

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 [Humana.com](https://www.humana.com) to view your issued certificate.

GAHJ68SEN 0123

SAMPLE

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'déé', t'áá jiik'eh, éí ná hóló, námboo ninaaltsoos yézhí, bee nées ho'dółzin 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).



Administrative Office:
1100 Employers Boulevard
Green Bay, Wisconsin 54344

Certificate of Insurance Humana Insurance Company

Policyholder:

Policy Number:

Effective Date:

Product Name:

In accordance with the terms of the *policy* issued to the *policyholder*, Humana Insurance Company certifies that a *covered person* is insured for the benefits described in this *certificate*. This *certificate* becomes the Certificate of Insurance and replaces any and all certificates and certificate riders previously issued.

A handwritten signature in black ink that reads "Bruce Broussard".

Bruce Broussard
President

NOTICE

BENEFITS UNDER THIS PPO PLAN ARE LIMITED WHEN YOU SEE A NON-NETWORK PROVIDER

The benefits in this PPO plan are designed to allow you to realize a lower *coinsurance* percent when you receive your services from a *network provider*. When your treatment is provided by a *non-network provider* you will have a higher *coinsurance* percent. Please review your schedules of benefits carefully to understand this difference in benefits.

EMERGENCY CARE

If you receive *emergency care* and cannot reasonably access care from your *network provider*, benefits for that *emergency care* rendered during the course of the emergency will be payable at the *network provider* benefit percentages. However, if you could have reasonably reached a *network provider*, benefits will be payable at the *non-network provider* benefit percentages.

The insurance *policy* under which this *certificate* is issued is **not** a policy of Workers' Compensation insurance and does not replace Workers' Compensation insurance. *You* should consult *your employer* to determine whether *your employer* is a subscriber to the Workers' Compensation system.

This is **not** a policy of Long Term Care insurance.

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

200400GA 01/16

SAMPLE

UNDERSTANDING YOUR COVERAGE

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 "Glossary" 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.

202000 01/19

Covered and non-covered expenses

We will provide coverage for services, equipment and supplies that are *covered expenses*. All requirements of the *policy* 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," the "Covered Expenses," the "Limitations and Exclusions," and the "Covered Expenses – Clinical Trials" sections and any amendment attached to the *certificate* to see when services or supplies are *covered expenses* or are non-covered expenses.

202100GA 01/23

How your policy 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" 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" applies.

Covered expenses are subject to the *maximum allowable fee*. We will apply the applicable *network provider* or *non-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" section of this *certificate* for more information on *our* claims processing procedures.

UNDERSTANDING YOUR COVERAGE (continued)

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

- The applicable *network provider* or *non-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 if you receive the following services from a *non-network provider* in the state of Georgia:

- *Emergency care*;
- Services while you are at a *network facility*, unless you choose to receive services from a *non-network provider* and you provide your written and oral 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 provide your consent to the *non-network provider* to obtain such services.

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 a *non-network provider*:

- *Air ambulance services*;
- *Emergency care* outside the state of Georgia;
- *Ancillary services* while you at a *network facility* in the state of Georgia, you choose to receive the services from a *non-network provider* and you provide your written and oral consent to the *non-network provider* to obtain such services;
- *Ancillary services* while you are at a *network facility* outside the state of Georgia;
- Services that are not considered *ancillary services* while you are at a *network facility* outside the state of Georgia and you do not provide your consent to the *non-network provider* to obtain such services;
- *Post stabilization services* you receive outside the state of Georgia 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 provide your consent to the *non-network provider* to obtain such services.

UNDERSTANDING YOUR COVERAGE (continued)

Any *copayment, deductible and/or coinsurance* you pay a *non-network provider* for the specific services listed above will apply 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 *policy*.
202150GA 01/23

Your choice of providers affects your benefits

We will pay benefits for *covered expenses* at a higher percentage most of the time if you see a *network provider*, so the amount you pay will be lower. Be sure to check if your *qualified provider* is a *network provider* before seeing them.

We may designate certain *network 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.

Unless stated otherwise in this *certificate*, we will pay a lower percentage if you see a *non-network provider*, so the amount you pay will be higher. *Non-network providers* have not signed an agreement with us for lower costs for services and they may bill you for any amount over the *maximum allowable fee*. If the *non-network provider* bills you any amount over the *maximum allowable fee*, you will have to pay that amount and any *copayment, deductible and coinsurance* to the *non-network provider*. Any amount you pay over the *maximum allowable fee* will not apply to your *deductible* or any *out-of-pocket limit*.

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

- Services while you are at a *network facility* in the state of Georgia, unless you choose to receive services from a *non-network provider* and you provide your written and oral consent to the *non-network provider* to obtain such services;
- *Ancillary services* while you at a *network facility* in the state of Georgia, you choose to receive the services from a *non-network provider* and you provide your written and oral consent to the *non-network provider* to obtain such services;
- *Ancillary services* while you are at a *network facility* outside the state of Georgia;
- Services that are not considered *ancillary services* while you are at a *network facility* outside the state of Georgia and you do not provide your 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 provide your consent to the *non-network provider* to obtain such services.

UNDERSTANDING YOUR COVERAGE (continued)

For all other services *you* receive from a *non-network provider*, *you* will be responsible to pay the *non-network provider copayment, deductible and/or coinsurance*, and *you* may also be responsible to pay any amount over the *maximum allowable fee for covered expenses* 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.

Refer to the "Schedule of Benefits" sections to see what *your network provider* and *non-network provider* benefits are.

202300GA 01/23

How to find a network provider

You may find a list of *network providers* at [Humana.com](https://www.humana.com). This list is subject to change and may be updated at least every 30 days. 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*.

202400GA 01/16

How to use your preferred provider organization (PPO) plan

You may receive services from a *network provider* or a *non-network provider* without a referral. Refer to the "Schedule of Benefits" for any *preauthorization* requirements.

202610 01/16

Continuity of care

You may be eligible to elect continuity of care if a *qualified provider* is listed as a *network provider* on Humana.com when *you* elect coverage under this plan during the *open enrollment period* and such *qualified provider* becomes a *non-network provider* subsequent to the *open enrollment period* in the succeeding year. *You* will only be responsible to pay the *non-network provider* the *network provider copayment, deductible and/or coinsurance for covered expenses* until the earlier of:

- 180 days from the *qualified provider's* termination as a *network provider*; or
- The last day of the current year.

You may also 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*;

UNDERSTANDING YOUR COVERAGE (continued)

- 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 *policy* 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 *policy* 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 *policy* remains in effect.

UNDERSTANDING YOUR COVERAGE (continued)

All terms and provisions of the *policy* are applicable to this "Continuity of care" provision.
202625GA 01/23

Seeking emergency care

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

You, or someone on your behalf, must call us within 48 hours after your admission to a 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.
202620 01/22

Seeking urgent care

If you need *urgent care*, 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.
202650 01/23

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 *policy* 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*. Call our customer service department at the telephone number listed on your ID card if you have any questions.
202700 01/16

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 specialist;

UNDERSTANDING YOUR COVERAGE (continued)

- *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 procedure or a discount from their normal charges.

202800 01/19

The certificate

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

203100 11/12

SAMPLE

COVERED EXPENSES

This "Covered Expenses" section describes the services that will be considered *covered expenses* under the *policy* for *preventive services* and medical services for a *bodily injury* or *sickness*. Benefits will be paid as specified in the "How your policy works" provision in the "Understanding Your Coverage" section and as shown on the "Schedules of Benefits," subject to any applicable:

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

Refer to the "Limitations and Exclusions" section listed in this *certificate*. All terms and provisions of the *policy* apply.

204000 01/23

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. *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).
- 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.

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.

204200GA 01/23

Child health supervision benefit

For a covered *dependent* child, benefits are payable for the periodic review of such child's physical and emotional health from birth through five years of age. *Covered expenses* for each visit shall include the following services in keeping with prevailing medical standards:

- A medical history;
- Physical examination;
- Developmental assessment and anticipatory guidance;
- Appropriate immunizations and laboratory tests;
- Hearing screenings; and
- Vision screenings.

COVERED EXPENSES (continued)

Benefits are limited to the above services provided by or under the supervision of one *health care practitioner* during the course of one visit. Benefits do not include periodic dental examinations or other dental services. The *deductible*, if any, does not apply.

204250GA 02/11

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 care.
- Home and office visits for diabetes.
- Diagnostic laboratory and radiology.
- Allergy testing.
- Allergy serum.
- Allergy injections.
- Injections other than allergy.
- *Surgery*, including anesthesia.
- Second surgical opinions.

204400 01/23

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 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*.

204425 01/21

COVERED EXPENSES (continued)

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*.

204450 01/16

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* are limited to the *maximum allowable fee* charged for a semi-private room in the *hospital* while *confined*.
- Services and supplies, other than *room and board*, provided by a *hospital* while *confined*.
- *Hospital* services for *inpatient* care for an appropriate length of stay as determined by a *health care practitioner* for a *covered person*, who is receiving benefits in connection with a mastectomy or lymph node dissection.

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*.

COVERED EXPENSES (continued)

- 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.

COVERED EXPENSES (continued)

Hospital outpatient advanced imaging

We will pay benefits for *covered expenses* incurred by you for *outpatient advanced imaging* in a *hospital's outpatient* department.
205450GA 01/23

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 and 96 hours following an uncomplicated cesarean section. If an earlier discharge is consistent with the most current protocols and guidelines of the American College of Obstetricians and Gynecologists or the American Academy of Pediatrics and is consented to by the mother and the attending *health care practitioner*, a post-discharge office visit to the *health care practitioner* or a home health care visit within the first 48 hours after discharge is also covered, subject to the terms of this *certificate*.
 - If a mother and newborn are discharged prior to the above lengths of stay, coverage shall be provided for up to two follow-up visits, provided that the first such visit shall occur within 48 hours of discharge. Such visits shall be conducted by a physician, a physician's assistant, or a registered nurse with experience and training in maternal and child health nursing. After conferring with the mother, the *health care provider* shall determine whether the initial visit will be conducted at home or at the office. Thereafter, he or she shall confer with the mother and determine whether a second visit is appropriate and where it shall be conducted. Services include but are not limited to: physician assessment of the newborn, parent education, assistance of the home support system, and the performance of any medically necessary and appropriate clinical tests. Such services shall be consistent with protocols and guidelines developed by national pediatric, obstetric, and nursing professional organizations for these services.
- For a newborn, *hospital confinement* during the first 48 hours or 96 hours following birth, as applicable and listed above for:
 - *Hospital* charges for routine nursery care;
 - The *health care practitioner's* charges for circumcision of the newborn child; and
 - The *health care practitioner's* charges for routine examination of the newborn before release from the *hospital*.
- If the covered newborn must remain in the *hospital* past the mother's *confinement*, services and supplies received for:
 - A *bodily injury* or *sickness*;
 - Care and treatment for premature birth; and
 - Medically diagnosed birth defects and abnormalities.

