

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 sample 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.

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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.



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, reading "Bruce Broussard".

Bruce Broussard
President

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**

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.

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" and the "Limitations and Exclusions" sections and any amendment attached to the *certificate* to see when services or supplies are *covered expenses* or are non-covered expenses.

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.

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*.

UNDERSTANDING YOUR COVERAGE (continued)

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 *qualified payment amount*, for *covered expenses* when you receive the following services from a *non-network provider*:

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

Any *copayment, deductible and/or coinsurance* you pay for services based on the *qualified payment amount* will be applied to the *network provider out-of-pocket limit*.

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

Concurrent review

In the case of a determination to certify an extended stay or additional services, we will notify the *health care practitioner* rendering the service within one working day of receipt of all information needed to complete the review process. Verbal notification will be followed by written or electronic confirmation within one working day after the notification. In the case of an adverse determination, notification will be given within 24 hours of making the adverse determination. If notification was verbal it will be followed by written notification within one working day. The service shall be continued without liability to you until you have been notified of the determination. Any reduction or termination of a previously approved course of treatment will be determined within an amount of time allowing for an appeal of the determination to be completed.

In cases involving urgent care, requests to extend a current course of treatment will be determined as follows:

- Within 24 hours of the request if the request for extension was received at least 24 hours before the expiration of the currently certified period of treatments; or
- Within 72 hours of the request, if the request was received on a Saturday, Sunday, or legal holiday.

Retrospective review

Within thirty (30) working days of receiving all the necessary information, we will complete the review and will provide written notice of the determination to you.

UNDERSTANDING YOUR COVERAGE (continued)

We are allowed one 15 day extension if:

- The extension is necessary due to matters beyond *our* control; and
- *You* are notified before the expiration of the 15 day extension regarding the circumstances for the extension and the date by which *we* expect to provide a determination.

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

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 facilities* are *network providers*.

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

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

For all other services *you* received 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* do not consent to the *non-network provider* to obtain such services.

UNDERSTANDING YOUR COVERAGE (continued)

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

How to find a network provider

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

How to use your 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.

Continuity of care

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

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

UNDERSTANDING YOUR COVERAGE (continued)

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.

All terms and provisions of the *policy* are applicable to this "Continuity of Care" provision.

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 an *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.

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.

UNDERSTANDING YOUR COVERAGE (continued)

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.

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;
- *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.

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*.

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.

Essential Health Benefits

Essential health benefits mean the items and services in the following categories defined by the United States Health and Human Services (HHS) as set forth by the Affordable Care Act and future federal regulations:

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

There are no annual or lifetime dollar limits on essential health benefits.

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

COVERED EXPENSES (continued)

- Preventive care and screenings for women, including pap smears and mammograms, 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.

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.

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*.

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*.

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*.

Health care practitioner inpatient services when provided in a hospital

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

Covered expenses include:

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

COVERED EXPENSES (continued)

- Services of a pathologist.
- Services of a radiologist.
- Services performed on an emergency basis in a *hospital* if the *sickness* or *bodily injury* being treated results in a *hospital confinement*.

Hospital outpatient services

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

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

Hospital outpatient surgical services

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

Health care practitioner outpatient services when provided in a hospital

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

Covered expenses include:

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

Hospital outpatient non-surgical services

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

Hospital outpatient advanced imaging

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

COVERED EXPENSES (continued)

Pregnancy and newborn benefit

We will pay benefits for *covered expenses* for a pregnancy that are incurred by a *covered person* or birth mother of a child adopted by a *covered person* within 90 days of birth.

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*.
- 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*;
 - Newborn hearing screening from birth until discharge;
 - 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 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 *covered expenses* incurred during the 31 days following the newborn's birth. After the 31 days following the newborn's birth, a *deductible* and/or *copayment*, if applicable, will be required for any of the newborn's *covered expenses*.

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.

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*.

COVERED EXPENSES (continued)

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." However, *you* will only be responsible to pay the *network provider copayment, deductible* and/or *coinsurance* to the *non-network provider* for *emergency care* based on the *qualified payment amount*.

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

Ambulance services

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

Ambulance and *air ambulance* services for an *emergency medical condition* provided by a *non-network provider* will be covered at the *network provider* benefit level, as specified in the "Ambulance services" benefit in the "Schedule of Benefits." *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*.

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*.

COVERED EXPENSES (continued)

Durable medical equipment and diabetes equipment

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

At our option, *covered expense* includes the purchase or rental of *durable medical equipment* or *diabetes equipment*. 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
- 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.

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*.

COVERED EXPENSES (continued)

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*.

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.

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.

COVERED EXPENSES (continued)

- Medical social services provided to the terminally ill *covered person* or his/her immediate covered *family members* under the direction of a *health care practitioner*, including:
 - Assessment of social, emotional and medical needs, and the home and family situation; and
 - Identification of the community resources available.
- Psychological and dietary counseling;
- Physical therapy;
- Part-time home health 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*.

Jaw joint benefit

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

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;
- Therapeutic 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 (continued)

Covered expenses do not include charges for:

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

Physical medicine and rehabilitative services

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

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

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

Spinal manipulations/adjustments

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

The "Schedule of Benefits" shows the maximum number of visits for spinal manipulations/adjustments, if any.

COVERED EXPENSES (continued)

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.

Health care practitioner services when provided in a skilled nursing facility

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

Covered expenses include:

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

Specialty drug medical benefit

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

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

Specialty drugs may be subject to *preauthorization* requirements. Refer to the "Schedule of Benefits" 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.

COVERED EXPENSES (continued)

Transplant services and immune effector cell therapy

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

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

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

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

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

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

COVERED EXPENSES (continued)

- Non-medical travel and lodging costs for:
 - The *covered person* receiving the transplant or *immune effector cell therapy*, if the *covered person* lives more than 100 miles from the transplant or *immune effector cell therapy* facility designated by *us*; and
 - One caregiver or support person (two, when the *covered person* receiving the transplant or *immune effector cell therapy* is under 18 years of age), if the caregiver or support person lives more than 100 miles from the transplant or *immune effector cell therapy* facility designated by *us*.

Non-medical travel and lodging costs include:

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

All non-medical travel and lodging costs for transplant and *immune effector cell therapy* are payable as specified in the "Schedule of Benefits" 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.

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*.

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.

COVERED EXPENSES (continued)

- 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*.

Eye prosthesis includes postsurgical lenses customarily used during convalescence from eye *surgery*, are covered when ordered by a *qualified provider*.

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.

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 an *accident* if the eyeglasses or contacts were not needed prior to the *accident*.

COVERED EXPENSES (continued)

- Eye exams for post-cataract *surgery* patients up to 1-year following the *surgery* and eyeglasses for post-cataract *surgery* members are covered when provided within 1-year following *surgery*.
- Dental treatment only if the charges are incurred for treatment of a *dental injury* to a *sound natural tooth*.

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

- Certain oral surgical operations as follows:
 - Excision of partially or completely impacted teeth;
 - Surgical preparation of soft tissues and excision of bone or bone tissue performed with or without extraction or excision of erupted, partially erupted or completely un-erupted teeth;
 - Excisions of tumors and cysts of the jaws, cheeks, lips, tongue, roof, and floor of the mouth and related biopsy of bone, tooth or related tissues when such conditions require pathological examinations;
 - Surgical procedures related to repositioning of teeth, tooth transplantation or re-implantation;
 - Services required to correct accidental injuries of the jaws, cheeks, lips, tongue, roof, and floor of the mouth;
 - Reduction of fractures and dislocation of the jaw;
 - External incision and drainage of cellulitis and abscess;
 - Incision and closure of accessory sinuses, salivary glands or ducts;
 - Frenectomy (the cutting of the tissue in the midline of the tongue); and
 - Orthognathic *surgery* for a *congenital anomaly*, *bodily injury* or *sickness* causing a *functional impairment*.
- Orthodontic treatment for a *congenital anomaly* related to or developed as a result of cleft palate, with or without cleft lip.
- 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.

COVERED EXPENSES (continued)

- 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).
- Private duty nursing.
- *Palliative care*.
- Routine foot care for a *covered person* with a systemic condition such as a metabolic, neurologic, or peripheral vascular disease that results in medically significant circulatory deficits or decreased sensation to the foot, 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, except the removal of the nail matrix;
 - Heel wedges, lifts or shoe inserts; and
 - Arch supports (foot orthotics) or orthopedic shoes.
- *Diabetes self-management training*.
- 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.

