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 to view your issued certificate.

OHHJ6DCEN 0123

Important

At Humana, it is important you are treated fairly.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Humana

Administrative Office:
640 Eden Park Drive
Cincinnati, OH 45202

Certificate of Coverage

HUMANA HEALTH PLAN OF OHIO, INC.

Group Plan Sponsor:

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

Effective Date:

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

Bruce Broussard
President

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.

HUMANA HEALTH PLAN OF OHIO, IS NOT A MEMBER OF ANY GUARANTY FUND

Humana Health Plan of Ohio, Inc. is not part of a guaranty fund. Accordingly, *you* are protected only to the extent of the hold harmless language included in the Humana Health Plan of Ohio, Inc. provider contract. In the event of the insolvency of Humana Health Plan of Ohio, Inc., *you* may be financially responsible for health care services rendered by a health care practitioner or medical facility that is not under contract with Humana Health Plan of Ohio, Inc., whether or not Humana Health Plan of Ohio, Inc. authorized the use of the health care practitioner or the medical facility.

For information on your coverage and how to obtain services, contact:

Humana Health Plan of Ohio, Inc.
640 Eden Park Drive
Cincinnati, OH 45202
1-866-4ASSIST

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

UNDERSTANDING YOUR COVERAGE

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

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

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*.

Covered and non-covered expenses

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

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

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

IMPORTANT: If you opt to receive vision care services or vision care materials that are not covered benefits under this plan, a participating vision care provider may charge you his or her normal fee for such services or materials. Prior to providing you with vision care services or vision care materials that are not covered benefits, the vision care provider will provide you with an estimated cost for each service or material upon your request.

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 master group contract works

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

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

Covered expenses are subject to the *maximum allowable fee. We* will apply the applicable *network provider* 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*; and
- Adjustments related to *our* claims processing procedures. Refer to the "Claims" section of this *certificate* for more information on *our* claims processing procedures.

You will be responsible to pay the applicable *network provider copayment, deductible* and/or *coinsurance.*

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*.

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*, 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 not able to travel by non-medical transportation to obtain services from a *network provider*; and
    - *You* do not consent to the *non-network provider* to obtain such services.

Any *copayment, deductible* and/or *coinsurance you* pay for services based on the *qualified payment amount* 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 *master group contract.*

Your choice of providers affects your benefits

We will pay benefits for *covered expenses* if *you* see a *network provider*. *We* may designate certain *network providers* for specific services. If *you* do not see the appointed *network provider* for these services, *we* may pay less.

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

We will apply the *network provider* benefit level and *you* will only be responsible to pay the *network provider copayment, deductible* and/or *coinsurance* for *covered expenses* when *you* receive the following services from 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* 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* 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 not able to travel by non-medical transportation to obtain services from a *network provider*; and
  - *You* did not consent to the *non-network provider* to obtain such services.

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

- 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:
  - The attending *qualified provider* determines *you* are able to travel by non-medical transportation to obtain services from a *network provider*; and
  - *You* consent to the *non-network provider* to obtain such services.

Refer to the "Schedule of Benefits" sections to see what *your* benefits are.

How to find a network provider

You may find a list of *network providers* at www.humana.com. This list is subject to change. Please check this list before receiving services from a *qualified provider*. *You* may also call *our* customer service department at 1-800-448-6262 as shown on *your* ID card to determine if a *qualified provider* is a *network provider*, or *we* can send the list to *you*. A *network provider* can only be confirmed by *us*.

How to use your health maintenance organization (HMO) plan

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

Selecting your primary care physician

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

You may change *your primary care physician* at www.humana.com or *you* may call the customer service department at 1-800-448-6262 as shown on *your* ID card. *You* must contact *us* before receiving services from a new *primary care physician*. *We* will send *you* a new ID card with *your* new *primary care physician's* name.

Use of network providers

In most cases, there are *network providers* for *your* health care. *Network providers* have agreed to provide *covered expenses* at lower costs. *You* must pay any *copayment, deductible* or *coinsurance you* owe to the *network provider*. The *network provider* will accept *your copayment, deductible* or *coinsurance* and the amount *we* pay as the full payment. *You* will not be billed for charges over the *maximum allowable fee.*

Be sure to determine if *your* provider is a *network provider* before *you* receive services from them. *We* offer many health care plans, and a *qualified provider* who is a *network provider* for one plan may not be a *network provider* for this plan.

Use of non-network providers

If a *network provider* cannot provide the *covered expenses you* need or they cannot treat *your* condition, *you* must have a referral from *your primary care physician* that is approved by *us* to receive services from a *non-network provider*. Only the services approved by *us* will be a *covered expense* and will be covered at the *network provider* benefit level. *You* are only responsible to pay any *copayment, deductible* and *coinsurance*.

Continuity of care

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

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

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

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

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

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

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

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

Continuity of care is not available if:

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

If *you* are not a continuing care patient, and a network provider agreement with a *primary care physician* or *hospital* is terminated, if *you* are affected *you* will be notified within thirty days of the date of termination. Claims will be paid for *covered expenses* when *you* receive services from such terminated provider between the date of the terminated agreement and five days after notification is mailed.

All terms and provisions of the *master group contract* are applicable to this "Continuity of care" provision.

Seeking emergency care

If *you* need services for an *emergency*, 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 an *emergency medical condition*. If *your* condition does not allow *you* to call *us* within 48 hours after *your admission*, contact *us* as soon as *your* condition allows. *We* may transfer *you* to a *network hospital* in the *service area* when *your* condition is stable.

Seeking urgent care

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

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 provisions in this *certificate* will not change what is decided between *you* and *qualified providers* regarding *your* medical condition or treatment options. *Qualified providers* act on *your* behalf when they order services. *You* and *your qualified providers* make all decisions about *your* health care, no matter what *we* cover. *We* are not responsible for anything said or written by a *qualified provider* about *covered expenses* and/or what is not covered under this *certificate*. Please call *our* customer service department at 1-800-448-6262 as shown on *your* ID card if *you* have any questions.

Our financial arrangements with network providers

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

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

The certificate

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

COVERED EXPENSES

This "Covered Expenses" section describes the services that will be considered *covered expenses*. Benefits will be paid as specified in the "How your master group contract works" provision in the "Understanding Your Coverage" section and as shown on the "Schedule 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 apply in this *certificate*.

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:

  - Female sterilization;
  - 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;
  - Preventive counseling, such as STD prevention counseling;

- Routine preventive imaging services;
- One screening mammography every year, regardless of the women's age or risk factors, including breast tomosynthesis;
- 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.

For the recommended *preventive services* that apply to *your* plan *year*, refer to the HHS website at www.healthcare.gov/center/regulations/prevention.html or call the customer service department at 1-800-448-6262 as shown on *your* ID card.

Male sterilization services

We will pay benefits for *covered expenses* incurred by *you* for male sterilization. Refer to the "Preventive services" provision in this "Covered Expenses" section for female sterilization.

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*.

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 self-management training*.
- Diagnostic laboratory and radiology.
- Allergy testing.
- Allergy serum extracts.
- Allergy injections.
- Injections other than allergy.
- *Surgery*, including anesthesia.
- Second surgical opinions.

Virtual visit services

We will pay benefits for *covered expenses* incurred by *you* for *virtual visits*. *Virtual visits* must be for services that would otherwise be a *covered expense* if provided during a face-to-face consultation between a *covered person* and a *health care practitioner*. *Virtual visit covered expenses* are provided on the same basis and to the same extent as in-person *covered expenses*.

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" provisions 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 charged for a semi-private room in the *hospital* while *confined.*

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

Health care practitioner inpatient services when provided in a hospital

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

Covered expenses include:

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

Hospital outpatient services

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

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

Hospital outpatient surgical services

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

Health care practitioner outpatient services when provided in a hospital

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

Covered expenses include:

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

Hospital outpatient non-surgical services

Covered expenses include 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.

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 request by either a physician, 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; and

  - *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.

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 *emergency care*, including the treatment and stabilization of an *emergency medical condition.*

Emergency care provided by a *network provider* or *non-network provider* will be covered at the *network provider* benefit level as specified under "Emergency care" benefit on 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* or *skilled nursing facility* to *your* home.

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.*

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

- Ordered by employer, school, fire or public safety official and *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 level as specified in the Ambulance services benefit on the "Schedule of Benefits." The amount *you* pay for *emergency ambulance* services provided by a *non-network provider* will not exceed the amount *you* would pay if the *emergency ambulance* services 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 *ambulance* and *air ambulance covered expenses.*

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*, including, but not limited to:

- Hemodialysis equipment;
- Crutches;
- Pressure machines;

- Infusion pump for IV fluids and medicines;
- Glucometers;
- Augmentive communication devices;
- Tracheotomy tube; and
- Cardiac, neonatal and sleep apnea monitors.

Charges for delivery and installation of the *durable medical equipment* and *diabetes equipment* is a *covered expense,* if applicable.