COVERED EXPENSES (continued)

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.

205500GA 01/22

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." You will only be responsible to pay the *network provider copayment*, *deductible* and/or *coinsurance* to the *non-network provider*.

Benefits under this "Emergency services" provision are not available if the services provided do not meet the definition of *emergency medical condition*.

205700GA 01/23

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, as specified in the "Ambulance services" benefit in the "Schedule of Benefits." You may be required to pay the *non-network provider* any amount not paid by us, as follows:

- For *ambulance* services, 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*; and
- 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*.

205750GA 01/23

COVERED EXPENSES (continued)

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.

205800 01/22

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 or maintenance is not a result of misuse or abuse; 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

COVERED EXPENSES (continued)

- Replacement is not due to lost or stolen equipment, or misuse or abuse of the equipment; or
- Replacement is required due to a change in *your* condition that makes the current equipment non-functional.

205900 01/20

Hearing aid devices and services

We will pay benefits for *covered expenses* incurred by *covered persons* under the age of 19 who have a hearing loss that has been verified by a *health care practitioner* and a licensed audiologist. Coverage will include one *hearing aid* per hearing impaired ear every 48-months not to exceed \$3,000.00 per *hearing aid*.

Covered expenses include the following:

- Initial *hearing aid* evaluation;
- Fitting, dispensing, programming, servicing, repairs;
- Follow-up maintenance, adjustments, ear molds, ear mold impressions; and
- Auditory training, and probe microphone measurements to ensure appropriate gain and output, as well as verifying benefit from the system selected according to acceptable professional standards.

In the event that a *hearing aid* can no longer adequately meet the needs of the *covered person* and the *hearing aid* can no longer be adequately repaired or adjusted, the *hearing aid* shall be replaced.

206230GA 01/19

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*.

206250 01/21

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*.

COVERED EXPENSES (continued)

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

Home health care *covered expenses* are limited to:

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

206300 01/21

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 *policy*.

Hospice care benefits are payable as shown in the "Schedule of Benefits" for the following hospice services:

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

COVERED EXPENSES (continued)

- Psychological and dietary counseling;
- Physical therapy;
- Part-time home health aide services for up to eight hours in any one day; and
- Medical supplies, drugs and medicines for *palliative care*.

Hospice care *covered expenses* do not include:

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

206400 01/23

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.

The following are *covered expenses*:

- A single examination including a history, physical examination, muscle testing, range of motion measurements, and psychological evaluation, as necessary;
- 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;
- Diagnostic therapeutic masticatory muscle and temporomandibular joint injections;
- Appliance therapy utilizing an appliance, that does not permanently alter tooth position, jaw position or bite. Benefits for reversible appliance therapy will be based on the *maximum allowable fee* for use of a single appliance, regardless of the number of appliances used in treatment. The benefit for the appliance therapy will include an allowance for all jaw relation and position diagnostic services, office visits, adjustments, training, repair, and replacement of the appliance; and
- Surgical procedures.

Covered expenses do not include charges for:

- Occlusal analysis;
- Any irreversible procedure, including, but not limited to: orthodontics, occlusal adjustment, crowns, onlays, fixed or removable partial dentures, and full dentures; or
- Any procedure not specifically listed as a *covered expense*.

206500GA 01/22

COVERED EXPENSES (continued)

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;
- Spinal manipulations/adjustments;
- Speech therapy or speech pathology services;
- Audiology services;
- Cognitive rehabilitation services;
- Respiratory or pulmonary rehabilitation services; and
- Cardiac rehabilitation services.

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

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* for a *covered person* with a *congenital anomaly*, developmental delay or defect:

- Physical therapy services;
- Occupational therapy services;
- Spinal manipulations/adjustments on an *inpatient* or *outpatient* basis;
- Speech therapy or speech pathology services; and
- Audiology services.

The "Schedule of Benefits" shows the maximum number of visits for *habilitative services*, if any.
206600 01/22

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" shows the maximum length of time for which we will pay benefits for charges made by a *skilled nursing facility*, if any.
206800 01/22

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 (continued)

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.

206810 01/17

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" 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 "Covered Expenses – 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.

206820 01/22

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 (continued)

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 *policy*.

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

COVERED EXPENSES (continued)

- 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" 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 *policy* are applicable.

206850

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*.

206900 01/21

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.
- Prosthetic devices and supplies, including but not limited to limbs and eyes. Coverage will be provided for prosthetic devices to:
 - Restore the previous level of function lost as a result of a *bodily injury* or *sickness*; or
 - Improve function caused by a *congenital anomaly*.

Covered expense for prosthetic devices includes repair or replacement, if not covered by the manufacturer, and if due to:

- A change in the *covered person's* physical condition causing the device to become non-functional; or
- Normal wear and tear.
- Cochlear implants, when approved by *us*, for a *covered person* with bilateral severe to profound sensorineural deafness.

COVERED EXPENSES (continued)

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;

COVERED EXPENSES (continued)

- 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.
 - 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.
- Enteral formulas, nutritional supplements and low protein modified foods for use at home by a *covered person* that are prescribed or ordered by a *health care practitioner* and are for the treatment of an inherited metabolic disease, e.g. phenylketonuria (PKU).
- 207000GA 01/23
- *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.
 - *Diabetes self-management training*.

COVERED EXPENSES (continued)

- 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.

- *Medically necessary outpatient* self-management training, including medical nutrition therapy, when prescribed by a *health care practitioner*, for the treatment of:

- Insulin-dependent diabetes;
- Insulin-using diabetes;
- Gestational diabetes; or
- Non insulin-using diabetes.

Outpatient self-management training and education must be provided by a certified, registered, or licensed *health care practitioner*, which has expertise in diabetes. *Covered expenses* for *outpatient* self-management training and education will conform to current standards established by the American Diabetes Association.

207005GA 01/23

- Scientifically proven bone density testing for the prevention, diagnosis, and treatment of osteoporosis for *covered persons*, who are qualified individuals. A qualified individual means a *covered person*, who is an:
 - Estrogen-deficient woman or individual at clinical risk of osteoporosis as determined directly or indirectly by a *health care practitioner*, and who is considering treatment;
 - Individual with osteoporotic vertebral abnormalities;

COVERED EXPENSES (continued)

- Individual with primary hyperparathyroidism; or
- Individual receiving long-term glucocorticoid therapy;
- Individual being monitored directly or indirectly by a *health care practitioner* to assess the response to or efficacy of approved osteoporosis drug therapies.

207010GA 01/16

- General anesthesia and associated services from a *hospital, free-standing facility, or health care treatment facility* in conjunction with dental care provided by a *health care practitioner* when any of the following are met:
 - A *covered person* is a *dependent* child seven years of age or younger;
 - A *covered person* is developmentally disabled;
 - A successful result cannot be expected from dental care provided under local anesthesia because of a neurological or other medically compromising condition; or
 - A *covered person* has sustained extensive facial or dental trauma.

207015GA

- Contraceptive implant systems and devices approved by the United States Food and Drug Administration for contraceptive purposes.

207020GA

COVERED EXPENSES - PEDIATRIC DENTAL

This "Covered Expenses – Pediatric Dental" section describes the services that will be considered *covered expenses* for *pediatric dental services* under the *policy*. Benefits for *pediatric dental services* will be paid on a *reimbursement limit* basis and as shown in the "Schedule of Benefits – 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 and Exclusions" section of this *certificate* for *pediatric dental services* not covered by the *policy*. All terms and provisions of the *policy* apply.

207100 01/19

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 "Covered Expenses – Pediatric Dental" and the "Schedule of Benefits – Pediatric Dental" sections means a person, who is eligible and enrolled for benefits provided under the *policy* up to the end of the month following the date he or she attains age 19.

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.

COVERED EXPENSES - PEDIATRIC DENTAL (continued)

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 the services;
- The fee most often charged in the geographical area where the service was performed;
- The 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 and 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.

COVERED EXPENSES - PEDIATRIC DENTAL (continued)

The bill *you* receive for services provided by *non-network providers* may be significantly higher than the *reimbursement limit*. In addition to the *deductible*, *copayments* and *coinsurance*, *you* are responsible for the difference between the *reimbursement limit* and the amount the provider bills *you* for the services. Any amount *you* pay to the provider in excess of the *reimbursement limit* will not apply to *your deductible* or *out-of-pocket limit*.

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*.

207125 01/19

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. If the total cost of periapical and bitewing x-rays exceeds the cost of a complete series of x-rays, we will consider these as a complete series.
- Bitewing x-rays. Limited to 2 sets per year.

COVERED EXPENSES - PEDIATRIC DENTAL (continued)

- Other x-rays, including intra-oral periapical and occlusal and extra-oral x-rays. Limited to x-rays necessary to diagnose a specific treatment.
- 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 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.
207160 01/19

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.
 - Recementing of inlays, onlays, crowns and bridges.
- 207175 01/18

COVERED EXPENSES - PEDIATRIC DENTAL (continued)

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, crowns, veneers, core build-ups and posts, implant supported crowns and abutments. 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, crowns 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.
- 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:
 - Retreatment of previous root canal therapy. Any test, intraoperative x-rays, laboratory or any other follow-up care is considered integral to root canal therapy.

COVERED EXPENSES - PEDIATRIC DENTAL (continued)

- Root canal retreatment, including root canal treatments and root canal fillings for permanent and primary teeth. 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, onlays, and crowns. Limited to 1 per tooth every 5 years.
 - 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 and provisional implant crown. 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.

COVERED EXPENSES - PEDIATRIC DENTAL (continued)

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.

207180 01/19

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.

207200 01/18

COVERED EXPENSES - PEDIATRIC DENTAL (continued)

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.

207225 01/17

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*.

207250 01/17

COVERED EXPENSES - PEDIATRIC DENTAL (continued)

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*.

207275 01/17

Limitations and exclusions

Refer to the "Limitations and Exclusions" 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 *policy*.
 - By an employee of any *covered person* covered by the *policy*.

For the purposes of this exclusion, *covered person* means the *employee* and/or the *employee's dependents* enrolled for benefits under the *policy* and as defined in the "Glossary" 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;

COVERED EXPENSES - PEDIATRIC DENTAL (continued)

- 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.
- 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 apexogenesis;
 - Vital pulpotomy; or
 - Pulp debridement or pulpal therapy.

