than 72 hours after *we* have received the request. If the *expedited review* is a concurrent review and an adverse determination is made, the service or treatment shall continue to be covered according to the *policy* until the *covered person* has been notified of the determination by *us.*

We will provide written confirmation of the decision concerning an *expedited review* within three (3) calendar days of providing notification of that decision, if the initial notification was not in writing.

In any case where the *expedited review* process does not resolve a difference of opinion between *us* and *you* or *your designated representative, you* or *your designated representative* may request an independent external review.

We will not provide an *expedited review* for retrospective *adverse benefit determinations.*

Voluntary second level review

If *you* are dissatisfied or unable to resolve *your* concerns through the first level appeal process, *you* or *your designated representative* may request a voluntary second level review in writing to the address provided on the denial letter *you* received. If *you* request a voluntary second level review for a service that was denied based on the "Limitations/Exclusions (What is Not Covered)" section of this *certificate*, *you* or *your designated representative* must send a medical basis statement from a medical professional stating that the exclusion was applied incorrectly.

The voluntary second level review may be performed, at the option of the *covered person* following completion of the first level review process. Request for the voluntary second level review must be filed within 60 calendar days or the next business day following the 60 calendar days after receipt of the first level review *adverse benefit determination.* This review will be performed by a *health care practitioner* with appropriate expertise who was not involved in the previous *appeal* process and has no direct financial interest in the *appeal* or outcome of the review.

You or *your designated representative* may appear in person or by telephone conference at the review meeting to explain the *grievance* and to provide any relevant evidence in support of the claim for benefits. The voluntary second level review meeting will be held within 60 calendar days of receiving the request for a voluntary second level review. *You* or *your designated representative* will be notified in writing at least 20 calendar days in advance of the review meeting date. *We* will provide the *covered person*, upon request, copies of the materials *we* will present at the review meeting at least (5) five calendar days prior to the date of the review meeting. The *covered person* has a responsibility to submit a copy of the materials that the *covered person* plans to present or have presented on his or her behalf at the review meeting to *us* at least (5) five calendar days prior to the date of the review meeting. The *covered person* also has a responsibility within (7) seven calendar days in advance of the review meeting to inform *us* if the *covered person* intends to have an attorney present to represent the *covered person's* interests. A written decision will be provided to *you* or *your designated representative* within seven (7) calendar days of completing the review meeting.

Exhaustion of remedies

Upon completion of the internal appeals process under this section, *you* or *your designated representative* will have exhausted his or her administrative remedies under the plan. If *we* fail to adhere to all requirements of the internal appeal process, except for failures that are based on *de minimis* violations, the claim shall be deemed to have been denied and *you* or *your designated representative* may request an external review.

After exhaustion of remedies, *you* or *your designated representative* may pursue any other legal remedies available, which may include bringing civil action under ERISA section 502(a) for judicial review of the plan's determination. Additional information may be available from the local U.S. Department of Labor Office.

External review

Within four (4) months or the next business day following the four (4) months after *you* or *your designated representative* receives notice of an *adverse benefit determination* after the completion of exhaustion of the internal appeal process, *you* or *your designated representative* may file a written request for an external review.

A request for an external review may be made if an *adverse benefit determination* has been made when *we* have denied a request for an alternate standard or a waiver of a standard that would otherwise be applicable to an individual under a wellness and prevention program that offers incentives or rewards for satisfaction of a standard related to a health risk factor.

A request for an external review may be made if an *adverse benefit determination* has been made involving a recommended or requested medical service that is experimental or investigational if the treating *health care practitioner* certifies that the recommended or requested health care service or treatment will be less effective if not started immediately, and the treating *health care practitioner* certifies:

- That the standard health care services has not improved the *covered person's* condition or are not medically appropriate; or

- There is no standard health care service or treatment available that is covered by the carrier that is more beneficial to the *covered person* than the recommended or requested health care services or treatment, and that the *health care practitioner* is a board certified or board eligible *health care practitioner* qualified to practice in the area of medicine appropriate to treat the *covered person's* condition.

Please refer to the provision titled "Expedited external review" if the *adverse benefit determination* involves an *urgent-care claim* or an ongoing course of treatment.

The request for an external review must:

- Be submitted to *us* in writing. For claims protected under the Federal No Surprises Act, refer to *our* decision letter for instructions on how to request an external review;
- Include a signed consent, authorizing *us* to disclose protected health information, including medical records pertinent to the external review; and
- Include a completed "Request for Independent External Review of Carrier's Final Adverse Determination" form.

If *we* receive an incomplete request for an external review that does not meet *our* filing procedures, *we* will notify *you* or *your designated representative* of the failure to file a complete request for external review as soon as possible, but no later the (5) five days following the receipt of the incomplete request.

You or *your designated representative* may contact *us* at the following:

HUMANA INSURANCE COMPANY
GRIEVANCE AND APPEAL DEPARTMENT
P.O. BOX 14546
LEXINGTON, KY 40512-4546

Upon receipt of a complete request for an external review, *we* will within two (2) *business days*:

- Reverse the *adverse benefit determination* based on the information submitted and notify *you* or *your designated representative* within one (1) *business day* of the reversal; or
- Provide a copy of the request to the *commissioner*.

Within two (2) *business days* from the time the *commissioner* receives a request, the *commissioner* will select an *IRE* to conduct the external review. Within one (1) *business day* of that selection *we* will notify *you* or *your designated representative* of the entity assigned.

