

## **Plan Year 2023**

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

**If you are already a member, please sign in or register on [Humana.com](https://www.humana.com) to view your issued certificate.**

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SAMPLE

## Important

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### At Humana, it is important you are treated fairly.

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

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

### Auxiliary aids and services, free of charge, are available to you.

#### Call the number on your ID card (TTY: 711)

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

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

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

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

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

주의 : 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.

ID 카드에 적혀 있는 번호로 전화해 주십시오 (TTY: 711)

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

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

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

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

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

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

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

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

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。

お手持ちの ID カードに記載されている電話番号までご連絡ください (TTY: 711)

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

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

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



Administrative Office:  
1100 Employers Boulevard  
Green Bay, WI 54344

## Certificate of Insurance Humana Insurance Company

**Policyholder:**

**Policy Number:**

**Effective Date:**

**Product Name:**

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

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

Bruce Broussard  
President

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.

**NOTICE:** IF *YOU* OR *YOUR* FAMILY MEMBERS ARE COVERED BY MORE THAN ONE HEALTH CARE PLAN, *YOU* MAY NOT BE ABLE TO COLLECT BENEFITS FROM BOTH PLANS. EACH PLAN MAY REQUIRE *YOU* TO FOLLOW ITS RULES OR USE SPECIFIC DOCTORS AND *HOSPITALS*, AND IT MAY BE IMPOSSIBLE TO COMPLY WITH BOTH PLANS AT THE SAME TIME. READ ALL OF THE RULES VERY CAREFULLY, INCLUDING THE COORDINATION OF BENEFITS SECTION, AND COMPARE THEM WITH THE RULES OF ANY OTHER PLAN THAT COVERS *YOU* OR *YOUR* FAMILY.

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

SAMPLE

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## UNDERSTANDING YOUR COVERAGE

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As you read the *certificate*, you will see some words are printed in italics. Italicized words may have different meanings in the *certificate* than 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.

The state of Ohio and the federal government establish patient protections that include protections from *non-network providers'* surprise bills (balance billing) for *emergency care* and other specified items or services. We will comply with these state and federal requirements including how we process claims from certain *non-network providers*.

### Essential health benefits

This *certificate* does not apply annual dollar limits or lifetime dollar limits to *covered expenses* that are *essential health 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.

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



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## UNDERSTANDING YOUR COVERAGE (continued)

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- 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*.

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

- *Ambulance* services;
- *Emergency care* at a *non-network emergency facility*; and
- *Unanticipated non-network care* at a *network facility*, other than *ancillary services*.

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

- *Air ambulance* services;
- *Emergency care* when the *non-network provider* is located outside the state of Ohio;
- *Ancillary services* while you are at a *network facility*, other than *unanticipated non-network care*;
- Services that are not considered *ancillary services* while you are at a *network facility* located outside the state of Ohio, and you did not consent to the *non-network provider* to obtain such services; or
- *Post-stabilization services* when you did 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* or for *unanticipated non-network care*, 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*.

### Your choice of providers affects your benefits

We will pay benefits for *covered expenses* at a higher percentage 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.

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## UNDERSTANDING YOUR COVERAGE (continued)

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

- *Unanticipated non-network care* while you are at a *network facility* located in the state of Ohio;
- *Ancillary services* while you are at a *network facility*;
- Services that are not considered *ancillary services* while you are at a *network facility* located outside the state of Ohio, and you did not consent to the *non-network provider* to obtain such services; or
- *Post-stabilization services* when you did not consent to the *non-network provider* to obtain such services.

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 the following services received from a *non-network provider*:

- Services, other than *ancillary services*, when you have the ability to request a *network provider* while you are at a *network facility* located in the state of Ohio;
- Services that are not considered *ancillary services* while you are at a *network facility* located outside the state of Ohio, and you consent to the *non-network provider* to obtain such services; or
- *Post-stabilization services* when you consent to the *non-network provider* to obtain such services.

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

### How to find a network provider

You may find a list of *network providers* at [www.humana.com](http://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.



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## UNDERSTANDING YOUR COVERAGE (continued)

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### 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.

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.

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## UNDERSTANDING YOUR COVERAGE (continued)

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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*, for an *emergency medical condition*, call 9-1-1 or go to the nearest emergency facility.

*You*, or someone on *your* behalf, must call *us* within 48 hours after *your admission* to a *non-network hospital* for *emergency care*. 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.

### 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.

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## UNDERSTANDING YOUR COVERAGE (continued)

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### 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 providers*, 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*.

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## COVERED EXPENSES

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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.

### 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* and as required by state law.

The *preventive services* list is subject to change as the federal guidelines are updated.

- Services with an A or B rating in the current recommendations of the United States Preventive Services Task Force (USPSTF).
- Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC).
- Preventive care for infants, children and adolescents provided in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA).
- Preventive care for women provided in the comprehensive guidelines supported by HRSA, including the following: family planning counseling and education, female sterilization procedures, and all Food and Drug Administration (FDA) approved contraceptive methods for women as prescribed by a *health care practitioner*, including over-the-counter FDA approved contraceptive methods for women as prescribed by a *health care practitioner* and procedures to implant and remove internally implanted time-release contraceptives and intrauterine devices.

*Preventive services* also include:

- Flexible sigmoidoscopies and screening colonoscopies;
- Health education counseling and programs and materials, including tobacco cessation, stress management and chronic conditions;
- Routine hearing screenings and hearing exams to determine the need for hearing correction;
- Preventive vision screenings (not including refractions);
- Routine immunizations for *covered persons* under age 19;
- Immunization vaccines for adults;

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## COVERED EXPENSES (continued)

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- Preventive counseling, such as STD prevention counseling;
- Routine preventive imaging services;
- Routine physical maintenance exams, including well-woman exams;
- Scheduled prenatal care exams and first postpartum follow-up consultation and exam;
- Routine preventive retinal photography screenings;
- Tuberculosis tests;
- Cervical cancer screenings; routine pap smear including a screening test for human papillomavirus (HPV) that is approved by the FDA;
- Cholesterol tests (lipid panel and profile);
- Diabetes screening (fasting blood glucose tests);
- Fecal occult blood tests;
- HIV tests;
- Prostate specific antigen tests for a male covered person; and
- Certain sexually transmitted disease (STD) tests.

If you receive services for a screening mammography, the total amount payable to any *network provider* or *non-network provider* will not exceed 130% of the lowest *Medicare* reimbursement rate in Ohio.

For the recommended *preventive services* that apply to your plan year, refer to the HHS website at [www.healthcare.gov/center/regulations/prevention.html](http://www.healthcare.gov/center/regulations/prevention.html) or call the customer service telephone number on your ID card.

### Child health supervision services

*Covered expenses* include charges for *covered persons* through age eight for the periodic review of a child's physical and emotional status as recommended by the American Academy of Pediatrics:

- History;
- Physical examination;
- Developmental assessment;
- Anticipatory guidance;
- Immunizations;
- Laboratory services; and
- Hearing screenings for newborns and infants.

### Health care practitioner home and 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*.

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## COVERED EXPENSES (continued)

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### Health care practitioner home and 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 extracts.
- Allergy injections.
- Injections other than allergy.
- *Surgery*, including anesthesia.
- Second surgical opinions.

### 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 care" 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*.



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## COVERED EXPENSES (continued)

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- Services and supplies, other than *room and board*, provided by a *hospital* while *confined*.

### Health care practitioner inpatient services when provided in a hospital

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

*Covered expenses* include:

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

### Hospital outpatient services

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

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

### Hospital outpatient surgical services

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

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## COVERED EXPENSES (continued)

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### 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 the following diagnostic services provided in a *hospital's outpatient* department in connection with non-surgical services:

- X-ray and other radiology services, including mammograms for any person diagnosed with breast disease;
- Laboratory and pathology services;
- Cardiographic, encephalographic and radioisotope tests;
- Nuclear cardiology imaging studies;
- Ultrasound services;
- Electrocardiograms (EKG);
- Electromyograms (EMG – muscle testing and nerve conduction studies) except surface EMG's are not a *covered expense*;
- Echographies;
- Doppler studies;
- Brainstem evoke potentials (BAER);
- Somatosensory evoke potentials (SSEP);
- Visual evoked potentials (VEP); and
- Bone density studies.

Coverage is included for central supply (IV tubing) or pharmacy (dye) as part of the diagnostic service when necessary to perform the service.

### Hospital outpatient advanced imaging

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

### Pregnancy and newborn benefit

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

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## COVERED EXPENSES (continued)

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*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* or certified nurse midwife in collaboration with a *health care practitioner*, a post-discharge office visit to the *health care practitioner* or a home health care visit within the first 72 hours after discharge is also covered, subject to the terms of this *certificate*.
- Follow-up care requested by either a physician or advanced practice registered nurse, as defined by state law, after delivery is also covered. Services covered as follow-up care include:
  - Physical assessment of the mother and newborn;
  - Parent education;
  - Assistance and training in breast or bottle feeding;
  - Assessment of the home support system;
  - *Medically necessary* and appropriate clinical tests, and any other services that are consistent with the follow-up care recommended in the protocols and guidelines developed by the national organizations that represent pediatric, obstetric, and nursing professionals. The coverage applies to services provided in a medical setting or through home health care visits. The coverage shall apply to a home health care visit only if the health care professional who conducts the visit is knowledgeable and experienced in maternity and newborn care.
- Therapeutic abortions if recommended by the attending *health care practitioner*. A therapeutic abortion means an abortion performed to save the life or health of the mother, or as a result of incest or rape.
- For a newborn, *hospital confinement* during the first 48 hours or 96 hours following birth, as applicable and listed above for:
  - *Hospital charges for routine nursery care*;
  - The *health care practitioner's* charges for circumcision of the newborn child; and
  - The *health care practitioner's* charges for routine examination of the newborn before release from the *hospital*.
- If the covered newborn must remain in the *hospital* past the mother's *confinement*, services and supplies received for:
  - A *bodily injury* or *sickness*;
  - Care and treatment for premature birth; and
  - Medically diagnosed birth defects and abnormalities.

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## COVERED EXPENSES (continued)

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

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

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

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

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

### Emergency care

If you are experiencing an *emergency*, call 9-1-1 or go to the nearest emergency facility. We will pay benefits for *covered expenses* incurred by you for an *emergency care*, including the treatment and stabilization of an *emergency medical condition*.