207300 01/19

COVERED EXPENSES - PEDIATRIC VISION CARE

This "Covered Expenses – Pediatric Vision Care" section describes the services that will be considered *covered expenses* for *pediatric vision care* under the *policy*. Benefits for *pediatric vision care* will be paid on a *reimbursement limit* basis and as shown in the "Schedule of Benefits – 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 the *certificate*, unless otherwise specifically defined in this benefit. Refer to the "Limitations and exclusions" provision in this section and the "Limitations and Exclusions" section of this *certificate* for *pediatric vision care* expenses not covered by the *policy*. All terms and provisions of the *policy* apply.

207500 01/19

Definitions

The following terms are specific to *pediatric vision care* benefits:

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 "Covered Expenses – Pediatric Vision Care" section and the "Schedule of Benefits – Pediatric Vision Care" section means a person who is eligible and enrolled for benefits provided under the *policy* up to the end of the month following the date he or she attains age 19.

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 is the maximum fee allowed for *pediatric vision care*. *Reimbursement limit* for *pediatric vision care* is the lesser of:

- The actual cost for covered services or *materials*;
- The fee most often charged in the geographical area where the service was performed or *materials* provided;

COVERED EXPENSES - PEDIATRIC VISION CARE

(continued)

- 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.

The bill *you* receive for services provided by, or *materials* obtained from *non-network providers* may be significantly higher than the *reimbursement limit*. In addition to *deductibles*, *copayments* and *coinsurance*, *you* are responsible for the difference between the *reimbursement limit* and the amount the provider bills *you* for the *services* or *materials*. Any amount *you* pay to the provider in excess of the *reimbursement limit* will not apply to *your deductible* or *out-of-pocket limit*.

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.

207550 01/23

Pediatric vision care benefit

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

- *Comprehensive eye exam*.

COVERED EXPENSES - PEDIATRIC VISION CARE (continued)

- Prescription lenses and standard lens options, including polycarbonate, scratch coating, ultraviolet-coating, blended lenses, intermediate lenses, progressive lenses, photochromatic lenses, polarized lenses, fashion and gradient tinting, oversized lenses, glass-grey prescription sunglass lenses, anti-reflective coating, and hi-index lenses. If a *covered person* sees a *network provider*, the *network provider of materials* will show the *covered person* the selection of lens options covered by the *policy*. If a *covered person* selects a lens option that is not included in the lens option selection the *policy* covers, the *covered person* is responsible for the difference in cost between the *network provider of materials* reimbursement amount for covered 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 *policy*. If a *covered person* selects a frame that is not included in the frame selection the *policy* 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 *policy*. If a *covered person* selects a contact lens that is not part of the contact lens selection the *policy* 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 *policy* 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 mopia;
 - Aniseikonia;
 - Aniridia;
 - Corneal disorders;
 - Post-traumatic disorders; or
 - Irregular astigmatism.
- *Low vision* services includes 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.

207600GA 01/23

COVERED EXPENSES - PEDIATRIC VISION CARE

(continued)

Limitations and exclusions

In addition to the "Limitations and Exclusions" section of this *certificate* and any limitations specified in the "Schedule of Benefits – 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 *policy*, shown in the "Schedule of Benefits – Pediatric Vision Care" or in the "Schedule of Benefits" of this *certificate*.
- *Materials* covered by the *policy* that are lost, stolen, broken, or damaged will only be replaced at normal intervals as specified in the "Schedule of Benefits – Pediatric Vision Care".

207625 01/18

Refer to the "Limitations and Exclusions" 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 – 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.

207650 01/17

COVERED EXPENSES - CLINICAL TRIALS

Definitions

The following are definitions of terms as they are used in this provision:

100020GA 09/09

Cancer screenings and examinations means screenings and examinations for cancer in accordance with the most recently published guidelines and recommendations established by any of the following:

- American College of Physicians;
- American College of Obstetricians and Gynecologists; or
- American Academy of Pediatricians.

100030GA

Qualified clinical trial means a trial that must be a trial that is approved by one of the following:

- A Cooperative Group or one of the National Institutes of Health;
- The United States Food and Drug Administration, in the form of an investigational new drug application;
- The United States Department of Defense;
- The United States Veterans' Administration;
- The National Cancer Institute; or
- An Institutional Review Board of any accredited school of medicine, nursing or pharmacy in the State of Georgia.

100040GA

Routine patient care costs means those costs associated with the provision of health care services, including drugs, items, devices and services that would otherwise be covered under the *policy* if those drugs, items, devices and services were not provided in connection with an approved *qualified clinical trial* program, including the following:

- Health care services includes routine care that would otherwise be a *covered expense* if the *covered person* were not participating in *qualified clinical trial*;
- Health care services required solely for the provision of the investigational drug, item, device or service;
- Health care services required for the clinically appropriate monitoring of the investigational item or service;
- Health care services provided for the prevention of complications arising from the provision of the investigational drug, item, device or service; and
- Health care services needed for the reasonable and necessary care arising from the provision of the investigational drug, item, device, or service, including the diagnosis or treatment of the complications.

Routine patient care costs do not include the costs associated with the provision of any of the following:

COVERED EXPENSES - CLINICAL TRIALS (continued)

- Drugs that are *experimental, investigational* or for research purposes and devices that have not been approved by the United States Food and Drug Administration associated with the *qualified clinical trial*;
- Services other than health care services, such as travel, housing, companion expenses, and other non-clinical expenses, that *you* may require as a result of the treatment being provided for purposes of the *qualified clinical trial*. Reimbursement for travel and lodging accommodations is only applicable when it is otherwise available as a benefit in the *certificate*.
- Any item or service that is provided solely to satisfy data collection and analysis that is not directly used in the clinical management of the *covered person*;
- Health care services which, except for the fact they are not being provided in a *qualified clinical trial*, are otherwise specifically excluded from coverage under this *policy*;
- Health care services which are inconsistent with widely accepted and established standards of care or diagnosis; or
- Health care services customarily provided by the research sponsors free of charge for any enrollee in the trial.

100050GA 11/12

Participation in a qualified clinical trial

Notwithstanding any exclusion or provision in the *policy*, we will pay benefits for *routine patient care costs* for *you* if *you* are eligible to participate according to the trial protocol and:

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

100055GA 11/12

Qualified clinical trials routine patient care costs benefit

Notwithstanding any exclusion or provision in the *policy*, we will pay benefits for *routine patient care costs* for *you* if *you* are:

- A Georgia resident covered by *us*;
- Diagnosed with cancer; and
- Accepted into a Phase I, Phase II, Phase III or Phase IV *qualified clinical trial* for cancer or a life threatening condition.

Covered expenses for *routine patient care costs* associated with a *qualified clinical trial* will be covered the same as for any other *sickness*.

COVERED EXPENSES - CLINICAL TRIALS (continued)

The *routine patient care costs* benefit for a *qualified clinical trial* as stated in this provision is not covered, and will not be duplicated, under any provision of the *policy*.

100060GA 11/12

Cancer screenings and examinations benefit

Notwithstanding any exclusion or provision in the *policy*, we will pay benefits for *cancer screenings and examinations*.

Covered expenses for *cancer screenings and examinations* will be covered the same as *sickness*.

The *cancer screenings and examinations* benefit as stated in this provision is not covered, and will not be duplicated, under any provision of the *policy*.

100070GA 09/09

SAMPLE

COVERED EXPENSES - BEHAVIORAL HEALTH

This "Covered Expenses – Behavioral Health" section describes the services that will be considered *covered expenses* for *mental health services* and *chemical dependency services* under the *policy*. Benefits will be paid as specified in the "How your policy works" provision of the "Understanding Your Coverage" section and as shown in the "Schedule of Benefits – Behavioral Health." Refer to the "Schedule of Benefits" for any service not specifically listed in the "Schedule of Benefits – Behavioral Health." Benefits are subject to any applicable:

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

Refer to the "Limitations and Exclusions" section listed in this *certificate*. All terms and provisions of the *policy* apply.

208000GA 01/23

Acute inpatient services

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

208100 01/16

Acute inpatient health care practitioner services

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

208470 01/20

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" or "Schedule of Benefits – Behavioral Health" sections of this *certificate*. You will only be responsible to pay the *network provider copayment*, *deductible* and/or *coinsurance* to the *non-network provider*.

Benefits under this "Emergency services" provision are not available if the services provided do not meet the definition of *emergency medical condition*.

208425GA 01/23

COVERED EXPENSES - BEHAVIORAL HEALTH (continued)

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 *mental health services* and *chemical dependency services*.

208450 01/21

Outpatient services

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

208500 01/23

Skilled nursing facility services

We will pay benefits for *covered expenses* incurred by you in a *skilled nursing facility* for *mental health services* and *chemical dependency 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*.

208525 01/20

Home health care services

We will pay benefits for *covered expenses* incurred by you, in connection with a *home health care plan*, for *mental health services* and *chemical dependency 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 mileage or travel time to and from the *covered person's* home;
- Wage or shift differentials for any representative of a *home health care agency*;
- Charges for supervision of *home health care agencies*;
- Charges for services of a home health aide;
- *Custodial care*; or
- The provision or administration of *self-administered injectable drugs*, unless otherwise determined by us.

208550 01/20

COVERED EXPENSES - BEHAVIORAL HEALTH (continued)

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" 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 "Covered Expenses – 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.
208600 01/23

Residential treatment facility services

We will pay benefits for *covered expenses* incurred by you for *mental health services* and *chemical dependency* services provided while *inpatient* or *outpatient* in a *residential treatment facility*.
208650 01/19

COVERED EXPENSES - PHARMACY SERVICES

This "Covered Expenses – Pharmacy Services" section describes *covered expenses* under the *policy* for *prescription* drugs, including *specialty drugs*, dispensed by a *pharmacy*. Benefits are subject to applicable *cost share* shown on the "Schedule of Benefits – Pharmacy Services" section of this *certificate*.

Refer to the "Limitations and Exclusions," "Limitations and Exclusions – Pharmacy Services," "Glossary" and "Glossary – Pharmacy Services" sections in this *certificate*. All terms and provisions of the *policy* apply, including *prior authorization* requirements specified in the "Schedule of Benefits – Pharmacy Services" of this *certificate*.

Coverage description

We will cover *prescription* drugs that are received by you under this "Covered Expenses – 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).
- Enteral formulas and nutritional supplements for the treatment of phenylketonuria (PKU) or other inherited metabolic disease, or as otherwise determined by *us*.
- 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*.

Notwithstanding any other provisions of the *policy*, 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.

