

## **Plan Year 2023**

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

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

TNHJ6DREN 0123

SAMPLE

## Important

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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



Administrative Office:  
1100 Employers Boulevard  
Green Bay, Wisconsin 54344

## Certificate of Insurance Humana Insurance Company

**Policyholder:**

**Policy Number:**

**Effective Date:**

**Product Name:**

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

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

Bruce Broussard  
President

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

This is not a policy of Long Term Care insurance.

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

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## UNDERSTANDING YOUR COVERAGE

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

### Essential health benefits

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

### Covered and non-covered expenses

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

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

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

Refer to the "Schedule of Benefits," the "Covered Expenses" and the "Limitations and Exclusions" sections and any amendment attached to the *certificate* to see when services or supplies are *covered expenses* or are non-covered expenses.

### How your policy works

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

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

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

- Those in excess of the negotiated amount by contract, directly or indirectly, between *us* and the *qualified provider*; or

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## UNDERSTANDING YOUR COVERAGE (continued)

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- Those in excess of the *maximum allowable fee*; and
- Adjustments related to *our* claims processing procedures. Refer to the "Claims" section of this *certificate* for more information on *our* claims processing procedures.

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

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

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

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

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

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

### Your choice of providers affects your benefits

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

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



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## UNDERSTANDING YOUR COVERAGE (continued)

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

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

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

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

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

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

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

### How to find a network provider

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

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## UNDERSTANDING YOUR COVERAGE (continued)

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### How to use your preferred provider organization (PPO) plan

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

### How to compare costs for services

You may have access to *our* provider search and cost-of-care estimation tools by signing into *your* secured account at [www.humana.com](http://www.humana.com) or by calling *our* customer service department at the number listed on the back of *your* ID card. This tool will help *you* find comparable health care services available from *network providers*. You may obtain an estimate of *your* out-of-pocket costs for health care services received from a *network provider*.

### Continuity of care

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

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

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

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

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



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## UNDERSTANDING YOUR COVERAGE (continued)

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

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

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

Continuity of care is not available if:

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

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

### Seeking emergency care

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

*You*, or someone on *your* behalf, must call *us* within 48 hours after *your admission* to a *hospital* for *emergency medical condition*. If *your* condition does not allow *you* to call *us* within 48 hours after *your admission*, contact *us* as soon as *your* condition allows.

### Seeking urgent care

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

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## UNDERSTANDING YOUR COVERAGE (continued)

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### Our relationship with qualified providers

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

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

### Our financial arrangements with network providers

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

- Many *network providers* are paid on a discounted fee-for-services basis. This means they have agreed to be paid a set amount for each *covered expense*; and
- Hospitals may be paid on a Diagnosis Related Group (DRG) basis or a flat fee per day basis for inpatient services. Outpatient services are usually paid on a flat fee per service or procedure or a discount from their normal charges.

### The certificate

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

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## COVERED EXPENSES

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

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

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

### Preventive services

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

- Services with an A or B rating in the current recommendations of the United States Preventive Services Task Force (USPSTF).
- Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC).
- Preventive care for infants, children and adolescents provided in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA).
- Preventive care for women provided in the comprehensive guidelines supported by HRSA.
- Low dose screening mammography for a female *covered person* as follows:
  - Baseline mammogram age 35-40;
  - Annual mammogram age 35-40 if the *covered person* is at high risk based on:
    - Family history;
    - Dense breast tissue; or
    - Additional factors that may increase the *covered person's* risk of breast cancer; and
  - Annual mammogram over age 40, based on *health care practitioner's* recommendation.

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

### Health care practitioner office services

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

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## COVERED EXPENSES (continued)

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### Health care practitioner office visit

*Covered expenses include:*

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

### Telehealth and telemedicine services

We will pay benefits for *covered expenses* incurred by you for *telehealth* and *telemedicine* services for the diagnosis and treatment of a *sickness or bodily injury*. *Telehealth* or *telemedicine* services must be:

- Services that would otherwise be a *covered expense* if provided during a face-to-face consultation between a *covered person* and a *health care practitioner*;
- Provided to a *covered person* at the *originating site*; and
- Provided by a *health care practitioner* at the *distant site*.

*Telehealth* and *telemedicine* services must comply with:

- Federal and state licensure requirements;
- Accreditation standards; and
- Guidelines of the American Telemedicine Association or other qualified medical professional societies to ensure quality of care.

### Health care practitioner services at a retail clinic

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

### Hospital services

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

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

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## COVERED EXPENSES (continued)

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### Hospital inpatient services

*Covered expenses include:*

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

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

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

*Covered expenses include:*

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

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## COVERED EXPENSES (continued)

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### Hospital outpatient surgical services

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

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

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

*Covered expenses* include:

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

### Hospital outpatient non-surgical services

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

### Hospital outpatient advanced imaging

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

### Pregnancy and newborn benefit

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

*Covered expenses* include:

- A minimum stay in a *hospital* for 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated cesarean section. If an earlier discharge is consistent with the most current protocols and guidelines of the American College of Obstetricians and Gynecologists or the American Academy of Pediatrics and is consented to by the mother and the attending *health care practitioner*, a post-discharge office visit to the *health care practitioner* or a home health care visit within the first 48 hours after discharge is also covered, subject to the terms of this *certificate*.
- For a newborn, *hospital confinement* during the first 48 hours or 96 hours following birth, as applicable and listed above for:
  - *Hospital* charges for routine nursery care;
  - The *health care practitioner's* charges for circumcision of the newborn child; and
  - The *health care practitioner's* charges for routine examination and hearing screening of the newborn before release from the *hospital*. Newborns born in any other setting than a *hospital* are referred (by an attending *health care practitioner*) to the Department of Health for hearing screening.



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## COVERED EXPENSES (continued)

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- 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 services

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

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

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

### Ambulance services

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

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

- For *ambulance* services, you will be responsible to pay the *network provider copayment*, *deductible* and/or *coinsurance*. You may also be responsible to pay any amount over the *maximum allowable fee* to a *non-network provider*. *Non-network providers* have not agreed to accept discounted or negotiated fees, and may bill you for charges in excess of the *maximum allowable fee*; and

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## COVERED EXPENSES (continued)

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- For *air ambulance* services, you will only be responsible to pay the *network provider copayment*, *deductible* and/or *coinsurance* based on the *qualified payment amount*.

### Ambulatory surgical center services

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

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

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

*Covered expenses* include:

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

### Durable medical equipment

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

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

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

- Manufacturer's warranty is expired; and
- Repair or maintenance is not a result of misuse or abuse; and
- Repair cost is less than replacement cost.

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

- Manufacturer's warranty is expired; and
- Replacement cost is less than repair cost; and

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## COVERED EXPENSES (continued)

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- 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.

### Hearing aids and services for covered persons to age 18

We will pay benefits for *covered expenses* incurred by a covered *dependent* child under the age of 18 for *hearing aids* prescribed by a *health care practitioner* or a licensed audiologist. *Covered expense* includes ear molds and services necessary to select, fit and adjust the *hearing aid*.

*Covered expense* does not include batteries, cords and other assistive listening devices, such as FM systems.