*Emergency care* provided by a *non-network provider* will be covered at the *network provider* benefit level, as specified in the "Emergency care" benefit in the "Schedule of Benefits." The amount you pay for *emergency care* provided by a *non-network provider* will not exceed the amount you would have paid if the *emergency care* had been provided by a *network provider*. You will only be responsible to pay the *network provider copayment*, *deductible* and/or *coinsurance* to the *non-network provider* for *emergency care*.

Benefits under this "Emergency care" provision must be for an *emergency medical condition* as defined in the "Glossary" section of the *certificate*.

### Ambulance services

We will pay benefits for *covered expenses* incurred by you for:

- Professional *ambulance* or *air ambulance* transportation from your home, scene of accident or medical *emergency* to a *hospital*;
- Professional *ambulance* or *air ambulance* transportation between *hospitals*;
- Professional *ambulance* or *air ambulance* transportation between a *hospital* and *skilled nursing facility*; or
- Professional *ambulance* or *air ambulance* transportation from a *hospital* and *skilled nursing facility* to your home; and

Treatment of a *sickness* or *bodily injury* by medical professionals from a professional *ambulance* and *air ambulance* service when you are not transported will be covered if *medically necessary*.

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## COVERED EXPENSES (continued)

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*Ambulance and air ambulance services are a covered expense only when medically necessary, unless:*

- Ordered by an employer, school, fire or public safety official *you* are not in a position to refuse; or
- *You* are required by *us* to move from a *non-network provider* to a *network provider*.

*Ambulance and air ambulance services for an emergency provided by a non-network provider will be covered at the network provider benefit, as specified in the "Ambulance services" benefit on the "Schedule of Benefits." You may be required to pay any amount not paid by us.*

- For ground *ambulance* services in the state of Ohio, *you* will only be responsible for the *network provider copayment, deductible and/or coinsurance*;
- For ground *ambulance* services outside the state of Ohio, *you* will be responsible for the *network provider copayment, deductible and/or coinsurance* and any amount over the *maximum allowable fee*. *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*; or
- For *air ambulance*, *you* will only be responsible for the *network provider copayment, deductible and/or coinsurance*.

### **Ambulatory surgical center services**

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

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

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

*Covered expenses include:*

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

### **Durable medical equipment and diabetes equipment**

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

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## COVERED EXPENSES (continued)

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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 the following diagnostic services provided in a *free-standing facility*:

- X-ray and other radiology services, including mammograms for any person diagnosed with breast disease;
- Laboratory and pathology services;
- Cardiographic, encephalographic and radioisotope tests;
- Nuclear cardiology imaging studies;
- Ultrasound services;
- Electrocardiograms (EKG);
- Electromyograms (EMG – muscle testing and nerve conduction studies) except surface EMG's are not a *covered expense*;
- Echographies;
- Doppler studies;
- Brainstem evoke potentials (BAER);
- Somatosensory evoked potentials (SSEP);
- Visual evoked potentials (VEP); and
- Bone density studies.

Coverage is included for central supply (IV tubing) or pharmacy (dye) as part of the diagnostic services when necessary to perform the service.



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## COVERED EXPENSES (continued)

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

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

### Free-standing facility advanced imaging

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

### Home health care services

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

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 with a life expectancy of 18 months or less.

If the above criteria is not met, no benefits will be payable under the *policy*.

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## COVERED EXPENSES (continued)

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

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

### Temporomandibular joint dysfunction (TMJ)

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

*Covered expenses* include but are not limited to:

- Examinations 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;

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## COVERED EXPENSES (continued)

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- Therapeutic injections;
- Appliance therapy utilizing an appliance which 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.

### Physical medicine and rehabilitative services

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

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

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

### 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*;

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## COVERED EXPENSES (continued)

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- 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.

### 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 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.

*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;

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## COVERED EXPENSES (continued)

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

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

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

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

- *Hospital and health care practitioner services.*
- Acquisition of cell therapy products for *immune effector cell therapy*, acquisition of *stem cells* or solid organs for transplants and associated donor costs, including pre-transplant or *immune effector cell therapy* services, the acquisition procedure, and any complications resulting from the harvest and/or acquisition. Donor costs for post-discharge services and treatment of complications will not exceed the treatment period of 365 days from the date of discharge following harvest and/or acquisition.
- Non-medical travel and lodging costs for:
  - The *covered person* receiving the transplant or *immune effector cell therapy*, if the *covered person* lives more than 100 miles from the transplant or *immune effector cell therapy* facility designated by *us*; and
  - One caregiver or support person (two, when the *covered person* receiving the transplant or *immune effector cell therapy* is under 18 years of age), if the caregiver or support person lives more than 100 miles from the transplant or *immune effector cell therapy* facility designated by *us*.

Non-medical travel and lodging costs include:

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

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## COVERED EXPENSES (continued)

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

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

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

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.



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## COVERED EXPENSES (continued)

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

*Covered expense* does not include:

- Replacement orthotics;
  - Dental braces; or
  - Oral or dental splints and appliances, unless custom made for the treatment of documented obstructive sleep apnea.
- The following special supplies, dispensed up to a 30-day supply, when prescribed by *your* attending *health care practitioner*:
    - Surgical dressings;
    - Catheters;
    - Colostomy bags, rings and belts; and
    - Flotation pads.
  - The initial pair of eyeglasses or contacts needed due to cataract *surgery* or an *accident* if the eyeglasses or contacts were not needed prior to the *accident*.
  - Dental treatment only if the charges are incurred for treatment of a *dental injury* to a *sound natural tooth*.

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

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

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## COVERED EXPENSES (continued)

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- One screening mammography every year, including digital breast tomosynthesis.
- *Medically necessary* supplemental breast cancer screening recommended by the attending health care provider for an adult female *covered person* who meets one of the two following conditions:
  - The female *covered person's* preventive screening mammograph demonstrates she has dense breast tissue; or
  - The female *covered person* is at an increased risk of breast cancer due to family history, prior personal history of breast cancer, ancestry, genetic predisposition, or other reasons as determined by her health care provider.
- For a *covered person*, who is receiving benefits in connection with a mastectomy, service for:
  - Reconstructive *surgery* of the breast on which the mastectomy has been performed;
  - *Surgery* and reconstruction on the non-diseased breast to achieve symmetrical appearance; and
  - Prostheses and treatment of physical complications for all stages of mastectomy, including lymphedemas.
- Reconstructive *surgery* resulting from:
  - A *bodily injury*, infection or other disease of the involved part, when a *functional impairment* is present; or
  - A *congenital anomaly* that resulted in a *functional impairment*.

Expenses for reconstructive *surgery* due to a psychological condition are not considered a *covered expense*, unless the condition(s) described above are also met.

- Enteral formulas, nutritional supplements and low protein modified foods for use at home by a *covered person* that are prescribed or ordered by a *health care practitioner* and are for the treatment of an inherited metabolic disease, e.g. phenylketonuria (PKU).
- The following *habilitative services*, as ordered and performed by a *health care practitioner*, for a *covered person*, with a developmental delay or defect or *congenital anomaly*:
  - Physical therapy services;
  - Occupational therapy services;
  - Spinal manipulations/adjustments;
  - Speech therapy or speech pathology services; and
  - Audiology services.

*Habilitative services* apply toward the "Physical medicine and rehabilitative services" maximum number of visits specified in the "Schedule of Benefits."

- *Telehealth* services for the diagnosis and treatment of a *sickness* or *bodily injury*. *Telehealth* services 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*;

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## COVERED EXPENSES (continued)

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- Provided on the same basis and to the same extent as in-person *covered expenses*;
  - Provided to a *covered person* at the *originating site*; and
  - Provided by a *health care practitioner* at the *distant site*.
- *Palliative care*.
  - *Diabetes self-management training*.
  - Routine costs, including *routine patient 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:

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.

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## COVERED EXPENSES - BEHAVIORAL HEALTH AND BIOLOGICALLY BASED MENTAL ILLNESS

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

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

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

You can obtain information on opioid overuse and prevention programs and case management tools available for high risk individuals, by calling the customer service department at 1-800-448-6262 as shown on your ID card.

### Acute inpatient services

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

### Emergency care

If you are experiencing an *emergency*, call 9-1-1 or go to the nearest emergency facility. 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 health services, biologically based mental illness and chemical dependency*.

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## COVERED EXPENSES - BEHAVIORAL HEALTH AND BIOLOGICALLY BASED MENTAL ILLNESS (continued)

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*Emergency care* provided by *non-network provider* will be covered at the *network provider* benefit level as specified in the "Emergency care" benefit in the "Schedule of Benefits – Behavioral Health and Biologically Based Mental Illness" or "Schedule of Benefits," subject to the *maximum allowable fee*. The amount you pay for *emergency care* provided by a *non-network provider* will not exceed the amount you would have paid if the *emergency care* had been provided by a *network provider*. You are only responsible to pay the *non-network provider* any applicable *network provider copayment*, *deductible* and/or *coinsurance* for services received.

Benefits under this "Emergency care" provision must be for an *emergency medical condition* as defined in the "Glossary" section, for conditions related to *mental health services*, *biologically based mental illness* or *chemical dependency*.

### Urgent care services

We will pay benefits for *urgent care covered expenses* incurred by you for charges made by an *urgent care center* or an *urgent care qualified provider* for *mental health services*, *biologically based mental illness* and *chemical dependency* services.

### Outpatient services

We will pay benefits for *covered expenses* incurred by you for *mental health services*, *biologically based mental illness* and *chemical dependency* services, including services in a *health care practitioner's office*, *retail clinic* or *health care treatment facility*. Coverage includes *outpatient therapy*, *intensive outpatient programs*, *partial hospitalization*, *telehealth*, and other *outpatient services*. This coverage includes assessments, evaluations, or tests to diagnose *autism spectrum disorders* and the following services to treat *autism spectrum disorders*:

- Speech and language therapy or occupational therapy and therapeutic care provided by a speech therapist, occupational therapist or physical therapist;
- Clinical therapeutic intervention (therapies supported by empirical evidence, including but not limited to applied behavioral analysis) provided by under the supervision of a professional who is licensed, certified or registered by the appropriate state agency in accordance with a health treatment plan;
- *Outpatient behavioral health* services, including psychiatric care and psychological care; and
- Services necessary to determine the need or effectiveness of drugs, medicines or medications.

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## COVERED EXPENSES - BEHAVIORAL HEALTH AND BIOLOGICALLY BASED MENTAL ILLNESS (continued)

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Visit limits listed in the "Schedule of Benefits" section for speech therapy and occupational therapy and visit limits listed in the "Schedule of Benefits – Behavioral Health and Biologically Based Mental Illness" for *behavioral health* therapy do not apply to *autism spectrum disorders*. Refer to the "Schedule of Benefits – Pharmacy Services" for coverage of the drugs, medicines or medications.