COVERED EXPENSES (continued)

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.
- Bone density screening, including any necessary diagnostic follow-up care related to the screening test.
 - *Hospital* and office charges, and administration of general anesthesia when provided in conjunction with dental care for:
 - A covered child age 5 and under;
 - A *covered person* who is severely disabled;
 - A *covered person* who has a medical or behavioral condition for which it is *medically necessary* to receive hospitalization or general anesthesia for dental care; or
 - A *covered person* who is determined by a licensed dentist or physician to require such services in order to prevent significant medical risk.
 - Penile prosthesis, when *medically necessary*, for physiological impotence.

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 this *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 other terms and provisions of the *policy* apply.

Definitions

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

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

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

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

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

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*.

COVERED EXPENSES - PEDIATRIC DENTAL (continued)

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

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

Pediatric dental services benefit

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

Class I services

- Periodic and comprehensive oral evaluations. Limited to 2 per year.
- Limited, problem focused oral evaluations. Limited to 2 per year.
- Periodontal evaluations. Limited to 2 per year. Benefit allowed only for a *covered person* showing signs or symptoms of periodontal disease and for patients with risk factors such as smoking, diabetes or related health issues. No benefit is payable when performed with a cleaning (prophylaxis). Benefits are not available when a comprehensive oral evaluation is performed.
- Cleaning (prophylaxis), including all scaling and polishing procedures. Limited to 2 per year.
- Intra-oral complete series x-rays (at least 14 films, including bitewings) or panoramic x-ray. Limited to 1 every 5 years. 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.
- 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 3 per year.
- Application of sealants to the occlusal surface of permanent molars that are free of decay and restorations. Limited to 1 per tooth per year.
- Installation of space maintainers for retaining space when a primary tooth is prematurely lost. *Pediatric dental services* do not include separate adjustment expenses.

COVERED EXPENSES - PEDIATRIC DENTAL (continued)

- Recementation of space maintainers.
- Removal of fixed space maintainers.
- Distal shoe space maintainer - fixed – unilateral.

Class II services

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

Class III services

- Restorative services as follows:
 - Initial placement of laboratory-fabricated restorations, for a permanent tooth, when the tooth, as a result of extensive decay or a traumatic injury, cannot be restored with a direct placement filling material. *Pediatric dental services* include inlays, onlays, 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;

COVERED EXPENSES - PEDIATRIC DENTAL (continued)

- 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 4 per quadrant per *year*.
 - 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.
 - Occlusal adjustments when performed in conjunction with a periodontal surgical procedure. Limited to 1 per quadrant every 3 *years*.
 - Clinical crown lengthening – hard tissue.
 - Tissue graft procedures, including: pedicle soft tissue graft procedure, free soft tissue graft procedure (including donor site surgery); and subepithelial connective tissue graft procedures (including donor site surgery).
- Separate fees for pre- and post-operative care and re-evaluation within 3 months are not considered *pediatric dental services*.
- Endodontic procedures as follows:
 - Root canal therapy, including root canal treatments and root canal fillings for permanent teeth and primary teeth. Any test, intraoperative, x-rays, laboratory or any other follow-up care is considered integral to root canal therapy.
 - Retreatment of previous root canal therapy. Any test, intraoperative, x-rays, exam, laboratory, or any other follow-up care is considered integral to root canal therapy.
 - Periradicular surgical procedures for permanent teeth, including apicoectomy, root amputation, tooth reimplantation 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.

COVERED EXPENSES - PEDIATRIC DENTAL (continued)

- 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 2 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.

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; and
 - 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.

COVERED EXPENSES - PEDIATRIC DENTAL (continued)

- General anesthesia or conscious sedation subject to *clinical review* and administered by a *dentist* in conjunction with covered oral surgical procedures, periodontal and osseous surgical procedures, and periradicular surgical procedures, for *pediatric dental services*. General anesthesia is not considered a *pediatric dental service* if administered for, including but not limited to, the following:
 - Pain control, unless the *covered person* has a documented allergy to local anesthetic.
 - Anxiety.
 - Fear of pain.
 - Pain management.
 - Emotional inability to undergo a surgical procedure.

Class IV services

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

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

- For the treatment of and appliances for tooth guidance, interception and correction.
- Related to covered orthodontic treatment, including:
 - X-rays.
 - Exams.
 - Space retainers.
 - Study models.

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

Integral service

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

- Local anesthetics.
- Bases.
- Pulp testing.
- Pulp caps.
- Study models/diagnostic casts.
- *Treatment plans*.
- Occlusal (biting or grinding surfaces of molar and bicuspid teeth) adjustments.
- Nitrous oxide.
- Irrigation.
- Tissue preparation associated with impression or placement of a restoration.

COVERED EXPENSES - PEDIATRIC DENTAL (continued)

Pretreatment plan

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

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

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

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

Pretreatment plan process and timing

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

Alternate services

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

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

Limitations and exclusions

Refer to the "Limitations 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.

COVERED EXPENSES - PEDIATRIC DENTAL (continued)

- 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 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;
 - 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.

COVERED EXPENSES - PEDIATRIC DENTAL (continued)

- 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.

SAMPLE

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 this *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 other terms and provisions of the *policy* apply.

Definitions

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

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

Covered person under this "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 means the maximum fee allowed for *pediatric vision care*. *Reimbursement limit* for *pediatric vision care* is the lesser of:

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

COVERED EXPENSES - PEDIATRIC VISION CARE

(continued)

- 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.

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. One-year warranty for frames.

Covered expenses includes repairs to prescription eyeglasses, as needed.

- 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 myopia;
 - Aniseikonia;
 - Aniridia;
 - Corneal disorders;
 - Post-traumatic disorders; or
 - Irregular astigmatism.
- *Low vision* services include the following:
 - Comprehensive *low vision* testing and evaluation.
 - *Low vision* supplementary testing.
 - *Low vision* aids include the following:
 - Spectacle-mounted magnifiers.
 - Hand-held and stand magnifiers.
 - Hand-held or spectacle-mounted telescopes.
 - Video magnification.

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."

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.
- Three 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.

COVERED EXPENSES - BEHAVIORAL HEALTH

This "Covered Expenses – Behavioral Health" section describes the services that will be considered *covered expenses* for *mental illness, alcoholism, drug abuse or substance use* 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*; and
- *Coinsurance* percentage.

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

Acute inpatient services

We will pay benefits for *covered expenses* incurred by you due to an *admission or confinement* for *acute inpatient services* for *mental illness, alcoholism, drug abuse or substance use* services provided in a *hospital or health care treatment facility*.

Acute inpatient health care practitioner services

We will pay benefits for *covered expenses* incurred by you for *mental illness, alcoholism, drug abuse or substance use* services provided by a *health care practitioner*, including *virtual visits*, in a *hospital or health care treatment facility*.

Emergency services

We will pay benefits for *covered expenses* incurred by you for *emergency care*, including the treatment and stabilization of an *emergency medical condition* for *mental illness, alcoholism, drug abuse or substance use* services.

Emergency care provided by *non-network providers* will be covered at the *network provider* benefit level as specified in the "Emergency services" benefit in the "Schedule of Benefits" or "Schedule of Benefits – Behavioral Health" sections of this *certificate*. However, you will only be responsible to pay the *non-network provider* the *network provider copayment, deductible and/or coinsurance* to the *non-network provider* for *emergency care* based on the *qualified payment amount*.

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

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 illness, alcoholism, drug abuse or substance use services*.

Outpatient services

We will pay benefits for *covered expense* incurred by you for *mental illness, alcoholism, drug abuse or substance use services*, including services in a *health care practitioner office, retail clinic or health care treatment facility*. Coverage includes *outpatient therapy, intensive outpatient programs, partial hospitalization, virtual visits*, and other *outpatient services*.

Skilled nursing facility services

We will pay benefits for *covered expenses* incurred by you in a *skilled nursing facility* for *mental illness, alcoholism, drug abuse or substance use services*. *Your confinement to a skilled nursing facility must be based upon a written recommendation of a health care practitioner.*

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

Home health care services

We will pay benefits for *covered expenses* incurred by you, in connection with a *home health care plan*, for *mental illness, alcoholism, drug abuse or substance use 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*.