### Free-standing facility services

#### Free-standing facility diagnostic laboratory and radiology services

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

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

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

#### Free-standing facility advanced imaging

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

### Home health care services

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

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

Home health care *covered expenses* are limited to:

- Care provided by a *nurse*;
- Physical, occupational, respiratory or speech therapy;
- Medical social work and nutrition services;
- Medical supplies, except for *durable medical equipment*; and
- Laboratory services.

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## COVERED EXPENSES (continued)

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Home health care *covered expenses* do not include:

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

### Hospice services

We will pay benefits for *covered expenses* incurred by you for a *hospice care program*. A *health care practitioner* must certify that the *covered person* is terminally ill with a life expectancy of 18 months or less.

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

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

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

Hospice care *covered expenses* do not include:

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

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## COVERED EXPENSES (continued)

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### Jaw joint benefit

We will pay benefits for *covered expenses* incurred by *you* during a plan of treatment for any jaw joint problem, including temporomandibular joint disorder, craniomaxillary disorder, craniomandibular disorder, head and neck neuromuscular disorder, or other conditions of the joint linking the jaw bone and the skull, subject to the maximum benefit shown in the "Schedule of Benefits," if any. Expenses covered under this jaw joint benefit are not covered under any other provision of this *certificate*.

The following are *covered expenses*:

- A single examination including a history, physical examination, muscle testing, range of motion measurements, and psychological evaluation, as necessary;
- Diagnostic x-rays;
- Physical therapy of necessary frequency and duration, limited to a multiple modality benefit when more than one therapeutic treatment is rendered on the same date of service;
- Therapeutic injections;
- Appliance therapy utilizing an appliance that does not permanently alter tooth position, jaw position or bite. Benefits for reversible appliance therapy will be based on the *maximum allowable fee* for use of a single appliance, regardless of the number of appliances used in treatment. The benefit for the appliance therapy will include an allowance for all jaw relation and position diagnostic services, office visits, adjustments, training, repair, and replacement of the appliance; and
- Surgical procedures.

*Covered expenses* do not include charges for:

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

### Physical medicine and rehabilitative services

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

- Physical therapy services;
- Occupational therapy services;
- Spinal manipulations/adjustments;
- Speech therapy or speech pathology services;
- Audiology services;
- Cognitive rehabilitation services;

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## COVERED EXPENSES (continued)

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- Respiratory or pulmonary rehabilitation services; and
- Cardiac rehabilitation services.

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

### Skilled nursing facility services

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

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

### Health care practitioner services when provided in a skilled nursing facility

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

*Covered expenses* include:

- Medical services furnished by an attending *health care practitioner* to you while you are confined in a *skilled nursing facility*;
- 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.



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## COVERED EXPENSES (continued)

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*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 the following procedures:

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

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

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

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

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

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## COVERED EXPENSES (continued)

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

Non-medical travel and lodging costs include:

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

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

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

### Urgent care services

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

### Additional covered expenses

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

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

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## COVERED EXPENSES (continued)

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

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

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

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

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

*Covered expense* does not include:

- Replacement orthotics;
  - Dental braces; or
  - Oral or dental splints and appliances, unless custom made for the treatment of documented obstructive sleep apnea.
- The following special supplies, dispensed up to a 30-day supply, when prescribed by *your* attending *health care practitioner*:
  - Surgical dressings;
  - Catheters;
  - Colostomy bags, rings and belts; and
  - Flotation pads.
- The initial pair of eyeglasses or contacts needed due to cataract *surgery* or an *accident* if the eyeglasses or contacts were not needed prior to the *accident*.
- Dental treatment only if:
  - The charges are incurred for treatment of a *dental injury* to a *sound natural tooth*; and
  - The procedure is performed on a minor eight (8) years of age or younger and cannot be safely performed in a dental office setting.

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## COVERED EXPENSES (continued)

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

- Certain oral surgical operations as follows:
  - Excision of partially or completely impacted teeth;
  - Surgical preparation of soft tissues and excision of bone or bone tissue performed with or without extraction or excision of erupted, partially erupted or completely un-erupted teeth;
  - Excisions of tumors and cysts of the jaws, cheeks, lips, tongue, roof, and floor of the mouth and related biopsy of bone, tooth or related tissues when such conditions require pathological examinations;
  - Surgical procedures related to repositioning of teeth, tooth transplantation or re-implantation;
  - Services required to correct accidental injuries of the jaws, cheeks, lips, tongue, roof, and floor of the mouth;
  - Reduction of fractures and dislocation of the jaw;
  - External incision and drainage of cellulitis and abscess;
  - Incision and closure of accessory sinuses, salivary glands or ducts;
  - Frenectomy (the cutting of the tissue in the midline of the tongue); and
  - Orthognathic *surgery* for a *congenital anomaly*, *bodily injury* or *sickness* causing a *functional impairment*.
- Diagnostic imaging and supplemental breast screenings.
- For a *covered person*, who is receiving benefits in connection with a mastectomy, service for:
  - Reconstructive *surgery* of the breast on which the mastectomy has been performed;
  - *Surgery* and reconstruction on the non-diseased breast to achieve symmetrical appearance; and
  - Prostheses and treatment of physical complications for all stages of mastectomy, including lymphedemas.
- Reconstructive *surgery* resulting from:
  - A *bodily injury*, infection or other disease of the involved part, when a *functional impairment* is present; or
  - A *congenital anomaly* that resulted in a *functional impairment*.

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

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

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## COVERED EXPENSES (continued)

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- The following *habilitative services*, as ordered and performed by a *health care practitioner*, for a *covered person*:

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

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

- *Palliative care*.
- *Diabetes self-management training*.
- Routine costs for a *covered person* participating in an approved Phase I, II, III, or IV clinical trial.

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

Routine costs do not include services or items that are:

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

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

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

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.
- Chemotherapy, radiation therapy and dialysis.

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## COVERED EXPENSES - BEHAVIORAL HEALTH

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

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

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

### Acute inpatient services

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

### Emergency services

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

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

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



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## COVERED EXPENSES - BEHAVIORAL HEALTH (continued)

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### Urgent care services

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

### Outpatient services

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

### Skilled nursing facility services

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

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

### Home health care services

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

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

Home health care *covered expenses* do not include:

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

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## COVERED EXPENSES - BEHAVIORAL HEALTH (continued)

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### 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* and *chemical dependency* services provided while *inpatient* or *outpatient* in a *residential treatment facility*.

### Autism spectrum disorders

We will pay benefits for *covered expenses* incurred by you for treatment of autism spectrum disorders. Autism spectrum disorders means neurological disorders, usually appearing in the first three years of life, that affect normal brain functions and are typically manifested by impairments in communication and social interaction, as well as restrictive, repetitive and stereotyped behaviors.