### Skilled nursing facility services

We will pay benefits for *covered expenses* incurred by you in a *skilled nursing facility* for *mental health services*, *biologically based mental illness* and *chemical dependency* services. Your confinement to a *skilled nursing facility* must be based upon a written recommendation of a *health care practitioner*.

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

### Home health care services

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

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

Home health care *covered expenses* do not include:

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

### 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*;



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## COVERED EXPENSES - BEHAVIORAL HEALTH AND BIOLOGICALLY BASED MENTAL ILLNESS (continued)

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- *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 health services, biologically based mental illness* and *chemical dependency* services provided while *inpatient* or *outpatient* in a *residential treatment facility*.

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## COVERED EXPENSES - PHARMACY SERVICES

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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 on *our drug list* that are prescribed or ordered for a *covered person* diagnosed with an *autism spectrum disorder* by a *health care practitioner* that is either a developmental pediatrician or a psychologist trained in *autism spectrum disorders*.
- 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*.
- Drugs, medicines or medications and *specialty drugs* prescribed for off-label indications recognized through peer-reviewed medical literature.
- Insulin and *diabetes supplies*.
- *Self-administered injectable drugs* approved by *us*.
- Hypodermic needles, syringes or other methods of delivery when prescribed by a *health care practitioner* for use with insulin or *self-administered injectable drugs*. (Hypodermic needles, syringes or other methods of delivery used in conjunction with covered drugs may be available at no cost to *you*).
- Enteral formulas and nutritional supplements for the treatment of phenylketonuria (PKU) or other inherited metabolic disease, or as otherwise determined by *us*.
- Spacers and/or peak flow meters for the treatment of asthma.
- Drugs, medicines or medications on the Preventive Medication Coverage *drug list* with a *prescription* from a *health care practitioner*.

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## COVERED EXPENSES - PHARMACY SERVICES (continued)

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

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

You can obtain information on opioid overuse and prevention programs and case management tools available for high risk individuals by calling the customer service department at 1-800-448-6262 as shown on your ID card.

### About our drug list

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

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## COVERED EXPENSES - PHARMACY SERVICES (continued)

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### 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](http://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.

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## COVERED EXPENSES - PHARMACY SERVICES (continued)

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### Non-formulary drug expedited exception request

An expedited exception request for coverage of a clinically appropriate non-formulary drug based on exigent circumstances may be initiated by *you*, *your* appointed representative or *your* prescribing *health care practitioner* by calling the customer service number on *your* ID card, in writing or *electronically* by visiting *our* website at [www.humana.com](http://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.

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## COVERED EXPENSES - PHARMACY SERVICES (continued)

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### 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](http://www.humana.com) or call the customer service telephone number on *your* ID card.

A covered *prescription* drug for the treatment of *stage four advanced metastatic cancer* and associated conditions will not be subject to *step therapy* when the use of the *prescription* drug is consistent with either of the following:

- The United States Food and Drug Administration;
- The National Comprehensive Cancer Network Drugs and Biologics Compendium indication; or
- Best practice for the treatment of *stage four advanced metastatic cancer*, as supported by peer-reviewed medical literature.

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

- 48 hours for a request related to *urgent care* services.
- 10 calendar days for all other requests.

A *step therapy* exception request will be considered granted if we do not either approve or deny the request within the applicable timeframes specified in this provision.

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

- The *prescription* drug requiring *step therapy* is contraindicated;
- You tried the required *prescription* drug in the same pharmacologic class or with the same mechanism of action as the required drug, while under the *health benefit plan* currently in force or while covered under another *health benefit plan* because the *prescription* drug was not effective or had a diminished effect, or because of an adverse event; or
- You are stable on a *prescription* drug selected by your *health care practitioner* for the medical condition under consideration;

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 "Step therapy exception request appeal" provision of this section.

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## COVERED EXPENSES - PHARMACY SERVICES (continued)

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### Step therapy exception request appeal

If we deny a *step therapy* exception request, *your* prescribing *health care practitioner* may appeal the decision on *your* behalf. The appeal will be between *your health care practitioner* requesting the *step therapy* exception and a clinical peer who is a *health care practitioner* in the same or a similar specialty that typically manages the medical condition, procedure or treatment.

From the time an appeal of a denied *step therapy* exception request is received by *us*, *we* will either grant or deny the appeal and provide notice within the following time frames:

- 48 hours for an appeal related to *urgent care* services;
- Ten calendar days for all other appeals.

An appeal of a denied *step therapy* exception request will be considered granted if *we* do not either grant or deny the appeal within the applicable timeframes specified in this provision.

If the appeal does not resolve the disagreement, an external review may be requested as described in the "Complaint and Appeal Procedures" section of this *certificate*.



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## LIMITATIONS AND EXCLUSIONS

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

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

- Treatments, services, supplies, or *surgeries* that are not *medically necessary*, except *preventive services*.
- A *sickness* or *bodily injury* arising out of, or in the course of, any employment for wage, gain or profit. This exclusion applies whether or not *you* have Workers' Compensation coverage.
- 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*.
- Private duty nursing.
- Services rendered by a standby physician, *surgical assistant* or *assistant surgeon*, unless *medically necessary*.
- Any service not rendered by the billing provider.
- Any service not substantiated in the medical records of the billing provider.
- Any amount billed for a professional component of an automated:
  - Laboratory service; or
  - Pathology service.

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## LIMITATIONS AND EXCLUSIONS (continued)

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- Expenses for services, *prescriptions*, equipment, or supplies received outside the United States or from a foreign provider, unless:
  - For *emergency care*;
  - The *employee* is traveling outside the United States due to employment with the *employer* sponsoring the *policy* and the services are not covered under any Workers' Compensation or similar law; or
  - The *employee* and *dependents* live outside the United States and the *employee* is in *active status* with the *employer* sponsoring the *policy*.
- Education or training, except for *diabetes self-management training* and *habilitative services*.
- Educational or vocational therapy, testing, services, or schools, including therapeutic boarding schools and other therapeutic environments. Educational or vocational videos, tapes, books, and similar materials are also excluded.
- 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, except as otherwise provided for in the "Covered Expenses" section of this *certificate*.
- 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*:

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## LIMITATIONS AND EXCLUSIONS (continued)

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- A *health care practitioner*:
  - During an office visit; or
  - While an *outpatient*; or
- A *home health care agency* as part of a covered *home health care plan*.
- Certain *specialty drugs* administered by a *qualified provider* in a *hospital's outpatient* department, except as specified in the "Access to non-formulary drugs" provision in the "Covered Expenses - Pharmacy Services" section of this *certificate*.
- Hearing aids, the fitting of hearing aids or advice on their care; 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*.
- *Infertility services*; or reversal of elective sterilization.
- In vitro fertilization regardless of the reason for treatment.
- Services for or in connection with a transplant or *immune effector cell therapy* if:
  - The expense relates to storage of cord blood and stem cells, unless it is an integral part of a transplant approved by *us*.
  - 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*.
  - 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*.
- *Cosmetic surgery* and cosmetic services or devices.
- Hair prosthesis, hair transplants or implants and wigs.

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## LIMITATIONS AND EXCLUSIONS (continued)

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- Dental services, appliances or supplies for treatment of the teeth, gums, jaws or alveolar processes, including but not limited to, any *oral surgery*, *endodontic services* or *periodontics*, implants and related procedures, orthodontic procedures, and any dental services related to a *bodily injury* or *sickness* unless otherwise stated in this *certificate*.
- The following types of care of the feet:
  - Shock wave therapy of the feet;
  - The treatment of weak, strained, flat, unstable or unbalanced feet;
  - Hygienic care, and the treatment of superficial lesions of the feet, such as corns, calluses, or hyperkeratosis;
  - The treatment of tarsalgia, metatarsalgia, or bunion, except surgically;
  - 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, except for diabetes or hammer toe.
- *Custodial care* and *maintenance care*.
- Any loss while serving in the armed forces that is contributed to, or caused by:
  - War or any act of war, whether declared or not;
  - Insurrection; or
  - Any conflict involving armed forces of any authority.
- Services relating to a *sickness* or *bodily injury* as a result of:
  - Engagement in an illegal profession or occupation; or
  - Commission of or an attempt to commit a criminal act.

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

- Expenses for any membership fees or program fees, including but not limited to, health clubs, health spas, aerobic and strength conditioning, work-hardening programs, and weight loss or surgical programs, and any materials or products related to these programs.
- Surgical procedures for the removal of excess skin and/or fat in conjunction with or resulting from weight loss or 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;

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## LIMITATIONS AND EXCLUSIONS (continued)

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- Personal comfort items including cervical pillows, gravity lumbar reduction chairs, swimming pools, whirlpools, spas, or saunas;
  - Medical equipment including:
    - Blood pressure monitoring devices, unless prescribed by a *health care practitioner* for *preventive services* and ambulatory blood pressure monitoring is not available to confirm diagnosis of hypertension;
    - PUVA lights; and
    - Stethoscopes;
  - Communication system, telephone, television, or computer systems and related equipment or similar items or equipment;
  - Communication devices, except after surgical removal of the larynx or a diagnosis of permanent lack of function of the larynx.
- Duplicate or similar rentals or purchases of *durable medical equipment* or *diabetes equipment*.
  - Therapy and testing for treatment of allergies including, but not limited to, services related to clinical ecology, environmental allergy and allergic immune system dysregulation and sublingual antigen(s), extracts, neutralization tests and/or treatment unless such therapy or testing is approved by:
    - The American Academy of Allergy and Immunology; or
    - The Department of Health and Human Services or any of its offices or agencies.
  - Lodging accommodations or transportation, except as provide for under the "Covered Expenses" section in this *certificate*.
  - Communications or travel time.
  - Bariatric *surgery*, any services or complications related to bariatric *surgery*, and other weight loss products or services.
  - Non-therapeutic abortions.
  - *Alternative medicine*.
  - Acupuncture, unless:
    - The treatment is *medically necessary*, appropriate and is provided within the scope of the acupuncturist's license; and
    - *You* are directed to the acupuncturist for treatment by a licensed physician.
  - Services rendered in a premenstrual syndrome clinic or holistic medicine clinic.
  - Services of a midwife, unless the midwife is certified and practicing under the supervision of a physician.
  - Vision examinations or testing for the purposes of prescribing corrective lenses.