Within two (2) *business days* of receipt of the notice from *us*, *you* or *your designated representative* may provide the *commissioner* with documentation regarding potential conflict of interest of the *IRE* assigned. If the *commissioner* determines the *IRE* presents a conflict of interest, the *commissioner* will, within one (1) *business day*, assign another *IRE* to conduct the external review.

Within five (5) *business days* of receipt of the notice from *us*, *you* or *your designated representative* may provide additional information to the *IRE* that shall be considered during the review.

Within five (5) *business days* from the date the *commissioner* notifies *us* of the *IRE* assigned *we* will provide the *IRE* with the documents and information considered in making the *adverse benefit determination.* Within two (2) *business days* of receipt of the documentation the *IRE* will provide *you* or *your designated representative* with an index of all materials submitted to them.

The *IRE* will notify *you* or *your designated representative*, *your* health care provider and *us* of any additional medical information required. Within five (5) *business days* of the request, *you, your designated representative* or *your health care practitioner* must submit the additional information or an explanation of why the additional information is not being submitted to the *IRE* and *us.*

Within 45 calendar days after the date the *IRE* receives the request for an external review, the *IRE* will notify *you* or *your designated representative* of its determination.

Upon receipt of the decision to reverse the *adverse benefit determination we* will:

- For concurrent and *prospective reviews*, approve the coverage within one (1) *business day*; or
- For *retrospective reviews*, approve the coverage within five (5) *business days*; and
- Provide *you* or *your designated representative* written notice of the approval within one (1) *business day* of our approval of coverage.

An external review decision is binding on *us* and on *you* except to the extent *you* have other remedies available under federal or state law and *we* have other remedies available under federal or state law; however the determination of the *IRE* will create a rebuttable presumption in any subsequent action. *You* or *your designated representative* may not file a subsequent request for external review involving *our* adverse determination for which *you* have already received an external review decision.

Expedited external review

You or *your designated representative* may request an expedited external review except for retrospective *adverse benefit determination* which are not eligible for expedited external review in writing:

- At the same time *you* request an expedited internal appeal of an *adverse benefit determination* for an *urgent-care claim* or when *you* are receiving an ongoing course of treatment; or
- When *you* receive an *adverse benefit determination* or *final adverse benefit determination* of:

  - An *urgent-care claim*. The request must include a physician's certification that *your* medical condition meets the criteria;
  - An admission, availability of care, continued stay or health care service for which *you* received emergency services, but *you* have not been discharged from the facility.

If *we* receive an incomplete request for an expedited external review that does not meet *our* filing procedures, *we* will notify *you* or *your designated representative* of the failure to file a complete request for an expedited external review as soon as possible, but no later than 24 hours following the receipt of the incomplete request.

If the request qualifies for an expedited external review, an *IRE* will be assigned. *You* or *your designated representative* will be notified of the determination with 72 hours of the receipt of the request.

Within one (1) *business day* of receipt of a complete request for an expedited external review, *we* will notify and provide a copy of the request to the *commissioner* in an expeditious method.

Within one (1) *business day* from the time the *commissioner* receives a request, the *commissioner* will select an *IRE* to conduct the external review. Within one (1) *business day* of that selection *we* will notify *you* of the entity assigned.

Immediately upon receipt of the notification, *we* will provide the *IRE* with the documents and information considered in making the *adverse benefit determination.*

If the *IRE* reverses *our* final *adverse benefit determination, we* will immediately approve the coverage that was the subject of the final *adverse benefit determination.*

Legal actions and limitations

No legal action to recover on the *master group contract* may be brought until 60 days after written proof of loss has been given in accordance with the "Proof of loss" provision of the *master group contract.*

No legal action to recover on the *master group contract* may be brought after three years from the date written proof of loss is required to be given.

14. Information on Policy and Rate Changes

Modification of master group contract

The *master group contract* may be modified by *us*, upon renewal of the *master group contract*, as permitted by state and federal law. The *group plan sponsor* will be notified in writing or *electronically* at least 90 days prior to the effective date of the change.

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

Corrections due to clerical errors or clarifications that do not change benefits are not modifications of the *master group contract* and may be made by *us* at any time without prior consent of, or notice to, the *group plan sponsor*.

Discontinuation of coverage

If *we* decide to discontinue offering a particular group health plan:

- The *group plan sponsor* and the *employees* will be notified of such discontinuation at least 90 days prior to the date of discontinuation of such coverage; and
- The *group plan sponsor* will be given the option to purchase all other group plans providing medical benefits that are being offered by *us* at such time.

If *we* cease doing business in the *small employer* group market, the *group plan sponsors* and *covered persons* will be notified of such discontinuation at least 180 days prior to the date of discontinuation of such coverage.

Premium contributions

Your employer must pay the required premium to *us* as they become due. *Your employer* may require *you* to contribute toward the cost of *your* coverage. Failure of *your employer* to pay any required premium to *us* when due may result in the termination of *your* coverage. The Commissioner of Insurance will be notified of such discontinuation at least 225 days prior to the date of discontinuation of such coverage.

Premium rate change

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

15. Definitions

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

A

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

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

- On a regular *full-time* basis; and
- Is maintaining a bona fide *employer-employee* relationship with the *group plan sponsor* of the *master group contract* on a regular basis.