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
- The equipment is worn out or no longer functions; and
- The equipment is damaged and cannot be repaired; 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 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.

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.

Home health care *covered expenses* are limited to:

- Care provided by a *nurse*;
- Diagnostic services provided and billed by the *home health care agency*;
- Physical, occupational, respiratory or speech therapy;
- Medical social work and nutrition services;
- Services provided by a trained home health aide employed by the *home health care agency*;
- Home infusion therapy;
- *Durable medical equipment* as specified in the "Durable medical equipment and diabetes equipment" provision;
- *Prescription* drugs provided and billed by the home health care agency. Refer to the "Specialty Drug in a medical place of service" provision for *specialty drugs* administered in home health care;
- Private duty nursing; and
- Medical appliances, equipment and supplies.

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*;
- *Custodial care*; or
- The provision or administration of *self-administered injectable drugs*, unless otherwise determined by *us*.

Hospice services

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

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

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

- *Room and board* in a hospice facility;
- Diagnostic services;
- Skilled nursing services provided by a *nurse*;
- Part-time nursing care provided by or supervised by a registered nurse (R.N.);
- Home health aide services;
- 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, speech and inhalation therapy if part of a treatment plan; and
- Medical supplies, drugs, and medicines for *palliative care*.

Hospice care *covered expenses* do not include:

- Services by volunteers or persons who do not regularly charge for their services; or
- Household maintenance.

Infertility counseling and testing

We will pay benefits for *covered expenses* incurred by *you* for infertility counseling and testing services. *We* will pay benefits for *covered expenses* incurred by *you* for the diagnostic and exploratory procedures to determine infertility, including surgical procedures to correct the medically diagnosed disease or condition of the reproductive organs. Does not include infertility drugs.

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 (joint connecting the lower jaw to the temporal bone at the side of the head) and, craniomandibular disorder (head and neck muscle).

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;
- Therapeutic injections;
- Appliance therapy utilizing an appliance that does not permanently alter tooth position, jaw position or bite. Benefits for reversible appliance therapy will be based on the 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;
- Speech therapy or speech pathology services;
- Audiology services;
- Cognitive rehabilitation services;
- Respiratory or pulmonary rehabilitation services; and
- Cardiac rehabilitation services.

Physical medicine and/or rehabilitative services may be provided on an *outpatient* basis or in a day rehabilitation program. A day rehabilitation program means physical medicine and/or rehabilitative services provided at a *rehabilitation facility* for four to eight hours a day, 2 or more days a week to a *covered person* who does not require *inpatient* care. A minimum of two therapy services must be provided for day rehabilitation program to be a *covered expense.*

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

Habilitative services

We will pay benefits for *covered expenses* incurred by *you* for following the *habilitative services* ordered and performed by a *health care practitioner* for a *covered person* with a *congenital anomaly,* developmental delay or defect:

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

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

Spinal manipulations/adjustments and manipulation therapy

We will pay benefits for *covered expenses* incurred by *you* for spinal manipulations/adjustments and manipulation therapy performed by a *health care practitioner.* Spinal manipulations/adjustments focuses on the joints of the spine and nervous system and manipulation therapy include equal emphasis on the joints and surrounding muscles, tendons and ligaments.

The "Schedule of Benefits" shows the maximum number of visits for spinal manipulations/adjustments and manipulation therapy, 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* in lieu of a *hospital admission.*

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

Health care practitioner services when provided in a skilled nursing facility

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

Covered expenses include:

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

Specialty drug medical benefit

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

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

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

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

Transplant services and immune effector cell therapy

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

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

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

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

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

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

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

- *Hospital* and *health care practitioner* services.

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

- Non-medical travel and lodging costs for:

    - The *covered person* receiving the transplant or *immune effector cell therapy*, if the *covered person* lives more than 75 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 75 miles from the transplant or *immune effector cell therapy* facility designated by *us*.

Non-medical travel and lodging costs include:

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

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

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:

- Acupuncture services:
  - When *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.
- 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.
- Chemotherapy, radiation therapy, inhalation therapy and dialysis treatments.
- Prosthetic devices and supplies:
  - Replace all or part of a missing body part and its adjoining tissues; or
  - Replace all or part of the function of a permanently useless or malfunctioning body part.

Covered expenses include purchase, fitting needed adjustment, repair and replacement of prosthetic devises. Prosthetic devices include, but are not limited to:

- Aids and supports for defective parts of the body including but not limited to internal heart valves, mitral valve, internal pacemaker, pacemaker power sources, synthetic or homograft vascular replacements, fracture fixations devices internal to the body surface, replacements for injured or disease bone and joint substances, mandibular reconstruction appliances, bone screws, plates, and vitallium heads for joint reconstruction;

- Left Ventricular Artificial Devices (LVAD) (only when used as a bridge to a heart transplant);

- Breast prosthesis whether internal or external, following a mastectomy;

- Replacements for all or part of absent parts of the body extremities, such as artificial limbs, artificial eye, etc.;

- Intraocular lens implantation for the treatment of cataract or aphakia;

- Restoration prosthesis (composite facial prosthesis).

Repair or replacement of prosthetic devices is a *covered expense*, 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.

Covered expense does not include:

- Dentures, replacing teeth or structures directly supporting teeth;
- Dental appliance;
- Such non-rigid appliance as elastic stockings, garter belts, arch supports and corsets;
- Artificial heart implants;
- Penile prosthesis in men suffering impotency resulting from a *sickness* or *bodily injury.*

- Cochlear implants.

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

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

- Orthotics used to support, align, prevent, or correct deformities. Taxes, shipping, postage and handling charges are covered. Orthotic appliances may be replaced once per *year* per *covered person* when *medically necessary.* Additional replacements will be allowed for *covered persons* under the age of 18 due to rapid growth, or for any *covered person* when an appliance is damaged and cannot be repaired.

Covered expenses include, but are not limited to:

- Cervical collars;
- Ankle foot orthosis;
- Corsets (back and special surgical);
- Splints (extremity);
- Trusses and supports;
- Slings;
- Wristlets;
- Built-up shoe; and
- Custom made shoe inserts.

Covered expense does not include:

- Dental braces; or
- Oral or dental splints and appliances.

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

  - Surgical dressings;
  - Needles/syringes;
  - Catheters;
  - Ostomy bags and supplies; and
  - Flotation pads.

- The initial pair of eyeglasses or contacts needed due to cataract *surgery* or an *accident*. Both lenses and frames are a *covered expense* if *you* select eyeglasses and frames when cataracts are removed from only one eye or only one eye was injured in an *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.

  Covered expenses include, but are not limited to:

  - Oral examinations;
  - X-rays;
  - Tests and laboratory examinations;
  - Restorations;
  - Prosthetic services;
  - Oral surgery;
  - Mandibular/maxillary reconstruction; and
  - Anesthesia.

  Coverage is available in a *hospital* if the *covered person's* condition requires a *hospital* setting.

- 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*;
  - Initiation of immunosuppressive;
  - Direct treatment of acute cancer; and
  - Cleft palate and tongue release for the diagnosis of tongue-tied.
- Orthodontic treatment for a *congenital anomaly* related to or developed as a result of cleft palate, with or without cleft lip.
- *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;
- Prostheses and treatment of physical complications for all stages of mastectomy, including lymphedema; and
- A minimum of four surgical bras per *year*.

- Reconstructive *surgery* resulting from:

  - A *bodily injury*, infection or other disease of the involved part; or
  - A *congenital anomaly*.

  Reconstructive *surgery* to correct an earlier treatment is covered, if the earlier treatment would have been a *covered expense* under this *certificate.* Expenses for reconstructive *surgery* due to a psychological condition are not considered a *covered expense*, unless the condition(s) described above are also met.

- Wigs following the treatment of cancer, limited to one per *year*.

- Hemangiomas, and port wine stains of the head and neck areas.

- Limb deformities such as club hand, club foot, syn dactyl (webbed digits), polydactyly (supernumerary digits), macodactylis.

- Otoplasty when performed to improve hearing by directing sound in the ear canal, when ear or ears are absent or deformed from trauma, *surgery*, disease, or *congenital anomaly*.

- *Congenital anomaly* that causes skull deformity such as Crouzon's disease.

- 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).

- *Palliative care*.

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

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

- 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, other than a clinical trial for cancer, according to the trial protocol and:

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

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

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

COVERED EXPENSES – PEDIATRIC DENTAL

This "Covered Expenses – Pediatric Dental" section describes the services that will be considered *covered expenses pediatric dental services* under this *certificate.* Benefits for *pediatric dental services* will be paid as shown in the "Schedule of Benefits – Pediatric Dental," subject to any applicable:

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

All terms used in this benefit have the same meaning given to them in the *certificate,* unless otherwise specifically defined in this benefit. Refer to the "Limitations and exclusions" provision in this section and the "Limitations and Exclusions" section of this *certificate* for *pediatric dental services* that are not *covered expenses.* All terms and provisions apply.