COVERED EXPENSES - PHARMACY SERVICES (continued)

Prescription drug coverage restrictions

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

- By restricting your *pharmacy* services to a single *network pharmacy* store or physical location of your choice;
- By restricting your *specialty pharmacy* services to a specific *specialty pharmacy* of your choice, 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 all of your *prescriptions* to be prescribed by a specific *network health care practitioner* of your choice.

When we determine it is necessary to restrict your *pharmacy* services, only *prescriptions* obtained from the specific *network pharmacy* store or physical location or *specialty pharmacy* will be eligible to be considered *covered expenses*. Additionally, only *prescriptions* prescribed by the specific *network health care practitioner* 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.

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.

COVERED EXPENSES - PHARMACY SERVICES (continued)

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.

COVERED EXPENSES - PHARMACY SERVICES (continued)

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*.
210900GA 01/23

COVERED EXPENSES - PHARMACY SERVICES (continued)

Step therapy exception request

Your health care practitioner may submit to us a written step therapy exception request for a clinically appropriate prescription drug. The health care practitioner should use the prior authorization form on our website at www.humana.com or call the customer service telephone number on your ID card.

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.
- 2 business days for a standard request.

A written *step therapy* exception request will be approved when the request includes the prescribing *health care practitioner's* written statement and supporting documentation that:

- The *prescription* drug requiring *step therapy* is contraindicated or will cause an adverse reaction or physical or mental harm to *you*;
- The *prescription* drug requiring *step therapy* has been ineffective in the treatment of *your* disease or medical condition;
- *You* previously discontinued taking the *prescription* drug required under *step therapy*, or another *prescription* drug in the same pharmacologic class or with the same mechanism of action as the required drug, while under the *policy* currently in force or while covered under another *policy*, because the *prescription* drug was not effective or had a diminished effect, or because of an adverse event; or
- *You* are stable on a previously prescribed *prescription* drug selected by *your health care practitioner* for the medical condition under consideration.

A *step therapy* exception request will be considered granted if *we* do not deny a *step therapy* exception request within:

- 24 hours after receipt of an expedited *step therapy* exception request.
- 2 business days after receipt of a standard *step therapy* exception request.

If *we* deny a *step therapy* exception request, *we* will provide *you* or *your* appointed representative, and *your* prescribing *health care practitioner*:

- The reason for the denial;
- An alternative covered medication; and
- The right to appeal *our* decision as described in the "Grievance Procedures" section of this certificate.

211000GA 01/23

LIMITATIONS AND EXCLUSIONS

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*.

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 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.
211600 01/19
- 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 insurance.
- Any portion of the amount *we* determine *you* owe for a service 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. This does not include *Medicaid* benefits.
- Any service not ordered by a *health care practitioner*.
212000GA 01/21
- Private duty nursing.
- 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.

LIMITATIONS AND EXCLUSIONS (continued)

- Any amount billed for a professional component of an automated:
 - Laboratory service; or
 - Pathology service.
- Expenses for services, *prescriptions*, equipment, or supplies received outside the United States or from a foreign provider, unless:
 - For *emergency care*;
 - The *employee* is traveling outside the United States due to employment with the *employer* sponsoring the *policy* and the services are not covered under any Workers' Compensation or similar law; or
 - The *employee* and *dependents* live outside the United States and the *employee* is in *active status* with the *employer* sponsoring the *policy*.
- 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.

212600 01/22

- Services provided by a *covered person's family member*.
- *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 enteral formulas, nutritional supplements or low protein modified food products for the treatment of an inherited metabolic disease, e.g. phenylketonuria (PKU).
- Over-the-counter, non-prescription medications, 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*.

213250 01/23

- Growth hormones, except as otherwise specified in the pharmacy services sections of this *certificate*.

LIMITATIONS AND EXCLUSIONS (continued)

- *Prescription drugs and self-administered injectable drugs*, except as specified in the "Covered Expenses – Pharmacy Services" section in this *certificate* or unless administered to *you*:
 - While an *inpatient* in a *hospital*, *skilled nursing facility*, *health care treatment facility*, or *residential treatment facility*;
 - By the following, when deemed appropriate by *us*:
 - A *health care practitioner*:
 - During an office visit; or
 - While an *outpatient*; or
 - A *home health care agency* as part of a covered *home health care plan*.
- 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 "Covered Expenses - Pharmacy Services" section of this *certificate*.
213700GA 01/23
- Hearing aids, the fitting of hearing aids or advice on their care; implantable hearing devices, except for *hearing aids* for *covered persons* under the age of 19 and cochlear implants as otherwise stated in this *certificate*.
- Services received in an emergency room, unless required because of *emergency care*.
- 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*.
- *Infertility services*; or reversal of elective sterilization.
- In vitro fertilization regardless of the reason for treatment.
214100GA 01/20
- 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 *policy*.

LIMITATIONS AND EXCLUSIONS (continued)

- 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 *policy*.
- 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.
- *Cosmetic surgery* and cosmetic services or devices.
- Hair prosthesis, hair transplants or implants and wigs.
214400 01/22
- 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;
 - 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

LIMITATIONS AND EXCLUSIONS (continued)

- 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).

214900 01/23

- 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*.
- 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 system, 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 or transportation.

215300 01/22

LIMITATIONS AND EXCLUSIONS (continued)

- Communications or travel time.
- Bariatric *surgery*, any services or complications related to bariatric *surgery*, and other weight loss products or services.
- 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.
- *Alternative medicine.*
215800GA 01/22
- 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 "Covered Expenses – 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 "Covered Expenses – Pediatric Vision Care" section in this *certificate*.
- *216300 01/16*
- Services and supplies which are:
 - Rendered in connection with mental illnesses not classified in the International Classification of Diseases of the U.S. Department of Health and Human Services; or
 - Extended beyond the period necessary for evaluation and diagnosis of learning and behavioral disabilities or for mental retardation.
- Marriage counseling.

LIMITATIONS AND EXCLUSIONS (continued)

- Expenses for:
 - Employment;
 - School;
 - Sports;
 - Camp;
 - Travel; or
 - The purposes of obtaining insurance.
- Expenses for care and treatment of non-covered procedures or services.
216650GA 01/23
- 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 *policy*.
- *Pre-surgical/procedural testing duplicated during a hospital confinement.*
216880GA 01/16

LIMITATIONS AND EXCLUSIONS - PHARMACY SERVICES

This "Limitations and Exclusions – Pharmacy Services" section describes the limitations and exclusions under the *policy* that apply to *prescription* drugs, including *specialty drugs*, dispensed by a *pharmacy*. Please refer to the "Limitations and Exclusions" 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 *policy*.
- 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*, unless the drug is considered an anti-cancer drug that has been found to be safe and effective in formal clinical studies.

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

LIMITATIONS AND EXCLUSIONS - PHARMACY SERVICES

(continued)

- Dietary supplements and nutritional products, except enteral formulas and nutritional supplements for the treatment of phenylketonuria (PKU) or other inherited metabolic disease. Refer to the "Covered Expenses" section of the *certificate* for coverage of low protein modified foods.
- 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).
- *Infertility services* including medications.
- Any drug prescribed for impotence and/or sexual dysfunction.
- 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*.

LIMITATIONS AND EXCLUSIONS - PHARMACY SERVICES

(continued)

- 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* (except for immunizations consistent with the American Academy of Pediatrics immunization schedule) 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 with the exception of prescription inhalents used in the treatment of asthma or other life threatening bronchial ailments 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.
- Any portion of a *prescription* fill or refill with the exception of prescription inhalents used in the treatment of asthma or other life threatening bronchial ailments 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.
- Any portion of a *specialty drug prescription* fill or refill with the exception of prescription inhalents used in the treatment of asthma or other life threatening bronchial ailments 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*; or
 - Exceeds the duration-specific *dispensing limit*.

LIMITATIONS AND EXCLUSIONS - PHARMACY SERVICES (continued)

- Any drug for which *we* require *prior authorization* or *step therapy* and it is not obtained.
- 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*.

216900GA 01/19

ELIGIBILITY AND EFFECTIVE DATES

Eligibility date

Employee eligibility date

The *employee* 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 *policyholder* and *us*; and
 - The *employee* is in an *active status*.
- 217000 01/19

Dependent eligibility date

Each *dependent* is eligible for coverage on:

- The date the *employee* is eligible for coverage, if he or she has *dependents* who may be covered on that date;
- The date of the *employee's* marriage for any *dependents* (spouse or child) acquired on that date;
- The date of birth of the *employee's* natural-born child;
- The date of placement of the child for the purpose of adoption by the *employee*, or the date the child is legally adopted by the *employee*, whichever occurs first; or
- The date the power of attorney is signed and notarized, that authorizes grandparents and great grandparents the authority to act on behalf of a dependent grandchild until a copy of a revocation of the power of attorney is received; 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.

217100GA 01/16

Enrollment

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

217150 04/09

Employee enrollment

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

ELIGIBILITY AND EFFECTIVE DATES (continued)

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.

217200 01/18

Dependent enrollment

If electing *dependent* coverage, the *employee* must enroll eligible *dependents*, as agreed to by the *policyholder* 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.

217300 01/18

Newborn and adopted dependent enrollment

A newborn *dependent* will be automatically covered from the date of birth to 31 days of age. An adopted *dependent* will be automatically covered from the date of adoption or placement of the child in the home with the *employee* for the purpose of adoption, whichever occurs first, for 31 days. The *employee* must notify *us* of the birth or adoption within 31 days after the date of birth or adoption.

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 with the *employee* 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.

ELIGIBILITY AND EFFECTIVE DATES (continued)

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 with the *employee* 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 with the *employee* 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.

217400GA 01/16

Special enrollment

Special enrollment is available if the following apply:

- You have a change in family status due to:
 - Marriage;
 - 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 with the *employee* for the purpose of adoption; and
 - You enroll within 31 days after the *special enrollment date*; or
- You are an *employee* or *dependent* eligible for coverage under the *policy*, 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 or death of a spouse;
- Loss of dependent eligibility, such as attainment of the limiting age;
- Termination of your employer's contribution for the coverage;

ELIGIBILITY AND EFFECTIVE DATES (continued)

- 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;
- 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 *policy*; and
 - You enroll within 31 days after the *special enrollment date*; or
- You are an *employee* or *dependent* eligible for coverage under the *policy*, 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 *policy*, and:
 - You become eligible for a premium assistance subsidy under *Medicaid* or CHIP; and
 - You enroll within 60 days after the *special enrollment date*.

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*.
217500GA 01/19

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 policy* or added to the *policy*, 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 *policy* 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*.
217600 04/09

ELIGIBILITY AND EFFECTIVE DATES (continued)

Open enrollment

Eligible *employees* or *dependents*, who do not enroll for coverage under the *policy* 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.

217620 01/16

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.

217650 04/09

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*.