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.

Residential treatment facility services

We will pay benefits for *covered expenses* incurred by you for *mental illness, alcoholism, drug abuse or substance abuse* services provided while *inpatient* or *outpatient* in a *residential treatment facility*.

Autism spectrum disorders

We will pay *covered expenses* incurred by a *covered person* for the diagnosis and treatment of *autism spectrum disorders* provided by a *health care practitioner*, licensed psychologist, autism specialist, or an intensive individual service provider. *Covered expense* also includes *applied behavioral analysis* therapy.

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*).
- Psychotherapeutic drugs used for treatment of *mental illness*.
- 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.
- Orally administered cancer medications used to kill or slow the growth of cancerous cells prescribed by a *health care practitioner*.
- Drugs, medicines or medications on the Preventive Medication Coverage *drug list* with a *prescription* from a *health care practitioner*.

COVERED EXPENSES - PHARMACY SERVICES (continued)

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.

Restrictions on choice of providers

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

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

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

About our drug list

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

Prescription drug assistance program

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

COVERED EXPENSES - PHARMACY SERVICES (continued)

Access to medically necessary contraceptives

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

Access to non-formulary drugs

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

Non-formulary drug standard exception request

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

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

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

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

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

COVERED EXPENSES - PHARMACY SERVICES (continued)

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* identification card, in writing, or electronically by visiting *our* website at www.humana.com. We will respond to an expedited exception request within 24 hours of receipt of the request. An exigent circumstance exists when a *covered person* is:

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

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

- Statement that an exigent circumstance exists and explain the harm that could reasonably be expected to the *covered person* if the requested non-formulary drug is not provided within the timeframes of the standard exception request; and
- Justification supporting the need for the prescribed non-formulary drug to treat the *covered person's* condition, including a statement that all covered drugs on the *drug list* on any tier:
 - Will be or have been ineffective;
 - Would not be as effective as the non-formulary drug; or
 - Would have adverse effects.

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

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

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

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

Non-formulary drug exception request external review

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

COVERED EXPENSES - PHARMACY SERVICES (continued)

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

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

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

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

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

Step therapy 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.
- 72 hours 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* has been ineffective in the treatment of *your* disease or medical condition; or
- Based on sound clinical evidence or medical and scientific evidence, the *prescription* drug requiring *step therapy*:
 - Is expected or likely to be ineffective based on *your* known relevant clinical characteristics and the known characteristics of the *prescription* drug regimen; or
 - Will cause or will likely cause an adverse reaction in or physical harm to *you*.

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 "Complaint and Appeals Procedures" section of this *certificate*.

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*.
- Benefits will not be provided for services, injuries or diseases arising out of, or in the course of, any employment for wage gain or profit, to the extent *you* are covered or are required to be covered by the Workers' Compensation law. If *you* enter into a settlement giving up *your* right to recover future medical benefits under a Workers' Compensation law, the *policy* will not pay those medical benefits that would have been payable in absence of that settlement.
- Care and treatment given in a *hospital* owned or run by any government entity, unless *you* are legally required to pay for such care and treatment. However, care and treatment provided by military *hospitals* to *covered persons* who are armed services retirees and their *dependents* are not excluded.
- Any service furnished while *you* are *confined in* a *hospital* or institution owned or operated by the United States government or any of its agencies for any military service-connected *sickness* or *bodily injury*.
- Services, or any portion of a service for which no charge is made.
- Services, or any portion of a service *you* would not be required to pay for, or would not have been charged for, in the *absence* of this 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.
- Any service not ordered by a *health care practitioner*.
- Services rendered by a standby physician, *surgical assistant* or *assistant surgeon* unless *medically necessary*.
- Any service not rendered by the billing provider.
- Any service not substantiated in the medical records of the billing provider.
- Any amount billed for a professional component of an automated:
 - Laboratory service; or
 - Pathology service.

LIMITATIONS AND EXCLUSIONS (continued)

- Any expense incurred for services received outside of the United States while *you* are residing outside of the United States for more than six months in a *year* and are not a resident of Kansas, except as required by law for *emergency care* services.
- Education or training, except for *diabetes self-management training* and *habilitative services*.
- Educational or vocational therapy, testing, services, or schools, including therapeutic boarding schools and other therapeutic environments. Educational or vocational videos, tapes, books, and similar materials are also excluded.
- Services provided by a *covered person's family member*.
- *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*.
- Growth hormones, except as otherwise specified in the pharmacy services sections of this *certificate*.
- *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*.

LIMITATIONS AND EXCLUSIONS (continued)

- 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."
- Hearing aids, the fitting of hearing aids or advice on their care; implantable hearing devices, except for cochlear implants as otherwise stated in this *certificate*.
- 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*.
- Reversal of elective sterilization.
- Any expense for:
 - Artificial insemination;
 - In vitro fertilization, regardless of the reason for treatment;
 - Gamete Intrafallopian Transfer (GIFT);
 - Zygote Intrafallopian Transfer (ZIFT);
 - Tubal ovum transfer;
 - Embryo freezing or transfer;
 - Sperm storage or banking;
 - Ovum storage or banking;
 - Embryo or zygote banking; and
 - Any other assisted reproductive techniques or cloning methods, provided to achieve pregnancy.
- 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*.
 - The expense relates to the donation or acquisition of an organ or tissue for a recipient who is not covered by *us*.

LIMITATIONS AND EXCLUSIONS (continued)

- 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 except for *mastectomy* and *mastectomy bras*.
- Hair prosthesis, hair transplants or implants and wigs.
- Dental services, appliances or supplies for treatment of the teeth, gums, jaws or alveolar processes, including but not limited to, any *oral surgery*, *endodontic services* or *periodontics*, implants and related procedures, orthodontic procedures, and any dental services related to a *bodily injury* or *sickness* unless otherwise stated in this *certificate*.
- The following types of care of the feet, unless due to a systemic condition, such as metabolic, neurologic, or peripheral vascular disease that results in significant circulatory deficits or decreased sensation of the feet:
 - Shock wave therapy of the feet;
 - The treatment of weak, strained, flat, unstable or unbalanced feet;
 - Arch supports (foot orthotics) or orthopedic shoes;
 - 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.
- *Custodial care* and *maintenance care*.
- Any loss contributed to, or caused by:
 - War or any act of war, whether declared or not;
 - Insurrection; or
 - Any conflict involving armed forces of any authority.
- Services relating to a *sickness* or *bodily injury* as a result of:
 - Engagement in an illegal profession or occupation; or
 - Commission of or an attempt to commit a criminal act.

This exclusion does not apply to any *sickness* or *bodily injury* resulting from an act of domestic violence or a medical condition (including both physical and mental health conditions).

LIMITATIONS AND EXCLUSIONS (continued)

- 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*.
- 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.
- Communications or travel time.
- Bariatric *surgery*, any services or complications related to bariatric *surgery*, and other weight loss products or services. Refer to the "Preventive services" provision in the "Covered Expenses" section for coverage that is available for obesity screening and counseling.

LIMITATIONS AND EXCLUSIONS (continued)

- Accidental bodily injuries arising out of a motor vehicle accident to the extent such benefits are payable under any medical expense payment provision, including such benefits mandated by law, of any automobile policy.
- Medical or surgical *elective abortion* unless the pregnancy would endanger the life of the mother.
- *Alternative medicine*. This exclusion does not apply to biofeedback for urinary incontinence for a *covered person*.
- 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*.
- Services and supplies which are rendered in connection with mental illnesses not classified in the Diagnostic and Statistical Manual of Mental Disorders, fourth edition, (DSM-IV 1994) of the American Psychiatric Association.
- Marriage counseling.
- Expenses for:
 - Employment;
 - School;
 - Sport;
 - Camp;
 - Travel; or
 - The purposes of obtaining insurance.

LIMITATIONS AND EXCLUSIONS (continued)

- Expenses for care and treatment of non-covered procedures or services.
- Expenses for treatment of complications of non-covered procedures or services.
- Expenses incurred for services prior to the *effective date* or after the termination date of *your* coverage under the *policy*. Coverage will be extended as described in the "Extension of Benefits" section, required by state law.
- *Pre-surgical/procedural testing* duplicated during a *hospital confinement*.