Definitions

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

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

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

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

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

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

Expense incurred date means the date on which:

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

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

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

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

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

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

Pediatric dental services benefit

We will pay benefits for *covered expenses* incurred by a *covered person* for *pediatric dental services*, which include those provided via teledentistry. *Pediatric dental services* include the following as categorized below. Please note this is not a complete list of *pediatric dental services*. Coverage for a *dental emergency* is limited to *palliative dental care* only:

Class I services

- Periodic and comprehensive oral evaluations. Limited to 2 per *year*.

- Limited, problem focused oral evaluations. Limited to 2 per *year*.

- Periodontal evaluations. Limited to 2 per *year*. Benefit allowed only for a *covered person* showing signs or symptoms of periodontal disease and for patients with risk factors such as smoking, diabetes or related health issues. No benefit is payable when performed with a cleaning (prophylaxis). Benefit are not available when a comprehensive oral evaluation is performed.

- Cleaning (prophylaxis), including all scaling and polishing procedures. Limited to 2 per *year*.

- Intra-oral complete series x-rays (at least 14 films, including bitewings) or panoramic x-ray. Limited to 1 every 5 *years*. If the total cost of periapical and bitewing x-rays exceeds the cost of a complete series of x-rays, *we* will consider these as a complete series.

- Bitewing x-rays. Limited to 2 sets per *year*.
- Other x-rays, including intra-oral periapical and occlusal and extra-oral x-rays. Limited to x-rays necessary to diagnose a specific treatment.
- Topical fluoride treatment. Limited to 2 per *year*.
- Application of sealants to the occlusal surface of permanent molars that are free of decay and restorations. Limited to 1 per tooth every 3 *years*.
- Installation of initial space maintainers for retaining space when a primary tooth is prematurely lost. *Pediatric dental services* do not include separate adjustment expenses.
- Recementation of space maintainers.
- Removal of fixed space maintainers.
- Distal shoe space maintainer – fixed – unilateral.

Class II services

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

Class III services

- Restorative services as follows:

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

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

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

- Periodontic services as follows:

  - Periodontal scaling and root planning. Limited to 1 per quadrants every 2 *years*.

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

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

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

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

  - Clinical crown lengthening – hard tissue.

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

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

- Endodontic procedures as follows:

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

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

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

- Partial pulpotomy for apexogenesis for permanent teeth.

- Vital pulpotomy for primary teeth.

- Pulp debridement, pulpal therapy (resorbable) for permanent and primary teeth.

- Apexification/recalcification for permanent and primary teeth.

• Prosthodontics services as follows:

- Denture adjustments when done by a *dentist*, other than the one providing the denture, or adjustments performed more than six months after initial installation.

- Initial placement of bridges, complete dentures, and partial dentures. Limited to 1 every 5 *years*. *Pediatric dental services* include pontics, inlays, onlays, and crowns. Limited to 1 per tooth every 5 *years.*

- Replacement of bridges, complete dentures and partial dentures. *Pediatric dental services* include the replacement of the existing prosthesis if:

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

- Tissue conditioning.

- Denture relines or rebases. Limited to 1 every 3 *years* after 6 months of installation.

- Post and core build-up in addition to partial denture retainers with or without core build up. Limited to 1 per tooth every 5 *years*.

• The following simple oral surgical services as follows:

- Extraction of coronal remnants of a primary tooth.
- Extraction of an erupted tooth or exposed root for permanent and primary teeth.

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

  Implant supported removable denture for:

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

- Miscellaneous services as follows:

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

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

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

Class IV services

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

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

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

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

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

Integral service

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

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

Pretreatment plan

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

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

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

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

Pretreatment plan process and timing

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

Alternate services

If two or more services are acceptable to correct a dental condition, *we* will base the benefits payable on the least expensive *pediatric dental service* that produces a professionally satisfactory result, as determined by *us*.

Limitations and exclusions

Refer to the "Limitations and Exclusions" section of this *certificate* for additional exclusions. Unless specifically stated otherwise, no benefit will be provided for, or on account of, the following items:

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

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

- Any service that:

  - Is not eligible for benefits based on the *clinical review*;
  - Does not offer a favorable prognosis;
  - Does not have uniform professional acceptance; or
  - Is deemed to be experimental or investigational in nature.

- Preventive control programs including, but not limited to, oral hygiene instructions, plaque control, take-home items, prescriptions and dietary planning.

- Replacement of dentures that have been lost, stolen or misplaced.

COVERED EXPENSES - PEDIATRIC VISION CARE

This "Covered Expenses – Pediatric Vision Care" section describes the services that will be considered *covered expenses* for *pediatric vision care*. Benefits for *pediatric vision care* will be paid as shown in the "Schedule of Benefits – Pediatric Vision Care" subject to any applicable:

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

All terms used in this benefit have the same meaning given to them in the *certificate*, unless otherwise specifically defined in this benefit. Refer to the "Limitations and exclusions" provision in this section and the "Limitations and Exclusions" section of this *certificate* for *pediatric vision care* expenses that are not *covered expenses*. All terms and provisions apply.

Definitions

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

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

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

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

Severe vision problems mean the best-corrected acuity is:

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

COVERED EXPENSES – PEDIATRIC VISION CARE (continued)

Pediatric vision care benefit

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

- *Comprehensive eye exam.*

- Prescription lenses and standard lens options, including polycarbonate, scratch coating, ultraviolet-coating, blended lenses, intermediate lenses, progressive lenses, photochromatic lenses, polarized lenses, fashion and gradient tinting, oversized lenses, glass-grey prescription sunglass lenses, anti-reflective coating, and hi-index lenses. If a *covered person* sees a *network provider*, the *network provider* of *materials* will show the *covered person* the selection of lens options covered by this *certificate.* If a *covered person* selects a lens option that is not included in the lens option selection, the *covered person* is responsible for the difference in cost between the *network provider* of *materials* reimbursement amount for covered lens options and the retail price of the lens options selected.

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

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

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

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

- *Low vision* services includes the following:

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

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

Limitations and exclusions

In addition to the "Limitations and Exclusions" section of this *certificate* and any limitations specified in the "Schedule of Benefits – Pediatric Vision Care," benefits for *pediatric vision care* are limited as follows:

- In no event will benefits exceed the lesser of the limits of the *master group contract*, shown in the "Schedule of Benefits – Pediatric Vision Care" or in the "Schedule of Benefits" of this *certificate.*
- *Materials* covered by the *master group contract* that are lost, stolen, broken or damaged will only be replaced at normal intervals as specified in the "Schedule of Benefits – Pediatric Vision Care."

Refer to the "Limitations and Exclusions" section of this *certificate* for additional exclusions. Unless specifically stated otherwise, no benefits for *pediatric vision care* will be provided for, or on account of, the following items:

- Orthoptic or vision training and any associated supplemental testing.
- Two or more pair of glasses, in lieu of bifocals or trifocals.
- Medical or surgical treatment of the eye, eyes or supporting structures.
- Any services and/or *materials* required by an *employer* as a condition of employment.
- Safety lenses and frames.
- Cosmetic items.
- Any services or *materials* not listed in this benefit section as a covered benefit or in the "Schedule of Benefits – Pediatric Vision Care."
- Expenses for missed appointments.
- Any charge from a providers' office to complete and submit claim forms.
- Treatment relating to or caused by disease.
- Non-prescription *materials* or vision devices.
- Costs associated with securing *materials.*
- Artistically painted lenses.

COVERED EXPENSES - BEHAVIORAL HEALTH AND BIOLOGICALLY BASED MENTAL ILLNESS

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. Benefits will be paid as specified in the "How your master group contract 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.

Covered expenses for *virtual visits* are provided for *behavioral health* and *biologically based mental illness. Behavioral health* and *biologically based mental illness virtual visit covered expenses* are provided in the same manner as in-person *behavioral health* and *biologically based mental illness covered expenses*.

Refer to the "Limitations and Exclusions" section listed in this *certificate*. All terms and provisions 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 *virtual visits*, in a *hospital* or *health care treatment facility*.

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

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 treatment and stabilization of an *emergency medical condition* for conditions related to *mental health services, biologically based mental illness* and *chemical dependency*. *You* are responsible for any applicable *copayment, deductible* and/or *coinsurance* for services received.

Emergency care provided by a *network provider* or *non-network provider* will be covered at the *network provider* benefit level as specified in this "Emergency care" benefit on the "Schedule of Benefits – Behavioral Health and Biologically Based Mental Illness." 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 define 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 *outpatient mental health services, biologically based mental illness* and *chemical dependency* services, including services in a *health care practitioner* office, *retail clinic,* or *health care treatment facility*. Coverage includes *outpatient* therapy, applied behavioral analysis, *intensive outpatient programs, partial hospitalization, virtual visits,* and other *outpatient* services. This coverage also includes the following services to treat *autism spectrum disorder*.

- 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.

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

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 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*;
- *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*;
- *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*.