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

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

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

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

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

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

Air ambulance means a professionally operated helicopter or airplane, provided by a licensed ambulance service, equipped for the transportation of a sick or injured person to or from the nearest medical facility qualified to treat the person's *sickness* or *bodily injury.*

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

Ambulance means a professionally operated ground vehicle, provided by a licensed ambulance service, equipped for the transportation of a sick or injured person to or from the nearest medical facility qualified to treat the person's *sickness* or *bodily injury.*

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

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

Ancillary services mean *covered expenses* that are:

- Items or services related to emergency medicine, anesthesiology, pathology, radiology, or neonatology;
- Provided by *assistant surgeons*, hospitalists or intensivists;
- Diagnostic laboratory or radiology services; and
- Items or services provided by a *non-network provider* when a *network provider* is not available to provide the services at a *network facility*.

Assistant surgeon means a *health care practitioner* who assists at *surgery* and is a Doctor of Medicine (MD), Doctor of Osteopathic Medicine (DO), Doctor of Podiatric Medicine (DPM) or where state law requires a specific *health care practitioner* be treated and reimbursed the same as an MD, DO or DPM.

B

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

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

Biologically based mental illness means:

- Schizophrenia;
- Bipolar-affective disorders;
- Major depressive disorders;
- Schizoaffective disorders;
- Specific obsessive-compulsive disorders; and
- Panic disorder.

Birthing center means a *free-standing facility* that is specifically licensed to perform uncomplicated pregnancy care, delivery and immediate care after delivery for a *covered person*.

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

C

Certificate means this benefit plan document that describes the benefits, provisions and limitations of the *master group contract.* This *certificate* is part of the *master group contract* and is subject to the terms of the *master group contract.*

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

Civil union means a relationship established by two eligible persons pursuant to the CO Civil Union Act that entitles them to receive the benefits and protections and be subject to the responsibilities of spouses.

Coinsurance means the amount expressed as a percentage of the *covered expense* that *you* must pay.

Complications of pregnancy means conditions with diagnoses which are distinct from pregnancy but adversely affected by pregnancy or caused by pregnancy. Such conditions include:

- Acute nephritis;
- Nephrosis;
- Cardiac decompensation;
- Missed abortion;
- A nonelective cesarean section;
- Terminated ectopic pregnancy; or
- Spontaneous termination of pregnancy which occurs during a period of gestation in which a viable birth is not possible.

Complications of pregnancy does not mean:

- False labor;
- Occasional spotting;
- Rest prescribed during the period of pregnancy;
- Morning sickness;
- Hyperemesis gravidarum;
- Preeclampsia;
- Conditions associated with the management of a difficult pregnancy but which do not constitute distinct *complications of pregnancy*; or
- An elective cesarean section.

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

Congenital anomaly means an abnormality of the body that is present from the time of birth.

15. Definitions (continued)

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

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

Co-surgeon means one of two or more *health care practitioners* furnishing a single *surgery* which requires the skill of multiple surgeons each in a different specialty, performing parts of the same *surgery* simultaneously.

Covered expense means:

- *Medically necessary* services to treat a *sickness* or *bodily injury* such as:
  - Procedures;
  - *Surgeries*;
  - Consultations;
  - Advice;
  - Diagnosis;
  - Referrals;
  - Treatment;
  - Supplies;
  - Drugs, including *prescription* and *specialty drugs*;
  - Devices; or
  - Technologies;
- *Preventive services*;
- *Pediatric dental services*; or
- *Pediatric vision care*.

To be considered a *covered expense*, services must be:

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

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

Custodial care means services given to *you* if:

- *You* need services including, but not limited to, assistance with dressing, bathing, preparation and feeding of special diets, walking, supervision of medication which is ordinarily self-administered, getting in and out of bed, and maintaining continence;

- The services *you* require are primarily to maintain, and not likely to improve, *your* condition; or
- The services involve the use of skills which can be taught to a layperson and do not require the technical skills of a *nurse*.

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

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

D

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

Dental injury means an injury to a *sound natural tooth* caused by a sudden and external force that could not be predicted in advance and could not be avoided. It does not include biting or chewing injuries, unless the biting or chewing injury is a result of an act of domestic violence or a medical condition (including both physical and mental health conditions).

Dentist means an individual, who is duly licensed to practice dentistry or perform *oral surgery* and is acting within the lawful scope of his or her license.

Dependent means a covered *employee's*:

- Legally recognized spouse;
- A partner in a *civil union*;
- Natural born child, step-child, legally adopted child, or child placed for adoption or foster care whose age is less than the limiting age;
- Unmarried child of any age who is medically certified as disabled and is dependent upon the parent;
- Child whose age is less than the limiting age and for whom the *employee* has received a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN) to provide coverage, if the *employee* is eligible for family coverage until:
  - Such QMCSO or NMSN is no longer in effect; or
  - The child is enrolled for comparable health coverage, which is effective no later than the termination of the child's coverage under the *master group contract.*

Under no circumstances shall *dependent* mean a grandchild or great grandchild, unless *you* are a grandparent who has become the permanent legal guardian or adoptive parent of that grandchild.