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## LIMITATIONS AND EXCLUSIONS (continued)

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- 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*.
- Services and supplies which are:
  - Rendered in connection with mental illnesses not classified in the International Classification of Diseases of the U.S. Department of Health and Human Services; or
  - Extended beyond the period necessary for evaluation and diagnosis of learning and behavioral disabilities or for intellectual disabilities.
- Marriage counseling.
- Expenses for:
  - Employment;
  - School;
  - Sport;
  - Camp;
  - Travel; or
  - The purposes of obtaining insurance, unless provided under *preventive services* in the "Covered Expenses" section in this *certificate*.
- 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*.
- *Pre-surgical/procedural testing* duplicated during a *hospital confinement*.

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## LIMITATIONS AND EXCLUSIONS - PHARMACY SERVICES

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This "Limitations and Exclusions – Pharmacy Services" section describes the limitations and exclusions under the *policy* that apply to *prescription* drugs, including *specialty drugs*, dispensed by a *pharmacy*. Please refer to the "Limitations and Exclusions" section of this *certificate* for additional limitations.

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

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

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



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## LIMITATIONS AND EXCLUSIONS - PHARMACY SERVICES

### (continued)

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- 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*.
- Anabolic steroids.
- Any drug used for the purpose of weight loss.
- Any drug used for cosmetic purposes, including, but not limited to:
  - Dermatologicals or hair growth stimulants; or
  - Pigmenting or de-pigmenting agents.
- Any drug or medicine that is lawfully obtainable without a *prescription* (over-the-counter drugs), except:
  - Insulin; and
  - Drugs, medicines or medications and supplies on the Preventive Medication Coverage *drug list* when obtained from a *network pharmacy* with a *prescription* from a *health care practitioner*.
- Compounded drugs that:
  - Are prescribed for a use or route of administration that is not FDA approved or compendia supported;
  - Are prescribed without a documented medical need for specialized dosing or administration;
  - Only contain ingredients that are available over-the-counter;
  - Only contain non-commercially available ingredients; or
  - Contain ingredients that are not FDA approved, including bulk compounding powders.
- Abortifacients (drugs used to induce abortions).
- *Infertility services* including medications.
- Any drug prescribed for impotence and/or sexual dysfunction.
- Any drug, medicine or medication that is consumed or injected at the place where the *prescription* is given, or dispensed by the *health care practitioner*.
- The administration of covered medication(s).

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## LIMITATIONS AND EXCLUSIONS - PHARMACY SERVICES

### (continued)

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- *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 we require *prior authorization* or *step therapy* and the prescribing *health care practitioner* fails to demonstrate through generally accepted standards of medical practice that the services are *medically necessary*.
- *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 30-day supply when received from a *retail pharmacy* that does not participate in *our* program, which allows *you* to receive a 90-day supply of a *prescription* fill or refill.
- Any portion of a *specialty drug prescription* fill or refill that exceeds a 30-day supply, unless otherwise determined by *us*.
- Any portion of a *prescription* fill or refill that:
  - Exceeds *our* drug-specific *dispensing limit*;
  - Is dispensed to a *covered person*, whose age is outside the drug-specific age limits defined by *us*;
  - Is refilled early, as defined by *us*; or
  - Exceeds the duration-specific *dispensing limit*.

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## LIMITATIONS AND EXCLUSIONS - PHARMACY SERVICES

### (continued)

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- Any drug for which *we* require *prior authorization* or *step therapy* and the prescribing *health care practitioner* fails to demonstrate through generally accepted standards of medical practice that the services are *medically necessary*.
- Any drug for which a charge is customarily not made.
- Any drug, medicine or medication received by *you*:
  - Before becoming covered; or
  - After the date *your* coverage has ended.
- Any costs related to the mailing, sending or delivery of *prescription* drugs.
- Any intentional misuse of this benefit, including *prescriptions* purchased for consumption by someone other than *you*.
- Any *prescription* fill or refill for drugs, medicines or medications that are lost, stolen, spilled, spoiled, or damaged.
- Drug delivery implants and other implant systems or devices.
- Treatment for onychomycosis (nail fungus).
- 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*.

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## ELIGIBILITY AND EFFECTIVE DATES

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### 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;
- 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.

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## ELIGIBILITY AND EFFECTIVE DATES (continued)

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We reserve the right to require an eligible *employee* to submit evidence of health status. No eligible *employee* will be refused enrollment or charged a different premium than other *group* members based on *health status-related factors*. 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.

We reserve the right to require an eligible *dependent* to submit evidence of health status. No eligible *dependent* will be refused enrollment or charged a different premium than other *group* members based on *health status-related factors*. We will administer this provision in a non-discriminatory manner.

### Newborn and adopted dependent enrollment

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

If additional premium is not required to add additional *dependents* and if *dependent* child coverage is in force as of the newborn's date of birth in the case of newborn *dependents* or the earlier of the date of adoption or placement of the child 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* you must enroll the *dependent* child and pay the additional premium within 31 days:

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

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

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## ELIGIBILITY AND EFFECTIVE DATES (continued)

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### 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*, except for enrollment due to a court or administrative order for a child; 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 this *policy*; and
    - You enroll within 31 days after the *special enrollment date*; or

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## ELIGIBILITY AND EFFECTIVE DATES (continued)

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- You are an *employee* or *dependent* eligible for coverage under the *policy*, and:
  - Your *Medicaid* coverage or your Children's Health Insurance Program (CHIP) coverage terminated as a result of loss of eligibility; and
  - You enroll within 60 days after the *special enrollment date*; or
- You are an *employee* or *dependent* eligible for coverage under the *policy*, and
  - You become eligible for a premium assistance subsidy under *Medicaid* or CHIP; and
  - You enroll within 60 days after the *special enrollment date*.

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

### 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.



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## ELIGIBILITY AND EFFECTIVE DATES (continued)

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### 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* is the date of birth if the newborn is not a *late applicant*.

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

Premium is due within 31 days after the date of birth of a newborn or after the date of adoption or date of placement with the *employee* for the purpose of adoption to have coverage continued beyond the first 31 days. Additional premium may not be required when *dependent* coverage is already in force.

### Open enrollment effective date

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

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## ELIGIBILITY AND EFFECTIVE DATES (continued)

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### Retired employee coverage

#### Retired employee eligibility date

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

#### Retired employee enrollment

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

#### Retired employee effective date

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

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## REPLACEMENT OF COVERAGE

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### Applicability

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

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

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

### 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.

### 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 provider out-of-pocket limit* under the *policy* if the medical expense was incurred in the same calendar year the *policy* first becomes effective.

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## TERMINATION PROVISIONS

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### 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 should 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, except if the EGA provides coverage for a retiree class of *employees* and the retiree is in an eligible class of retirees, selected by the *employer*;
- The date of an *employee* request for termination of 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*.

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## TERMINATION PROVISIONS (continued)

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### 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* the *maximum allowable fee* 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

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## CONTINUATION

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### 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 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" provision 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* and the *employer's* prior group plan replaced by the *policy* for at least three consecutive months prior to termination;
- The *covered person's* coverage must be terminated for any other reason other than involuntary termination for cause; and
- The *employee* is entitled to unemployment compensation benefits at the time of termination of employment.

There is no right to continuation if:

- 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.

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.

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## CONTINUATION (continued)

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If this state continuation option is selected, continuation will be permitted for a maximum of 12 months. The premium rate shall not exceed the *group* premium. The premium will be payable in advance to the *policyholder* on a monthly basis. Continuation may not terminate until the earliest of:

- 12 months after the date the election is made;
- The date timely premium payments are not made on *your* behalf;
- The date the *group* coverage terminates in its entirety;
- 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 *policyholder* is responsible for sending *us* the premium payments for those individuals who choose to continue their health insurance. If the *policyholder* fails to make proper payment of the premiums to *us*, we are relieved of all liability for any health insurance that was continued and the liability will rest with the *policyholder*.

If the *policy* is replaced by similar coverage under another group plan:

- Coverage is available under the replacement coverage for the balance of the period that the *covered person* would have remained covered under the prior plan if that coverage had remained in force;
- The minimum level of benefits under the replacement coverage will be the applicable level of benefits of the prior plan reduced by any benefits payable under the prior plan; and
- The prior plan will continue to provide benefits to the extent of its accrued liabilities and extension of benefits as if replacement had not occurred.

### Continuation of coverage for military reservists

Ohio law provides special rights to continuation coverage to:

- A covered *employee* who is a *reservist* called or ordered to active duty;
- Your covered *dependent* spouse or covered *dependent* child, if you are a *reservist* called or ordered to active duty.

A **reservist** means a member of a reserve component of the armed forces of the United States, including a member of the Ohio National Guard and the Ohio Air National Guard.

Coverage may continue for a period of 18 months after the date on which the *reservist* or covered *dependent's* coverage would otherwise terminate. This 18 month continuation of coverage period may be extended to a 36 month period from the date coverage would terminate if any of the following events occur during the 18 month period:

- Death of the *reservist*;
- The divorce or separation of a *reservist* from the *reservist's* spouse;
- The covered *dependent* child no longer meets the definition of *dependent* under this *policy*.



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## CONTINUATION (continued)

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If *you* are eligible and *you* elect to continue coverage under this provision, *you* must file a written request for continuation and pay the first premium contribution to the *employer* on the earliest of the following:

- 31 days after the date on which *your* coverage would otherwise terminate;
- 31 days after the date of the notification of *your* right to continue coverage from the *employer*.

Continued coverage under this section shall terminate in the event of any of the following:

- *You* or *your* covered *dependent* enroll in another group health plan, unless the new group health plan contains an exclusion or limitation with respect to any *pre-existing condition* of *yours* or *your* covered *dependents*. This does not include coverage under the Civilian Health and Medical Program of the Uniformed Services;
- The expiration of the 18 month or 36 month continuation period;
- The end of the month in which *you* or *your* covered *dependent* fail to make timely payment of premium; or
- The date the *employer* terminates participation under the *policy*.

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## COORDINATION OF BENEFITS

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

The order of benefit determination rules govern the order in which each *plan* will pay a claim for benefits. The *plan* that pays first is called the *primary plan*. The *primary plan* must pay benefits in accordance with its policy terms without regard to the possibility that another *plan* may cover some expenses. The *plan* that pays after the *primary plan* is the *secondary plan*. The *secondary plan* may reduce the benefits it pays so that payments from all *plans* do not exceed 100% of the total *allowable expense*.