COVERED EXPENSES – PHARMACY SERVICES

This "Covered Expenses – Pharmacy Services" section describes *covered expenses* 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 apply, including *prior authorization* requirements specified in the "Schedule of Benefits – Pharmacy Services" of this *certificate*.

Coverage description

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

Covered *prescription* drugs are:

- Drugs, medicines or medications and *specialty drugs* that under federal or state law may be dispensed only by *prescription* from a *health care practitioner*.
- Drugs, medicines or medications and *specialty drugs* included on *our drug list*.
- Drugs, medicines or medications prescribed for off-label indications recognized through peer-reviewed medical literature.
- Insulin and *diabetes supplies*.
- Injectable drugs and *self-administered injectable drugs* approved by *us*.
- Hypodermic needles, syringes or other methods of delivery when prescribed by a *health care practitioner* for use with insulin or *self-administered injectable drugs*. (Hypodermic needles, syringes or other methods of delivery used in conjunction with covered drugs may be available at no cost to *you*).
- Enteral formulas and nutritional supplements for the treatment of phenylketonuria (PKU) or other inherited metabolic disease, or as otherwise determined by *us*.
- Spacers and/or peak flow meters for the treatment of asthma.
- Drugs, medicines or medications on the Preventive Medication Coverage *drug list* with a *prescription* from a *health care practitioner*.

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

Restrictions on choice of providers

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

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

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

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. It also indicates *dispensing limits*, *specialty drug* designation and any applicable *prior authorization* or *step therapy* requirements. This information is reviewed on a regular basis by a Pharmacy and Therapeutics committee made up of physicians and *pharmacists*. Placement on the *drug list* does not guarantee *your health care practitioner* will prescribe that *prescription* drug, medicine or medication for a particular medical condition. *You* can obtain a copy of *our drug list* by visiting *our* website at www.humana.com or calling the customer service telephone number on *your* ID card.

Prescription drug assistance program

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

Access to non-formulary drugs

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

Non-formulary drug standard exception request

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

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

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

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

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

Non-formulary drug expedited exception request

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

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

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

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

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

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

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

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

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

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

Non-formulary drug exception request external review

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

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

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

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

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

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

Step therapy exception request

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

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 grant 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.

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.*

LIMITATIONS AND EXCLUSIONS

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

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

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

LIMITATIONS AND EXCLUSIONS (continued)

- Any service not rendered by the billing provider.
- Any service not substantiated in the medical records of the billing provider.
- Any amount billed for a professional component of an automated:
  - Laboratory service; or
  - Pathology service.
- Education, or training, except for *diabetes self-management training* and *habilitative services*.
- Educational or vocational therapy, testing, services, or schools, including therapeutic boarding schools and other therapeutic environments. Educational or vocational videos, tapes, books, and similar materials are also excluded.
- Services provided by a *covered person's family member*.
- *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*:
    - A *health care practitioner:*
      - During an office visit; or
      - While an *outpatient*; or
    - A *home health care agency* as part of a covered *home health care plan*.

LIMITATIONS AND EXCLUSIONS (continued)

- Certain *specialty drugs* administered by a *qualified provider* in a *hospital's outpatient* department, except as specified in the "Access to non-formulary drugs" provision in the "Covered Expenses - Pharmacy Services" 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* that are not *medically necessary* to diagnose or correct the disease of the reproductive organs; or reversal of elective sterilization, unless otherwise stated in this *certificate.*

- In vitro fertilization regardless of the reason for treatment.

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

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

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

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

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

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

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

- *Cosmetic surgery* and cosmetic services or devices. Complications from a non-covered procedure that require the need for *medically necessary* basic health care service is a *covered expense.*

- Hair prosthesis, hair transplants or implants, except for wigs as provided for in the "Covered Expenses" section in this *certificate.*

LIMITATIONS AND EXCLUSIONS (continued)

- For dental x-rays, supplies & appliances and all associated expenses, including hospitalization and anesthesia, except as required by law. The only exceptions to this are for any of the following;

  - Under the "Covered Expenses – Pediatric Dental" section in this *certificate*;
  - Transplant preparation;
  - Initiation of immunosuppressive; and
  - Direct treatment of acute traumatic injury, cancer or cleft palate.

- The following types of care of the feet:

  - Shock wave therapy of the feet;
  - The treatment of weak, strained, flat, unstable, or unbalanced feet: and
  - Arch supports (foot orthotics) or orthopedic shoes, except for diabetes or hammer toe.

- The following types of care of the feet, unless you have diabetes:

  - Non-surgical treatment of tarsalgia, metatarsalgia or bunion;
  - The cutting of toenails, except the removal of the nail matrix;
  - Heel wedges, lifts or shoe inserts.

- *Custodial care* and *maintenance care*.

- Any loss 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.

- Expenses for any membership fees or program fees, including but not limited to, health clubs, health spas, aerobic and strength conditioning, work-hardening programs, and weight loss or surgical programs and any materials or products related to these programs.

- Surgical procedures for the removal of excess skin and/or fat in conjunction with or resulting from weight loss or a weight loss *surgery*.

- Expenses for services that are primarily and customarily used for environmental control or enhancement (whether or not prescribed by a *health care practitioner*) and certain medical devices including, but not limited to:

  - Common household items including air conditioners, air purifiers, water purifiers, vacuum cleaners, waterbeds, hypoallergenic mattresses or pillows, or exercise equipment;

  - Motorized transportation equipment (e.g. scooters), escalators, elevators, ramps, or modifications or additions to living/working quarters or transportation vehicles;

  - Personal hygiene equipment including bath/shower chairs, transfer equipment or supplies or bed side commodes;

- Personal comfort items including cervical pillows, gravity lumbar reduction chairs, swimming pools, whirlpools, spas, or saunas;
- Communication systems, telephone, television, or computer systems and related equipment or similar items or equipment;
- Communication devices, except after surgical removal of the larynx or a diagnosis of permanent lack of function of the larynx, (augmentive communication devices are a *covered expense* when deemed appropriate by *us*).

- Duplicate or similar rentals or purchases of *durable medical equipment* or *diabetes equipment.*
- Lodging accommodations or transportation, except as provided for under the "Covered Expenses" section in this *certificate.*
- Communications, other than *telehealth,* or travel time.
- Weight loss products or services unless specified in the "Covered Expenses" section of this *certificate.*
- Bariatric *surgery* and services related to bariatric *surgery,* and other weight loss products or services. Complications from a non-covered procedure that require the need for any *medically necessary* basic health care service is a *covered expense*.
- Non-therapeutic abortions.
- *Alternative medicine*.
- Acupuncture, unless otherwise specified in the "Covered Expenses" section in this *certificate.*
- Services rendered in a premenstrual syndrome clinic or holistic medicine clinic.
- Vision examinations or testing for the purposes of prescribing corrective lenses, except *comprehensive eye exams* provided under the "Covered Expenses – Pediatric Vision Care" section in this *certificate.*
- Orthoptic/vision training (eye exercises).
- Radial keratotomy, refractive keratoplasty or any other *surgery* or procedure to correct myopia, hyperopia or stigmatic error.
- The purchase or fitting of eyeglasses or contact lenses, except as:
  - The result of an *accident* or following cataract *surgery* as stated in this *certificate*.
  - Otherwise specified in the "Covered Expenses – Pediatric Vision Care" section in this *certificate.*

LIMITATIONS AND EXCLUSIONS (continued)

- Services and supplies which are:

  - 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 incurred for services prior to the *effective date* or after the termination date of *your* coverage under the *master group contract.* Coverage will be extended as described in the "Extension of Benefits" section, as required by state law.

- Any care, treatment, services, equipment, or supplies received outside of the *service area*:

  - If *you* could have reasonably foreseen or anticipated their need prior to departure from the *service area*; and
  - Which are not authorized by *us*.

- *Pre-surgical/procedural testing* duplicated during a *hospital confinement.*

LIMITATIONS AND EXCLUSIONS - PHARMACY SERVICES

This "Limitations and Exclusions – Pharmacy Services" section describes the limitations and exclusions 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 in this *certificate*.
- 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, except as provided for under "Health care practitioner office services" in both the "Schedule of Benefits" and "Covered Expenses" section in this *certificate*.
- Therapeutic devices or appliances, including, but not limited to:
  - Hypodermic needles and syringes (except when prescribed by a *health care practitioner* for use with insulin and *self-administered injectable drugs*, whose coverage is approved by *us*);
  - Support garments;
  - Test reagents;
  - Mechanical pumps for delivery of medications; and
  - Other non-medical substances.

LIMITATIONS AND EXCLUSIONS - PHARMACY SERVICES (continued)

- Dietary supplements and nutritional products, except enteral formulas and nutritional supplements for the treatment of phenylketonuria (PKU) or other inherited metabolic disease. Refer to the "Covered Expenses" section of the *certificate* for coverage of low protein modified foods.

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

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

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

- Any drug used for the purpose of weight loss.

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

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

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

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

- Compounded drugs that:

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

- Abortifacients (drugs used to induce abortions).

- Medication for *infertility services*.