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## COVERED EXPENSES - PHARMACY SERVICES

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

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

### Coverage description

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

Covered *prescription* drugs are:

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

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

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## COVERED EXPENSES - PHARMACY SERVICES (continued)

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### Restrictions on choice of providers

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

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

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

### About our drug list

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

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## COVERED EXPENSES - PHARMACY SERVICES (continued)

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### Access to non-formulary drugs

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

### Non-formulary drug standard exception request

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

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

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

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

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

### Non-formulary drug expedited exception request

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

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

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## COVERED EXPENSES - PHARMACY SERVICES (continued)

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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.

### Step therapy exception request

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

A written *step therapy* exception request will be granted or denied within two business days of receiving the exception request and all information necessary to complete the review is provided in the prescribing *health care practitioner's* written statement that includes supporting documentation of the following:

- The *prescription* drug requiring *step therapy*:
  - Is contraindicated;



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## COVERED EXPENSES - PHARMACY SERVICES (continued)

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- Will likely cause an adverse reaction, physical or mental harm to *you* due to a documented adverse event with previous use of the required *prescription* drug or a documented medical condition, including a comorbid condition;
- Based on *your* known clinical characteristics and known characteristics of the required *prescription* drug, the *prescription* drug requiring *step therapy*:
  - Is expected to be ineffective in the treatment of *your* disease or medical condition;
  - Is not in *your* best interest based on clinical appropriateness, because *your* use of the drug is expected to:
    - Cause a significant barrier to *your* adherence to or compliance with *your* plan of care;
    - Worsen a comorbid condition;
    - Decrease *your* ability to achieve or maintain reasonable functional ability in performing daily activities; or
- *You* are currently receiving a positive therapeutic outcome on a *prescription* drug selected by *your health care practitioner* for the medical condition under consideration while on a current or previous health plan, and *your health care practitioner* provides documentation that the change in *prescription* drug required by the *step therapy* protocol is expected to be ineffective or cause *you* harm based on *your* known characteristics and the known characteristics of the required *prescription* drug.

A *step therapy* exception request is considered granted if *our* response to the request is not received by the prescribing *health care practitioner* within the above specified timeframe.

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

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

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## LIMITATIONS AND EXCLUSIONS

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

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

- Treatments, services, supplies, or *surgeries* that are not *medically necessary*, except *preventive services*.
- A *sickness* or *bodily injury* arising out of, or in the course of, any employment for wage, gain or profit. This exclusion applies when law or other arrangements require *your employer* to provide Workers' Compensation coverage or other similar coverage whether or not a claim has been filed for 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 service, *you* would not be required to pay for, or would not have been charged for, in the absence of this insurance, except for services provided by a non-governmental charitable research hospital.
- Any portion of the amount *we* determine *you* owe for a service that the provider waives, rebates or discounts, including *your copayment*, *deductible* or *coinsurance*.
- Care and treatment of a *sickness* or *bodily injury* that are paid by or through a government program.
- Any service not ordered by a *health care practitioner*.
- Private duty nursing.
- Services rendered by a standby physician, *surgical assistant* or *assistant surgeon* unless *medically necessary*.
- Any service not rendered by the billing provider.
- Any service not substantiated in the medical records of the billing provider.
- Any amount billed for a professional component of an automated:
  - Laboratory service; or
  - Pathology service.
- Expenses for services, *prescriptions*, equipment, or supplies received outside the United States or from a foreign provider, unless:
  - For *emergency care*;

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## LIMITATIONS AND EXCLUSIONS (continued)

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- The *employee* is traveling outside the United States due to employment with the *employer* sponsoring the *policy* and the services are not covered under any Workers' Compensation or similar law; or
- The *employee* and *dependents* live outside the United States and the *employee* is in *active status* with the *employer* sponsoring the *policy*.
- Education or training, except for *diabetes self-management training* and *habilitative services*.
- Educational or vocational therapy, testing, services, or schools, including therapeutic boarding schools and other therapeutic environments. Educational or vocational videos, tapes, books, and similar materials are also excluded.
- Services provided by a *covered person's family member*.
- *Ambulance* and *air ambulance* services for routine transportation to, from, or between medical facilities and/or a *health care practitioner's* office.
- Any drug, biological product, device, medical treatment, or procedure which is *experimental, investigational or for research purposes*, except for routine costs associated with clinical trials as specified in the "Covered Expenses" section of this *certificate*.
- 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, 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*.

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## LIMITATIONS AND EXCLUSIONS (continued)

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- 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 covered *dependent* children under age 18; implantable hearing devices, except for cochlear implants as otherwise stated in this *certificate*.
- Services received in an emergency room, unless required because of *emergency care*.
- Weekend non-emergency *hospital admissions*, specifically *admissions* to a *hospital* on a Friday or Saturday at the convenience of the *covered person* or his or her *health care practitioner* when there is no cause for an emergency *admission* and the *covered person* receives no *surgery* or therapeutic treatment until the following Monday.
- *Hospital inpatient* services when you are in *observation status*.
- *Infertility services*; or reversal of elective sterilization.
- In vitro fertilization regardless of the reason for treatment.
- Services for or in connection with a transplant or *immune effector cell therapy* if:
  - The expense relates to storage of cord blood and stem cells, unless it is an integral part of a transplant approved by *us*.
  - Not approved by *us*, based on *our* established criteria.
  - Expenses are eligible to be paid under any private or public research fund, government program except *Medicaid*, or another funding program, whether or not such funding was applied for or received.
  - The expense relates to the transplantation of any non-human organ or tissue, unless otherwise stated in the *policy*.
  - The expense relates to the donation or acquisition of an organ or tissue for a recipient who is not covered by *us*.
  - The expense relates to a transplant or *immune effector cell therapy* performed outside of the United States and any care resulting from that transplant or *immune effector cell therapy*. This exclusion applies even if the *employee* and *dependents* live outside the United States and the *employee* is in *active status* with the *employer* sponsoring the *policy*.
- Services provided for:
  - Immunotherapy for recurrent abortion;
  - Chemonucleolysis;
  - Sleep therapy;
  - Light treatments for Seasonal Affective Disorder (S.A.D.);
  - Immunotherapy for food allergy;
  - Prolotherapy; or
  - Sensory integration therapy.

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## LIMITATIONS AND EXCLUSIONS (continued)

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

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

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

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## LIMITATIONS AND EXCLUSIONS (continued)

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- Motorized transportation equipment (e.g. scooters), escalators, elevators, ramps or modifications or additions to living/working quarters or transportation vehicles;
  - Personal hygiene equipment including bath/shower chairs, transfer equipment or supplies or bed side commodes;
  - Personal comfort items including cervical pillows, gravity lumbar reduction chairs, swimming pools, whirlpools, spas, or saunas;
  - Medical equipment including:
    - Blood pressure monitoring devices, unless prescribed by a *health care practitioner* for *preventive services* and ambulatory blood pressure monitoring is not available to confirm diagnosis of hypertension;
    - PUVA lights; and
    - Stethoscopes;
  - Communication system, telephone, television, or computer systems and related equipment or similar items or equipment;
  - Communication devices, except after surgical removal of the larynx or a diagnosis of permanent lack of function of the larynx.
- Duplicate or similar rentals or purchases of *durable medical equipment* or *diabetes equipment*.
  - Therapy and testing for treatment of allergies including, but not limited to, services related to clinical ecology, environmental allergy and allergic immune system dysregulation and sublingual antigen(s), extracts, neutralization tests and/or treatment unless such therapy or testing is approved by:
    - The American Academy of Allergy and Immunology; or
    - The Department of Health and Human Services or any of its offices or agencies.
  - Lodging accommodations or transportation.
  - Communications or travel time.
  - Bariatric *surgery*, any services or complications related to bariatric *surgery*, and other weight loss products or services.
  - *Sickness* or *bodily injury* for which no-fault medical payment or expense coverage benefits are paid or payable under any automobile, homeowners, premises, or any other similar coverage.
  - Elective medical or surgical abortion unless:
    - The pregnancy would endanger the life of the mother;
    - The pregnancy is a result of rape or incest; or
    - The fetus is non-viable.
  - *Alternative medicine*.