The limiting age means the end of the month the *dependent* child attains age 26. Each *dependent* child is covered to the limiting age regardless if the child is:

- Married;
- A tax dependent;
- A student;
- Employed;
- Residing with or receiving financial support from *you*;
- Eligible for other coverage through employment; or
- Residing or working outside of the *service area*. Benefits for *dependents* residing outside of the *service area* are limited to *emergency care* and *urgent care* services as specified in the "Dependent eligibility date" provision, unless additional coverage is provided by addenda or authorized by *us*.

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

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

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

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

Distant site means the location of a *health care practitioner* at the time a *telehealth* or *telemedicine* service is provided.

Durable medical equipment means equipment that meets all of the following criteria:

- It is prescribed by a *health care practitioner*;
- It can withstand repeated use;
- It is primarily and customarily used for a medical purpose rather than being primarily for comfort or convenience;

- It is generally not useful to *you* in the absence of *sickness* or *bodily injury*;
- It is appropriate for home use or use at other locations as necessary for daily living;
- It is related to and meets the basic functional needs of *your* physical disorder;
- It is not typically furnished by a *hospital* or *skilled nursing facility*; and
- It is provided in the most cost effective manner required by *your* condition, including, at *our* discretion, rental or purchase.

E

Early intervention services means services that are authorized through an *eligible child's individualized family service plan*.

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

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

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

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

Eligible child means an infant or toddler, from birth up to the child's third birthday who is an eligible *dependent* and who has significant delays in development or has a diagnosed physical or mental condition that has a high probability of resulting in significant delays in development, and who is eligible for services under Colorado statute.

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

Emergency care means services provided in an emergency facility or *urgent care center* for an *emergency medical condition.*

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

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

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

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

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

- The *employer* is a sole proprietorship, partnership or corporation;
- The sole proprietorship or other entity (other than a partnership) has at least one common-law employee (other than the business owner and his or her spouse); and
- The sole proprietor, partner or corporate officer is actively performing activities relating to the business, gains their livelihood from the sole proprietorship, partnership or corporation and is in an *active status* at the *employer's* usual place of business or some other location, which is usual for the sole proprietor's, partner's or corporate officer's particular duties.

If specified on the Employer Group Application and approved by *us*, *employee* also includes retirees of the *employer*. A retired *employee* is not required to be in *active status* to be eligible for coverage under the *master group contract.*

Employer means the sponsor of this *group* plan or any subsidiary or affiliate described in the Employer Group Application. An *employer* must either employ at least one common-law employee or be a partnership with a bona fide partner who provides services on behalf of the partnership. A business owner and his or her spouse are not considered common-law employees for this purpose if the entity is considered to be wholly owned by one individual or one individual and his or her spouse.

Endodontic services mean the following dental procedures, related tests or treatment and follow-up care:

- Root canal therapy and root canal fillings;
- Periradicular *surgery*;
- Apicoectomy;
- Partial pulpotomy; or
- Vital pulpotomy.

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

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

F

Family member means *you*, *your* spouse, or a partner in a *civil union.* It also means *your*, *your* spouse, or a partner in a *civil union's* child, brother, sister, or parent.

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

Full-time, for an *employee*, means a work week of the number of hours determined by the *group plan sponsor*.

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

G

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

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

H

Habilitative services mean services and devices that help a *covered person* retain, learn or improve skills and functioning for daily living that are offered in parity with, and in addition to, any rehabilitative services offered in this *certificate.* Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

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

Health care treatment facility means a facility, institution or clinic, duly licensed by the appropriate state agency to provide medical services or *behavioral health* services and is primarily established and operating within the scope of its license.

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

15. Definitions (continued)

Health status-related factor means any of the following:

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

Hearing aid means any wearable, non-disposable instrument or device designed to aid or compensate for impaired human hearing, including any parts or ear molds.

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

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

Home health care plan means a plan of care and treatment for *you* including hospice services to be provided in the place *you* designate as *your* primary residence which may be a private residence, retirement community, assisted living, nursing or Alzheimer facility. To qualify, the *home health care plan* must be established and approved by a *health care practitioner*. The services to be provided by the plan must require the skills of a *nurse*, or another *health care practitioner* and must not be for *custodial care*.

Hospice care program means a program of palliative support and interdisciplinary team services providing physical, psychological, spiritual, and bereavement care for terminally ill individuals and their families within a continuum of patient and home care available 24 hours, 7 days a week. A hospice must be licensed by the Department of Public Health and Environment. Hospice services shall be provided at home, a licensed hospice, and/or other licensed health facility. Hospice services include but are not limited to: nursing, physician, certified nurse aide, nursing services delegated to other assistants, homemaker, physical therapy, pastoral counseling, trained volunteer, and social services.

An interdisciplinary team is a group of qualified individuals, which include but are not limited to a physician, registered nurse, clergy/counselor, volunteer director, and/or trained volunteers, and appropriate staff who collectively have expertise in meeting the special needs of hospice patients and their families.

Hospice respite care means the level of care received when the patient is in a licensed facility to provide the caregiver a period of relief. *Inpatient hospice respite care* may be provided only on an intermittent, non-routine, short-term basis.

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

- It must provide, for a fee, medical care and treatment of sick or injured patients on an *inpatient* basis;
- It must provide or operate, either on its premises or in facilities available to the *hospital* on a pre-arranged basis, medical, diagnostic, and surgical facilities;
- Care and treatment must be given by and supervised by physicians. Nursing services must be provided on a 24-hour basis and must be given by or supervised by registered nurses;
- It must be licensed by the laws of the jurisdiction where it is located. It must be operated as a *hospital* as defined by those laws; and
- It must not be primarily a:
  - Convalescent, rest or nursing home; or
  - Facility providing custodial, educational or rehabilitative care.