### Definitions

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

- *Plan* includes: group and nongroup insurance contracts, health insuring corporation (HIC) contracts, closed panel *plans* or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental *plan*, as permitted by law.
- *Plan* does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; supplemental coverage as described in Revised Code sections 3923.37 and 1751.56; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental *plans*, unless permitted by law.

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

*Plan* means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other *plans*. Any other part of the contract providing health care benefits is separate from this *plan*. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

***Primary* /*secondary*** means the order of benefit determination rules determine whether this *plan* is a *primary plan* or *secondary plan* when the person has health care coverage under more than one *plan*.

When this *plan* is *primary*, it determines payment for its benefits first before those of any other *plan* without considering any other *plan*'s benefits. When this *plan* is *secondary*, it determines its benefits after those of another *plan* and may reduce the benefits it pays so that all *plan* benefits do not exceed 100% of the total *allowable expense*.

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## COORDINATION OF BENEFITS (continued)

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**Allowable expense** is a health care expense, including *deductibles*, *coinsurance* and *copayments*, that is covered at least in part by any *plan* covering the person. When a *plan* provides benefits in the form of services, the reasonable cash value of each service will be considered an *allowable expense* and a benefit paid. An expense that is not covered by any *plan* covering the person is not an *allowable expense*. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an *allowable expense*.

The following are examples of expenses that are not *allowable expenses*:

- The difference between the cost of a semi-private hospital room and a private hospital room is not an *allowable expense*, unless one of the *plans* provides coverage for private hospital room expenses.
- 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 methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an *allowable expense*.
- If a person is covered by two or more *plans* that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an *allowable expense*.
- If a person is covered by one *plan* that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another *plan* that provides its benefits or services on the basis of negotiated fees, the *primary plan's* payment arrangement shall be the *allowable expense* for all *plans*. However, if the provider has contracted with the *secondary plan* to provide the benefit or service for a specific negotiated fee or payment amount that is different than the *primary plan's* payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the *allowable expense* used by the *secondary plan* to determine its benefits.
- The amount of any benefit reduction by the *primary plan* because a covered person has failed to comply with the *plan provisions* is not an *allowable expense*. Examples of these types of *plan provisions* include second surgical opinions, precertification of admissions, and preferred provider arrangements.

**Closed panel plan** is a *plan* that provides health care 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 coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

**Custodial parent** is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

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## COORDINATION OF BENEFITS (continued)

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### Order of benefit determination rules

When a person is covered by two or more *plans*, the rules for determining the order of benefit payments are as follows:

- The *primary plan* pays or provides its benefits according to its terms of coverage and without regard to the benefits of under any other *plan*.
- Except as provided in the next paragraph, a *plan* that does not contain a coordination of benefits provision that is consistent with this regulation is always *primary* unless the provisions of both *plans* state that the complying *plan* is *primary*.

Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this 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 calculating payment of its benefits only when it is *secondary* to that other *plan*.

Each *plan* determines its order of benefits using the first of the following rules that apply:

- **Non-dependent or dependent.** The *plan* that covers the person other than as a *dependent*, for example as an *employee*, member, *policyholder*, subscriber or retiree is the *primary plan* and the *plan* that covers the person as a *dependent* is the *secondary plan*. 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. a retired employee), then the order of benefits between the two *plans* is reversed so that the *plan* covering the person as an *employee*, member, *policyholder*, subscriber or retiree is the *secondary plan* and the other *plan* is the *primary plan*.
- **Dependent child covered under more than one *plan*.** Unless there is a court decree stating otherwise, when a dependent child is covered by more than one *plan* the order of benefits is determined as follows:
  - (a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:
    - The *plan* of the parent whose birthday falls earlier in the calendar year is the *primary plan*;  
or
    - If both parents have the same birthday, the *plan* that has covered the parent the longest is the *primary plan*.
    - However, if one spouse's *plan* has some other coordination rule (for example, a "gender rule" which says the father's *plan* is always *primary*), we will follow the rules of that *plan*.

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## COORDINATION OF BENEFITS (continued)

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(b) For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:

- If a court decree states that one of the parents is responsible for the dependent 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 *plan* years commencing after the *plan* is given notice of the court decree;
- If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph (a) above shall determine the order of benefits;
- If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph (a) above shall determine the order of benefits; or
- If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:
  - The *plan* covering the *custodial parent*;
  - The *plan* covering the spouse of the *custodial parent*;
  - The *plan* covering the *non-custodial parent*; and then
  - The *plan* covering the spouse of the *non-custodial parent*.

For a dependent child covered under more than one *plan* of individuals who are not the parents of the child, the provisions above shall determine the order of benefits as if those individuals were the parents of the child.

**Active employee or retired or laid-off employee.** The *plan* that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the *primary plan*. The *plan* covering that same person as a retired or laid-off employee is the *secondary plan*. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other *plan* does not have this rule, and as a result, the *plans* do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled "Non-Dependent or Dependent" can determine the order of benefits.

**COBRA or state continuation coverage.** If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another *plan*, the *plan* covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the *primary plan* and the COBRA or state or other federal continuation coverage is the *secondary plan*. If the other *plan* does not have this rule, and as a result, the *plans* do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled "Non-Dependent or Dependent" can determine the order of benefits.

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

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## COORDINATION OF BENEFITS (continued)

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

### Effect on the benefits of this plan

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

### Right to receive and release needed information

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

### Facility of payment

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

### Right of recovery

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

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## COORDINATION OF BENEFITS (continued)

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### 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.

### Coordination disputes

If *you* believe that *we* have not paid a claim properly, *you* should first attempt to resolve the problem by contacting *us* at the number listed on *your* identification documentation or at *our* Website at [www.humana.com](http://www.humana.com). If *you* are not satisfied *you* may proceed to the next level in the review process outlined under the "Complaints and Appeal Procedures" section of this *certificate*. If *you* are still not satisfied, *you* may call the Ohio Department of Insurance for instructions on filing a consumer complaint. Call 1-800-686-1526, or visit the Department's website at <http://insurance.ohio.gov>.



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## CLAIMS

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*Network providers* will submit claims to *us* on *your* behalf. If *you* utilize a *non-network provider* for *covered expenses*, *you* may have to submit a notice of claim to *us*. Notice of claim must be given to *us* in writing or by *electronic mail* as required by *your* plan, or as soon as is reasonably possible thereafter. Notice must be sent to *us* at *our* mailing address shown on *your* ID card or at *our* website at [www.humana.com](http://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](http://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 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](http://www.humana.com) by clicking on "For Providers" and "Claims Resources."

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## CLAIMS (continued)

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

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

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

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

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## CLAIMS (continued)

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

### To whom benefits are payable

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

Benefit payments for *covered expenses* 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 that *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
- The services are for the specific services listed in the "How your policy works" provision in the "Understanding Your Coverage" section of this *certificate* that are payable at the *network provider* benefit level.

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

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## CLAIMS (continued)

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

### Time of payment of claims

Payments due under the *policy* will be paid immediately or within 30 days in accordance with state law after receipt of written or *electronic* proof of loss.

### Right to request overpayments

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

- Made in error;
- Made to *you* or any party on *your* behalf, where *we* determine 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* will recover any payment made to a provider no later than two years after the payment was made, except in the case where a payment was based on fraudulent information from the provider. If the provider fails to make a timely response to *our* request for overpayment, *we* reserve the right to deduct the overpayment from other payments owed to the provider. *We* reserve the right to adjust any amount applied in error to the *deductible* or *out-of-pocket* limit.

### Right to collect needed information

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

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

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

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## CLAIMS (continued)

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### Exhaustion of time limits

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

### Recovery rights

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

### Duty to cooperate in good faith

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

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

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

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

### Workers' compensation

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

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

*We* shall have first priority to recover benefits *we* have paid from any funds that are paid or payable by Workers' Compensation or similar coverage as a result of any *sickness* or *bodily injury*, and *we* shall not be responsible for contributing to any attorney fees or recovery expenses under a Common Fund or similar doctrine.

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## CLAIMS (continued)

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

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

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

### Right of subrogation

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

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

*We* may enforce *our* subrogation rights by asserting a claim to any coverage to which *you* may be entitled. In the event that funds available from the above sources are not sufficient to fully compensate *you* for *your* loss, the amount *we* are entitled to recover will be reduced by the same proportion that *you* are unable to recover.

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

### Right of reimbursement

If benefits are paid under the *policy*, and *you* recover from any legally responsible person, their insurer, or any uninsured motorist, underinsured motorist, medical payment/expense, Workers' Compensation, no-fault, or other similar coverage, *we* have the right to recover from *you* an amount equal to the amount *we* paid.



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## CLAIMS (continued)

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

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

The obligation to reimburse *us* in full exists, regardless of whether the settlement, compromise, or judgment designates the recovery as including or excluding medical expenses. In the event that funds available from the above sources are not sufficient to fully compensate *you* for *your* loss, the amount *we* are entitled to recover will be reduced by the same proportion that *you* are unable to recover.

### Assignment of recovery rights

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

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

### Cost of legal representation

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

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



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## COMPLAINT AND APPEAL PROCEDURES

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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.

### Internal appeal/external review definitions

The following terms are specific to this provision:

***Adverse benefit determination*** means a decision by *us*:

- To deny, reduce, or terminate a requested health care service or payment in whole or in part, including all of the following:
  - A determination that the health care service does not meet *our* requirements of medical necessity, appropriateness, health care setting, level of care, or effectiveness, including experimental or investigational treatments;
  - A determination of an individual's eligibility for individual *health insurance coverage*, including coverage offered to individuals through a non-employer group, to participate in a plan or *health insurance coverage*;
  - A determination that a health care service is not a covered benefit;
  - The imposition of exclusion, source of injury, network, or any other limitation on benefits that would otherwise be covered.
- Not to issue individual *health insurance coverage* to an applicant, including coverage offered to individuals through a non-employer group;
- To *rescind* coverage on a *health benefit plan*.

An *adverse benefit determination* does not include an *adverse pre-service determination*.

***Adverse pre-service determination*** means a decision by *us* to deny a *preauthorization* request or *prior authorization* request to authorize coverage for a health care service prior to the service being performed, provided, or prescribed.

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## COMPLAINT AND APPEAL PROCEDURES (continued)

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**Authorized representative** means an individual who represents a *covered person* in an *internal appeal* or external review process of an *adverse pre-service determination* or an *adverse benefit determination* who is any of the following:

- A person to whom a covered individual has given express, written consent to represent that individual in an *internal appeals* process or external review process of an *adverse benefit determination*;
- A person authorized by law to provide substituted consent for a *covered person*;
- A *family member* or a treating health care professional, but only when the *covered person* is unable to provide consent.