217700 01/19

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.

219800 01/16

ELIGIBILITY AND EFFECTIVE DATES (continued)

Newborn and adopted dependent effective date

The effective date of coverage for a newborn *dependent* is the date of birth if the newborn is not a *late applicant*.

The *effective date* of coverage for an adopted *dependent* is the date of adoption or the date of placement in the home with the *employee* for the purpose of adoption, whichever occurs first, if the *dependent* child is not a *late applicant*.

Premium is due for any period of *dependent* coverage whether or not the *dependent* is subsequently enrolled, unless specifically not allowed by applicable law. Additional premium may not be required when *dependent* coverage is already in force.

219900GA 01/16

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 *policy* year as agreed to by the *policyholder* and *us*.

219950 04/09

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 insured under the *policy* 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.

220100 01/19

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.

220200 04/09

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.

220300 04/09

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 *policy* and:

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

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

221000GA 01/20

Deductible credit

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

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

221200 01/20

Waiting period credit

If the *employee* had not completed the initial *waiting period* under the *policyholder'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 *policy*, if any. The *employee* will then be eligible for coverage under the *policy* when the balance of the *waiting period* has been satisfied.

221300

Out-of-pocket limit

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

221400 01/20

TERMINATION PROVISIONS

Termination of insurance

The date of termination, as described in this "Termination Provisions" section, may be the actual date specified or the end of that month, as selected by *your employer* on the Employer Group Application (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 *policy*. Notice must be provided to *us* within 31 days of the change.

When *we* receive notification of a change in eligibility status in advance of the effective date of the change, insurance 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.

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 pass the requested termination date.

222000 01/17

Otherwise, insurance terminates on the earliest of the following:

- The date the *group policy* terminates;
- The end of the period for which required premium was paid to *us*;
- The date the *employee* terminated employment with the *employer*;
- The date the *employee* is no longer qualified as an *employee*;
- The date *you* fail to be in an eligible class of persons as stated in the EGA;
- The date the *employee* entered full-time military, naval or air service;
- 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 in writing or electronically for termination of insurance for the *employee* or *dependents*;
- For a *dependent*, the date the *employee's* insurance terminates;
- For a *dependent*, the date the *employee* ceases to be in a class of *employees* eligible for *dependent* insurance;
- The date *your dependent* no longer qualifies as a *dependent*;
- For any benefit, the date the benefit is deleted from the *policy*; or

TERMINATION PROVISIONS (continued)

- The date fraud or an intentional misrepresentation of a material misrepresentation is committed by *you*. For more information on fraud and intentional misrepresentation, refer to the "Fraud" provision in the "Miscellaneous Provisions" section of this *certificate*.

222100GA 01/17

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

222300 01/22

EXTENSION OF BENEFITS

Extension of coverage for total disability

We extend limited health insurance benefits if:

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

223000 01/18

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

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

223100GA 01/16

CONTINUATION

Continuation options in the event of termination

If health insurance terminates:

- It may be continued as described in the "State continuation of health insurance" or the "State continuation of health insurance after age 60" provision; or
- It may be continued under the continuation provisions as provided by the Consolidated Omnibus Budget Reconciliation Act (COBRA), if applicable.

A complete description of the "State continuation of health insurance" is below, and a complete description of the "State continuation of health insurance after age 60" in the Continuation after age 60 provision follows.

224000GA

State continuation of health insurance

Upon payment of premium, *you* may continue medical coverage for *you* and *your* covered *dependents* for the fraction of the policy month remaining at termination, if any, plus three additional months if:

- *You* were covered under the *policy* and any other group coverage providing similar benefits which the *policy* replaced for at least six consecutive months prior to termination;
- *Your* coverage under the *policy* was not terminated for any of the following reasons;
 - The *employee's* employment was terminated for cause;
 - The *employee* failed to make timely payment of premium;
 - The *employer* terminated participation under the *policy* or *you* were no longer eligible for coverage under the *policy* with respect to an insured class; and
- Coverage is not immediately replaced by similar group coverage.

You must pay premium on a monthly basis in advance to the *employer*. Premiums will be the same as those for *your* group coverage including any portion formerly paid by the *employer*. If the *employer's* plan terminates during the time *you* are covered under this continuation, the *employer* must notify *you* in writing prior to the date of termination that *your* coverage is being terminated.

When coverage provided under this provision ends, *you* have the right to exercise the "State Continuation of Health Insurance after age 60" provision, if eligible.

224100GA 01/16

CONTINUATION AFTER AGE 60

State continuation of health insurance after age 60

This provision applies to *you* only if:

- *You* are covered under a group plan which covers 20 or more *employees*;
- *You* are 60 years of age or older on the date on which *your* coverage under COBRA or the "State continuation of health insurance" provision began; and
- Coverage under COBRA or the "State continuation of health insurance" provision ends.

In the event and to the extent that this provision is applicable, election of coverage under COBRA or under the "State continuation of health insurance" provision shall constitute election of continuation of coverage under this provision without further action by *you*. The notice requirements of COBRA or the "State continuation of health insurance" provision, whichever is applicable, shall apply to coverage provided under this provision.

224150GA

Extension of continuation

You and *your* eligible *dependents* who were covered under COBRA or the "State continuation of health insurance" provision may extend *your* coverage after the expiration of the period provided under such coverage, unless the following applies to *you*;

- Termination of *your* employment was voluntary for other than health reasons;
- Termination of *your* coverage occurred because *your* employment terminated due to reasons which would cause a forfeiture of unemployment compensation under Chapter 8 of Title 34, the Employment Security Law;
- Termination of coverage was because *you* failed to pay the required premium;
- The group coverage was immediately replaced by similar group coverage; or
- The group coverage was terminated in its entirety or was terminated with respect to a class to which *you* belonged.

221460GA

Extension for survivorship continuation and extension of continuation after divorce

You and *your* covered *dependent* children, if any, whose coverage would otherwise terminate because of the dissolution of marriage or legal separation, or death of the employee, may continue coverage under the plan if:

CONTINUATION AFTER AGE 60 (continued)

- *You*, the surviving spouse, are 60 years of age or older at the time of death of the *employee*; or
- *You*, the divorced spouse, are 60 years of age or older at the time of dissolution of the marriage or legal separation.

224170GA

Premium

The monthly Premium for coverage under this provision will not be greater than 120% of the total of the following:

- The amount *you* would be charged, if *you* were a current group member; and
- The amount *your employer* would contribute toward the premium, if *you* were a current group member.

You must pay the first premium for coverage under this provision on the regular due date following the expiration of the period of coverage provided under COBRA or the "State continuation of health insurance" provision.

224180GA

Termination of continuation

Your right to coverage under this provision will terminate on the earliest of the following:

- The date *you* fail to pay (including any grace period allowed by the policy) any required premium, when due;
- The date *your employer's* group plan is terminated; (if the group plan is replaced, coverage will continue under the new group plan.)
- The date *you* become insured under any group health plan; or
- The date *you* become eligible for *Medicare* coverage.

224190GA 01/16

COORDINATION OF BENEFITS

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

226000 01/18

Definitions

The following definitions are used exclusively in this provision.

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

Plan includes:

- Group and non-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, including "No Fault" and Medical Payments coverages; and
- *Medicare* or other governmental benefits, as permitted by law. This does not include a state plan under *Medicaid*.

Plan does not include:

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

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

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

COORDINATION OF BENEFITS (continued)

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

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

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

- If a *covered person* is confined in a private *hospital* room, the difference between the cost of a semi-private room in the *hospital* and the private room, (unless the patient's stay in a private *hospital* room is medically necessary in terms of generally accepted medical practice, or one of the *plans* routinely provides coverage for *hospital* private rooms) is not an *allowable expense*.
- If a person is covered by two or more *plans* that compute their benefits payments on the basis of usual and customary fees, any amount in excess of the highest usual and customary fees for a specific benefit is not an *allowable expense*.
- If a person is covered by two or more *plans* that provide benefits or services on the basis of negotiated fees, any amount in excess of the highest of the fees is not an *allowable expense*.
- If a person 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.

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

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

COORDINATION OF BENEFITS (continued)

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.

226100GA 01/19

Order of determination rules

General

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

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

226200

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:

COORDINATION OF BENEFITS (continued)

- The parents are married;
 - The parents are not separated (whether or not they have been married); or
 - A court decree awards joint custody without specifying that one 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 parent is responsible for the child's health care expenses or health care coverage and the *plan* of that parent has actual knowledge of those terms, that *plan* is *primary*. This rule applies to *claim determination periods* or plan years commencing after the *plan* is given notice of the court decree.
 - If the parents are not married, or are separated (whether or not they ever have been married) or are divorced, the order of benefits is:
 - The *plan* of the *custodial parent*;
 - The *plan* of the spouse of the *custodial parent*;
 - The *plan* of the non-*custodial parent*; and then
 - The *plan* of the spouse of the non-*custodial parent*.
-
- **Active or inactive employee.** The *plan* that covers a person as an *employee*, who is neither laid off nor retired, is *primary*. The same would hold true if a person is a *dependent* of a person covered as a retiree and an *employee*. If the other *plan* does not have this rule, and if, as a result, the *plans* do not agree on the order of benefits, this rule is ignored.
 - **Continuation coverage.** If a person whose coverage is provided under a right of continuation provided by federal or state law also is covered under another *plan*, the *plan* covering the person as an *employee*, member, subscriber or retiree (or as that person's *dependent*) is *primary*, and the continuation coverage is *secondary*. If the other *plan* does not have this rule, and if, as a result, the *plans* do not agree on the order of benefits, this rule is ignored.
 - **Longer or shorter length of coverage.** The *plan* that covered the person as an *employee*, member, subscriber or retiree longer is *primary*.

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

226300 01/19

Effects on the benefits of this plan

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

COORDINATION OF BENEFITS (continued)

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

226400 01/17

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.

226500

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.

226600

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.

226700

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.

227100 01/23

CLAIMS

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* as required by *your* plan, or as soon as is reasonably possible thereafter. Notice must be sent to *us* at *our* mailing address shown on *your* ID card or at *our* website at www.humana.com.
228000GA 01/23

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 10 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.

228100GA 01/23

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.

228200 01/19

CLAIMS (continued)

Claims processing procedures

Qualified provider services are subject to *our* claims processing procedures. *We* use *our* claims processing procedures to determine payment of *covered expenses*. *Our* claims processing procedures include, but are not limited to, claims processing edits and claims payment policies, as determined by *us*. *Your qualified provider* may access *our* claims processing edits and claims payment policies on *our* website at www.humana.com by clicking on "For Providers" and "Claims Resources."