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

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

I

Immune effector cell therapy means immune cells or other blood products that are engineered outside of the body and infused into a patient. *Immune effector cell therapy* may include acquisition, integral chemotherapy components and engineered immune cell infusion.

Individualized family service plan or ***IFSP*** means a written plan that authorizes *early intervention services* to an *eligible child* and the child's family.

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

- In vitro fertilization;
- Gamete Intrafallopian Transfer (GIFT);
- Zygote Intrafallopian Transfer (ZIFT);
- Tubal ovum transfer;
- Embryo freezing or transfer;
- Sperm storage or banking;
- Ovum storage or banking;
- Embryo or zygote banking; and
- Any other assisted reproductive techniques or cloning methods.

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

Intensive outpatient program means *outpatient* services providing:

- Group therapeutic sessions greater than one hour a day, three days a week;
- *Behavioral health* therapeutic focus;

- Group sessions centered on cognitive behavioral constructs, social/occupational/educational skills development and family interaction;
- Additional emphasis on recovery strategies, monitoring of participation in 12-step programs and random drug screenings for the treatment of *chemical dependency*; and
- Physician availability for medical and medication management.

Intensive outpatient program does not include services that are for:

- *Custodial care*; or
- Day care.

J

K

L

Late applicant means an *employee* or *dependent* who requests enrollment for coverage under the *master group contract* more than 31 days after his or her *eligibility date*, later than the time period specified in the "Special enrollment" provision, or after the *open enrollment period*.

M

Maintenance care means services and supplies furnished mainly to:

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

Master group contract means the legal agreement between *us* and the *group plan sponsor*, including the Employer Group Application and *certificate*.

Materials means frames, lenses and lens options, or contact lenses and low vision aids.

Maximum allowable fee for a *covered expense* is the lesser of:

- The fee charged by the provider for the services;
- The fee that has been negotiated with the provider whether directly or through one or more intermediaries or shared savings contracts for the services;
- The fee established by *us* by comparing rates from one or more regional or national databases or schedules for the same or similar services from a geographical area determined by *us*;
- The fee based upon rates negotiated by *us* or other payors with one or more *network providers* in a geographic area determined by *us* for the same or similar services; or

- The fee based upon the provider's cost for providing the same or similar services as reported by such provider in its most recent publicly available *Medicare* cost report submitted to the Centers for Medicare & Medicaid Services (CMS) annually; or

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

The "lesser of" reimbursement method described above applies to all *covered expenses*, except for the following services *you* receive from *non-network providers* in the state of Colorado:

- *Ambulance* services;
- *Emergency care*;
- *Ancillary services*;
- Services that are not considered *ancillary services* when *you* are at a *network facility* and *you* do not consent to the *non-network provider* to obtain such services; and
- *Post-stabilization services* when:

    - The attending *qualified provider* determines *you* are not able to travel by non-medical transportation to obtain services from a *network provider*; and
    - *You* do not consent to the *non-network provider* to obtain such services.

Maximum allowable fee for a *covered expense* for *ambulance* services is a minimum of three hundred twenty-five percent of the *Medicare* reimbursement rate for the same service provided in the same geographic area, including mileage.

Maximum allowable fee for *covered expenses* for *emergency care* provided by *non-network health care provider* in an emergency department of a *non-network facility* in the state of Colorado, is an amount equal to the greater of:

- One hundred ten percent of the median *network provider* rate of reimbursement for that service in the same geographic area;

- The sixtieth percentile of the *network provider* rate of reimbursement for the same service in the same geographic area for the prior year based on commercial claims data from the all-payer health claims database when available; or

- The fee paid by *Medicare* for the same services, as required by the state of Colorado.

Maximum allowable fee for *covered expenses* for *emergency care* received from a *non-network facility* in the state of Colorado, not operated by the Denver Health and Hospital Authority, is an amount equal to the greater of:

- One hundred five percent of *our* median *network provider* rate of reimbursement for that service provided in a similar facility or setting in the same geographic area;

- The median *network provider* rate of reimbursement for the same service provided in a similar facility or setting in the same geographic area for the prior year based on claims data from the Colorado all-payer health claims database when available; or

- The fee paid by *Medicare* for the same services, as required by the state of Colorado.

Maximum allowable fee for *covered expenses* for *emergency care* received from a *non-network facility* operated by the Denver Health and Hospital Authority is an amount equal to the greater of:

- Two hundred fifty percent of the *Medicare* reimbursement rate for the same services provided in a similar facility or setting in the same geographic area;
- The median *network provider* rate of reimbursement for the same service provided in a similar facility or setting in the same geographic area for the prior year based on claims data from the Colorado all-payer health claims database when available;
- The fee calculated using the same method to determine *maximum allowable fee* for a *covered expense*, other than *emergency care* services provided by *non-network providers*; or
- The fee paid by *Medicare* for the same services, as required by the state of Colorado.