**Covered person** means a *group plan sponsor*, subscriber, enrollee, member, or individual covered by a *health benefit plan*. *Covered person* does include the *covered person's* authorized representative with regard to an *internal appeal* or external review.

**Covered benefits** or **benefits** means those *health care services* to which a *covered person* is entitled under the terms of a *health benefit plan*.

**Final adverse benefit determination** means an *adverse benefit determination* that is upheld at the completion of our *internal appeals* process.

**Grievance** is a complaint submitted in writing to us.

**Health benefit plan** means a *policy*, contract, certificate, or agreement offered by us to provide, deliver, arrange for, pay for, or reimburse any of the costs of *health care services*.

**Health care services** means services for the diagnosis, prevention, treatment, cure, or relief of a health condition, *sickness*, *bodily injury*, or disease.

**Independent review organization** (IRO) means an entity that is accredited to conduct independent external reviews of *adverse benefit determinations*.

**Internal appeal** means a written or oral request to us from a *covered person* or an *authorized representative* to reconsider an initial *adverse pre-service determination* or an initial *adverse benefit determination*.

**Rescission** or **rescind** means a cancellation or discontinuance of coverage that has a retroactive effect. *Rescission* does not include a cancellation or discontinuance of coverage that has only a prospective effect or a cancellation or discontinuance of coverage that is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

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## COMPLAINT AND APPEAL PROCEDURES (continued)

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**Stabilize** means the provision of such medical treatment as may be necessary to assure, within reasonable medical probability that no material deterioration of a *covered person's* medical condition is likely to result from or occur during a transfer, if the medical condition could result in any of the following:

- Placing the health of the *covered person* or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy;
  - Serious impairment to bodily functions;
  - Serious dysfunction of any bodily organ or part.
- In the case of a woman having contractions, "*stabilize*" means such medical treatment as may be necessary to deliver, including the placenta.

**Superintendent** means the superintendent of insurance.

### Reconsideration

*You* have the right to have *your health care practitioner, health care treatment facility* or other health care provider request a reconsideration of an initial or concurrent *adverse benefit determination*. The request for reconsideration must be made in writing by *your provider* with *your* prior consent. The reconsideration will be processed within three (3) days of receipt by *us*. If the reconsideration process does not resolve the difference of opinion, then *you* or an *authorized person* may file an *appeal*.

A reconsideration is not a prerequisite to an internal or external review of an *adverse determination*.

Should *your* medical condition warrant an expedited reconsideration, *you* will receive notification within twenty-four (24) hours from *our* receipt of the request for reconsideration.

### Grievances

In the event *your* problem has not been resolved at the informal level, *you* may file a *grievance*. We address grievances from *covered persons* using the following process:

*You* or an *authorized representative* may initiate a *grievance*. A *grievance* may relate to any dissatisfaction *you* may have with the plan, including a complaint regarding:

- The availability, delivery or quality of services; or
- Matters pertaining to the contractual relationship between *you* and the plan.

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## COMPLAINT AND APPEAL PROCEDURES (continued)

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### Internal appeals process

An *internal appeal* may be submitted for the following complaints:

- Cancellation, non-renewal, *rescission* or termination of *your* coverage;
- An initial *adverse benefit determination* made pursuant to utilization review for a post-service claim; or
- Claims payment, handling or reimbursement for services.

An *internal appeal* may also be submitted for an *adverse pre-service determination*.

We will appoint one or more persons who were not involved in the initial *adverse pre-service determination* or the initial *adverse determination* to review the *internal appeal*. The person or persons appointed to review an *internal appeal* involving a clinical issue will include at least one clinical peer (a physician or other provider in the same or a similar specialty that typically manages the medical condition, procedure or treatment).

You will be notified in writing of a final decision within thirty (30) days of receipt of the *internal appeal* for an *adverse benefit determination*. The written notice will explain the resolution of the *internal appeal* and the right to an external review.

We will provide a final decision for an *internal appeal* of an *adverse pre-service determination* within:

- 48 hours after we receive the appeal for urgent care services. We will notify the *health care practitioner* within 24 hours if additional information is required.
- 10 calendar days after we receive the appeal that is not for urgent care services.

The final decision will explain the resolution of the *internal appeal* and the right to an external review.

For purposes of an *internal appeal* of an *adverse pre-service determination*, urgent care services mean medical care or other service for a condition where application of the timeframe for making routine or non-life threatening care determinations:

- Could seriously jeopardize the life, health, or safety of the *covered person* or others, due to the *covered person's* psychological state; or
- Would subject the *covered person* to adverse health consequences without the requested care or treatment, in the opinion of the *health care practitioner* that has knowledge of the *covered person's* medical or behavioral condition.

### Expedited internal review of an adverse benefit determination

For an expedited internal review, *your* provider must certify that *your* condition could, in the absence of immediate medical attention, result in any of the following:

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## COMPLAINT AND APPEAL PROCEDURES (continued)

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- Placing *your* health or, if *you* are pregnant, the health of the unborn child in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

We will accept requests for an expedited internal review, in writing or orally. If the criteria is met for an expedited internal review, we will notify *you* verbally of the resolution within seventy-two (72) hours. Written resolution will be sent within 3 calendar days.

If we fail to notify *you* of a final decision within the thirty (30) days of receipt of the *internal appeal* (seventy-two (72) hours for an expedited internal review), *you* may treat the delay as a denial and proceed to the "External Review" process.

### External review process

We are required by Ohio law to provide a process that allows a person covered under a *health benefit plan* or a person applying for *health benefit plan* coverage to request an independent external review of an *adverse pre-service determination* or an *adverse benefit determination*. The following is a summary of the external review process.

### Opportunity for external review

An external review may be conducted by an *Independent Review Organization (IRO)* or by the Ohio Department of Insurance. The *covered person* does not pay for the external review. There is no minimum cost of *health care services* denied in order to qualify for an external review. However, the *covered person* must generally exhaust our internal appeal process before seeking an external review. Exceptions to this requirement will be included in the notice of the *adverse benefit determination*.

### External review by an IRO

A *covered person* is entitled to an external review by an *IRO* in the following instances:

- The *adverse benefit determination* involves a medical judgment or is based on any medical information;
- The *adverse benefit determination* indicates the requested service is experimental or investigational, the requested *health care service* is not explicitly excluded in the *covered person's health benefit plan*, and the treating physician certifies at least one of the following:
  - Standard *health care services* have not been effective in improving the condition of the *covered person*;

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## COMPLAINT AND APPEAL PROCEDURES (continued)

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- Standard *health care services* are not medically appropriate for the *covered person*;
- No available standard *health care service* covered by *us* is more beneficial than the requested *health care service*.

There are two types of *IRO* reviews, standard and expedited. A standard review is normally completed within 30 days. An expedited review for urgent medical situations is normally completed within 72 hours and can be requested if any of the following applies:

- The *covered person's* treating physician certifies that the *adverse benefit determination* involves a medical condition that could seriously jeopardize the life or health of the *covered person* or would jeopardize the *covered person's* ability to regain maximum function if treatment is delayed until after the time frame of an expedited internal appeal.
- The *covered person's* treating physician certifies that the *final adverse benefit determination* involves a medical condition that could seriously jeopardize the life or health of the *covered person* or would jeopardize the *covered person's* ability to regain maximum function if treatment is delayed until after the time frame of a standard external review.
- The *final adverse benefit determination* concerns an admission, availability of care, continued stay, or *health care service* for which the *covered person* received *emergency care*, but has not yet been discharged from a facility.
- An expedited internal appeal is already in progress for an *adverse benefit determination* of experimental or investigational treatment and the *covered person's* treating physician certifies in writing that the recommended *health care service* or treatment would be significantly less effective if not promptly initiated.

NOTE: An expedited external review is not available for retrospective *final adverse benefit determinations* (meaning the *health care service* has already been provided to the *covered person*).

### External review by the Ohio Department of Insurance

A *covered person* is entitled to an external review by the Department in either of the following instances:

- The *adverse benefit determination* is based on a contractual issue that does not involve a medical judgment or medical information.
- The *adverse benefit determination* for an emergency health condition indicates that medical condition did not meet the definition of *emergency care* AND *our* decision has already been upheld through an external review by an *IRO*.



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## COMPLAINT AND APPEAL PROCEDURES (continued)

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### Request for external review

Regardless of whether the external review case is to be reviewed by an *IRO* or the Department of Insurance, the *covered person*, or an *authorized representative*, must request an external review through *us* within 180 days of the date of the notice of *final adverse benefit determination* issued by *us*.

All requests must be in writing, except for a request for an expedited external review. Expedited external reviews may be requested electronically or orally. The *covered person* will be required to consent to the release of applicable medical records and sign a medical records release authorization. If the request is complete *we* will initiate the external review and notify the *covered person* in writing, or immediately in the case of an expedited review, that the request is complete and eligible for external review. The notice will include the name and contact information for the assigned *IRO* or the Ohio Department of Insurance (as applicable) for the purpose of submitting additional information. When a standard review is requested, the notice will inform the *covered person* that, within 10 business days after receipt of the notice, they may submit additional information in writing to the *IRO* or the Ohio Department of Insurance (as applicable) for consideration in the review. *We* will also forward all documents and information used to make the *adverse benefit determination* to the assigned *IRO* or the Ohio Department of Insurance (as applicable). If the request is not complete *we* will inform the *covered person* in writing and specify what information is needed to make the request complete. If *we* determine that the *adverse benefit determination* is not eligible for external review, *we* must notify the *covered person* in writing and provide the *covered person* with the reason for the denial and inform the *covered person* that the denial may be appealed to the Ohio Department of Insurance. The Ohio Department of Insurance may determine the request is eligible for external review regardless of the decision by *us* and require that the request be referred for external review. The Department's decision will be made in accordance with the terms of the *health benefit plan* and all applicable provisions of the law.

### IRO assignment

When *we* initiate an external review by an *IRO*, the Ohio Department of Insurance web based system randomly assigns the review to an accredited *IRO* that is qualified to conduct the review based on the type of *health care service*. An *IRO* that has a conflict of interest with *us*, the *covered person*, the health care provider or the health care facility will not be selected to conduct the review.