SAMPLE

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

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).
- 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*.
- The administration of covered medication(s).

LIMITATIONS AND EXCLUSIONS - PHARMACY SERVICES (continued)

- *Prescriptions* that are to be taken by or administered to *you*, in whole or in part, while *you* are a patient in a facility where drugs are ordinarily provided on an *inpatient* basis by the facility. *Inpatient* facilities include, but are not limited to:
 - *Hospital*;
 - *Skilled nursing facility*; or
 - *Hospice facility*.
- Injectable drugs, including, but not limited to:
 - Immunizing agents, unless for *preventive services* determined by *us* to be dispensed by or administered in a *pharmacy*;
 - Biological sera;
 - Blood;
 - Blood plasma; or
 - *Self-administered injectable drugs* or *specialty drugs* for which *prior authorization* or *step therapy* is not obtained from *us*.
- *Prescription* fills or refills:
 - In excess of the number specified by the *health care practitioner*; or
 - Dispensed more than one year from the date of the original order.
- Any portion of a *prescription* fill or refill that exceeds a 90-day supply when received from a *mail order pharmacy* or a retail *pharmacy* that participates in *our* program, which allows *you* to receive a 90-day supply of a *prescription* fill or refill.
- Any portion of a *prescription* fill or refill that exceeds a supply sufficient for 34 consecutive days of therapy 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 that exceeds a supply sufficient for 34 consecutive days of therapy, 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*.
- 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.

LIMITATIONS AND EXCLUSIONS - PHARMACY SERVICES

(continued)

- 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*.

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*.

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 or adopted newborn child;
- The date of placement of the child for the purpose of adoption by the *employee*; or
- The date specified in a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN) for a child, or a valid court or administrative order for a spouse, which requires the *employee* to provide coverage for a child or spouse as specified in such orders.

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

Enrollment

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

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.

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.

ELIGIBILITY AND EFFECTIVE DATES (continued)

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

Dependent enrollment

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

Newborn and adopted dependent enrollment

A newborn *dependent* will be covered automatically from the date of birth. An adopted newborn *dependent* will be covered automatically from the date of birth if a petition for adoption was filed within 31 days of the birth of the child.

An adopted *dependent* will be automatically covered for 31 days from the earliest of:

- The date the petition for adoption was filed; or
- Placement of the child with the *employee* for the purpose of 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* and adopted newborn *dependents* or the earlier of the date of petition for adoption, 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.

If premium is required to add *dependents* to continue coverage beyond the initial 31 days of coverage, *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 petition for adoption, 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 petition for adoption, 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.

ELIGIBILITY AND EFFECTIVE DATES (continued)

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, legal separation 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;
 - 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

ELIGIBILITY AND EFFECTIVE DATES (continued)

- 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*.

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*.

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.

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.

ELIGIBILITY AND EFFECTIVE DATES (continued)

Employee effective date

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

Dependent effective date

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

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

Newborn and adopted dependent effective date

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

Maternity benefits apply to the costs of birth of any child legally adopted by *you* as long as the following conditions are met:

- The child is adopted within 90 days of birth; and
- *You* have paid all *deductibles* and *copayments*.

The *policy* may be considered excess coverage to any other coverage the natural mother may have for maternity benefits. If other coverage exists, the agency, attorney or person arranging the adoption shall make arrangements, based on the Coordination of Benefits section for the appropriate policy to pay the costs associated with the birth. *We* are not required to pay any costs in excess of what *we* would have paid if the natural mother and *child* had received the maternity and newborn care directly from *us*.

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*.

REPLACEMENT OF COVERAGE

Applicability

This "Replacement of Coverage" section applies when an *employer's* previous group health plan not offered by Humana Insurance Company 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*.

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.

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

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

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.

Out-of-pocket limit

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

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 past the requested termination date.

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

TERMINATION PROVISIONS (continued)

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.

SAMPLE

EXTENSION OF BENEFITS

Extension of health insurance for inpatient confinement

If a *covered person* is receiving hospital services when the policy terminates, *we* will extend limited health insurance benefits for any covered inpatient *hospital* services until the earliest of:

- The last day of a 31 day period following the date the *policy* terminated; or
- The date the inpatient *hospital* confinement ended; or
- The date any maximum benefit is reached.

SAMPLE

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

A complete description of the "State continuation of health insurance" and "Continuation of coverage for Dependents" provisions follows.

State continuation of health insurance

A *covered person* whose coverage terminates shall have the right to continuation under the *policy* as follows.

An *employee* may elect to continue coverage for himself or herself.

If an *employee* was insured for *dependent* coverage when his or her health insurance terminated, an *employee* may choose to continue health insurance for any *dependent* who was insured by the *policy*. The same terms with regard to the availability of continued health insurance described below will apply to *dependents*.

In order to be eligible for this option,

- The *employee* must have been continuously covered under the *policy* for at least three consecutive months prior to termination, and
- The *covered person's* coverage must be terminated for any other reason other than involuntary termination for cause.

There is no right to continuation if:

- The termination of coverage was for cause as allowed by the *policy*;
- The termination of coverage occurred because the *employee* failed to pay the required premium contribution;
- The discontinued *group* coverage was replaced by similar group coverage within 31 days of the discontinuance;
- The *covered person* is or could be covered by *Medicare*;
- The *covered person* has similar benefits under another group or individual plan whether insured or self insured;
- The *covered person* is eligible for similar benefits under another group plan whether insured or self insured; or
- Similar benefits are provided for or available to the *covered person* under any state or federal law.

CONTINUATION (continued)

Written application and payment of the first premium for continuation must be made within 31 days after the date coverage terminates or within 31 days after the *covered person* has been given any required notice. No evidence of insurability is required to obtain continuation.

If this state continuation option is selected, continuation will be permitted for a maximum of 18 months. The premium rate will be 100% of the *group* premium. The premium will be payable in advance to *us* on a monthly basis. Continuation may not terminate until the earliest of:

- Eighteen months after the date the election is made;
- The date timely premium payments are not made;
- The date on which the *covered person* is or could be covered under *Medicare*;
- The date on which the *covered person* is covered for similar benefits under another group or individual policy;
- The date on which the *covered person* is eligible for similar benefits under another group plan; or
- The date on which similar benefits are provided for or available to the *covered person* under any state or federal law.

The *covered person* is responsible for sending *us* the premium payments for those individuals who choose to continue their health insurance. If the *covered person* fails to make proper payment of the premiums to *us*, *we* are relieved of all liability for any health insurance that was continued.

Continuation of coverage for dependents

Continuation of coverage is available for *dependents* who are no longer eligible for the health insurance provided by the *policy* because of:

- The death of the covered *employee*;
- The retirement of the covered *employee*; or
- The severance of the family relationship.

Each *dependent* may choose to continue these benefits for up to 18 months after the date the coverage would have normally terminated. *We* must receive proper notice of the choice to continue coverage, but *we* will not require evidence of insurability.

Proper notice of the choice to continue coverage is given as follows:

- The covered *employee* or *dependent* must give the *policyholder* written notice within 31 days of any severance of the family relationship that might activate this continuation option; and
- The *policyholder* must give written notice to each affected *dependent* of the continuation option immediately upon receipt of notice of severance of the family relationship or upon receipt of notice of the *employee's* death or retirement;
- The *dependent* must give written notice to *us* of his or her desire to exercise the continuation option within 31 days from the date of the *employee's* death, retirement, or the severance of the family relationship.

CONTINUATION (continued)

Premiums must be paid each month in advance for coverage to continue. The *covered employee* or *dependent* is responsible for sending *us* the premium payments for those individuals who choose to continue their coverage.

The option to continue coverage is not available if:

- The termination of coverage was for cause as allowed by the *policy*;
- A *dependent* becomes eligible for similar group coverage either on an insured or self insured basis;
- The *dependent* was not continuously covered by the *policy* and the Prior Plan replaced by the *policy* for at least three months prior to the date coverage terminates, except in the case of an infant under three months of age; or
- The *dependent* elects to continue his or her coverage under the terms and conditions described in (COBRA).