Claims processing procedures include the interaction of a number of factors. The amount determined to be payable for a *covered expense* may be different for each claim because the mix of factors may vary. Accordingly, it is not feasible to provide an exhaustive description of the claims processing procedures, but examples of the most commonly used factors are:

- The complexity of a service;
- Whether a service is one of multiple same-day services such that the cost of the service to the *qualified provider* is less than if the service had been provided on a different day. For example:
 - Two or more *surgeries* performed the same day;
 - Two or more endoscopic procedures performed during the same day; or
 - Two or more therapy services performed the same day;
- Whether a *co-surgeon, assistant surgeon, surgical assistant* or any other *qualified provider*, who is billing independently is involved;
- When a charge includes more than one claim line, whether any service is part of or incidental to the primary service that was provided, or if these services cannot be performed together;
- Whether the service is reasonably expected to be provided for the diagnosis reported;
- Whether a service was performed specifically for *you*; or
- Whether services can be billed as a complete set of services under one billing code.

We develop *our* claims processing procedures in *our* sole discretion based on *our* review of correct coding initiatives, national benchmarks, industry standards, and industry sources such as the following, including any successors of the same:

- *Medicare* laws, regulations, manuals, and other related guidance;
- Federal and state laws, rules and regulations, including instructions published in the Federal Register;
- National Uniform Billing Committee (NUBC) guidance including the UB-04 Data Specifications Manual;
- American Medical Association's (AMA) Current Procedural Terminology (CPT®) and associated AMA publications and services;
- Centers for Medicare & Medicaid Services' (CMS) Healthcare Common Procedure Coding System (HCPCS) and associated CMS publications and services;
- International Classification of Diseases (ICD);
- American Hospital Association's Coding Clinic Guidelines;
- Uniform Billing Editor;
- American Psychiatric Association's (APA) Diagnostic and Statistical Manual of Mental Disorders (DSM) and associated APA publications and services;
- Food and Drug Administration guidance;

CLAIMS (continued)

- Medical and surgical specialty societies and associations;
- Industry-standard utilization management criteria and/or care guidelines;
- *Our* medical and pharmacy coverage policies; and
- Generally accepted standards of medical, behavioral health and dental practice based on credible scientific evidence recognized in published peer reviewed literature.

Changes to any one of the sources may or may not lead *us* to modify current or adopt new claims processing procedures.

Subject to applicable law, *qualified providers* who are *non-network providers* may bill *you* for any amount *we* do not pay even if such amount exceeds the allowed amount after *we* apply claims processing procedures. Any such amount paid by *you* will not apply to *your deductible* or any *out-of-pocket limit*. *You* will also be responsible for any applicable *deductible, copayment, or coinsurance*.

You should discuss *our* claims processing edits, claims payment policies and medical or pharmacy coverage policies and their availability with any *qualified provider*, who is a *non-network provider*, prior to receiving any services. *You* or *your qualified provider* may access *our* claims processing edits and claims payment policies on *our* website at www.humana.com by clicking "For Providers" and "Claims resources." *Our* medical and pharmacy coverage policies may be accessed on *our* website at www.humana.com under "Medical Resources" by clicking "Coverage Policies." *You* or *your qualified provider* may also call *our* toll-free customer service number listed on *your* ID card to obtain a copy of a claims processing edit, claims payment policy or coverage policy.
228250 01/23

Other programs and procedures

We may introduce new programs and procedures that apply to *your* coverage under the *policy*. *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.
228275 01/22

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.
228300 05/05

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.

CLAIMS (continued)

Benefit payments for *covered expenses* rendered 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* request *we* direct a payment of selected medical benefits to the health care provider on whose charge the claim is based and *we* consent;
- The *covered expenses* are for *emergency care*; or
- The services are for the *covered expenses* *we* apply the *network provider copayment, deductible* and/or *copayment* to, as specified in the "How your policy works" provision in the "Understanding Your Coverage" 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.

228400GA 01/23

Time of payment of claims

Payments due under the *policy* will be paid no more than 30 days after receipt of written or 15 working days for *electronic* proof of loss.

If *we* fail to provide benefits payable under the *policy* upon receipt of written or *electronic* proof of loss, *we* shall have 15 working days thereafter to send *you* a letter or notice which:

- States the reason(s) *we* have not paid the claim; and
- Gives a written itemization of any documents or other information needed to process the claim.

When all of the listed documents or other information needed to process the claim has been received, *we* shall have 15 working days thereafter to either pay or deny the claim and give *you* the reasons if there is a denial.

Claims not paid as above will be increased by interest at 12% per annum on the proceeds or benefits due under the terms of the policy.

228500GA 02/12

Right to request overpayments

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

- Made in error;

CLAIMS (continued)

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

We reserve the right to adjust any amount applied in error to the *deductible* or *out-of-pocket limit*.
228700 01/16

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 *policy*.

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.
228800 01/16

Exhaustion of time limits

If *we* fail to complete a claim determination or appeal within the time limits set forth in the *policy*, the claim shall be deemed to have been denied and *you* may proceed to the next level in the review process outlined under the "Complaint and Appeal Procedures" section of this *certificate* or as required by law.
228900

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* that *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.

CLAIMS (continued)

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*.

229100 01/16

Workers' compensation

This *policy* 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 benefits *we* have paid 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 responsible for contributing to any 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 *policy*, *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*.

229300 01/19

CLAIMS (continued)

Right of reimbursement; coverage voided by non-cooperation

If *you* or *your* covered *dependent* has a claim for damages or a right to recover damages from a responsible person, his insurer, any Uninsured Motorist or Underinsured Motorist, or other similar coverage for any *sickness* or *bodily injury* for which benefits are payable under this *policy*. *We* may have the Right of reimbursement. *Our* Right of reimbursement shall be limited to the recovery of any benefits paid for medical expenses, prescription and specialty drugs, disability, or dental under this *policy*, but shall not include non-medical items. Recovery may include compromise, judgment, or other settlements. Should a dispute as to the amount of reimbursement arise, the health plan may seek a declaratory judgment in court as to what amount is due, if any. Our Right to reimbursement is limited by any applicable state law or rule limiting the rights of the insurer to recover the expenses it has paid on *your* behalf. The beneficiary will cooperate with *us* in an effort to recover from the legally liable person or insured for *bodily injuries* and losses, which necessitate *covered* expenses by this *policy*. *You* or *your* attorney must inform *us* of any legal action or settlement agreement at least ten days prior to settlement or trial. *We* will then notify *you* of the amount *we* seek to recover for covered benefits paid. *Our* recovery may be reduced by the pro-rata share of *your* attorney's fees and expenses of litigation.

229350GA 11/12

COMPLAINT AND APPEAL PROCEDURES

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;
- A determination of *your* eligibility for group coverage under the *policy*;
- Any *rescission* of coverage or cancellation of coverage not attributed to a failure to pay premiums that is applied retroactively.

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

Appeal means a written, oral or *electronic* request for reconsideration of an *adverse benefit determination*.

Authorized representative means someone *you* have appropriately authorized to act on *your* behalf, including *your* health care provider.

Complaint means a written communication submitted by *you* or *your authorized representative* regarding dissatisfaction with any aspect of the plan, other than a claim or service denial, including a previous problem that is not resolved to *your* satisfaction.

Experimental treatment determination means a determination by *us* or on *our* behalf, which denies in part or in full, requested services to which all of the following apply:

- The proposed treatment has been reviewed;
- Based on the information provided, a determination has been made by *us* or on *our* behalf that the services were considered *experimental, investigational, or for research purposes*; and
- Based on the information provided, *we* have denied either the proposed treatment or payment for the treatment.

Independent Review Organization (IRO) means an organization of medical professionals with no connection to *your* health plan, qualified to review *your* dispute.

Qualified Reviewer means an individual who reviews *adverse benefit determinations* involving medical necessity or services denied as experimental/investigational and:

- Hold an active, unrestricted medical license;
- Is from the same or similar specialty who typically treats the medical condition or provides the treatment in question;
- Is currently in active practice in the same or similar specialty and typically manages the medical condition or disease;
- Is knowledgeable of, and has experience providing the health care service under review;

COMPLAINT AND APPEAL PROCEDURES (continued)

- Considers all known aspects of the health care service under review, including, but not limited to, a review of all pertinent medical or other records provided by the *covered person's* health care provider, any relevant records provided by a facility, and any medical or other literature provided by the health care provider;
- Did not participate in the initial *adverse benefit determination* or any prior *appeal* decision; and
- Are not subordinates of the individual who made the initial *adverse benefit determination* or prior *appeal* decision.

Review panel means one or more *qualified reviewers* who review second level *adverse benefit determinations* involving medical necessity or services denied as experimental/investigational. The *review panel* will include one *health care practitioner* other than *our* medical director.

Urgent care claim means a claim for treatment or services, that if delayed could seriously jeopardize the life or health of the *covered person*, their ability to regain maximum function or in the opinion of the treating physician would subject the *covered person* to severe pain that cannot be adequately managed without the treatment.

230010GA 01/23

Complaints

If you have a *complaint* regarding dissatisfaction with any aspect of the plan, please call *our* Customer Service Department as soon as possible. The toll-free number is on *your* identification card or you may write to *us* at the address listed below. We will review the *complaint* and you will be notified of a final decision not later than 60 days after *our* receipt of the *complaint*. At any time, you may file an *appeal* described below.

Grievance and Appeal Department
P.O. Box 14546
Lexington, KY 40512-4546

230020GA 01/21

Internal appeals

A *qualified reviewer* will review all internal *appeals* involving medical necessity or services denied as experimental/investigational.

First level review

If you are dissatisfied with *our* determination of *your* claim, you may *appeal* the decision. *Appeals* must be submitted to *us* within 180 calendar days from the receipt of an *adverse benefit determination*. *Appeals* involving medical necessity or experimental/investigational *adverse benefit determinations* can be submitted by you, your provider or your *authorized representative*. All other *appeals* can be submitted by you or your *authorized representative*. A request for a first level review of an *adverse benefit determination* may be made by you or your *authorized representative* orally, by *electronic* means or in writing at the following address:

COMPLAINT AND APPEAL PROCEDURES (continued)

Grievance and Appeal Department
P.O. Box 14546
Lexington, KY 40512-4546

We will acknowledge receipt in writing within five business days of receipt. We will investigate the appeal and notify you or your authorized representative of the determination no later than:

- 15 calendar days after the date we received the request for a pre-service or concurrent *adverse benefit determination*; or
- 30 calendar days after the date we received the request for post-service *adverse benefit determinations*.