### IRO review and decision

The *IRO* must consider all documents and information considered by *us* in making the *adverse benefit determination*, any information submitted by the *covered person* and other information such as; the *covered person's* medical records, the attending health care professional's recommendation, consulting reports from appropriate health care professionals, the terms of coverage under the *health benefit plan*, the most appropriate practice guidelines, clinical review criteria used by *us* or *our* utilization review organization, and the opinions of the *IRO's* clinical reviewers. The *IRO* will provide a written notice of its decision within 30 days of receipt by *us* of a request for a standard review or within 72 hours of receipt by *us* of a request for an expedited review. This notice will be sent to the *covered person*, *us* and the Ohio Department of Insurance and must include the following information:

- A general description of the reason for the request for external review.



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## COMPLAINT AND APPEAL PROCEDURES (continued)

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- The date the independent review organization was assigned by the Ohio Department of Insurance to conduct the external review.
- The dates over which the external review was conducted.
- The date on which the independent review organization's decision was made.
- The rationale for its decision.
- References to the evidence or documentation, including any evidence-based standards that was used or considered in reaching its decision.

NOTE: Written decisions of an *IRO* concerning an *adverse benefit determination* that involves a health care treatment or service that is stated to be experimental or investigational also includes the principle reason(s) for the *IRO's* decision and the written opinion of each clinical reviewer including their recommendation and their rationale for the recommendation.

### Binding nature of external review decision

An external review decision is binding on *us* except to the extent *we* have other remedies available under state law. The decision is also binding on the *covered person* except to the extent the *covered person* has other remedies available under applicable state or federal law. A *covered person* may not file a subsequent request for an external review involving the same *adverse benefit determination* that was previously reviewed unless new medical or scientific evidence is submitted to *us*.

### If you have questions about your rights or need assistance

*You* may contact *us* at the following address: Grievance and Appeal Department P.O. Box 14546, Lexington, KY 40512-4546 or call *our* Customer Service Department at the toll-free number shown on *your* identification card.

*You* may also contact the Ohio Department of Insurance:

Ohio Department of Insurance  
ATTN: Consumer Affairs  
50 West Town Street, Suite 300, Columbus, OH 43215  
800-686-1526 / 614-644-2673  
614-644-3744 (fax)  
614-644-3745 (TDD)

Contact ODI Consumer Affairs:

<https://secured.insurance.ohio.gov/ConsumServ/ConServComments.asp>

File a Consumer Complaint:

<http://insurance.ohio.gov/Consumer/OCS/Pages/ConsCompl.aspx>

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## COMPLAINT AND APPEAL PROCEDURES (continued)

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### Exhaustion of remedies

*You or your authorized representative must exhaust the internal appeal process prior to initiating an external review except in the following instances:*

- *We agree to waive the exhaustion requirement;*
- *You or your authorized representative did not receive a written decision of your internal appeal within the required time frame;*
- *We fail to meet all requirements of the internal appeal process unless the failure:*
  - *Was insignificant or lacked importance;*
  - *Would not or would likely not cause prejudice or harm to you;*
  - *Was for a good cause and beyond our control; or*
  - *Is not reflective of a pattern or practice of non-compliance.*
- *An expedited external review is sought together with an expedited internal review.*

*You or your authorized representative may not request an external review of an adverse benefit determination involving a retrospective utilization review decision until our internal appeal process has been exhausted unless we agree to waive the exhaustion requirement.*

*In the event we deny a request for an external review because the internal appeal process has not been exhausted, you or your authorized representative may request an explanation from us. We must provide a written explanation within 10 days. You or your authorized representative may request a review of this explanation from the superintendent. If the superintendent upholds our explanation, you or your authorized representative may resubmit the request to us for an internal appeal within 10 days. Time periods for re-filing the internal appeal shall begin upon the receipt of the superintendent's notice.*

*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.*

### Legal actions and limitations

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

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

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## DISCLOSURE PROVISIONS

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### 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.

### 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 non-cost health education seminar.

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## DISCLOSURE PROVISIONS (continued)

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

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

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

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

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

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

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

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

### 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*.

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## DISCLOSURE PROVISIONS (continued)

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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.

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

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

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## MISCELLANEOUS PROVISIONS

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### Entire contract

The entire contract is made up of the *policy* (which include this *certificate*), the application of the *policyholder*, incorporated by reference herein, and the applications or enrollment forms, if any, of the *covered persons*. All statements made by the *policyholder* or by a *covered person* are considered to be representations, not warranties. This means that the statements are made in good faith. No statement will void the *policy*, reduce the benefits it provides or be used in defense to a claim unless it is contained in a written or *electronic* application or enrollment form and a copy is furnished to the person making such statement or his or her beneficiary.

### Additional policyholder responsibilities

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

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

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

### Certificates of insurance

A *certificate* setting forth the benefits available to the *employee* and the *employee's* covered dependents will be available at [www.humana.com](http://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 differ with the terms of this *certificate*, the terms of this *certificate* will control.

### Incontestability

No misstatement made by the *policyholder*, except 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*.

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## MISCELLANEOUS PROVISIONS (continued)

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

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

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

### Fraud

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

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

### Clerical error or misstatement

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

### 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 31 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*.

### Discontinuation of coverage

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

- The *policyholder* and the *employees* will be notified of such discontinuation at least 90 days prior to the date of discontinuation of such coverage; and



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## MISCELLANEOUS PROVISIONS (continued)

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- The *policyholder* will be given the option to purchase any other group health plan providing medical benefits that are being offered by *us* at such time.

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

### 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).

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## GLOSSARY

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

### A

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

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

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

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

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

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

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

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

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

***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*.

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## GLOSSARY (continued)

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**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*.

**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.

**Autism spectrum disorder** means any pervasive development disorders or autism spectrum disorder as defined by the most recent edition of the Diagnostic and Statistical Manual or Mental Disorders published by the American Psychiatric Association available at the time a *covered person* is first evaluated for suspected developmental delay.

## B

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

**Biologically based mental illness** means schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders, obsessive-compulsive disorder, panic disorder as these terms are defined in the most recent edition of the diagnostic and statistical manual of mental disorders published by the American psychiatric association.

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## GLOSSARY (continued)

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

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

### C

**Certificate** means this benefit plan document that describes the benefits, provisions and limitations of the *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.

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

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

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

**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 for the diagnosis, prevention, treatment, cure, or relief of a *sickness* or *bodily injury*, such as:
  - Procedures;
  - *Surgeries*;
  - Consultations;
  - Advice;
  - Diagnosis;
  - Referrals;
  - Treatment;
  - Supplies;
  - Drugs, including *prescription* and *specialty drugs*;
  - Devices; or
  - Technologies;

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## GLOSSARY (continued)

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- *Preventive services.*

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*.

## 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).

**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;

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## GLOSSARY (continued)

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- 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.

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

- Incapable of self-sustaining employment by reason of physical handicap or intellectual disability; and
- Primarily dependent upon the *employee* for support and maintenance.

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

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

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

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



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## GLOSSARY (continued)

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**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* 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*.

**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** or **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.



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## GLOSSARY (continued)

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**Emergency care or Emergency services** means:

- A medical screening examination, as required by federal law, that is within the capability of the emergency department, including ancillary services routinely available to the emergency department to evaluate an *emergency medical condition*; and
- Such further medical examination and treatment that are required by federal law to *stabilize* an *emergency medical condition* and that are within the available capabilities of the staff and facilities, including any trauma and burn center.

*Emergency care* for an *emergency* or *emergency medical condition* does not mean services for the convenience of the *covered person* or the provider of treatment or services.

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

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

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

If specified on the Employer Group Application and approved by us, *employee* also includes retirees of the *employer*. A retired *employee* is not required to be in *active status* to be eligible for coverage under the *policy*.

**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.

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## GLOSSARY (continued)

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

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

**Experimental, investigational or for research purposes** means a drug, biological product, device, treatment, or procedure that meets any one of the following criteria, as determined by *us*:

- Cannot be lawfully marketed without the final approval of the United States Food and Drug Administration (FDA) and lacks such final FDA approval for the use or proposed use, unless (a) found to be accepted for that use in the most recently published edition of the United States Pharmacopeia-Drug Information for Healthcare Professional (USP-DI) or in the most recently published edition of the American Hospital Formulary Service (AHFS) Drug Information; (b) identified as safe, widely used and generally accepted as effective for that use as reported in nationally recognized peer reviewed medical literature published in the English language as of the date of service; or (c) is mandated by state law;
- Is a device required to receive Premarket Approval (PMA) or 510K approval by the FDA but has not received a PMA or 510K approval;
- Is not identified as safe, widely used and generally accepted as effective for the proposed use as reported in nationally recognized peer reviewed medical literature published in the English language as of the date of service;
- Is the subject of a National Cancer Institute (NCI) Phase I, II or III trial or a treatment protocol comparable to a NCI Phase I, II or III trial, or any trial not recognized by NCI regardless of phase; or
- Is identified as not covered by the Centers for Medicare & Medicaid Services (CMS) Medicare Coverage Issues Manual, a CMS Operational Policy Letter or a CMS National Coverage Decision, except as required by state or federal law.

## F

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

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## GLOSSARY (continued)

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

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

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

### 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, or chemical dependency services and is primarily established and operating within the scope of its license.

**Health insurance coverage** means medical coverage under any hospital or medical service policy or certificate, hospital or medical service plan contract or health maintenance organization (HMO) contract offered by a health insurance issuer. "Health insurance issuer" means an insurance company, insurance service or insurance organization (including an HMO) that is required to be licensed to engage in the business of insurance in a state and that is subject to the state law that regulates insurance.

**Health status-related factor** means any of the following:

- Health status or medical history;
- Medical condition, either physical or mental;
- Claims experience;
- Receipt of health care;
- Genetic information;
- Disability; or
- Evidence of insurability, including conditions arising out of acts of domestic violence.

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## GLOSSARY (continued)

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**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* and, as estimated by their physicians, are expected to live 18 months or less as a result of that *sickness*.

**Hospital** means an institution that meets all of the following requirements:

- It must provide, for a fee, medical care and treatment of sick or injured patients on an *inpatient* basis;
- It must provide or operate, either on its premises or in facilities available to the *hospital* on a pre-arranged basis, medical, diagnostic, and surgical facilities;
- Care and treatment must be given by and supervised by physicians. Nursing services must be provided on a 24-hour basis and must be given by or supervised by registered nurses;
- It must be licensed by the laws of the jurisdiction where it is located. It must be operated as a *hospital* as defined by those laws; and
- It must not be primarily a:
  - Convalescent, rest or nursing home; or
  - Facility providing custodial, educational or rehabilitative care.

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

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

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## GLOSSARY (continued)

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### 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;
- If *chemical dependency*, additional emphasis on recovery strategies, monitoring of participation in 12-step programs and random drug screenings for the treatment of *chemical dependency*; and
- Physician availability for medical and medication management.