Maximum allowable fee for *covered expenses* when *you* receive the following services from *non-network providers* at a *network facility* in the state of Colorado:

- *Ancillary services*;
- Services that are not considered *ancillary services* when *you* are at a *network facility* and *you* do not consent to the *non-network provider* to obtain such services; and
- *Post-stabilization services* when:
  - The attending *qualified provider* determines *you* are not able to travel by non-medical transportation to obtain services from a *network provider*; and
  - *You* do not consent to the *non-network provider* to obtain such services,

is the greater of:

- One hundred ten percent of the median *network provider* rate of reimbursement for that service in the same geographic area; or
- The sixtieth percentile of the *network provider* rate of reimbursement for the same service in the same geographic area for the prior year based on commercial claims data from the all-payer health claims database when available.

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

Medically necessary means health care services that a *health care practitioner* exercising prudent clinical judgment would provide to his or her patient for the purpose of preventing, evaluating, diagnosing, or treating a *sickness* or *bodily injury*, or its symptoms. Such health care service must be:

- In accordance with generally accepted standards of medical practice;
- Clinically appropriate in terms of type, frequency, extent, site and duration, and considered effective for the patient's *sickness* or *bodily injury*;
- Neither sourced from a location, nor provided primarily for the convenience of the patient, physician or other health care provider;

- Not more costly than an alternative source, service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the patient's *sickness* or *bodily injury*; and
- Performed in the least costly site or sourced from, or provided by the least costly *qualified provider*.

For the purpose of *medically necessary*, generally accepted standards of medical practice means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations, the views of physicians practicing in relevant clinical areas and any other relevant factors.

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

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

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

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

N

Network facility means a *hospital*, *hospital outpatient* department or *ambulatory surgical center* that has been designated as such or has signed an agreement with *us* as an independent contractor, or has been designated by *us* to provide services to all *covered persons.* *Network facility* designation by *us* may be limited to specified services.

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

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

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

Non-network facility means a *hospital*, *hospital outpatient* department or *ambulatory surgical center* that has not been designated by *us* as a *network facility*.

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

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

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

Nurse means a registered nurse (R.N.), a licensed practical nurse (L.P.N.), or a licensed vocational nurse (L.V.N.).

O

Observation status means *you* are receiving *hospital outpatient* services to help the *health care practitioner* decide if *you* need to be admitted as an *inpatient*.

Open enrollment period means no less than a 31-day period of time, occurring annually for the *group*, during which *employees* have an opportunity to enroll themselves and their eligible *dependents* for coverage under the *master group contract.*

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

- Surgical removal of full bony impactions;
- Mandibular or maxillary implant;
- Maxillary or mandibular frenectomy;
- Alveolectomy and alveoplasty;
- Orthognathic *surgery*;
- *Surgery* for treatment of temporomandibular joint syndrome/dysfunction; and
- Periodontal surgical procedures, including gingivectomies.

Originating site means the location of a *covered person* at the time a *telehealth* or *telemedicine* service is being furnished.

Out-of-pocket limit means the amount of *copayments*, *deductibles* and *coinsurance you* must pay for *covered expenses*, as specified in the "Out-of-pocket limit" provision in the "Schedule of Benefits (Who Pays What" section, either individually or combined as a covered family, per *year* before a benefit percentage is increased.

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

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

P

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

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

- Has a comprehensive and intensive interdisciplinary psychiatric treatment under the supervision of a psychiatrist for *mental health services* or a psychiatrist or addictionologist for *chemical dependency*, and patients are seen by a psychiatrist or addictionologist, as applicable, at least once a week;
- Provides for social, psychological and rehabilitative training programs with a focus on reintegration back into the community and admits children and adolescents who must have a treatment program designed to meet the special needs of that age range; and
- Has physicians and appropriately licensed behavioral health practitioners readily available for the emergent and urgent needs of the patients.

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

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

Partial hospitalization does not include services that are for:

- *Custodial care*; or
- Day care.

Pediatric dental services mean the following services:

- Ordered by a *dentist*; and
- Described in the "Pediatric dental" provision in this "Benefits/Coverage (What is Covered) – Pediatric Dental" section.

Pediatric vision care means the services and *materials* specified in the "Pediatric vision care benefit" provision in the "Benefits/Coverage (What is Covered) – Pediatric Vision Care" section.

Periodontics means the branch of dentistry concerned with the study, prevention and treatment of diseases of the tissues and bones supporting the teeth. *Periodontics* includes the following dental procedures, related tests or treatment and follow-up care:

- Periodontal maintenance;
- Scaling and root planing;
- Gingivectomy;
- Gingivoplasty; or
- Osseous *surgery.*

Placed for adoption means circumstances under which a person assumes or retains a legal obligation or partially or totally support a child in anticipation of the child's adoption. A placement terminates at the time such legal obligation terminates.

Post-stabilization services means services *you* receive in *observation status* or during an *inpatient* or *outpatient* stay in a *network facility* related to an *emergency medical condition* after *you* are stabilized.