Continued coverage terminates on the earliest of the following dates:

- The last day of the 18 month period following the date the *dependent* was no longer eligible for coverage;
- The date the *dependent* becomes eligible for similar group benefits, either on an insured or self insured basis;
- The date timely premium payments are not made; or
- The date the *policy* terminates.

The *covered person* is responsible for sending *us* the premium payments for those individuals who choose to continue their health insurance. If the *covered person* fails to make proper payment of the premiums to *us*, *we* are relieved of all liability for any health insurance that was continued.

MEDICAL CONVERSION PRIVILEGE

Eligibility

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

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

Only persons covered under the *policy* on the date coverage terminates are eligible to be covered under the Medical Conversion Policy.

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

A Medical Conversion Policy is not available when:

- *You* are not a legal resident of Kansas;
- The *employer's* participation in the *policy* terminates and medical coverage is replaced within 31 days by another group insurance plan;
- *You* are covered for similar benefits by another hospital, surgical, medical, or major medical expense insurance policy or hospital or medical service subscriber contract or medical practice or other prepayment plan, or by any other plan or program;
- *You* are eligible for similar benefits, whether or not actually provided coverage, under any arrangement of coverage for individuals in a group, whether on an insured or uninsured basis; or

Similar benefits are provided for or are available to *you* under any state or federal law.

Please contact *us* for details regarding other coverage options that may be available to *you*.

Overinsurance - duplication of coverage

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

MEDICAL CONVERSION PRIVILEGE (continued)

Medical conversion policy

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

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

Effective date and premium

You have 31 days after the date *your* coverage terminates under the *policy* to apply and pay the required premium for *your* Medical Conversion Policy. The premium must be paid in advance. *You* may obtain application forms from *us* via the internet or by request in writing. The Medical Conversion Policy will be effective on the day after *your group* medical coverage ends, if *you* enroll and pay the first premium within 31 days after the date *your* coverage ends.

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

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 group *plans* do not exceed 100% of the total *allowable expense*.

Definitions

The following definitions are used exclusively in this provision.

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

Plan includes:

- Group insurance contracts and health maintenance organization (HMO) contracts;
- Uninsured arrangements of group or group-type coverage;
- Group coverage through closed panel plans;
- Group-type contracts;
- Medical care components of long-term care contracts, such as skilled nursing care; and
- Medicare or other governmental benefits, as permitted by law;
- Nongroup insurance contract issued on or after January 1, 2014;
- Nongroup coverage through closed panel plans issued on or after January 1, 2014;
- Group and nongroup insurance contracts and subscriber contracts that pay or reimburse for the cost of dental care.

Plan does not include:

- Hospital indemnity coverage or other fixed indemnity coverage;
- Specified disease or specified accident coverage;
- Accident only coverage;
- Benefits for non-medical care components of group long-term care contracts;
- Medicare supplement policies;
- A state plan under *Medicaid*; or
- A governmental plan, which by law, provides benefits that are in excess of those of any private insurance plan or other non-governmental plan.

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

- If a *covered person* is confined in a private *hospital* room, the difference between the cost of a semi-private room in the *hospital* and the private room, (unless the patient's stay in a private *hospital* room is medically necessary in terms of generally accepted medical practice, or one of the *plans* routinely provides coverage for *hospital* private rooms) is not an *allowable expense*.
- If a person is covered by two or more *plans* that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement or other similar reimbursement methodology, any amount in excess charged by the provider of the highest reimbursement amount for a specific benefit is not an *allowable expense*.
- 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 excludes benefits for services provided by other providers, except in the cases of emergency or referral by a panel member.

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

COORDINATION OF BENEFITS (continued)

Order of determination rules

General

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

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

Rules

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

- **Non-dependent or dependent.** The *plan* that covers the person other than as a *dependent*, including as an *employee*, member, subscriber or retiree, is *primary* and the *plan* that covers the person as a *dependent* is *secondary*. However, if the person is a *Medicare* beneficiary and, as a result of federal law, *Medicare* is *secondary* to the *plan* covering the person as a *dependent*; and *primary* to the *plan* covering the person as other than a *dependent* (e.g. retired *employee*); then the order of benefits between the two *plans* is reversed so that the *plan* covering the person as an *employee*, member, subscriber or retiree is *secondary* and the other *plan* is *primary*.
- **Dependent child covered under more than one *plan*.** The order of benefits when a child is covered by more than one *plan* is:
 - The *primary plan* is the *plan* of the parent whose birthday is earlier in the year if:
 - The parents are married;
 - The parents are not separated (whether or not they 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*.

COORDINATION OF BENEFITS (continued)

- 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*.

Effects on the benefits of this plan

When this *plan* is *secondary*, benefits may be reduced to the difference between the *allowable expense* (determined by the *primary plan*) and the benefits paid by any *primary plan* during the *claim determination period*. Payment from all *plans* will not exceed 100% of the total *allowable expense*. If a *covered person* is enrolled in two or more closed panel plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one *closed panel plan*, COB shall not apply between that *plan* and the other *closed panel plan*.

COORDINATION OF BENEFITS (continued)

Right to receive and release needed information

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

Facility of payment

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

Right of recovery

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

CONSUMER EXPLANATORY BOOKLET

IMPORTANT NOTICE

This is a summary of only a few of the provisions of your health plan to help you understand coordination of benefits, which can be very complicated. This is not a complete description of all of the coordination rules and procedures, and does not change or replace the language contained in your insurance contract, which determines your benefits.

Double Coverage

It is common for family members to be covered by more than one health care plan. This happens, for example, when a husband and wife both work and choose to have family coverage through both employers.

When you are covered by more than one group health plan, state law permits your insurers to follow a procedure called "coordination of benefits" to determine how much each should pay when you have a claim. The aim is to make sure that the combined payments of all *plans* do not add up to more than your covered health care expenses.

COORDINATION OF BENEFITS (continued)

Coordination of benefits (COB) is complicated, and covers a wide variety of circumstances. This is only an outline of some of the most common ones. If *your* situation is not described, read *your* evidence of coverage or contact *your* state insurance department.

Primary or Secondary?

You will be asked to identify all the *plans* that cover family members. *We* need this information to determine whether *we* are *primary* or *secondary*. The *primary plan* always pays first.

Any *plan* which does not contain *your* state's coordination of benefits rules will always be *primary*.

When this plan is primary

If *you* or a family member is covered under another *plan* in addition to this one, *we* will be *primary* when:

- **Your own expenses**
 - The claim is for *your* own health care expenses, unless *you* are covered by *Medicare* and both *you* and *your* spouse are retired.
- **Your spouse's expenses**
 - The claim is for *your* spouse, who is covered by *Medicare*, and *you* are not both retired
- **Your child's expenses**
 - The claim is for the health care expenses of a child covered by this *plan* and;
 - *Your* birthday is earlier in the year than *your* spouse's. This is known as the "birthday rule;" or
 - *You* are not married and *you* have informed *us* of a court decree that makes *you* responsible for the child's health care expenses; or
 - There is no court decree, but *you* have custody of the child.

Other situations

We will be *primary* when any other provisions of state or federal law require *us* to be.

How we pay claims when we are primary

When *we* are the *primary plan*, *we* will pay the benefits provided by *your* contract, as if *your secondary plan* did not exist.

How we pay claims when we are secondary

We will be *secondary* whenever the rules do not require *us* to be *primary*.

COORDINATION OF BENEFITS (continued)

How we pay claims when we are secondary

When we are the *secondary plan*, we do not pay until after the *primary plan* has paid its benefits. We will then pay part or all of the *allowable expenses* left unpaid. An *allowable expense* is a health care service or expense covered by one of the *plans*, including copayments and deductibles.

- If there is a difference between the amount the *plans* allow, we will base our payment on the higher amount. However, if the *primary plan* has a contract with the provider, *our* combined payments will not be more than the contract calls for. Health maintenance organizations (HMO) and preferred provider organizations (PPO) usually have contracts with their providers.
- We will determine our payment by subtracting the amount the *primary plan* paid from the amount we would have paid if we had been *primary*. We will use any savings to pay the balance of any unpaid *allowable expenses* covered by either *plan*.
- We will not pay an amount the *primary plan* did not cover because you did not follow its rules and procedures. For example, if *your plan* has reduced its benefit because you did not obtain pre-certification, we will not pay the amount of the reduction, because it is not an *allowable expense*.