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## LIMITATIONS AND EXCLUSIONS (continued)

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

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## LIMITATIONS AND EXCLUSIONS - PHARMACY SERVICES

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

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

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

- *Legend drugs*, which are not deemed *medically necessary* by us.
- *Prescription* drugs not included on the *drug list*.
- Any amount exceeding the *default rate*.
- *Specialty drugs* for which coverage is not approved by us.
- Drugs not approved by the FDA.
- Any drug prescribed for intended use other than for:
  - Indications approved by the FDA; or
  - Off-label indications recognized through peer-reviewed medical literature.
- Any drug prescribed for a *sickness* or *bodily injury* not covered under the *policy*.
- Any drug, medicine or medication that is either:
  - Labeled "Caution - limited by federal law to investigational use;" or
  - *Experimental, investigational or for research purposes*,even though a charge is made to you.
- Allergen extracts.
- Therapeutic devices or appliances, including, but not limited to:
  - Hypodermic needles and syringes (except when prescribed by a *health care practitioner* for use with insulin and *self-administered injectable drugs*, whose coverage is approved by us);
  - Support garments;
  - Test reagents;
  - Mechanical pumps for delivery of medications; and
  - Other non-medical substances.

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## LIMITATIONS AND EXCLUSIONS - PHARMACY SERVICES

### (continued)

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

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## LIMITATIONS AND EXCLUSIONS - PHARMACY SERVICES

### (continued)

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

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## LIMITATIONS AND EXCLUSIONS - PHARMACY SERVICES

### (continued)

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- Any drug, medicine or medication received by *you*:
  - Before becoming covered; or
  - After the date *your* coverage has ended.
- Any costs related to the mailing, sending or delivery of *prescription* drugs.
- Any intentional misuse of this benefit, including *prescriptions* purchased for consumption by someone other than *you*.
- Any *prescription* fill or refill for drugs, medicines or medications that are lost, stolen, spilled, spoiled, or damaged.
- Drug delivery implants and other implant systems or devices.
- Treatment for onychomycosis (nail fungus).
- Any amount *you* paid for a *prescription* that has been filled, regardless of whether the *prescription* is revoked or changed due to adverse reaction or change in dosage or *prescription*.

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## ELIGIBILITY AND EFFECTIVE DATES

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### Eligibility date

#### Employee eligibility date

The *employee* is eligible for coverage on the date:

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

#### Dependent eligibility date

Each *dependent* is eligible for coverage on:

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

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

### Enrollment

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

#### Employee enrollment

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

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



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## ELIGIBILITY AND EFFECTIVE DATES (continued)

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

### Dependent enrollment

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

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

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

### Newborn and adopted dependent enrollment

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

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

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

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

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

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## ELIGIBILITY AND EFFECTIVE DATES (continued)

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### Special enrollment

Special enrollment is available if the following apply:

- You have a change in family status due to:
  - Marriage;
  - Divorce;
  - A Qualified Medical Child Support Order (QMCSO);
  - A National Medical Support Notice (NMSN);
  - The birth of a natural born child; or
  - The adoption of a child or placement of a child with the *employee* for the purpose of adoption; and
  - You enroll within 31 days after the *special enrollment date*; or
- You are an *employee* or *dependent* eligible for coverage under the *policy*, and:
  - You previously declined enrollment stating you were covered under another group health plan or other *health insurance coverage*; and
  - Loss of eligibility of such other coverage occurs, regardless of whether you are eligible for, or elect COBRA; and
  - You enroll within 31 days after the *special enrollment date*.

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

- Termination of employment or eligibility;
  - Reduction in number of hours of employment;
  - Divorce, legal separation or death of a spouse;
  - Loss of dependent eligibility, such as attainment of the limiting age;
  - Termination of your employer's contribution for the coverage;
  - Loss of individual HMO coverage because you no longer reside, live or work in the service area;
  - Loss of group HMO coverage because you no longer reside, live or work in the service area, and no other benefit package is available; or
  - The plan no longer offers benefits to a class of similarly situated individuals; or
- You had COBRA continuation coverage under another plan at the time of eligibility, and:
    - Such coverage has since been exhausted; and
    - You stated at the time of the initial enrollment that coverage under COBRA was your reason for declining enrollment; and
    - You enroll within 31 days after the *special enrollment date*; or
  - You were covered under an alternate plan provided by the *employer* that terminates, and:
    - You are replacing coverage with the *policy*; and
    - You enroll within 31 days after the *special enrollment date*; or

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## ELIGIBILITY AND EFFECTIVE DATES (continued)

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

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

### Dependent special enrollment

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

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

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

### Open enrollment

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

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

### Effective date

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

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## ELIGIBILITY AND EFFECTIVE DATES (continued)

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### Employee effective date

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

### Dependent effective date

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

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

### Newborn and adopted dependent effective date

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

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

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

### Open enrollment effective date

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

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## ELIGIBILITY AND EFFECTIVE DATES (continued)

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### Retired employee coverage

#### Retired employee eligibility date

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

#### Retired employee enrollment

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

#### Retired employee effective date

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

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## REPLACEMENT OF COVERAGE

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### Applicability

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

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

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

### Deductible credit

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

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

### Waiting period credit

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

### Out-of-pocket limit

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



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## TERMINATION PROVISIONS

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### Termination of insurance

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

*You and your employer* must notify *us* as soon as possible if *you* or *your dependent* no longer meets the eligibility requirements of the *policy*. Notice must be provided to *us* within 31 days of the change.

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

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

Otherwise, insurance terminates on the earliest of the following:

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

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## TERMINATION PROVISIONS (continued)

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### Termination for cause

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

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

SAMPLE

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## CONTINUATION

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### Continuation options in the event of termination

If health insurance terminates:

- It may be continued as described in the "State continuation of health insurance" provision;
- It may be continued as described in the "Continuation of coverage for dependents" provision, if applicable; or
- It may be continued under the continuation provisions as provided by the Consolidated Omnibus Budget Reconciliation Act (COBRA), if applicable. If *you* are eligible for COBRA, *you* may elect either COBRA continuation or State continuation of health insurance, but not both.