***Intensive outpatient program*** does not include services that are for:

- *Custodial care*; or
- Day care.

### J

### K

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## GLOSSARY (continued)

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### 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*.

**Level 1 network health care practitioner** means a *network health care practitioner* who:

- Specializes in pediatric or internal medicine; or
- Is a general practitioner, nurse practitioner, physician assistant, or registered nurse.

**Level 2 specialist network health care practitioner** means a *network health care practitioner* 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.

**Maximum allowable fee** for a *covered expense*, other than the following services you receive from a *non-network provider* located in the state of Ohio:

- Ambulance services;
- Emergency care at a non-network emergency facility; and
- Unanticipated non-network care at a network facility,

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.

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## GLOSSARY (continued)

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*Maximum allowable fee for covered expenses* when you receive the following services from a *non-network provider* located in the state of Ohio:

- *Ambulance* services;
- *Emergency care* at a non-network emergency facility; and
- *Unanticipated non-network care* at a *network facility*,

is an amount equal to the greatest of:

- The median fee negotiated with *network providers* for the same or similar service in the same geographic region;
- The fee calculated using the same method to determine *maximum allowable fee* for a *covered expense*, other than *emergency care* services provided by *non-network providers*; or
- The fee paid by *Medicare* for the same services.

**Medicaid** means a state program of medical care, as established under Title 19 of the Social Security Act of 1965, as amended.

**Medically necessary** means health care services that a *health care practitioner* exercising prudent clinical judgment would provide to his or her patient for the purpose of preventing, evaluating, diagnosing, or treating a *sickness* or *bodily injury* or its symptoms. Such health care service must be:

- In accordance with generally accepted standards of medical practice;
- Clinically appropriate in terms of type, frequency, extent, site and duration, and considered effective for the patient's *sickness* or *bodily injury*;
- Neither sourced from a location, nor provided primarily for the convenience of the patient, physician or other health care provider;
- Not more costly than an alternative source, service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the patient's *sickness* or *bodily injury*; and
- Performed in the least costly site or sourced from, or provided by the least costly *qualified provider*.

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

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

**Mental health services** mean those diagnoses and treatments related to the care of a *covered person* who exhibits mental, nervous or emotional conditions classified in the Diagnostic and Statistical Manual of Mental Disorders.

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

- 40 kilograms or greater per meter squared (kg/m<sup>2</sup>); or



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## GLOSSARY (continued)

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- 35 kilograms or greater per meter squared (kg/m<sup>2</sup>) 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 who has been designated by *us* to provide services to all *covered persons*. *Network facility* designation by *us* may be limited to specified services.

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

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

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

**Non-network health care practitioner** means a *health care practitioner* who has not been designated by *us* as a *network health care practitioner*.

**Non-network hospital** means a *hospital* which has not been designated by *us* as a *network hospital*.

**Non-network provider** means a *hospital, health care treatment facility, health care practitioner*, or other health services provider who has not been designated by *us* as a *network provider*.

**Nurse** means a registered nurse (R.N.), a licensed practical nurse (L.P.N.), or a licensed vocational nurse (L.V.N.).

### O

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

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

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## GLOSSARY (continued)

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**Oral surgery** means procedures to correct diseases, injuries and defects of the jaw and mouth structures. These procedures include, but are not limited to, the following:

- Surgical removal of full bony impactions;
- Mandibular or maxillary implant;
- Maxillary or mandibular frenectomy;
- Alveolectomy and alveoplasty;
- Orthognathic *surgery*;
- *Surgery* for treatment of temporomandibular joint syndrome/dysfunction; and
- Periodontal surgical procedures, including gingivectomies.

**Originating site** means the location of a *covered person* at the time a *telehealth* service is being furnished.

**Out-of-pocket limit** means the amount of *copayments*, *deductibles* and *coinsurance* you must pay for *covered expenses*, including any *preauthorization* penalty amount, 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 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.

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## GLOSSARY (continued)

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

*Partial hospitalization* does not include services that are for:

- Custodial care; or
- Day care.

**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*.

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## GLOSSARY (continued)

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**Prescription** means a direct order for the preparation and use of a drug, medicine or medication. The *prescription* must be written by a *health care practitioner* and provided to a *pharmacist* for *your* benefit and used for the treatment of a *sickness* or *bodily injury*, which is covered under this plan, or for drugs, medicines or medications on the Preventive Medication Coverage *drug list*. The drug, medicine or medication must be obtainable only by *prescription* or must be obtained by *prescription* for drugs, medicines or medications on the Preventive Medication Coverage *drug list*. The *prescription* may be given to the *pharmacist* verbally, *electronically* or in writing by the *health care practitioner*. The *prescription* must include at least:

- *Your* name;
- The type and quantity of the drug, medicine or medication prescribed, and the directions for its use;
- The date the *prescription* was prescribed; and
- The name and address of the prescribing *health care practitioner*.

**Preventive services** means services in the following recommendations appropriate for *you* during *your* plan year:

- Services with an A or B rating in the current recommendations of the USPSTF.
- Immunizations recommended by the Advisory Committee on Immunization Practices of the CDC.
- Preventive care for infants, children and adolescents provided in the comprehensive guidelines supported by the HRSA.
- Preventive care for women provided in the comprehensive guidelines supported by the HRSA, including the following: family planning counseling and education, female sterilization procedures, and all Food and Drug Administration (FDA) approved contraceptive methods for women as prescribed by a *health care practitioner*, including over-the-counter FDA approved contraceptive methods for women as prescribed by a *health care practitioner* and procedures to implant and remove internally implanted time-release contraceptives and intrauterine devices.

For the recommended *preventive services* that apply to *your* plan year, refer to the [www.healthcare.gov/center/regulations/prevention.html](http://www.healthcare.gov/center/regulations/prevention.html) website or call the customer service telephone number on *your* ID card. Refer to the "Preventive services" provision in the "Covered Expenses" section which includes *preventive services* covered by the *policy*.

## Q

**Qualified payment amount** means the lesser of:

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

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## GLOSSARY (continued)

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If sufficient information is not available for *us* to calculate the median of the contracted rates, the rate established by *us* through use of any database that does not have any conflict of interest and has sufficient information reflecting allowed amounts paid to a *qualified provider* for relevant services furnished in the applicable geographic region.

The *qualified payment amount* applies to *covered expenses* when *you* receive the following services from a *non-network provider*:

- *Air ambulance* services;
- *Emergency care* when the *non-network provider* is located outside the state of Ohio;
- *Ancillary services* while *you* are at a *network facility* in the state of Ohio and *you* have the ability to request services from a *network provider*;
- *Ancillary services* while *you* are at a *network facility* located outside the state of Ohio;
- Services that are not considered *ancillary services* while *you* are at a *network facility* located outside the state of Ohio, and *you* do not consent to the *non-network provider* to obtain such services; or
- *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.

***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*; or
  - Provide *preventive services*;

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*;

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## GLOSSARY (continued)

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- Provides a multidisciplinary treatment plan in a controlled environment, under the supervision of a physician who is able to provide treatment on a daily basis;
- Provides supervision and treatment by a Ph.D. psychologist, licensed therapist, psychiatric nursing staff or registered nurse;
- Provides programs such as social, psychological, family counseling and rehabilitative training, age appropriate for the special needs of the age group of patients, with focus on reintegration back into the community; and
- Provides structured activities throughout the day and evening.

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

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

**Room and board** means all charges made by a *hospital, residential treatment facility for behavioral health services* 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*.

**Routine patient costs** means all health care services for the treatment of cancer, including diagnostic modality, that is typically covered for cancer and that was not necessitated solely because of a cancer clinical trial.

## 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; (c) *biologically based mental illness* and (d) *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;



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## GLOSSARY (continued)

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

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

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

**Sound natural tooth** means a tooth that:

- Is organic and formed by the natural development of the body (not manufactured, capped, crowned, or bonded);
- Has not been extensively restored;
- Has not become extensively decayed or involved in periodontal disease; and
- Is not more susceptible to injury than a whole natural tooth (for example a tooth that has not been previously broken, chipped, filled, cracked, or fractured).

**Special enrollment date** means the date of:

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

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.

**Stabilize** means, with respect to an *emergency medical condition*, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the *covered persons'* medical condition is likely to result from or occur during a transfer of the *covered person* from a facility, if the medical condition could result in any of the following:

- Placing the health of the *covered person* or, with respect to a pregnant woman, the health of the woman, who is a *covered person*, or her unborn child, in serious jeopardy;



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## GLOSSARY (continued)

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- Serious impairment of bodily functions; or
- Serious dysfunction of any bodily organ or part.

In case of a woman having contractions, *stabilize* means such medical treatment as may be necessary to deliver, including the placenta.

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

**Surgery** means procedures categorized as Surgery in either the:

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

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

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

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

## T

**Telehealth** means services, provided via *electronic* or asynchronous communications.

## U

**Unanticipated non-network care** means *covered expenses*, including *covered expenses* for clinical laboratory services, provided by a *non-network provider* when:

- You did not have the ability to request services from a *network provider*; or
- The services are for *emergency care*.

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## GLOSSARY (continued)

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***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

### W

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

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

### 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

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## GLOSSARY – PHARMACY SERVICES

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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

***Associated conditions*** means the symptoms or side effects of *stage four advanced metastatic cancer* or its treatment, which would in the judgement of the *health care practitioner* in question, jeopardize the health of a *covered person* if left untreated.

### 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*.

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## GLOSSARY – PHARMACY SERVICES (continued)

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### 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** means a category of *prescription* drugs, medicines or medications within the *drug list* that are designated by *us* as level 1. The *prescription* drugs in this category are *generic drugs*.

**Level 2 drugs** means a category of *prescription* drugs, medicines or medications within the *drug list* that are designated by *us* as level 2. The *prescription* drugs in this category are *brand-name drugs*.

**Level 3 drugs** means a category of *prescription* drugs, medicines or medications within the *drug list* that are designated by *us* as level 3. The *prescription* drugs in this category are higher-cost *brand-name drugs*. *Specialty drugs* are not categorized as *level 3 drugs*.

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## GLOSSARY – PHARMACY SERVICES (continued)

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### 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*.

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## GLOSSARY – PHARMACY SERVICES (continued)

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**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*.

**Stage four advanced metastatic cancer** means a cancer that *has* spread from the primary or original site of the cancer to nearby tissues, lymph nodes, or other *areas or parts* of the body.

**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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