Pre-surgical/procedural testing means:

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

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

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

Prescription means a direct order for the preparation and use of a drug, medicine or medication. The *prescription* must be written by a *health care practitioner* and provided to a *pharmacist* for *your* benefit and used for the treatment of a *sickness* or *bodily injury*, which is covered under this plan, or for drugs, medicines or medications on the Preventive Medication Coverage *drug list.* The drug, medicine or medication must be obtainable only by *prescription* or must be obtained by *prescription* for drugs, medicines or medications on the Preventive Medication Coverage *drug list.* The *prescription* may be given to the *pharmacist* verbally, *electronically* or in writing by the *health care practitioner.* The *prescription* must include at least:

- *Your* name;
- The type and quantity of the drug, medicine or medication prescribed, and the directions for its use;
- The date the *prescription* was prescribed; and
- The name and address of the prescribing *health care practitioner.*

Preventive services means services in the following recommendations appropriate for *you* during *your* plan *year*:

- Services with an A or B rating in the current recommendations of the USPSTF.
- Immunizations recommended by the Advisory Committee on Immunization Practices of the CDC.
- Preventive care for infants, children and adolescents provided in the comprehensive guidelines supported by the HRSA.
- Preventive care for women provided in the comprehensive guidelines supported by the HRSA.

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

Primary care physician means a *network health care practitioner* who provides initial and primary care services to *covered persons*, maintains the continuity of *covered persons'* medical care and helps direct *covered persons* to *specialty care physicians* and other providers.

A *primary care physician* is a *health care practitioner* in one of the following specialties:

- Family medicine/General practice;
- Internal medicine;
- Obstetrics or Gynecology; and
- Pediatrics.

A pediatric subspecialist will be considered a *primary care physician* if the pediatric subspecialist:

- Has signed an agreement with *us* as a *primary care physician*;
- Is available to accept the *covered person* as a patient; and
- Is chosen by the *covered person* as their *primary care physician*.

Q

Qualified payment amount means the lesser of:

- Billed charges; or
- The median of the contracted rates negotiated by *us* with three or more *network providers* in the same geographic area for the same or similar services.

If sufficient information is not available for *us* to calculate the median of the contracted rates, the rate established by *us* through use of any database that does not have any conflict of interest and has sufficient information reflecting allowed amounts paid to a *qualified provider* for relevant services furnished in the applicable geographic region.

The *qualified payment amount* applies to *covered expenses* when *you* receive the following services from a *non-network provider*:

- *Air ambulance* services;
- *Emergency care* outside the state of Colorado;

- *Ancillary services* while *you* are at a *network facility* outside the state of Colorado;
- Services that are not considered *ancillary services* while *you* are at a *network facility* outside the state of Colorado, and *you* do not consent to the *non-network provider* to obtain such services; and
- *Post-stabilization services* received outside the state of Colorado when:

  - The attending *qualified provider* determines *you* are not able to travel by non-medical transportation to obtain services from a *network provider*; and
  - *You* do not consent to the *non-network provider* to obtain such services.

Qualified provider means a person, facility, supplier, or any other health care provider:

- That is licensed by the appropriate state agency to:

  - Diagnose, prevent or treat a *sickness* or *bodily injury*;
  - Provide *preventive services*;
  - Provide *pediatric dental services*; or
  - Provide *pediatric vision care*;

A *qualified provider* must provide services within the scope of their license and their primary purpose must be to provide health care services.

R

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

Rescission, ***rescind*** or ***rescinded*** means a cancellation or discontinuance of coverage that has a retroactive effect.

Residential treatment facility means an institution that:

- Is licensed as a 24-hour residential facility for *behavioral health* treatment, although not licensed as a *hospital*;
- Provides a multidisciplinary treatment plan in a controlled environment, under the supervision of a physician who is able to provide treatment on a daily basis;
- Provides supervision and treatment by a Ph.D. psychologist, licensed therapist, psychiatric nursing staff or registered nurse;
- Provides programs such as social, psychological, family counseling and rehabilitative training, age appropriate for the special needs of the age group of patients, with focus on reintegration back into the community; and
- Provides structured activities throughout the day and evening.

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

Retail clinic means a *health care treatment facility*, located in a retail store, that is often staffed by nurse practitioners and physician assistants who provide minor medical services on a "walk-in" basis (no appointment required).

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

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

S

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

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

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

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

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

A *skilled nursing facility* is not, except by incident, a rest home or a home for the care of the aged.

Small employer means any person, firm, corporation, partnership, or association actively engaged in business who, on at least 50% of its working days during the preceding calendar quarter, employed no more than 100 eligible *employees* and not less than one eligible *employee*, the majority of whom were employed within the State of Colorado or were residents of Colorado, and that was not formed for the purpose of purchasing insurance. All subsidiaries or affiliates of the *group plan sponsor* are considered one *employer* when the conditions specified in the "Subsidiaries or Affiliates" section of the *master group contract* are met.

Sound natural tooth means a tooth that:

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

Special enrollment date means the date of the special enrollment event specified in the "Special enrollment" provision within the "Eligibility" section. The *covered person* or *dependent* who has a special enrollment event may enroll for coverage outside of the *open enrollment period*.

To be eligible for special enrollment, *you* must meet the requirements specified in the "Special enrollment" provision within the "Eligibility" section of this *certificate*.

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

Specialty drug means a drug, medicine, medication, or biological used as a specialized therapy developed for chronic, complex *sicknesses* or *bodily injuries*. *Specialty drugs* may:

- Be injected, infused or require close monitoring by a *health care practitioner* or clinically trained individual;
- Require nursing services or special programs to support patient compliance;
- Require disease-specific treatment programs;
- Have limited distribution requirements; or
- Have special handling, storage or shipping requirements.