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

### State continuation of health insurance

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

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

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

In order to be eligible for this option:

- The *employee* must have been continuously covered under the *policy* or the policy it replaced for at least three consecutive months prior to termination;
- The *covered person's* coverage must be terminated for any reason, except discontinuance of the *policy* in its entirety or was terminated with respect to an insured class; and
- The *covered person* does not elect to continue coverage under the terms and conditions described in COBRA.

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.

Each *covered person* may choose to continue these benefits for up to maximum of three months plus the fraction of the month remaining, unless coverage is terminated during pregnancy. Continuation will be permitted for the term of the pregnancy including the fraction of the month remaining at the time of termination plus an additional six months after the pregnancy ends.

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## CONTINUATION (continued)

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The premium rate will be 100% of the *group* premium. The premium will be payable in advance to the *policyholder* on a monthly basis.

Continuation may not terminate until the earliest of:

- The time period, as referenced above, after the date the *employee* was no longer eligible for coverage;
- The date timely premium payments are not made on *your* behalf;
- The date the *group* coverage terminates in its entirety;
- The date on which the *covered person* is, or could be, covered under *Medicare*;
- The date on which the *covered person* is covered for similar benefits under another group or individual policy;
- The date on which the *covered person* is eligible for similar benefits under another group plan; or
- The date on which similar benefits are provided for, or available to, the *covered person* under any state or federal law.

The *policyholder* is responsible for sending *us* the premium payments for those individuals who choose to continue their health insurance.

### Continuation of coverage for dependents

Continuation of coverage is available for *dependents* whose coverage under the *policy* has been terminated for any reason, except discontinuance of the *policy* in its entirety.

Each *dependent* may choose to continue these benefits for a maximum of three months plus the fraction of the month remaining, unless:

- Coverage is terminated during the *dependent's* pregnancy. Continuation will be permitted for the term of the pregnancy including the fraction of the month remaining at the time of termination plus an additional six months after the pregnancy ends.
- The *policy* terminates because of divorce or death of the *employee* while *dependent* coverage is in force. The surviving *dependent* spouse and *dependent children* may continue to be insured for a period of 15 months plus the fraction of the month remaining at the time of termination.

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 the required notice. No evidence of insurability is required to obtain continuation.

- The covered *employee* or *dependent* must give the *policyholder* written notice within 30 days of any severance of the family relationship that might activate this continuation option; and
- The *policyholder* must give written notice to each affected *dependent* of the continuation option immediately upon receipt of notice of severance of the family relationship or upon receipt of notice of the *employee's* death or retirement; and
- The *dependent* must give written notice to the *policyholder* of his or her desire to exercise the continuation option within 30 days from the date of severance of the family relationship or the date of the *employee's* death or retirement.

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## CONTINUATION (continued)

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The *policyholder* must notify *us* of the choice to continue coverage upon receipt of it.

The option to continue coverage is not available if:

- The *policy* terminates;
- The *dependent* was not continuously covered under the *policy* and the Prior Plan replaced by the *policy* for at least three consecutive months prior to the date coverage terminates, except in the case of an infant under one year of age; or
- The *dependent* elects to continue his or her coverage under the terms and conditions described in COBRA.

Continued coverage terminates on the earliest of the following dates:

- The time period, as referenced above, after the date the *dependent* was no longer eligible for coverage;
- The date the *dependent* becomes eligible for similar group benefits, either on an insured or self-insured basis;
- The date timely premium payments are not made on *your* behalf; or
- The date the *policy* terminates.

The premium rate will be 100% of the *group* premium. The premium will be payable in advance to the *policyholder* on a monthly basis.

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

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## COORDINATION OF BENEFITS

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This "Coordination of Benefits" ("COB") provision applies to this Plan when an *employee* or the *employee's* covered *dependent* has health care coverage under more than one Plan. "Plan" and "this Plan" are defined below.

If this COB provision applies, the order of benefits determination rules should be looked at first. Those rules determine whether the benefits of this Plan are determined before or after those of another Plan. The benefits of this Plan:

- Shall not be reduced when, under the order of benefit determination rules, this Plan determines its benefits before another Plan; but,
- May be reduced when, under the order of benefits determination rules, another Plan determines its benefits first. The above reduction is described in the subsection "Effect on the Benefits of this Plan."

### Definitions

A **Plan** is any of these which provides benefits or services for, or because of, medical or dental care or treatment:

- Group insurance contracts, health maintenance organization (HMO) contracts or group-type coverage, whether insured or uninsured. This includes prepayment, group practices or individual practice coverage. It also includes coverage other than school accident-type coverage.
- Coverage under a governmental plan or required or provided by law. This does not include a state plan under *Medicaid* (Title XIX), Grants to States for Medical Assistance Programs, of the United States Social Security Act as amended from time to time). It also does not include any private insurance program or other non-governmental program.
- Each contract or other arrangement for coverage under the first or second bullet is a separate Plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate Plan.
- For the purposes of coordination of benefits, prescription drug coverage under this plan will be considered a separate Plan and will therefore only be coordinated with other prescription drug coverage.

**This Plan** is the part of the group contract that provides benefits for health care expenses.

### Primary Plan/Secondary Plan

- The order of benefit determination rules state whether this Plan is a Primary Plan or Secondary Plan as to another Plan covering the person.
- When this Plan is a Primary Plan, its benefits are determined before those of the other Plan and without considering the other Plan's benefits.
- When this Plan is a Secondary Plan, its benefits are determined after those of the other Plan and may be reduced because of the other Plan's benefits.
- When there are more than two Plans covering the person, this Plan may be a Primary Plan as to one or more other Plans, and may be a Secondary Plan as to a different Plan or Plans.



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## COORDINATION OF BENEFITS (continued)

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**Allowable Expense** means a necessary, reasonable, and customary item of expense for health care, when the item of expense is covered at least in part by one or more Plans covering the person for whom the claim is made.

- The difference between the cost of a private hospital room and the cost of a semi-private hospital room is not considered an Allowable Expense under the above definition unless the patient's stay in a private hospital room is medically necessary either in terms of generally accepted medical practice, or as specifically defined in the Plan.
- When a Plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid.

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

### Order of benefit determination rules

#### General

When there is a basis for a claim under this Plan and another Plan, this Plan is a Secondary Plan which has its benefits determined after those of the other Plan, unless:

- The other plan has rules coordinating its benefits with those of this Plan; and
- Both those rules and this Plan's rules, in the rules section below, require that this Plan's benefits be determined before those of the other Plan.