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

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

- The administration of covered medication(s).

LIMITATIONS AND EXCLUSIONS - PHARMACY SERVICES (continued)

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

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

- *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*.

- 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*.

LIMITATIONS AND EXCLUSIONS - PHARMACY SERVICES (continued)

- Any *prescription* fill or refill for drugs, medicines or medications that are lost, stolen, spilled, spoiled, or damaged.
- Drug delivery implants and other implant systems or devices.
- Any amount *you* paid for a *prescription* that has been filled, regardless of whether the *prescription* is revoked or changed due to adverse reaction or change in dosage or *prescription*.
- *Prescriptions* filled at a *non-network pharmacy*, except for *prescriptions* required during an emergency.

ELIGIBILITY AND EFFECTIVE DATES

Eligibility date

Employee eligibility date

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

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

Dependent eligibility date

Each *dependent* is eligible for coverage on:

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

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

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

Enrollment

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

Employee enrollment

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

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

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

Dependent enrollment

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

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

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

Newborn and adopted dependent enrollment

A newborn *dependent* will be automatically covered from the date of birth to 31 days of age. 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.

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

  Loss of eligibility of other coverage includes, but is not limited to:
  - Termination of employment or eligibility;
  - Reduction in number of hours of employment;
  - Divorce, legal separation or death of a spouse;
  - Loss of dependent eligibility, such as attainment of the limiting age;
  - Termination of your employer's contribution for the coverage;
  - Loss of individual HMO coverage because you no longer reside, live or work in the service area;
  - Loss of group HMO coverage because you no longer reside, live or work in the service area, and no other benefit package is available; or
  - The plan no longer offers benefits to a class of similarly situated individuals.

- You had COBRA continuation coverage under another plan at the time of eligibility, and
  - Such coverage has since been exhausted; and
  - You stated at the time of the initial enrollment that coverage under COBRA was your reason for declining enrollment; and
  - You enroll within 31 days after the *special enrollment date*; or

- You were covered under an alternate plan provided by the *employer* that terminates, and:
  - You are replacing coverage with the *master group contract*; and
  - You enroll within 31 days after the *special enrollment date*; or

- You are an *employee* or *dependent* eligible for coverage under the *master group contract,* and:

  - Your *Medicaid* coverage or your Children's Health Insurance Program (CHIP) coverage terminated as a result of loss of eligibility; and
  - You enroll within 60 days after the *special enrollment date*; or

- You are an *employee* or *dependent* eligible for coverage under the *master group contract,* and:

  - You become eligible for a premium assistance subsidy under *Medicaid* or CHIP; and
  - You enroll within 60 days after the *special enrollment date*.

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

Dependent special enrollment

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

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

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

Open enrollment

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

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

Effective date

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

ELIGIBILITY AND EFFECTIVE DATES (continued)

Employee effective date

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

Dependent effective date

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

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

Newborn and adopted dependent effective date

The *effective date* of coverage for a newborn *dependent* 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 *master group contract year* as agreed to by the *group plan sponsor* and *us.*

Retired employee coverage

Retired employee eligibility date

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

Retired employee enrollment

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

Retired employee effective date

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

Genetic screening

Eligibility for coverage under the *master group contract* is not subject to any genetic screening or testing or any results therein.

REPLACEMENT OF COVERAGE

Applicability

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

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

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

Deductible credit

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

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

Waiting period credit

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

Out-of-pocket limit

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

TERMINATION PROVISIONS

Termination of coverage

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 *master group contract.* Notice must be provided to *us* within 31 days of the change.

When *we* receive notification of a change in eligibility status in advance of the effective date of the change, coverage will terminate on the actual date specified by the *employer* or *employee* or at the end of that month, as selected by *your employer* on the EGA.

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

Otherwise, coverage terminates on the earliest of the following:

- The date the *master group contract* terminates;
- The end of the period for which required premiums were paid to *us*;
- The date the *employee* terminated employment with the *employer*;
- The date the *employee* no longer qualified as an *employee*;
- The date the *employee* no longer lives or works in the *service area*;
- The date *you* fail to be in an eligible class of persons as stated in the EGA;
- The date the *employee* 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 coverage for the *employee* or *dependents*;
- For a *dependent,* the date the *employee's* coverage terminates;
- For a *dependent,* the date the *employee* ceases to be in a class of *employees* eligible for *dependent* coverage;
- The date *your dependent* no longer qualifies as a *dependent*;
- For any benefit, the date the benefit is deleted from the *master group contract*; or

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

Termination for cause

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

- If *you* allow an unauthorized person to use *your* identification card or if *you* use the identification card of another *covered person.* Under these circumstances, the person who receives the services provided by use of the identification card will be responsible for paying *us* any amount *we* paid for those services.

- If *you* or the *group plan sponsor* 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.

EXTENSION OF BENEFITS

Extension of coverage for total disability

We extend limited coverage if:

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

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

- The date *your health care practitioner* certifies *you* are no longer *totally disabled*;
- The date any maximum benefit is reached; or
- The last day of a 90 consecutive day period following the date the *master group contract* terminated.

No insurance is extended to a child born as a result of a *covered person's* pregnancy.

The "Extension of coverage for total disability" provision does not apply to covered retired persons.

In the event the *master group contract* terminates while *you* are receiving *acute inpatient services*, *we* will continue coverage to the earliest of:

- The date of discharge from the *hospital*;
- The date *your health care practitioner* determines that *acute inpatient services* are no longer *medically necessary*;
- The date any maximum benefit is reached; or
- The date *your* coverage becomes effective under any new health insurance coverage.

CONTINUATION

Continuation options in the event of termination

If coverage terminates:

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

A complete description of the "State continuation of coverage" provision follows.

State continuation of coverage

A *covered person* whose coverage terminates shall have the right to continuation under the *master group contract* as follows:

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

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

In order to be eligible for this option:

- The *employee* must have been continuously covered under the *master group contract* 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.

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 *group plan sponsor* 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 *group plan sponsor* is responsible for sending *us* the premium payments for those individuals who choose to continue their coverage. If the *group plan sponsor* fails to make proper payment of the premiums to *us*, *we* are relieved of all liability for any coverage that was continued and the liability will rest with the *group plan sponsor*.

If the *master group contract* 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 and if replacement had not occurred.

Continuation of coverage for military reservists

Ohio law provides special rights to continuation coverage to:

- An *employee* covered under the *master group contract* who is a *reservist* called or ordered to active duty; or
- *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 the 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; or

CONTINUATION (continued)

- The covered *dependent* child no longer meets the definition of *dependent* under this *master group contract.*

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; or
- 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 health plan for active military personnel, including TRICARE;

- 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 *master group contract.* If the *master group contract* 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; and

    - The level of benefits under the replacement plan is the same as the level of benefits available to other eligible persons under the group plan.

COORDINATION OF BENEFITS

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* does 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*.

COORDINATION OF BENEFITS (continued)

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 expense*s:

- 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 *plan's*. 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.

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*;
  - If both parents have the same birthday, the *plan* that has covered the parent the longest is the *primary plan*; or
  - 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*.

(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 *plan*s 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.*

If the preceding rules do not determine the order of benefits, the *allowable expense*s 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 expense*s. 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 the 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.

COORDINATION OF BENEFITS (continued)

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. 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.

CLAIMS

Notice of claim

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

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

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

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

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

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

Proof of loss

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

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

Claims processing procedures

You are only responsible for any *deductible*, *coinsurance*, and applicable *copayment* for any *covered services* received. *Qualified provider* services are subject to *our* claims processing procedures. *We* use *our* claims processing procedures to determine payment of *covered expenses*. *Our* claims processing procedures include, but are not limited to, claims processing edits and claims payment policies, as determined by *us*. *Your qualified provider* may access *our* claims processing edits and claims payment policies on *our* Website at www.humana.com by clicking on "For Providers" and "Claims Resources."

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

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

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

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

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

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

You should discuss *our* claims processing edits, claims payment policies and medical or pharmacy coverage policies and their availability with any *qualified provider* prior to receiving any services. *You* or *your qualified provider* may access *our* claims processing edits and claims payment policies on *our* website at www.humana.com by clicking on "For Providers" and "Coverage Policies." *Our* medical and pharmacy coverage policies may be accessed on *our* website at www.humana.com under "Medical Resources" by clicking "Coverage Policies." *You* or *your qualified provider* may also call *our* toll-free customer service number at 1-800-448-6262 as shown 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 *master group contract*. *We* may also introduce limited pilot or test programs including, but not limited to, disease management, care management, expanded accessibility, or wellness initiatives.

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

Right to require medical examinations

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

To whom benefits are payable

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

Benefit payments for *covered expenses* 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* 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 you master group contract 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*.