Expedited internal review

You or your authorized representative may request an expedited internal review of an adverse *urgent-care claim* decision orally, *electronically* or in writing. We will notify you or your authorized representative of our decision as expeditiously as the *covered person's* condition requires, but in no event more than 48 hours of receipt of the request. Written resolution will be sent to you or your authorized representative within three calendar days.

Second level panel review

If you are dissatisfied or unable to resolve your concerns through the first level review, you or your authorized representative may request a second level panel review orally, in writing or *electronically* at the address provided on the denial letter you received.

A review panel will investigate your appeal. We will notify you or your authorized representative of the review panel's determination no later than:

- 15 calendar days after the date we received the request for a pre-service or concurrent *adverse benefit determination*; or
- 30 calendar days after the date we received the request for post-service *adverse benefit determinations*.

Expedited second level panel review

You or your authorized representative may request an expedited internal review of an adverse *urgent-care claim* decision orally or in writing. A review panel will investigate your appeal. We will notify you or your authorized representative of the decision as expeditiously as the *covered person's* condition requires, but in no event more than 24 hours from the receipt of the request.

230030GA 01/23

COMPLAINT AND APPEAL PROCEDURES (continued)

Exhaustion of remedies

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

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

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

230100 01/21

External review

If *you* or *your authorized representative* disagree with the outcome of the first and second level review decision, *you* or *your authorized representative* have the right to request an external review by an *Independent Review Organization (IRO)* if the *adverse benefit determination* involves an *experimental treatment determination*, *medically necessary determination*, a denial based on medical judgment, a *rescission* of coverage, or a claim protected under the Federal No Surprises Act. *Adverse benefit determinations* related to eligibility to participate in the plan are not eligible for external review.

You or *your authorized representative* must exhaust the internal *appeal* process before requesting an external review by an *IRO*. If *you* or *your authorized representative* wishes to file a request for an external review the request must be submitted in writing to the address listed below and received within four months or the next business day following the four month period from the receipt of the *adverse determination*. For claims protected under the Federal No Surprises Act, refer to *our* decision letter for instructions on how to request an external review.

Grievance and Appeal Department
P.O. Box 11268
Green Bay, WI 54307-1268

Within five business days of *our* receipt of the request, an *IRO* will be assigned to *your* case through an unbiased rotating selection process. The assigned *IRO* will send *you* or *your authorized representative* a notice of acceptance which will include notice of the right to submit additional information within ten business days of receipt of the notice from the *IRO*. The assigned *IRO* will also deliver a notice of the final external review decision in writing to *you*, *your authorized representative*, and *us* within 45 days of their receipt of the request.

Should the *IRO* find in *your* or *your authorized representative's* favor in whole or in part, *we* will take the necessary actions to ensure the implementation of the *IRO* decision.

230120GA 01/23

COMPLAINT AND APPEAL PROCEDURES (continued)

Expedited external review

An external expedited review is a review involving cases where the normal duration of the external independent review process would jeopardize a *covered person's* life, health or ability to regain maximum function. This request should be submitted to *us* immediately.

The *IRO* must provide a decision to *you* or *your authorized representative* and to *us* within 72 hours of the *IRO's* receipt of the request.

Once the *IRO* makes a final coverage decision, the final coverage decision is binding on *us* and *we* will take the necessary actions to ensure the implementation of the *IRO* decision.

230130GA 01/21

Legal actions and limitations

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

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

230200GA 01/19

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 *policy*, 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 *policy*, and the EAP services are not coordinated with *covered expenses* under the *policy*. 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.

230975

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 insured benefits under the *policy*. 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.

230985 01/17

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.

DISCLOSURE PROVISIONS (continued)

"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 *policy* or change any of the terms of this *policy*. *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 and if eligible, *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.

231075 01/16

Shared savings program

As a member of a Preferred Provider Organization Plan, *you* may obtain services from *network providers* who participate in the Preferred Provider Organization network, or *non-network providers* who do not participate in the Preferred Provider Organization network. If *you* choose a *network provider*, *your* out-of-pocket expenses are normally lower than if *you* choose a *non-network provider*.

DISCLOSURE PROVISIONS (continued)

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 in the services are subject to the Shared Savings Program and calculate *your deductible* and *coinsurance* on the discounted amount. Whether the 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 discontinued. *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.

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.

231100 01/18

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

MISCELLANEOUS PROVISIONS

Entire contract

The entire contract is made up of the *policy*, the application of the *policyholder*, incorporated by reference herein, and the applications or enrollment forms, if any, of the *covered persons*. All statements made by the *policyholder* 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 *policy*, 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.

232000 01/23

Additional policyholder responsibilities

In addition to responsibilities outlined in the *policy*, the *policyholder* is responsible for:

- Collection of premium; and
- Distributing and providing *covered person* access to:
 - Benefit plan documents and the Summary of Benefits and Coverage (SBC);
 - Renewal notices and *policy* modification information;
 - Discontinuance notices; and
 - Information regarding continuation rights.

No *policyholder* may change or waive any provision of the *policy*.

232100 01/18

Certificates of insurance

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 *policyholder* is responsible for providing *employees* access to the *certificate*.

232200 01/23

No document inconsistent with the *policy* 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 health 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.

232300 01/18

MISCELLANEOUS PROVISIONS (continued)

Incontestability

No misstatement made by the *policyholder*, except for fraud or an intentional misrepresentation of a material fact made in the application, may be used to void the *policy*.

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

- Nonpayment of premium; or
- Any fraud or intentional misrepresentation of a material fact made by *you*.

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

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

An independent incontestability period begins for each type of change in coverage or when a new application or enrollment form of the *covered person* is completed.

232400 01/23

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*.

232500 11/12

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*.

232600 11/12

Modification of policy

The *policy* may be modified by *us*, upon renewal of the *policy*, as permitted by state and federal law. The *policyholder* will be notified in writing or *electronically* as follows:

- For a *small employer*, at least 60 days prior to the effective date of change;
- For a *large employer*, at least 31 days prior to the effective date of the change.

MISCELLANEOUS PROVISIONS (continued)

The *policy* may be modified by agreement between *us* and the *policyholder* 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 *policy*. No agent has authority to modify the *policy*, waive any of the *policy* provisions, 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 *policy* and may be made by *us* at any time without prior consent of, or notice to, the *policyholder*.

The *policy* may be modified by *us* without prior consent of, or notice to, the *policyholder* when the changes are:

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

Modifications due to reasons other than those listed above, may be made by *us*, upon renewal of the *policy*, in accordance with state and federal law. The *policyholder* will be notified in writing or *electronically* at least 60 days prior to the effective date of such changes. Although *policyholder* consent is not required, the payment of premium after the effective date of such change constitutes the *policyholder's* consent to change.

232700GA 01/23

Discontinuation of coverage

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

- The *policyholder* and the *employees* will be notified of such discontinuation at least 90 days prior to the date of discontinuation of such coverage; and
- The *policyholder* will be given the option to purchase all (or, in the case of a large *employer*, any) other group health plans providing medical benefits that are being offered by *us* at such time.

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

232750 01/17

Premium contributions

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

232800

MISCELLANEOUS PROVISIONS (continued)

Premium rate change

*We reserve the right to change any premium rates, provided the change in rates will not apply to an existing *policyholder* who has not been effective under this *policy* for twelve consecutive months, 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*.*
232900GA

Small employers rate disclosure

You may request information on how we determine premium rates by calling our toll-free customer service number listed on your ID card.
232950GA 11/12

Assignment

*The *policy* and its benefits may not be assigned by the *policyholder*.*
233200

Emergency declarations

*We may alter or waive the requirements of the *policy* 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 *policy* requirements in response to an emergency declaration.*
233250 01/23

Conformity with statutes

*Any provision of the *policy* 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).*
233300

GLOSSARY

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*.

234000

A

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

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

- On a regular *full-time* basis or for the number of hours per week determined by the *policyholder*;
- For 48 weeks a year; and
- Is maintaining a bona fide *employer-employee* relationship with the *policyholder* of the *group policy* 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.

GLOSSARY (continued)

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*. Use of the *air ambulance* must be *medically necessary*. When transporting the sick or injured person from one medical facility to another, the *air ambulance* must be ordered by a *health care practitioner*.

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*. Use of the *ambulance* must be *medically necessary*. When transporting the sick or injured person from one medical facility to another, the *air ambulance* must be ordered by a *health care practitioner*.

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

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

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.
234800GA 01/23

B

Behavioral health means *mental health services* and *chemical dependency services* and mental, nervous or emotional conditions.

GLOSSARY (continued)

Birth 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*.

235100GA 01/22

C

Cancer screenings and examinations means screenings and examinations for cancer in accordance with the most recently published guidelines and recommendations established by any of the following:

- American College of Physicians;
- American College of Obstetricians and Gynecologists; or
- American Academy of Pediatricians.

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

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

Coinurance means the amount expressed as a percentage of the *covered expense* that *you* must pay. The percentage of the *covered expense* we pay is shown in the "Schedule of Benefits" sections.

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.

Contracted health care treatment facility means a *health care treatment facility* that is designated as such or has signed an agreement with *us* as an independent contract, or has been designated by *us* to provide services to all *covered persons*. *Contracted provider* designation by *us* may be limited to specified services.

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*, as shown in the "Schedule of Benefits" sections.

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.

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

GLOSSARY (continued)

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 *policy*; and
- Incurred when *you* are insured for that benefit under the *policy* 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 *policy*.

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*.

236100GA 01/23

GLOSSARY (continued)

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*. Any amount *you* pay exceeding the *maximum allowable fee* is not applied to the individual or family *deductibles*.

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;
- Natural born child, step-child, legally adopted child, or child placed for adoption, whose age is less than the limiting age;
- Grandchild or great grandchild if a written power of attorney exists that gives a grandparent authority to act on behalf of the grandchild. A parent of a minor child may delegate to any grandparent residing in this state, caregiving authority regarding the minor child when hardship prevents the parent from caring for the child.
- 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 *policy*.

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

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;

GLOSSARY (continued)

- A student;
- Employed;
- Residing or working outside of the network area;
- Residing with or receiving financial support from *you*; or
- Eligible for other coverage through employment.

A covered *dependent* child, who attains the limiting age while insured under the *policy*, remains eligible if the covered *dependent* child is:

- Mentally or physically handicapped; and
- Incapable of self-sustaining employment.

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

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

Diabetes equipment means blood glucose monitors and glucose monitors, including monitors designed to be used by legally blind or visually impaired individuals; injection aids, including those adaptable to meet the needs of the legally blind; insulin pumps and associated accessories; insulin infusion devices; and podiatric appliances and therapeutic shoes for the prevention of complications associated with diabetes; pen-like insulin injection devices; lancing devices associated with the drawing of blood samples for use with blood glucose monitors; and other medical equipment, non-disposable and durable medical equipment consistent with the current standards of care of the American Diabetes Association.