#### Rules

This Plan determines its order of benefits using the first of the following rules which applies:

- **Non-dependent/dependent.** The benefits of the Plan which covers the person as an employee, member or subscriber (that is, other than as a dependent) are determined before those of the Plan which covers the person as a dependent.
- **Dependent child/parents not separated or divorced.** Except as stated in subparagraph (III) below, when this Plan and another Plan cover the same child as a dependent of different persons, called "parents:"
  - I. The benefits of the Plan of the parent whose birthday falls earlier in a year are determined before those of the Plan of the parent whose birthday falls later in that year; but
  - II. If both parents have the same birthday, the benefits of the Plan which covered the parent longer are determined before those of the Plan which covered the other parent for a shorter period of time

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## COORDINATION OF BENEFITS (continued)

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- III. However, if the other Plan does not have the rules described in (I) immediately above, but instead has a rule based upon the gender of the parent, and if, as a result, the Plans do not agree on the order of benefits, the rule in the other Plan will determine the order of benefits.
- **Dependent child/separated or divorced parents.** If two or more Plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:
    - I. First, the Plan of the parent with custody of the child; and
    - II. Then, the Plan of the spouse of the parent with custody of the child; and
    - III. Finally, the Plan of the parent not having custody of the child.
  - IV. However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first. This paragraph does not apply with respect to any Claim Determination Period or plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.
  - **Active/inactive employee.** The benefits of a Plan which covers a person as an employee who is neither laid off nor retired (or as that employee's dependent) are determined before those of a Plan which covers that person as a laid off or retired employee (or as that employee's dependent). If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this bulleted section is ignored.
  - **Longer/shorter length of coverage.** If none of the above rules determines the order of benefits, the benefits of the Plan which covered an employee, member or subscriber longer are determined before those of the Plan which covered that person for the shorter time.

### Effect on the benefits of this plan

This Section applies when, in accordance with the above section. Order of determination rules, this Plan is a Secondary Plan as to one or more other Plans. In that event the benefits of this Plan or Plans are referred to as "the other Plans" immediately below.

The benefits of this Plan will be reduced when the sum of:

- The benefits that would be payable for the allowable expenses under this Plan in the absence of this COB provision; and
- The benefits that would be payable for the allowable expenses under the other Plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made; exceeds those allowable expenses in a claim determination period. In that case, the benefits of this Plan will be reduced so that they and the benefits payable under the other Plans do not total more than those Allowable Expenses.

When the benefits of this Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this Plan.

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## COORDINATION OF BENEFITS (continued)

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### Right to receive and release needed information.

Certain facts are needed to apply these COB rules. *We* have the right to decide which facts *we* need. *We* may get needed facts from or give them to any other organization or person. *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 pay the claim.

### Facility of payment

A payment under another Plan may include an amount which should have been paid under this Plan. If it does, *we* may pay that amount to the organization which made that 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 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 it 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;
- Insurance companies; or
- Other organizations.

The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

### General coordination of benefits with Medicare

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

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## CLAIMS

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### 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](http://www.humana.com).

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

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

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

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

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

### Proof of loss

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

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

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## CLAIMS (continued)

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### Claims processing procedures

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

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 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 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;

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## CLAIMS (continued)

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

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

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

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

### Other programs and procedures

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

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

### Right to require medical examinations

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

### To whom benefits are payable

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

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

- *You* request that *we* direct a payment of selected medical benefits to the health care provider on whose charge the claim is based and *we* consent to this request; or

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## CLAIMS (continued)

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- Your responsibility for the *covered expenses* is based off the *qualified payment amount*.

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

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

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

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

### Time of payment of claims

Payments due under the *policy* will be paid no more than 30 days 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; or
- Made to *you* and/or any party on *your* behalf, where *we* determine that such payment made is greater than the amount payable under the *policy*; or
- Made to *you* and/or any party on *your* behalf, based on fraudulent or misrepresented information; or
- Made to *you* and/or any party on *your* behalf for charges that were discounted, waived or rebated.

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

*Our* right to recover payments, as specified above, will be limited to 18 months from the date of the payment.

### 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 and/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;



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## CLAIMS (continued)

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- Providing copies of claims and settlement demands submitted to third parties in relation to a *bodily injury* or *sickness*;
- Disclosing details of liability settlement agreements reached with third parties in relation to a *bodily injury* or *sickness*; and
- Providing information *we* request to administer the *policy*.

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

### Exhaustion of time limits

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

### Recovery rights

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

### Duty to cooperate in good faith

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

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

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

In the event that *you* fail to cooperate with *us*, *we* shall be entitled to recover from *you* any payments made by *us*, unless *you* did not receive payment as part of a settlement, judgment or award.

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## CLAIMS (continued)

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### Duplication of benefits/other insurance

We will not provide duplicate coverage for benefits under the *policy* when a person is covered by *us* and has, or is entitled to, benefits as a result of their injuries from any other coverage including, but not limited to, first party uninsured or underinsured motorist coverage, any no-fault insurance, medical payment coverage (auto, homeowners or otherwise), workers compensation settlement or awards, other group coverage (including student plans), direct recoveries from liable parties, premises medical pay or any other insurer providing coverage that would apply to pay *your* medical expenses, except another "plan," as defined in the "Coordination of Benefits" section (e.g., group health coverage), in which case priority will be determined as described in the "Coordination of Benefits" section.

Where there is such coverage, *we* will not duplicate other coverage available to *you*. Where double coverage exists, *we* shall have the right to be repaid from whomever has received the overpayment from *us* to the extent of the duplicate coverage.

When applicable, *you* are required to provide *us* with authorization to obtain information about the other coverage available, and to cooperate in the recovery of overpayments from the other coverage, including executing any assignment of rights necessary to obtain payment directly from the other coverage available.

### Workers' compensation

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

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

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

*We* will exercise *our* right to recover when funds that are paid or will be payable by Workers' Compensation or similar coverage even though:

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

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

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## CLAIMS (continued)

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### Right of subrogation

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

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

### Right of reimbursement

*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 related to the settlement, compromise or judgment 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 and only to the extent not precluded or limited by any law or legal doctrine that prohibits an insurer from seeking reimbursement for its expenses until the insured is made whole.

### Assignment of recovery rights

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

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

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## CLAIMS (continued)

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If benefits are paid under the *policy* and *you* recover payment under any automobile, 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.

SAMPLE

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## COMPLAINT AND APPEAL PROCEDURES

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### Definitions

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

- A determination that, based on the information provided, the requested benefit is not *medically necessary* or does not meet the plan's requirements for appropriateness, health care setting, level of care or effectiveness;
- A determination of *your* eligibility to participate in the plan or health insurance coverage; or
- A determination that the benefit is not covered.

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

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

**Clinical peer** means a health care provider who holds a non-restricted license in a state of the United States and in the same or similar specialty that would typically manage the medical condition, procedure or treatment under review.

**Commissioner** means the Commissioner of Commerce and Insurance.

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

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

**Grievance** means a written appeal of an *adverse benefit determination* or *final adverse benefit determination* submitted by *you* or *your authorized representative* regarding:

- Availability, delivery or quality of health care services;
- Claims payment, handling or reimbursement for health care services;
- Matters pertaining to the contractual relationship between a *covered person* and *us*; or
- Matters pertaining to the contractual relationship between a health care provider and *us*.

**Independent Review Organization (IRO)** means an entity that conducts independent external reviews of *adverse benefit determinations* and *final adverse benefit determinations*.

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

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

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## COMPLAINT AND APPEAL PROCEDURES (continued)

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

- Could seriously jeopardize the life or health of the *covered person* or the ability of the *covered person* to regain maximum function; or
- In the opinion of a physician with knowledge of the *covered person's* medical condition, would subject the *covered person* to severe pain that cannot be adequately managed without the service that is the subject of the claim.

Humana 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."