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.

Questions About Coordination of Benefits?
Contact Your State Insurance Department

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 must submit a notice of claim to *us*. Notice of claim must be given to *us* in writing or by *electronic mail* as required by *your* plan, or as soon as is reasonably possible thereafter. Notice must be sent to *us* at *our* mailing address shown on *your* ID card or at *our* website at www.humana.com.

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

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

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

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

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

Proof of loss

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

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

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;

CLAIMS (continued)

- Food and Drug Administration guidance;
- 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.

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.

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 during the pendency of a claim. If *we* require a medical examination, it will be performed at *our* expense. *We* also have a right to request an autopsy at *our* expense in the case of death, if state law so allows.

To whom benefits are payable

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

CLAIMS (continued)

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

- *You* request *we* direct a payment of selected medical benefits to the health care provider on whose charge the claim is based and *we* consent to this request; or
- *Your* responsibility for the *covered expenses* is based off the *qualified payment amount*.

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

Except as stated above, if *you* submit a claim for payment to *us*, *we* will pay *you* directly for the *covered expenses*.

You are responsible to pay all charges to the provider when *we* pay *you* directly for *covered expenses*.

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.

Any benefits unpaid at *your* death may be paid to *your* estate. If benefits are payable to *your* estate, *we* may pay up to \$1,000 to anyone related to *you* by blood or marriage, whom *we* consider to be entitled to the benefits. *We* will be discharged to the extent of any such payment made in good faith.

Time of payment of claims

Payments due under the *policy* will be paid immediately after receipt of written or *electronic* proof of loss.

Right to request overpayments

Providers and/or *you* have the responsibility to return any overpayments to *us*. *We* reserve the right to recover any payments made by *us* that were:

- Made in error;
- Made to *you* or any party on *your* behalf, where *we* determine 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*.

We have the responsibility to make additional payments if an underpayment is made to a provider or *you*.

CLAIMS (continued)

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; 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.

Exhaustion of time limits

If *we* fail to complete a claim determination or send notice to the provider of services why payment is delayed within the time limits set forth in the *policy*, we will pay interest on the claim at the interest rate required by state law, unless a good faith dispute about the legitimacy of the claim exists.

COMPLAINT AND APPEAL PROCEDURES

We make every effort to resolve customer dissatisfaction issues at an informal level. Our customer service representatives are available to assist you with any issue relating to your health coverage or any aspect of your plan. Our customer service representatives may be reached at the telephone number listed on your identification card.

All terms used in this Complaint and Appeal Procedures provision have the same meaning given to them in the *certificate*, unless otherwise specifically defined in this provision.

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 based on:

- A determination that the benefit is not covered;
- The imposition of a source-of-injury exclusion, network exclusion, or other limitation on otherwise covered benefits;
- A determination that a benefit is experimental or investigational, or not medically necessary or appropriate;
- A determination of your eligibility for group coverage under the policy.

An *adverse benefit determination* also includes claims protected under the Federal No Surprises Act and any rescission of coverage. A rescission of coverage is not eligible for *external review*.

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

Commission means the Kansas Department of Insurance Commission.

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

External review organization (ERO) means an entity that conducts independent external reviews of *adverse benefit determinations* and *final adverse benefit determinations*. All ERO's shall be a nationally accredited external review organization which utilizes health care providers actively engaged in the practice of their profession in the state of Kansas who are qualified and credentialed with respect to the health care service review.

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

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

COMPLAINT AND APPEAL PROCEDURES (continued)

- Serious dysfunction of any bodily organ or part.

Emergency medical condition claim means a claim for covered services to which the application of the time periods for making non-emergency care determinations:

- Could seriously jeopardize the life or health of the *covered person* or the ability of the *covered person* to regain maximum function;
- In the opinion of a physician with knowledge of the *covered person's* medical condition, would subject the *covered person* to severe pain that cannot be adequately managed without the service that is the subject of the claim; or
- Coverage has been denied on a determination that the service or treatment is experimental or investigational, and in the opinion of a physician with knowledge of the *covered person's* medical condition, service or treatment for the medical condition will be significantly less effective if not promptly initiated.

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

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

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

Pre-service claim means a request for authorization of a benefit for which the plan conditions receipt of the benefit, in whole or in part, on advance approval.

Internal appeals

You or your authorized representative must appeal an *adverse benefit determination* within 180 days after receiving written notice of the denial (or partial denial). An appeal may be made by you or your authorized representative by means of written application to us by mail, postage prepaid to the address below:

**Humana Insurance Company
Attn: Grievance Department
P.O. Box 14546
Lexington, KY 40512-4546**

COMPLAINT AND APPEAL PROCEDURES (continued)

You or your authorized representative, on appeal, may request an expedited internal appeal of an adverse *emergency medical condition claim* decision orally or in writing. In such case, all necessary information, including the plan's benefit determination on review, will be transmitted between the plan and *you or your authorized representative* by telephone, FAX, or other available similarly expeditious method, to the extent permitted by applicable law.

You or your authorized representative may request an expedited external review at the same time a request is made for an expedited internal appeal of an *adverse benefit determination* for an *emergency medical condition claim* or when *you* are receiving an ongoing course of treatment.

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

You or your authorized representative may submit written comments, documents, records and other material relating to *adverse benefit determination* for consideration. *You* may also receive, upon request, reasonable access to, and copies of all documents, records and other relevant information considered during the appeal process.

You or your authorized representative on appeal may, upon request, discover the identity of medical or vocational experts whose advice was obtained on behalf of the plan in connection with the *adverse benefit determination* being appealed, as permitted under applicable law.

If the claims denial is based in whole, or in part, upon a medical judgment, including determinations as to whether a particular treatment, drug, or other service is experimental or investigational, or not *medically necessary* or appropriate, the person deciding the appeal will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The consulting health care professional will not be the same person who decided the initial appeal or a subordinate of that person.

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

Time periods for decisions on appeal

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

- **Emergency medical condition claims** - As soon as possible but not later than 72 hours after we received the appeal request;
- **Pre-service claims** - Within a reasonable period but not later than 30 days after we received the appeal request;
- **Post-service claims** - Within a reasonable period but not later than 60 days after we received the appeal request;
- **Concurrent-care decisions** - Within the time periods specified above depending on the type of claim involved.

COMPLAINT AND APPEAL PROCEDURES (continued)

Appeals denial notices

Notice of a claim denial (including a partial denial) will be provided to *you* or *your authorized representative* by mail, postage prepaid, or by FAX, as appropriate, within the time periods noted above.

A notice that a claim appeal has been denied will include:

- The specific reason or reasons for the *adverse benefit determination*;
- Reference to the specific plan provision upon which the determination is based;
- If any internal plan rule, protocol or similar criterion was relied upon to deny the claim. A copy of the rule, protocol or similar criterion will be provided to *you* or *your authorized representative*, free of charge;
- A statement of *you* or *your authorized representative's* right to external review, a description of the external review process, and the forms for submitting an external review request, including release forms authorizing *us* to disclose protected health information pertinent to the external review;
- A statement about *you* or *your authorized representative's* right to bring an action under §502(a) of ERISA;
- If an *adverse benefit determination* is based on medical necessity, *experimental* treatment or similar exclusion or limitation, the notice will provide an explanation of the scientific or clinical basis for the determination, free of charge. The explanation will apply the terms of the plan to the *covered person's* medical circumstances.

Exhaustion of remedies

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

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

External review

Within 120 days after *you* or *your authorized representative* receives notice of an *adverse benefit determination* or *final adverse benefit determination* involving *medical necessity* or experimental or investigational treatment, *you* or *your authorized representative* may request an external review. The request for external review must be made in writing to the *commission*. For claims protected under the Federal No Surprises Act, refer to *our* decision letter for the timeframe to submit the request and instructions on how to request an external review.

COMPLAINT AND APPEAL PROCEDURES (continued)

You or your authorized representative will be required to authorize release of any medical records that may be required to be reviewed for the purpose of reaching a decision on the external review. Please refer to the section titled 'Expedited external review' if the *adverse benefit determination* involves an *emergency medical condition claim* or an ongoing course of treatment.