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; including insulin syringes, insulin injection needles for use with pen-like insulin injection devices and other disposable parts required for insulin injection aids; prescriptive agents for controlling blood sugar levels; prescriptive non-insulin injectable agents for controlling blood sugar levels; glucagon emergency kits; alcohol swabs; and other single-use medical supplies consistent with the current standards of care of the American Diabetes Association.

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

GLOSSARY (continued)

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.

236800GA 01/22

E

Effective date means the date *your* coverage begins under the *policy*.

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

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

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

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

Emergency care means services provided in an emergency facility 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.

GLOSSARY (continued)

Emergency medical condition means *bodily injury* or *sickness* manifesting itself by acute symptoms of sufficient severity (including severe pain, regardless of the initial, interim, final, or other diagnosis given) 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, and gains their livelihood from the sole proprietorship, partnership or corporation and is in an *active status* at the *employer's* usual place of business or some other location, which is usual for the sole proprietor's, partner's or corporate officer's particular duties.

Employer means the sponsor of this *group insurance* 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;

GLOSSARY (continued)

- 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.

238000GA 01/23

F

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

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

Full-time, for an *employee*, means a work week of the number of hours determined by the *policyholder*.

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

238300 01/23

G

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

238400

H

Habilitative services mean health care services and devices that help a person keep, learn or improve skills and functioning for daily living. 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.

GLOSSARY (continued)

Health care practitioner means a practitioner professionally licensed 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, or institution, 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.

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 non-experimental and wearable instrument or device offered to aid or compensate for impaired human hearing that is worn in or on the body. The term *hearing aid* includes any parts, ear molds, repair parts, and replacement parts of such instrument or device, including, but not limited to, non-implanted bone anchored hearing aids, non-implanted bone conduction hearing aids, and frequency modulation systems. Personal sound amplification products do not qualify as hearing aids.

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

GLOSSARY (continued)

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

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.

239200GA 01/23

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.

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:

- Artificial insemination;
- In vitro fertilization;
- Gamete Intrafallopian Transfer (GIFT);
- Zygote Intrafallopian Transfer (ZIFT);
- Tubal ovum transfer;
- Embryo freezing or transfer;
- Sperm storage or banking;

GLOSSARY (continued)

- 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.

239600 01/22

J

K

L

Late applicant means an *employee* or *dependent*, who requests enrollment for coverage under the *policy* more than 31 days after his/her *eligibility date*, later than the time period specified in the "Special enrollment" provision, or after the *open enrollment period*.

Level 1 network health care practitioner means a *network health care practitioner* practicing in a *health care treatment facility* or *retail clinic*:

- With a specialty of pediatric or internal medicine; or
- Who is a general practitioner, nurse practitioner, physician assistant, or registered nurse.

Level 2 network health care practitioner means a *network health care practitioner*, practicing in a *health care treatment facility*, who has received training in a specific medical field other than those listed in the *level 1 network health care practitioner* definition.

239700 01/22

GLOSSARY (continued)

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.

Materials means frames, lenses and lens options, or contact lenses and low vision aids.

Maximum allowable fee for a *covered expense* for the following services in the state of Georgia:

- *Emergency care* services provided by *non-network providers*;
- Services you receive from a *non-network provider* while you are at a *network facility*, unless you choose to receive services from a *non-network provider* and you provide your written and oral consent 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 provide your consent to the *non-network provider* to obtain such services.

is the greater of:

- The verifiable median amount paid by all eligible health insurance issuers for similar services;
- The most recent verifiable amount agreed to by the *non-network provider* and *us* for the same service during the time the provider was a *network provider*; or
- A higher amount we deem appropriate given the complexity and circumstances of the services.

Maximum allowable fee for all other *covered expenses* 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;
- 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

GLOSSARY (continued)

- 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.

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 and not primarily for *our* economic benefit; and
- Performed in the least costly site or sourced from, or provided by the least costly *qualified provider* and not primarily for *our* economic benefit.

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 mental, nervous or emotional conditions 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:

- Being at least 100 pounds over or twice the ideal weight for frame, age, height, and gender as specified in the 1983 Metropolitan Life Insurance tables;
- 35 kilograms or greater per meter squared (kg/m^2) with an associated comorbidity or coexisting medical conditions such as hypertension, type II diabetes, life-threatening cardiopulmonary conditions, sleep apnea, or joint disease that is treatable, if not for the obesity; or
- 40 kilograms or greater per meter squared (kg/m^2) without such comorbidity.

240300GA 01/23

GLOSSARY (continued)

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* also includes a *birthing center, diagnostic and treatment center, hospice or similar institution in the state of Georgia* 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 treatment facility means a *health care treatment facility* that is 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 provider* 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 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.).

241000GA 01/23

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 the *employees* have an opportunity to enroll themselves and their eligible *dependents* for coverage under the *policy*.

GLOSSARY (continued)

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" section, either individually or combined as a covered family, per year before a benefit percentage is increased. Any amount you pay a *non-network provider* exceeding the *maximum allowable fee* is not applied to the *out-of-pocket limits*.

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*.
241600 01/23

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.

GLOSSARY (continued)

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 the "Covered Expenses – Pediatric Dental" section.

Pediatric vision care means the services and *materials* specified in the "Pediatric vision care benefit" provision in the "Covered Expenses – 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 surgical procedures.

Policy means the legal agreement between *us* and the *policyholder*, including the Employer Group Application and *certificate*, together with any riders, amendments and endorsements.

Policyholder means the legal entity identified as the *policyholder* on the face page of the *policy* or "Certificate of Insurance" who establishes, sponsors and endorses an employee benefit plan for insurance coverage.

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.

GLOSSARY (continued)

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

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. Refer to the "Preventive services" provision in the "Covered Expenses" section, which includes *preventive services* covered by the *policy*.

242500 01/23

Q

Qualified clinical trial means a trial that must be a trial that is approved by one of the following:

- A Cooperative Group or one of the National Institutes of Health;
- The United States Food and Drug Administration, in the form of an investigational new drug application;
- The United States Department of Defense;
- The United States Veterans' Administration;
- The National Cancer Institute; or
- An Institutional Review Board of any accredited school of medicine, nursing or pharmacy in the State of Georgia.

GLOSSARY (continued)

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 Georgia;
- *Ancillary services* while you are at a *network facility* in the state of Georgia and you choose to receive the services from a *non-network provider* and you provide your written and oral consent to the *non-network provider* to obtain such services;
- *Ancillary services* while you are at a *network facility* outside the state of Georgia;
- Services that are not considered *ancillary services* while you are at a *network facility* outside the state of Georgia and you do not provide your consent to the *non-network provider* to obtain such services;
- *Post stabilization services* you receive outside the state of Georgia 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 provide your 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 or treat a *sickness* or *bodily injury*;
 - Provide *preventive services*;
 - Provide *pediatric dental services*; or
 - Provide *pediatric vision care*;
- That provides services within the scope of their license; and
- Whose primary purpose is to provide health care services.

242550GA 01/23

GLOSSARY (continued)

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*.

242900 01/23

GLOSSARY (continued)

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*.

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

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

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

A *skilled nursing facility* is not, except by incident, a rest home or a home for the care of the aged.

Small employer means an *employer* who employed an average of one, but not more than 50, *employees* on business days during the preceding calendar year and who employs at least one *employee* on the first day of the year. All subsidiaries or affiliates of the *policyholder* are considered one *employer* when the conditions specified in the "Subsidiaries or Affiliates" section of the *policy* 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:

- Change in family status after the *eligibility date*;
- Loss of other coverage under another group health plan or other *health insurance coverage*;
- COBRA exhaustion;
- Loss of coverage under *your employer's* alternate plan;
- Termination of *your Medicaid* coverage or *your Children's Health Insurance Program (CHIP)* coverage as a result of loss of eligibility; or
- Eligibility for a premium assistance subsidy under *Medicaid* or CHIP.

GLOSSARY (continued)

To be eligible for special enrollment, *you* must meet the requirements specified in the "Special enrollment" provision within the "Eligibility and Effective Dates" section of this *certificate*.

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.

243800 01/23

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

GLOSSARY (continued)

- 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.

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

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

244000 01/22

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.

244200 01/21

V

Virtual visit means *telehealth* or *telemedicine* services.

W

Waiting period means the period of time, elected by the *policyholder*, that must pass before an *employee* is eligible for coverage under the *policy*.

We, us or **our** means the offering company as shown on the cover page of the *policy* and *certificate*.

244400 01/20

GLOSSARY (continued)

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 *policy*, the first *year* begins for *you* on the *effective date* of *your* insurance and ends on the following December 31st.

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

Z

244600 07/07

SAMPLE

GLOSSARY – PHARMACY SERVICES

All terms used in the "Schedule of Benefits – Pharmacy Services," "Covered Expenses – Pharmacy Services" and "Limitations and Exclusions – Pharmacy Services" sections have the same meaning given to them in the "Glossary" 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 *prescription drug 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*. Changes to the *drug list* are acted upon annually, a notification letter will be sent to *you* at least 60 days prior to the change. In the rare instance that a *specialty drug* is removed from the market because of failure to meet FDA guidelines, an FDA recall, or at the discretion of the manufacturer, a notification letter will be sent to *you* subsequently.

GLOSSARY – PHARMACY SERVICES (continued)

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

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. The *prescription* drugs in this category are highest-cost/high-technology drugs and *specialty drugs*.

GLOSSARY – PHARMACY SERVICES (continued)

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*.

Prescription drug deductible means the specified dollar amount for *prescription* drug covered expenses which *you*, either individually or combined as a covered family, must pay per year before *we* pay *prescription* drug benefits under the *policy*. These expenses do not apply toward any other *deductible*, if any, stated in the *policy*.

GLOSSARY – PHARMACY SERVICES (continued)

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

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V

W

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NOTICE

DISCRIMINATION AGAINST VICTIMS OF FAMILY VIOLENCE or SEXUAL ASSAULT

The laws of the State of Georgia prohibit insurers from unfairly discriminating against any person based upon his or her status as a victim of family violence.

We can not deny or refuse to accept an application; refuse to insure; refuse to renew; refuse to reissue; cancel, restrict, or otherwise terminate; charge a different rate for the same coverage; add a premium differential; or exclude or limit coverage for losses or deny a claim incurred by an insured on the basis that the applicant or insured is or has been a victim of family violence or sexual assault or that such person knows or has reason to know the applicant or insured may be a victim of family violence or sexual assault; nor shall any person take or fail to take any actions against an applicant or insured who provides shelter, counseling, or protection to victims of family violence or sexual assault.