### Filing a complaint

If *you* have a complaint about Humana or its *network providers*, please call *our* Customer Service Department as soon as possible. The toll-free number is identified on *your* identification card. Most problems may be resolved quickly in this manner.

*You* may also contact the Tennessee Department of Commerce and Insurance, the state agency that enforces Tennessee's insurance laws, for assistance at any time using the below contact information:

**Tennessee Department of Commerce and Insurance  
Insurance Division  
500 James Robertson Parkway  
Fourth Floor  
Nashville, TN 37243-1130  
Phone number: 1-800-342-4029 or 1-615-741-2218**

### Filing a grievance

*You* may file a *grievance* with *us* at any time. *Grievances* may be sent to *us* at the following:

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

### Internal appeals

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

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## COMPLAINT AND APPEAL PROCEDURES (continued)

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If *you* are dissatisfied with *our* first level review decision, *you* or *your authorized representative* may request a second level review in writing to the address provided on the denial letter *you* received.

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

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

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

On appeal, *you* or *your authorized representative* may review relevant documents and may submit issues and comments in writing.

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

### Time periods for decisions on appeal

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

- **Urgent-care claims** - As soon as possible but not later than 48 hours after *we* receive the appeal request;
- **Step therapy exception appeal** - Within 48 hours after *we* receive the appeal and all information necessary to complete the appeal;
- **Pre-service claims** - Within a reasonable period but not later than 30 days after *we* received the appeal request;
- **Concurrent-care decisions** - Within the time periods specified above depending on the type of claim involved;
- **Post-service claims** - Within a reasonable period but not later than 60 days after *we* receive the appeal request.

### Appeals denial notices

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

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

- The specific reason or reasons for the *adverse benefit determination*;



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## COMPLAINT AND APPEAL PROCEDURES (continued)

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

### Exhaustion of remedies

Upon completion of the internal appeals process under this section, *you* or *your authorized representative* will have exhausted his or her administrative remedies under the plan. If Humana fails to strictly adhere to all requirements of the internal appeal process, the claim shall be deemed to have been denied and *you* or *your authorized representative* may request an external review. *You* or *your authorized representative* may request an external review before the internal appeals process remedies have been exhausted if Humana agrees to waive the exhaustion requirement.

If the plan is governed by the Employee Retirement Income Security Act of 1974, as amended (ERISA), *you* or *your authorized representative* have the right to bring a civil action against the plan to obtain the remedies available pursuant to ERISA section 502(a) after completing the mandatory internal appeals process. If the plan is not governed by ERISA exhaustion of remedies is not required.

### External review

Within 6 months after *you* or *your authorized representative* receives notice of an *adverse benefit determination* or *final adverse benefit determination*, *you* or *your authorized representative* may request an external review. The request for external review must be made in writing to Humana except, for claims protected under the Federal No Surprises Act, refer to *our* decision letter for the timeframe to submit and instructions on how to request an external review. *You* or *your authorized representative* will be required to authorize release of any medical records that may be required to be reviewed for the purpose of reaching a decision on the external review. Please refer to the section titled "Expedited external review" if the *adverse benefit determination* involves an *urgent-care claim* or an ongoing course of treatment.

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## COMPLAINT AND APPEAL PROCEDURES (continued)

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*You or your authorized representative may contact the commissioner for assistance at any time at the address and telephone number below:*

**Tennessee Department of Commerce and Insurance  
Insurance Division  
500 James Robertson Parkway  
Fourth Floor  
Nashville, TN 37243-1130  
Phone number: 1-800-342-4029 or 1-615-741-2218**

### Expedited external review

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

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

If the request qualifies for an expedited external review, we will select an *IRO* and notify you or your authorized representative verbally or in writing of the resolution.

### Legal actions and limitations

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

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

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## DISCLOSURE PROVISIONS

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### Employee assistance program

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

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

### Discount programs

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

### Wellness programs

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

"Participatory" wellness programs do not require *you* to meet a standard related to a health factor. Examples of participatory wellness programs may include, but are not limited to, membership in a fitness center, certain preventive testing, or attending a 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.

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## DISCLOSURE PROVISIONS (continued)

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

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

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

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

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

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

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

### Shared savings program

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

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

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## DISCLOSURE PROVISIONS (continued)

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

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

SAMPLE

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## MISCELLANEOUS PROVISIONS

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### Entire contract

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

### Additional policyholder responsibilities

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

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

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

### Certificates of insurance

A *certificate* setting forth the benefits available to the *employee* and the *employee's* covered *dependents* will be available at [www.humana.com](http://www.humana.com) or in writing when requested. The *policyholder* is responsible for providing *employees* access to the *certificate*.

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

### Incontestability

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

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

- Nonpayment of premium; or
- Any fraud.

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## MISCELLANEOUS PROVISIONS (continued)

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

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

An independent incontestability period begins 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 back to the date of the fraudulent act after *we* provide *you* a 30 calendar day advance written notice that coverage will be *rescinded*. *You* have the right to appeal the *rescission*.

### Clerical error or misstatement

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

### Modification of policy

The *policy* may be modified by *us*, upon renewal of the *policy*, as permitted by state and federal law. The *policyholder* will be notified in writing or *electronically* at least 31 days prior to the effective date of the change.

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

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



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## MISCELLANEOUS PROVISIONS (continued)

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### Discontinuation of coverage

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

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

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

### Premium contributions

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

### Premium rate change

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

### Assignment

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

### Emergency declarations

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

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

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

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## MISCELLANEOUS PROVISIONS (continued)

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### Conformity with statutes

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

SAMPLE

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## GLOSSARY

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

### A

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

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

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

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

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

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

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

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

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

***Air ambulance*** means a professionally operated helicopter or airplane, provided by a licensed ambulance service, equipped for the transportation of a sick or injured person to or from the nearest medical facility qualified to treat the person's *sickness* or *bodily injury*. Use of the *air ambulance* must be *medically necessary*. When transporting the sick or injured person from one medical facility to another, the *air ambulance* must be ordered by a *health care practitioner*.

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

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## GLOSSARY (continued)

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**Ambulance** means a professionally operated ground vehicle, provided by a licensed ambulance service, equipped for the transportation of a sick or injured person to or from the nearest medical facility qualified to treat the person's *sickness* or *bodily injury*. Use of the *ambulance* must be *medically necessary*. When transporting the sick or injured person from one medical facility to another, the *ambulance* must be ordered by a *health care practitioner*.

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

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

**Ancillary services** mean *covered expenses* that are:

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

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

## B

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

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

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

## C

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

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## GLOSSARY (continued)

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

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

**Community mental health center** means a private entity qualified as a tax exempt organization under Internal Revenue Code s 501(c)(03) or a public entity created by private act of the general assembly which:

- Is primarily engaged in providing services for the diagnosis and treatment of emotionally disturbed and mentally ill persons, has a requirement that all mental health care be under a treatment plan approved and reviewed by a licensed physician or a licensed psychologist designated as a health care service provider, and has appropriate arrangements to assure that patients requiring medical services can be referred to a physician or *hospital*; and,
- Has been licensed as a mental health clinic facility by the Department of Mental Health and Mental Retardation, or by the licensing board of the state in which the *community mental health center* is located.