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

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

Right to collect needed information

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

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

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

Exhaustion of time limits

If *we* fail to complete a claim determination or appeal within the time limits set forth in the *master group contract,* 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 *master group contract.*

Duty to cooperate in good faith

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

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

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

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

Workers' compensation

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

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

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

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

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

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

Right of subrogation

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

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

We may enforce *our* subrogation rights by asserting a claim to any coverage to which *you* may be entitled. 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 *master group contract*, and *you* recover from any legally responsible person, their insurer, or any uninsured motorist, underinsured motorist, medical payment/expense, Workers' Compensation, no-fault, or other similar coverage, *we* have the right to recover from *you* an amount equal to the amount *we* paid and for the reasonable value of services and benefits provided under a managed care agreement.

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

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

The obligation to reimburse *us* in full exists, regardless of whether the settlement, compromise or judgment designates the recovery as including or excluding medical expenses. 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 *master group contract.* If payment is made by *us* on *your* behalf, *you* agree to assign to *us* the right *you* have against the other insurer for medical expenses *we* pay.

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

Cost of legal representation

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

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

COMPLAINT AND APPEAL PROCEDURES

We make every effort to resolve customer dissatisfaction issues at an informal level. *Our* customer service representatives are available to assist *you* with any issue relating to *your* health coverage or any aspect of *your* plan. *Our* customer service representatives may be reached at 1-800-448-6262 as shown on *your* ID card.

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

Definitions

The following definitions 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 applicant's eligibility for *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 *health insurance coverage* to an applicant.
- To *rescind* coverage on a health benefit plan.

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

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.

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 person* has given express, written consent to represent that *covered person* 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.

Concurrent-care decision means a decision by the plan to reduce or terminate *benefits* otherwise payable for a course of treatment that has been approved by *us* or a decision with respect to a request by a *covered person* to extend a course of treatment beyond the period of time or number of treatments that has been approved by *us.*

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 means a complaint submitted in writing to *us* regarding dissatisfaction with any aspect of the plan, other than a claim or service denial, including a previous problem that is not resolved to *your* satisfaction.

Health benefit plan means a *master group contract,* 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.*

Superintendent means the superintendent of insurance.

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

- Could seriously jeopardize the life or health of the *covered person* or the ability of the *covered person* to regain maximum function; or

- In the opinion of a physician with knowledge of the *covered person's* medical condition, would subject the *covered person* to severe pain that cannot be adequately managed without the service that is the subject of the claim.

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

Claims decisions

After a determination on a claim is made, *we* will notify the *covered person* within a reasonable time, as follows:

- **Pre-service claims** - *We* will provide notice of a favorable or *adverse pre service determination* within two business days after obtaining all necessary information regarding a proposed *admission*, procedure or *health care service* requiring a review determination.

  For *preauthorization* of an *admission*, procedure, or *health care service*, *we* will notify the provider rendering the service by telephone or facsimile within three business days after making the initial *preauthorization* determination. In the case of an *adverse pre service determination*, *we* will also provide written or *electronic* confirmation of the telephone notification to the *covered person* and the provider within one business day after making the telephone notification.

- ***Urgent-care claims*** – *We* will determine whether a particular claim is an *urgent-care claim*. This determination will be based on information furnished by or on behalf of a *covered person*. *We* will exercise *our* judgment when making the determination with deference to the judgment of a physician with knowledge of the *covered person's* condition. *We* may require a *covered person* to clarify the medical urgency and circumstances supporting the *urgent-care claim* for expedited decision-making.

  Notice of a favorable or *adverse benefit determination* will be made by *us* soon as possible, taking into account the medical urgency particular to the *covered person's* situation, but not later than 24 hours after receiving the *urgent-care claim*.

  If a claim does not provide sufficient information to determine whether, or to what extent, services are *covered expenses* under the plan, *we* will notify the *covered person* or, the *authorized representative* who files a claim, as soon as possible, but not more than 24 hours after receiving the *urgent-care claim*. The notice will describe the specific information necessary to complete the claim. The *covered person* or *authorized representative* will have a reasonable amount of time, taking into account the *covered person's* circumstances, to provide the necessary information – but not less than 48 hours.

  We will provide notice of the *urgent-care claim* determination as soon as possible but no more than 48 hours after the earlier of:

  - When *we* receive the specified information; or
  - The end of the period afforded the *covered person* to provide the specified additional information.

- ***Concurrent-care decisions*** - *We* will make a determination within one business day after obtaining all necessary information. *We* will notify the provider rendering the health care service by telephone or FAX within one business day after making the determination.

  In the case of a *concurrent-care decision* involving a reduction or termination of preauthorized benefits, *we* will notify the provider within one business day after telephone notification. *We* will notify the *covered person* or, the *authorized representative* of the *concurrent-care decision* sufficiently in advance of the reduction or termination to allow the *covered person* or, the *authorized representative* to appeal and obtain a determination.

We will decide *urgent-care claim*s involving an extension of a course of treatment as soon as possible taking into account medical circumstances. *We* will notify a *covered person* or, the *authorized representative* of the benefit determination, whether adverse or not, within 24 hours after *we* receive the claim, provided the claim is submitted to *us* 24 hours prior to the expiration of the prescribed period of time or number of treatments.

- **Post-service claims** - *We* will provide notice of a favorable *adverse benefit determination* within a reasonable time appropriate to the medical circumstances but no later than 30 days after *we* receive the claim. In the case of an *adverse benefit determination, we* will notify the *covered person* or, the *authorized representative* and the provider, in writing, within five business days after making the *adverse benefit determination.*

  This period may be extended an additional 15 days, if *we* determine the extension is necessary due to matters beyond *our* control. Before the end of the initial 30-day period, *we* will notify the affected *covered person* or, the *authorized representative* of the extension, the circumstances requiring the extension and the date by which *we* expect to make a decision.

  If the reason for the extension is because *we* do not have enough information to decide the claim, the notice of extension will describe the required information, and the *covered person* or, the *authorized representative* will have at least 45 days from the date the notice is received to provide the specified information. *We* will make a decision on the earlier of the date on which the *covered person* or, the *authorized representative* responds or the expiration of the time allowed for submission of the requested information.

Initial denial notices

Notice of a claim denial (including a partial denial) will be provided to *covered persons* by mail, postage prepaid, by FAX or by e-mail, as appropriate, within the time frames noted above. With respect to adverse decisions involving *urgent-care claims*, notice may be provided to *covered persons* orally within the time frames noted above. If oral notice is given, written notification must be provided no later than three days after oral notification.

A claims denial notice will convey the specific reason for the *adverse benefit determination* and the specific plan provisions upon which the determination is based. The notice will also include a description of any additional information necessary to perfect the claim and an explanation of why such information is necessary. The notice will disclose if any internal plan rule, protocol or similar criterion was relied upon to deny the claim and a copy of the rule, protocol or similar criterion will be provided to *covered persons*, free of charge. In addition to the information provided in the notice, a *covered person* has the right to request the diagnosis and treatment codes and descriptions upon which the determination is based.

The notice will describe *our* review procedures and the time limits applicable to such procedures, including a statement of the *covered person's* right to bring a civil action under ERISA Section 502(a) following an *adverse benefit determination* on review.

If an *adverse benefit determination* is based on medical necessity, *experimental* treatment or similar exclusion or limitation, the notice will provide an explanation of the scientific or clinical basis for the determination, free of charge. The explanation will apply the terms of the plan to the *covered person's* medical circumstances.

In the case of an adverse decision of an *urgent-care claim*, the notice will provide a description of *our* expedited review procedures.

For assistance with appeals, complaints or the external review process a *covered person* or, the *authorized representative* may write or call:

Ohio Department of Insurance
50 West Town Street
Third Floor – Suite 300
Columbus, OH 43215-1067

Phone: 800-686-1526 or 614-644-2673
TDD 614-644-3745
Fax: 614-644-3744

Website: http://insurance.ohio.gov/Pages/default.aspx
or
http://insurance.ohio.gov/Consumer/Pages/ConsumerTab1.aspx

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 days of receipt by *us.* If the reconsideration process does not resolve the difference of opinion, then *you* or an *authorized representative* may file an *appeal.*

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

Should *your* medical condition warrant an expedited reconsideration, *you* will receive notification within 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.

Internal appeals process

An *internal appeal* must be submitted to *us* within 180 calendar days from the receipt of an *adverse benefit determination.*

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 benefit 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 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.
- 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.

If *we* fail to notify *you* of a final decision within the 30 days of receipt of the *internal appeal, you* may treat the delay as a denial and proceed to the "External Review" process.

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:

- 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 are met for an expedited internal review, *we* will notify *you* verbally of the resolution within 48 hours. Written resolution will be sent within three calendar days.

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 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, if 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*;
  - Standard *health care services* are not medically appropriate for the *covered person*; or
  - 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 completed within 30 days after *our* receipt of the request for a standard external review. An expedited review for urgent medical situations is completed within 72 hours of *our* receipt of the request 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.

An expedited external review is not available for retrospective *final adverse benefit determination*s (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 Ohio Department of Insurance in the 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*.