If the request qualifies for an external review, the *commission* will notify *you or your authorized representative* in writing of the assignment of an *IRO* and the right to submit additional information. Additional information must be submitted within the first 7 business days of receipt of the letter. *You or your authorized representative* will be notified of the determination within 45 days of the *IRO's* receipt of the request.

Expedited external review

You or your authorized representative may request an expedited external review in writing or orally:

- At the same time *you* request an expedited internal appeal of an *adverse benefit determination* for an *emergency medical condition claim* or when *you* are receiving an ongoing course of treatment; or
- When *you* receive an *adverse benefit determination* or *final adverse benefit determination* of:
 - An *emergency medical condition claim*;
 - An admission, availability of care, continued stay or health care service for which *you* received emergency services, but *you* have not been discharged from the facility; or
 - An experimental or investigational treatment if the treating physician certifies, in writing, that the recommended service would be significantly less effective if not promptly initiated.

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

External review organization determination

The determination of the *external review organization* shall be binding on *you* and *us* except the decision of the *external review organization* may be reviewed directly by the district court at the request of either *you, your authorized representative* or *us*. The review by the district court will be considered a new review.

For assistance with appeals, complaints or the external review process, *you or your authorized representative* may contact the *commission* at the address and telephone number below:

Kansas Department of Insurance
Consumer Assistance Division
1300 SW Arrowhead Road Topeka, KS 66604
Website: <https://www.insurance.kansas.gov>
Email: webcomplaints@ksinsurance.org
Phone: 800-432-2484 or 785-296-7829

COMPLAINT AND APPEAL PROCEDURES (continued)

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 five years from the date written proof of loss is required to be given.

SAMPLE

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.

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.

Discount programs are not insurance products and are therefore not regulated under the Kansas Insurance Department. For protection measures one would need to contact the office of the Kansas Attorney General.

Wellness programs

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

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

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

DISCLOSURE PROVISIONS (continued)

The rewards may include, but are not limited to, 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, payment for all or a portion of a participatory wellness program or wellness credits to the *employer*.

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* identification 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.

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*.

If *you* choose to obtain services from a *non-network provider*, the services may be eligible for a discount to *you* under the Shared Savings Program. It is not necessary for *you* to inquire in advance about services that may be discounted. When processing *your* claim, *we* will automatically determine if the services are subject to the Shared Savings Program and calculate *your deductible* and *coinsurance* on the discounted amount. Whether 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 discounted. *We* cannot guarantee that services rendered by *non-network providers* will be discounted. The *non-network provider* discounts in the Shared Savings Program may not be as favorable as *network provider* discounts.

DISCLOSURE PROVISIONS (continued)

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 participating in the Shared Savings Program at the time treatment is received. Discounts are dependent upon availability and cannot be guaranteed.

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

SAMPLE

MISCELLANEOUS PROVISIONS

Entire contract

The entire contract is made up of the *policy*, the application of the *policyholder*, incorporated by reference herein the endorsement and the attached papers, 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.

Additional policyholder responsibilities

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

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

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

Certificates of insurance

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

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 appear to differ with the terms of this *certificate*, the terms of this *certificate* will control.

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*.

MISCELLANEOUS PROVISIONS (continued)

At any time, *we* may assert defenses based upon provisions in the *policy* which relate to *your* eligibility for coverage under the *policy*. This does not apply to any *health status related factor*.

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.

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 a court of law, *we* reserve the right to *rescind your* coverage after *we* provide *you* a 30 calendar day advance written notice that coverage will be *rescinded*. *You* have the right to appeal the *rescission*.

Clerical error or misstatement

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

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* at least 60 days prior to the effective date of the change.

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*.

MISCELLANEOUS PROVISIONS (continued)

Discontinuation of coverage

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

- The *policyholder*, *employees* and *covered persons* 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 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* 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.

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.

Premium rate change

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

Assignment

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

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.

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).

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*.

A

Abortion means the use or prescription of any instrument, medicine, drug or any other substance or device to terminate any pregnancy of a *covered person* known to be pregnant with the intention other than to increase the probability of a live birth, to preserve the life or health of the child after live birth, or to remove a dead unborn child who died as the result of natural causes in utero, accidental trauma or a criminal assault on the pregnant *covered person* or her unborn child and which causes the premature termination of the pregnancy.

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.

GLOSSARY (continued)

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

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

Applied behavior analysis means the design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement and functional analysis of the relationship between environment and behavior.

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.

GLOSSARY (continued)

Autism spectrum disorder means a neurobiological disorder, an illness of the nervous system, which includes, but not limited to:

- Autistic disorder;
- Asperger's disorder;
- Pervasive developmental disorder not otherwise specified;
- Rett's disorder; and
- Childhood disintegrative disorder.

B

Behavioral health means *mental illness, alcoholism, drug abuse or substance use services*.

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*.

C

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.

GLOSSARY (continued)

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.

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.

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

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

Covered expense means:

- *Medically necessary* services to treat a *sickness* or *bodily injury*, such as:
 - Procedures;

GLOSSARY (continued)

- 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*.

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;
- Newborn adopted child from moment of birth if petition for adoption was filed within 31 days of newborn's birth;
- Child, whose age is less than the limiting age, placed in the *employee's* home by a qualified child placement agency for adoption, from the date of placement, as certified by the *covered person*. The time from date of placement to the date petition for adoption is filed cannot exceed 280 days;
- 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;
- 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.

GLOSSARY (continued)

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 includes, but is not limited to, blood glucose monitors, including monitors designed to be used by blind individuals; insulin pumps and associated accessories; insulin infusion devices; and podiatric appliances for the prevention of complications associated with diabetes.

Diabetes self-management training includes, but is not limited to, the training provided to a *covered person* after the initial diagnosis of diabetes for care and management of the condition, including nutritional counseling and use of *diabetes equipment* and supplies. It also includes training when changes are required to the self-management regime and when new techniques and treatments are developed.

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

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

Durable medical equipment means equipment that meets all of the following criteria:

- It is prescribed by a *health care practitioner*;
- It can withstand repeated use;
- It is primarily and customarily used for a medical purpose rather than being primarily for comfort or convenience;
- It is generally not useful to *you* in the absence of *sickness* or *bodily injury*;
- It is appropriate for home use or use at other locations as necessary for daily living;
- It is related to and meets the basic functional needs of *your* physical disorder;
- It is not typically furnished by a *hospital* or *skilled nursing facility*; and
- It is provided in the most cost effective manner required by *your* condition, including, at *our* discretion, rental or purchase.

E

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

GLOSSARY (continued)

Elective abortion means an *abortion* for any reason other than to prevent the death of the *covered person* upon whom the *abortion* is performed, provided that an *abortion* may not be deemed one to prevent the death of the *covered person* based on a claim or diagnosis that she will engage in conduct which will result in the *covered person's* death.

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.

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

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

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

GLOSSARY (continued)

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

- The *employer* is a sole proprietorship, partnership or corporation;
- The sole proprietorship or other entity (other than a partnership) has at least one common-law employee (other than the business owner and his or her spouse); and
- The sole proprietor, partner or corporate officer is actively performing activities relating to the business, gains their livelihood from the sole proprietorship, partnership or corporation and is in an *active status* at the *employer's* usual place of business or some other location, which is usual for the sole proprietor's, partner's or corporate officer's particular duties.
- *Employee* may also include independent contractors of the *employer* if the *employer* includes the independent contractor under the *employer's* group health plan.

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;
- 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;

GLOSSARY (continued)

- Is the subject of a National Cancer Institute (NCI) Phase I, II, III, or IV trial or a treatment protocol comparable to a NCI Phase I, II, III, or IV trial, or any trial not recognized by NCI regardless of phase; or
- Is identified as not covered by the Centers for Medicare & Medicaid Services (CMS) Medicare Coverage Issues Manual, a CMS Operational Policy Letter or a CMS National Coverage Decision, except as required by state or federal law.

F

Family member means *you* 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 at least 30 hours and does not include an employee who works on a part-time, temporary or substitute basis.

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

G

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

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.

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, institution or clinic, duly licensed by the appropriate state agency to provide medical services or *behavioral health* services, and is primarily established and operating within the scope of its license.

GLOSSARY (continued)

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.

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*.