Stem cell means the transplant of human blood precursor cells. Such cells may be derived from bone marrow, circulating blood, or a combination of bone marrow and circulating blood obtained from the patient in an autologous transplant, from a matched related or unrelated donor, or cord blood. The *stem cell* transplant includes the harvesting, integral chemotherapy components and the *stem cell* infusion. A *stem cell* transplant is commonly referred to as a bone marrow transplant.

Surgery means procedures categorized as Surgery in either the:

- Current Procedural Terminology (CPT) manuals published by the American Medical Association; or
- Healthcare Common Procedure Coding System (HCPCS) Level II manual published by the Centers for Medicare & Medicaid Services (CMS).

The term *surgery* includes, but is not limited to:

- Excision or incision of the skin or mucosal tissues;
- Insertion for exploratory purposes into a natural body opening;
- Insertion of instruments into any body opening, natural or otherwise, done for diagnostic or other therapeutic purposes;
- Treatment of fractures;
- Procedures to repair, remove or replace any body part or foreign object in or on the body; and
- Endoscopic procedures.

Surgical assistant means a *health care practitioner* who assists at *surgery* and is not a Doctor of Medicine (MD), Doctor of Osteopathic Medicine (DO) or Doctor of Podiatric Medicine (DPM), or where state law does not require that specific *health care practitioners* be treated and reimbursed the same as an MD, DO or DPM.

T

Telehealth means services, other than *telemedicine*, provided via telephonic or *electronic* communications. *Telehealth* services must comply with the following, as applicable:

- Federal and state licensure requirements;
- Accreditation standards; and
- Guidelines of the American Telemedicine Association or other qualified medical professional societies to ensure quality of care.

Telemedicine means audio and video real-time interactive communication between a *covered person* at an *originating site* and a *health care practitioner* at a *distant site*. *Telemedicine* services must comply with the following, as applicable:

- Federal and state licensure requirements;
- Accreditation standards; and
- Guidelines of the American Telemedicine Association or other qualified medical professional societies to ensure quality of care.

U

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

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

V

Virtual visit means *telehealth* or *telemedicine* services.

W

Waiting period means the period of time, elected by the *group plan sponsor*, that must pass before an *employee* is eligible for coverage under the *master group contract.* The *waiting period* cannot exceed 90 days.

15. Definitions (continued)

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

Well child visit means a visit to a primary care provider that includes the following elements:

- Age appropriate physical exam (but not a complete physical exam unless this is age appropriate);
- History;
- Anticipatory guidance and education (e.g. examine family functioning and dynamics, injury prevention counseling, discuss dietary issues, review age appropriate behaviors, etc.);
- Growth and development assessment; and
- For older children, this also includes safety and health education counseling.

X

Y

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

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

Z

Pharmacy Services

All terms used in the "Schedule of Benefits (Who Pays What) – Pharmacy Services," "Benefits/Coverage (What is Covered) – Pharmacy Services" and "Limitations/Exclusions (What is Not Covered) – Pharmacy Services" sections have the same meaning given to them in the "Definitions" section of this *certificate*, unless otherwise specifically defined below:

A

B

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

C

Coinsurance means the amount expressed as a percentage of the *covered expense* that *you* must pay toward the cost of each separate *prescription* fill or refill dispensed by a *pharmacy*.

Copayment means the specified dollar amount to be paid by *you* toward the cost of each separate *prescription* fill or refill dispensed by a *pharmacy*.

Cost share means any applicable *deductible, copayment* and *coinsurance* that *you* must pay per *prescription* fill or refill.

D

Default rate means the fee based on rates negotiated by *us* or other payers with one or more *network providers* in a geographic area determined by *us* for the same or similar *prescription* fill or refill.

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

Drug list means a list of covered *prescription* drugs, medicines or medications and supplies specified by *us*.

E

F

G

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

H

HIV infection preventive drug means pre-exposure prophylaxis, post-exposure prophylaxis or other *prescription* drugs approved by the FDA for the prevention of HIV infection.

I

J

K

L

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

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

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

Level 3 drugs mean a category of *prescription* drugs, medicines or medications within the *drug list* that are designated by *us* as level 3.

Level 4 drugs mean a category of *prescription* drugs, medicines or medications within the *drug list* that are designated by *us* as level 4.

Level 5 drugs mean a category of *prescription* drugs, medicines or medications within the *drug list* that are designated by *us* as level 5.

M

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

N

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

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

as defined by *us*, to *covered persons*, including covered *prescription* fills or refills delivered to *your* home or health care provider.

Non-network pharmacy means a *pharmacy* that has not signed a direct agreement with *us* or has not been designated by *us* to provide:

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

as defined by *us*, to *covered persons*, including covered *prescription* fills or refills delivered to *your* home or health care provider.

O

P

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

Pharmacy means a licensed establishment where *prescription* drugs, medicines or medications are dispensed by a *pharmacist.*

Prior authorization means the required prior approval from *us* for the coverage of certain *prescription* drugs, medicines or medications, including *specialty drugs*. The required prior approval from *us* for coverage includes the dosage, quantity and duration, as *medically necessary* for the *covered person.*

Q

R

S

Specialty pharmacy means a *pharmacy* that provides covered *specialty pharmacy* services, as defined by *us,* to *covered persons.*

Step therapy means a requirement for *you* to first try certain drugs, medicines or medications or *specialty drugs* to treat *your* medical condition before *we* will cover another *prescription* drug, medicine, medication or *specialty drug* for that condition.

T

U

V

W

X

Y

Z

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