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* or *authorized representative* 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* or *authorized representative* 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* or *authorized representative* 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* will notify the *covered person* or *authorized representative* in writing and provide the reason for the denial and inform the *covered person* or, the *authorized representative* 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* initiates 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* or *authorized representative* 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 external review. This notice will be sent to the *covered person* or *authorized representative*, *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.
- 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 used or considered in reaching its decision.

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 1-800-448-6262 as shown on *your* ID 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

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 and 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 *master group contract* may be brought until sixty days after written proof of loss has been given in accordance with "Proof of loss" provision of the *master group contract.*

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

DISCLOSURE PROVISIONS

Employee assistance program

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

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

Discount programs

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

Wellness programs

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

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

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

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

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

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

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

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

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

The decision to participate in wellness program activities is voluntary 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 *covered person* under the health benefit plan, coverage is limited to *network providers*, unless for *emergency care.* For coverage to be available for *non-network providers* other than *emergency care*, *you* must receive a referral from *us.*

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

DISCLOSURE PROVISIONS (continued)

If *you* would like to inquire in advance to determine if services rendered by a *non-network provider* may be subject to the Shared Savings Program, please contact *our* customer service department at 1-800-448-6262 as 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.

MISCELLANEOUS PROVISIONS

Entire contract

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

Additional group plan sponsor responsibilities

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

- Collection of premium; and
- Distributing and providing *covered persons* access to:

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

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

Certificates

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

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

Incontestability

No misstatement made by the *group plan sponsor,* except for fraud or an intentional misrepresentation of a material fact made in the application, may be used to void the *master group contract.*

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

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

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

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 master group contract

The *master group contract* may be modified by *us,* upon renewal of the *master group contract,* as permitted by state and federal law. The *group plan sponsor* will be notified in writing or *electronically* at least 60 days prior to the effective date of the change.

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

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

Discontinuation of coverage

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

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

If *we* cease doing business in the *small employer* or the large *employer* group market, the *group plan sponsors*, *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 premium to *us* as they become due. *Your employer* may require *you* to contribute toward the cost of *your* coverage. Failure of *your employer* to pay any required premium to *us* when due may result in the termination of *your* coverage.

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 *master group contract* and its benefits may not be assigned by the *group plan sponsor*.

Emergency declarations

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

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

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

Conformity with statutes

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

GLOSSARY

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

A

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 *group plan sponsor*;
- For 48 weeks a year; and
- Is maintaining a bona fide *employer-employee* relationship with the *group plan sponsor* of the *master group contract* on a regular basis.

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

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

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

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

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

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

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

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

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

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

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

Ancillary services mean *covered expenses* that are:

- Items or services related to emergency medicine, anesthesiology, pathology, radiology, or neonatology;
- Provided by *assistant surgeons* hospitalists or intensivists;
- Diagnostic laboratory or radiology services; and
- Items or services provided by a *non-network provider* when a *network provider* is not available to provide the services at a *network provider 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 the following psychiatric illnesses as defined by the American Psychiatric Association in the Diagnostic and Statistical Manual (DSM):

- Schizophrenia;
- Paranoid and other psychotic disorders;
- Bipolar disorders (hypomanic, manic, depressive and mixed);

- Major depressive disorders (single episodes or recurrent);
- Schizoaffective disorders (bipolar or depressive);
- Pervasive development disorders;
- Obsessive-compulsive disorders;
- Panic disorder; and
- Depression in childhood and adolescence.

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

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

C

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

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

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

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*.

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;

- *Preventive services*;
- *Pediatric dental services*; or
- *Pediatric vision care.*

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

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

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

Custodial care means services given to *you* if:

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

- The services *you* require are primarily to maintain, and not likely to improve, *your* condition; or

- The services involve the use of skills which can be taught to a layperson and do not require the technical skills of a *nurse*.

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

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

D

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

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

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

Dependent means a covered *employee's*:

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

Under no circumstances shall *dependent* mean a grandchild, 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 with or receiving financial support from *you*;
- Eligible for other coverage through employment; or

- Residing or working outside of the *service area.* Benefits for *dependents* residing outside of the *service area* are limited to *emergency care* and *urgent care* services as specified in the "Dependent eligibility date" provision, unless additional coverage is provided by addenda or authorized by *us*.

A covered *dependent* child who attains the limiting age while covered under the *master group contract,* 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.

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*, other than the site the *covered person* is located, at the time a *telehealth* service is provided.

Domestic partner means an individual of the same or opposite gender, who resides with the covered *employee* in a long-term relationship of indefinite duration; and, there is an exclusive, mutual commitment in which the partners agree to be jointly responsible for each other's common welfare and share financial obligations. *We* will allow coverage for only one *domestic partner* of the covered *employee* at any one time. The *employee* and *domestic partner* must each be at a minimum 18 years of age, competent to contract, and not related by blood to a degree of closeness which would prohibit legal marriage in the state in which the *employee* and *domestic partner* both legally reside. *We* reserve the right to require an affidavit from the *employee* and *domestic partner* attesting that the domestic partnership has existed for a minimum period of 12 months and, periodically thereafter, to require proof that the *domestic partner* relationship continues to exist.

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 *master group contract.*

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

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

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

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.

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 *master group contract.*

Employer means the sponsor of this *group* plan or any subsidiary or affiliate described in the Employer Group Application. An *employer* must either employ at least one common-law employee or be a partnership with a bona fide partner who provides services on behalf of the partnership. A business owner and his or her spouse are not considered common-law employees for this purpose if the entity is considered to be wholly owned by one individual or one individual and his or her spouse.

Endodontic services mean the following dental procedures, related tests or treatment and follow-up care:

- Root canal therapy and root canal fillings;
- Periradicular *surgery*;
- Apicoectomy;
- Partial pulpotomy; or
- Vital pulpotomy.

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

- Cannot be lawfully marketed without the final approval of the United States Food and Drug Administration (FDA) and lacks such final FDA approval for the use or proposed use, unless (a) found to be accepted for that use in the most recently published edition of the United States Pharmacopeia-Drug Information for Healthcare Professional (USP-DI) or in the most recently published edition of the American Hospital Formulary Service (AHFS) Drug Information; (b) identified as safe, widely used and generally accepted as effective for that use as reported in nationally recognized peer reviewed medical literature published in the English language as of the date of service; or (c) is mandated by state law;

- Is a device required to receive Premarket Approval (PMA) or 510K approval by the FDA but has not received a PMA or 510K approval;

- Is not identified as safe, widely used and generally accepted as effective for the proposed use as reported in nationally recognized peer reviewed medical literature published in the English language as of the date of service;

- Is the subject of a National Cancer Institute (NCI) Phase I, II or III trial or a treatment protocol comparable to a NCI Phase I, II or III trial, or any trial not recognized by NCI regardless of phase; or

- Is identified as not covered by the Centers for Medicare & Medicaid Services (CMS) Medicare Coverage Issues Manual, a CMS Operational Policy Letter or a CMS National Coverage Decision, except as required by state or federal law.

F

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

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

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

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

G

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

Group plan sponsor means the legal entity identified as the *group plan sponsor* on the face page of the *master group contract* or "Certificate of Coverage" who establishes, sponsors and endorses an employee benefit plan for health care coverage.

H

Habilitative services mean 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 or *health care practitioner's* office, 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.

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 professional, 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 <u>not</u> be primarily a:
  - Convalescent, rest or nursing home; or
  - Facility providing custodial, educational or rehabilitative care.

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

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

I

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

Infertility services mean any treatment, supply, medication, or service provided to achieve pregnancy or to achieve or maintain ovulation. This includes, but is not limited to:

- Artificial insemination;
- In vitro fertilization;
- Gamete Intrafallopian Transfer (GIFT);
- Zygote Intrafallopian Transfer (ZIFT);
- Tubal ovum transfer;
- Embryo freezing or transfer;
- Sperm storage or banking;
- Ovum storage or banking;
- Embryo or zygote banking; and
- Any other assisted reproductive techniques or cloning methods.

Inpatient means *you* are *confined* as a registered bed patient.

Intensive outpatient program means *outpatient* services providing:

- Group therapeutic sessions greater than one hour a day, three days a week;
- *Behavioral health services* or *chemical dependency* therapeutic focus;
- Group sessions centered on cognitive behavioral constructs, social/occupational/educational skills development and family interaction;
- Additional emphasis on recovery strategies, monitoring of participation in 12-step programs and random drug screenings for the treatment of *chemical dependency*; and
- Physician availability for medical and medication management.

Intensive outpatient program does not include services that are for:

- *Custodial care*; or
- Day care.

J

K

L

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

M

Maintenance care means services and supplies furnished mainly to:

- Maintain, rather than improve, a level of physical or mental function; or
- Provide a protected environment free from exposure that can worsen the *covered person's* physical or mental condition.

Master group contract means the legal agreement between *us* and the *group plan sponsor*, including the Employer Group Application and *certificate*, together with any rider, amendments and endorsements.

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

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 greater of:

- The median fee negotiated with *network providers* for the same or similar service in the same geographic region; or
- 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 provider*; 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 a mental, nervous or emotional condition classified in the Diagnostic and Statistical Manual of Mental Disorders.