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;

GLOSSARY (continued)

- Care and treatment must be given by and supervised by physicians. Nursing services must be provided on a 24-hour basis and must be given by or supervised by registered nurses;
- It must be licensed by the laws of the jurisdiction where it is located. It must be operated as a *hospital* as defined by those laws; and
- It must not be primarily a:
 - Convalescent, rest or nursing home; or
 - Facility providing custodial, educational or rehabilitative care.

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

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

I

Immune effector cell therapy means immune cells or other blood products that are engineered outside of the body and infused into a patient. *Immune effector cell therapy* may include acquisition, integral chemotherapy components and engineered immune cell infusion.

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;
- 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.

GLOSSARY (continued)

Intensive outpatient program does not include services that are for:

- *Custodial care*; or
- Day care.

J

K

L

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

An *employee* or *dependent* who enrolls more than 31 days after his or her *eligibility date*, or more than 31 days after the *special enrollment date* is not considered to be a *late applicant* if the individual:

- Was covered under another group policy providing hospital, medical or surgical expense benefits or was covered under section 607(1) of ERISA at the time he or she was eligible to enroll;
- States in writing, at the time of the open enrollment period, that coverage under another group policy providing hospital, medical or surgical expense benefits was the reason for declining enrollment;
- Has lost coverage under another group policy providing hospital, medical or surgical expense benefits or under section 607(1) of ERISA as a result of the termination of employment, reduction in the number of hours of employment, termination of employer contributions toward such coverage, the termination of the other policy's coverage, death of a spouse or divorce or legal separation; or
- Has been ordered by a court to provide coverage for a spouse or minor child under the covered employee's or member's policy;
- Was under a COBRA continuation provision and the coverage is exhausted; and
- Requests enrollment within 30 days after the termination of coverage under the other policy.

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, physician assistant, registered nurse (R.N.), a licensed practical nurse (L.P.N.), or a licensed vocational nurse (L.V.N.), an advanced registered nurse practitioner (A.R.N.P.), or advanced practice registered nurse (A.P.R.N.).

GLOSSARY (continued)

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.

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* 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
- 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.

Fee data will be updated every six months.

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*;

GLOSSARY (continued)

- Neither sourced from a location, nor provided primarily for the convenience of the patient, physician or other health care provider;
- Not more costly than an alternative source, service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the patient's *sickness or bodily injury*; and
- Performed in the least costly site or sourced from, or provided by the least costly *qualified provider*.

For the purpose of *medically necessary*, generally accepted standards of medical practice means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations, the views of physicians practicing in relevant clinical areas and any other relevant factors.

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

Mental illness, alcoholism, drug abuse or substance use means disorders specified in the Diagnostic and Statistical Manual of Mental Disorders, fourth edition, (DSM-IV, 1994) of the American Psychiatric Association.

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

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

N

Network facility means a *hospital*, *hospital outpatient department* or *ambulatory surgical center* that has been designated as such or has signed an agreement with *us* as an independent contractor, or has been designated by *us* to provide services to all *covered persons*. *Network facility* designation by *us* may be limited to specified services.

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

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

GLOSSARY (continued)

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.), a licensed vocational nurse (L.V.N.), an advanced registered nurse practitioner (A.R.N.P.) or advanced practice registered nurse (A.P.R.N.).

O

Observation status means you are receiving *hospital outpatient* services to help the *health care practitioner* decide if you need to be admitted as an *inpatient*.

Open enrollment period means no less than a 31-day period of time, occurring annually for the *group*, during which the *employees* have an opportunity to enroll themselves and their eligible *dependents* for coverage under the *policy*.

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.

GLOSSARY (continued)

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*.

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 illness*, *alcoholism*, *drug abuse* or *substance use* mental health services or a psychiatrist or addictionologist for *chemical dependency*, and patients are seen by a psychiatrist or addictionologist, as applicable, at least once a week;
- Provides for social, psychological and rehabilitative training programs with a focus on reintegration back into the community and admits children and adolescents who must have a treatment program designed to meet the special needs of that age range; and
- Has physicians and appropriately licensed behavioral health practitioners readily available for the emergent and urgent needs of the patients.

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

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

GLOSSARY (continued)

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.

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*.

GLOSSARY (continued)

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 and screenings for infants, children and adolescents provided in the comprehensive guidelines supported by the HRSA.
- Preventive care and screenings for women, including pap smears and mammograms, 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.

Q

Qualified payment amount means the lesser of:

- Billed charges; or
- The median of the contracted rates negotiated by *us* with three or more *network providers* in the same geographic area for the same or similar services.

GLOSSARY (continued)

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*:

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

Qualified provider means a person, facility, supplier, or any other health care provider:

- That is licensed by the appropriate state agency to:
 - Diagnose, prevent or treat a *sickness* or *bodily injury*;
 - Provide *preventive services*;
 - Provide *pediatric dental services*; or
 - Provide *pediatric vision care*;

A *qualified provider* must provide services within the scope of their license and their primary purpose must be to provide health care services.

R

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

Rescission, rescind or rescinded means a cancellation or discontinuance of coverage that has a retroactive effect.

Residential treatment facility means an institution that:

- Is licensed as a 24-hour residential facility for *behavioral health* treatment, although not licensed as a *hospital*;

GLOSSARY (continued)

- 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, for a minimum of 6 hours a day.

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

Retail clinic means a *health care treatment facility*, located in a retail store, that is often staffed by nurse practitioners and physician assistants who provide minor medical services on a "walk-in" basis (no appointment required).

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

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

S

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

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;

GLOSSARY (continued)

- It must provide such services under the supervision of physicians at all times;
- It must provide 24-hours-a-day nursing services by or under the supervision of a registered nurse; and
- It must maintain a daily record for each patient.

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

Small employer means any person, firm, corporation, partnership or association eligible for group sickness and accident insurance pursuant to subsection (A) of K.S.A. 40-2209 and amendments thereto actively engaged in business whose total employed work force consisted of, on at least 50% of its working days during the preceding year, of at least two but not more than 50 eligible *employees*, the majority of whom were employed within the state.

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.

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.

GLOSSARY (continued)

Stem cell means the transplant of human blood precursor cells. Such cells may be derived from bone marrow, circulating blood, or a combination of bone marrow and circulating blood obtained from the patient in an autologous transplant, from a matched related or unrelated donor, or cord blood. The *stem cell* transplant includes the harvesting, integral chemotherapy components and the *stem cell* infusion. A *stem cell* transplant is commonly referred to as a bone marrow transplant.

Surgery means procedures categorized as Surgery in either the:

- Current Procedural Terminology (CPT) manuals published by the American Medical Association; or
- Healthcare Common Procedure Coding System (HCPCS) Level II manual published by the Centers for Medicare & Medicaid Services (CMS).

The term *surgery* includes, but is not limited to:

- Excision or incision of the skin or mucosal tissues;
- Insertion for exploratory purposes into a natural body opening;
- Insertion of instruments into any body opening, natural or otherwise, done for diagnostic or other therapeutic purposes;
- Treatment of fractures;
- Procedures to repair, remove or replace any body part or foreign object in or on the body; and
- Endoscopic procedures.

Surgical assistant means a *health care practitioner* who assists at *surgery* and is not a Doctor of Medicine (MD), Doctor of Osteopathic Medicine (DO) or Doctor of Podiatric Medicine (DPM), or where state law does not require that specific *health care practitioners* be treated and reimbursed the same as an MD, DO or DPM.

T

Telemedicine or telehealth mean *covered expenses* provided through real-time, two-way interactive audio, video or audio video communication between a *covered person* at an *originating site* and a *health care practitioner* at a *distant site*. *Telemedicine* or telehealth include the application of secure video conferencing or store and forward technology to provide or support health care delivery that facilitate the assessment, diagnosis, consultation, treatment, education and care management of a *covered person's* health care. *Telemedicine* or telehealth do not include:

- Health care providers that consist solely of telephone voice-only conversation, email or facsimile transmission; or
- A physician and a patient consists solely of an email or facsimile transmission.

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.

GLOSSARY (continued)

U

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

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

V

Virtual visit means *telemedicine* or telehealth services.

W

Waiting period means the period of time, elected by the *policyholder*, not to exceed 90 days, that must pass before an *employee* is eligible for coverage under the *policy*.

We, us or ***our*** means Humana Insurance Company.

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

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*.

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

U

V

W

X

Y

Z

SAMPLE

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