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

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

N

Network facility means a *hospital*, *hospital outpatient* department or *ambulatory surgical center* that has been designated as such or has signed an agreement with *us* as an independent contractor, or 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 *employees* have an opportunity to enroll themselves and their eligible *dependents* for coverage under the *master group contract.*

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

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

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

Out-of-pocket limit means the amount of *copayments*, *deductibles* and *coinsurance you* must pay for *covered expenses*, as specified in the "Out-of-pocket limit" provision in the "Schedule of Benefits" section, either individually or combined as a covered family, per *year* before a benefit percentage is increased.

Outpatient means *you* are not *confined* as a registered bed patient.

Outpatient surgery means *surgery* performed in a *health care practitioner's* office, *ambulatory surgical center*, or the *outpatient* department of a *hospital*.

P

Palliative care means care given to a *covered person* to relieve, ease, or alleviate, but not to cure, a *bodily injury* or *sickness*.

Partial hospitalization means *outpatient* services provided by a *hospital* or *health care treatment facility* in which patients do not reside for a full 24-hour period and:

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

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

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

Partial hospitalization does not include services that are for:

- *Custodial care*; or
- Day care.

Pediatric dental services mean the following services:

- Ordered by a *dentist*; and
- Described in the "Pediatric dental" provision in the "Covered Expenses – Pediatric Dental" section.

Pediatric vision care means the services and *materials* specified in the "Pediatric vision care benefit" provision in the "Covered Expenses – Pediatric Vision Care" section.

Periodontics means the branch of dentistry concerned with the study, prevention and treatment of diseases of the tissues and bones supporting the teeth. *Periodontics* includes the following dental procedures, related tests or treatment and follow-up care:

- Periodontal maintenance;
- Scaling and root planing;
- Gingivectomy;
- Gingivoplasty; or
- Osseous surgical procedures.

Post-stabilization services means services *you* receive in *observation status* or during an *inpatient* or *outpatient* stay in a *network facility* related to an *emergency medical condition* after *you* are stabilized.

Pre-surgical/procedural testing means:

- Laboratory tests or radiological examinations done on an *outpatient* basis in a *hospital* or other facility accepted by the *hospital* before *hospital confinement* or *outpatient surgery* or procedure;
- The tests must be accepted by the *hospital* or *health care practitioner* in place of like tests made during *confinement*; and
- The tests must be for the same *bodily injury* or *sickness* causing *you* to be *hospital confined* or to have the *outpatient surgery* or procedure.

Preauthorization means approval by *us*, or *our* designee, of a service prior to it being provided. Certain services require medical review by *us* in order to determine eligibility for coverage.

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

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

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

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

- Services with an A or B rating in the current recommendations of the USPSTF.
- Immunizations recommended by the Advisory Committee on Immunization Practices of the CDC.
- Preventive care for infants, children and adolescents provided in the comprehensive guidelines supported by the HRSA.
- Preventive care for women provided in the comprehensive guidelines supported by the HRSA, 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/preventive.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 *master group contract.*

Primary care physician means a *network health care practitioner* who provides initial and primary care services to *covered persons*, maintains the continuity of *covered persons* medical care and helps direct *covered persons* to *specialty care physicians* and other providers.

A *primary care physician* is a *health care practitioner* in one of the following specialties:

- Family medicine/General practice;
- Internal medicine; and
- Pediatrics.

A pediatric subspecialist will be considered a *primary care physician* if the pediatric subspecialist:

- Has signed an agreement with *us* as a *primary care physician*;
- Is available to accept the *covered person* as a patient; and
- Is chosen by the *covered person* as their *primary care physician*.

Q

Qualified payment amount means the lesser of:

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

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

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

- *Air ambulance services*;
- *Emergency care* 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 not able to travel by non-medical transportation to obtain services from a *network provider*; and
  - *You* did not consent to the *non-network provider* to obtain such services.

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

- That is licensed by the appropriate state agency to:

  - Diagnose, prevent or treat a *sickness* or *bodily injury*;
  - Provide *preventive services*;
  - Provide *pediatric dental services*; or
  - Provide *pediatric vision care*;

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

R

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

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

Residential treatment facility means an institution that:

- Is licensed as a 24-hour residential facility for *behavioral health* treatment, although not licensed as a *hospital*;
- Provides a multidisciplinary treatment plan in a controlled environment, under the supervision of a physician who is able to provide treatment on a daily basis;
- Provides supervision and treatment by a Ph.D. psychologist, licensed therapist, psychiatric nursing staff or registered nurse;
- Provides programs such as social, psychological, family counseling and rehabilitative training, age appropriate for the special needs of the age group of patients, with focus on reintegration back into the community; and
- Provides structured activities throughout the day and evening.

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

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

Room and board means all charges made by a *hospital*, *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.*

Service area means the geographic area designated by *us*, or as otherwise agreed upon between the *group plan sponsor* and *us* and approved by the Department of Insurance of the state in which the *master group contract* is issued, if such approval is required. The *service area* is the geographic area where the *network provider* services are available to *you.* A description of the *service area* is provided in the provider directories.

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

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

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

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

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

Sound natural tooth means a tooth that:

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

Special enrollment date means the date of:

- 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 care physician means a *health care practitioner* who has received training in a specific medical field other than the specialties listed as primary care.

Specialty drug means a drug, medicine, medication, or biological used as a specialized therapy developed for chronic, complex *sicknesses* or *bodily injuries*. *Specialty drugs* may:

- Be injected, infused or require close monitoring by a *health care practitioner* or clinically trained individual;
- Require nursing services or special programs to support patient compliance;
- Require disease-specific treatment programs;
- Have limited distribution requirements; or
- Have special handling, storage or shipping requirements.

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;

- Serious impairment of bodily functions; or
- 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.

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.

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

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

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*.

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

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

V

Virtual visit means *telehealth* services.

W

Waiting period means the period of time, elected by the *group plan sponsor*, that must pass before an *employee* is eligible for coverage under the *master group contract.*

We, us or ***our*** means the offering company as shown on the cover page of the *master group contract* 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 *master group contract,* the first *year* begins for *you* on the *effective date* of *your* coverage and ends on the following December 31st.

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

Z

GLOSSARY – PHARMACY SERVICES

All terms used in the "Schedule of Benefits – Pharmacy Services," "Covered Expenses – Pharmacy Services" and "Limitations and Exclusions – Pharmacy Services" sections have the same meaning given to them in the "Glossary" section of this *certificate,* unless otherwise specifically defined below:

A

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*.

E

F

G

Generic drug means a drug, medicine or medication that is manufactured, distributed, and available from a pharmaceutical manufacturer and identified by the chemical name, or any drug product that has been designated as generic by an industry-recognized source used by *us*.

H

I

J

K

L

Legend drug means any medicinal substance, the label of which, under the Federal Food, Drug and Cosmetic Act, is required to bear the legend: "Caution: Federal Law Prohibits dispensing without prescription."

Level 1 drugs mean a category of *prescription* drugs, medicines or medications within the *drug list* that are designated by *us* as level 1. The *prescription* drugs in this category are preferred, low-cost *generic drugs*.

Level 2 drugs mean 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 low-cost *generic drugs*.

Level 3 drugs mean 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 preferred *brand-name drugs* and higher-cost *generic drugs*.

Level 4 drugs mean a category of *prescription* drugs, medicines or medications within the *drug list* that are designated by *us* as level 4. The *prescription* drugs in this category are non-preferred *brand-name drugs* and high-cost *generic drugs*.

Level 5 drugs mean a category of *prescription* drugs, medicines or medications within the *drug list* that are designated by *us* as level 5. The *prescription* drugs in this category are highest-cost/high technology drugs and *specialty drugs*.

GLOSSARY – PHARMACY SERVICES (continued)

M

Mail order pharmacy means a *pharmacy* that provides covered *mail order pharmacy* services, as defined by *us*, and delivers covered *prescription* drug, medicine or medication fills or refills through the mail to *covered persons.*

N

Network pharmacy means a *pharmacy* that has signed a direct agreement with *us* or has been designated by *us* to provide:

- Covered *pharmacy* services;
- Covered *specialty pharmacy* services; or
- Covered *mail order pharmacy* services,

as defined by *us*, to *covered persons*, including covered *prescription* fills or refills delivered to *your* home or health care provider.

Non-network pharmacy means a *pharmacy* that has not signed a direct agreement with *us* or has not been designated by *us* to provide:

- Covered *pharmacy* services;
- Covered *specialty pharmacy* services; or
- Covered *mail order pharmacy* services,

as defined by *us*, to *covered persons*, including covered *prescription* fills or refills delivered to *your* home or health care provider.

O

P

Pharmacist means a person, who is licensed to prepare, compound and dispense medication, and who is practicing within the scope of his or her license.

Pharmacy means a licensed establishment where *prescription* drugs, medicines or medications are dispensed by a *pharmacist.*

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

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

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