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

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

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

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

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

**Covered expense** means:

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

- *Preventive services*.

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

- Ordered by a *health care practitioner*;

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## GLOSSARY (continued)

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

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

**Custodial care** means services given to *you* if:

- *You* need services including, but not limited to, assistance with dressing, bathing, preparation and feeding of special diets, walking, supervision of medication which is ordinarily self-administered, getting in and out of bed, and maintaining continence;
- The services *you* require are primarily to maintain, and not likely to improve, *your* condition; or
- The services involve the use of skills which can be taught to a layperson and do not require the technical skills of a *nurse*.

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

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

## D

**Deductible** means the amount of *covered expenses* that *you*, either individually or combined as a covered family, must pay per year before *we* pay benefits for certain specified *covered expenses*. Any amount *you* pay exceeding the *maximum allowable fee* is not applied to the individual or family *deductibles*.

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

**Dependent** means a covered *employee's*:

- Legally recognized spouse or *domestic partner*;
- Natural born child, step-child, legally adopted child, child placed for adoption, or any child for which the *employee* is a court appointed guardian, whose age is less than the limiting age;

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## GLOSSARY (continued)

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

The *domestic partner's* child cannot qualify as a *dependent* prior to the *employee's domestic partner* becoming a qualified *dependent*.

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

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

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

A covered *dependent* child, who attains the limiting age while insured under the *policy*, remains eligible if the covered *dependent* child is incapable of self-sustaining employment by reason of intellectual or physical disability.

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 above, continuously exist on and after the date the limiting age is reached. After two years from the date the first proof was furnished, *we* may not request such proof more often than annually. If satisfactory proof is not submitted to *us*, the child's coverage will not continue beyond the last date of eligibility.

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

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



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## GLOSSARY (continued)

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

**Distant site** means the location of a *health care practitioner* at the time a *telehealth* or *telemedicine* 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 6 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 *policy*.

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

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

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

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

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## GLOSSARY (continued)

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

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

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

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

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

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

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

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

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

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

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## GLOSSARY (continued)

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

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

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

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

## F

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

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## GLOSSARY (continued)

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

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

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

### G

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

### H

**Habilitative services** mean health care services and devices that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

**Health care practitioner** means a practitioner professionally licensed by the appropriate state agency to provide *preventive services* or diagnose or treat a *sickness* or *bodily injury* and who provides services within the scope of that license.

**Health care treatment facility** means a facility, institution or clinic, duly licensed by the appropriate state agency to provide medical services or *behavioral health* services, 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, health maintenance organization (HMO) contract offered by a health insurance issuer or TennCare program. "Health insurance issuer" means an insurance company, insurance service or insurance organization (including an HMO) that is required to be licensed to engage in the business of insurance in a state and that is subject to the state law that regulates insurance.

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

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

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## GLOSSARY (continued)

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**Hearing aid** means any wearable, non-experimental, non-disposable instrument or device designed for the ear and used to aid or compensate for impaired human hearing.

**Home health care agency** means a *home health care agency* or *hospital*, which meets all of the following requirements:

- It must primarily provide skilled nursing services and other therapeutic services under the supervision of physicians or registered nurses;
- It must be operated according to established processes and procedures by a group of medical professionals, including *health care practitioners* and *nurses*;
- It must maintain clinical records on all patients; and
- It must be licensed by the jurisdiction where it is located, if licensure is required. It must be operated according to the laws of that jurisdiction, which pertain to agencies providing home health care.

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

**Hospice care program** means a coordinated, interdisciplinary program provided by a hospice that is designed to meet the special physical, psychological, spiritual and social needs of a terminally ill *covered person* and his or her immediate *covered family members*, by providing *palliative care* and supportive medical, nursing and other services through at-home or *inpatient* care. A hospice must be licensed by the laws of the jurisdiction where it is located and must be operated as a hospice as defined by those laws. It must provide a program of treatment for at least two unrelated individuals who have been medically diagnosed as having no reasonable prospect for cure for their *sickness* and, as estimated by their physicians, are *expected* to live 18 months or less as a result of that *sickness*.

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

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

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

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

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## GLOSSARY (continued)

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- The Commission on the Accreditation of Rehabilitative Facilities.

### I

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

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

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

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

***Intensive outpatient program*** means *outpatient* services providing:

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

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

- *Custodial care*; or
- Day care.

### J

### K

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## GLOSSARY (continued)

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### L

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

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

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

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

### M

**Maintenance care** means services and supplies furnished mainly to:

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

**Maximum allowable fee** for a *covered expense* is the lesser of:

- The fee charged by the provider for the services;
- The fee that has been negotiated with the provider whether directly or through one or more intermediaries or shared savings contracts for the services;
- The fee established by *us* by comparing rates from one or more regional or national databases or schedules for the same or similar services from a geographical area determined by *us*;
- The fee based upon rates negotiated by *us* or other payors with one or more *network providers* in a geographic area determined by *us* for the same or similar services;
- The fee based upon the provider's cost for providing the same or similar services as reported by such provider in its most recent publicly available *Medicare* cost report submitted to the Centers for Medicare & Medicaid Services (CMS) annually; or
- The fee based on a percentage determined by *us* of the fee *Medicare* allows for the same or similar services provided in the same geographic area.

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



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## GLOSSARY (continued)

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

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

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

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

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

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

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

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## GLOSSARY (continued)

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### N

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

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

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

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

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

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

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

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

### O

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

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

**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.

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## GLOSSARY (continued)

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

**Out-of-pocket limit** means the amount of *copayments*, *deductibles* and *coinsurance* you must pay for *covered expenses*, as specified in the "Out-of-pocket limit" provision in the "Schedule of Benefits" section, either individually or combined as a covered family, per year before a benefit percentage is increased. Any amount you pay a *non-network provider* exceeding the *maximum allowable fee* is not applied to the *out-of-pocket limits*.

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

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

### P

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

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

- Has a comprehensive and intensive *interdisciplinary* psychiatric treatment under the supervision of a psychiatrist for *mental 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*.

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## GLOSSARY (continued)

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

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

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

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

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

**Pre-surgical/procedural testing** means:

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

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

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

**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*.

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## GLOSSARY (continued)

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**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, or as otherwise required by state law.
- Immunizations recommended by the Advisory Committee on Immunization Practices of the CDC.
- Preventive care for infants, children and adolescents provided in the comprehensive guidelines supported by the HRSA.
- Preventive care for women provided in the comprehensive guidelines supported by the HRSA.

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

### Q

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

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

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

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

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

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

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

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

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## GLOSSARY (continued)

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### R

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

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

**Residential treatment facility** means an institution that:

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

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

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

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

**Routine nursery care** means the charges made by a *hospital* or licensed birthing center for the use of the nursery. It includes normal services and supplies given to well newborn children following birth.

*Health care practitioner* visits are not considered *routine nursery care*. Treatment of a *bodily injury*, *sickness*, birth abnormality, or *congenital anomaly* following birth and care resulting from prematurity is not considered *routine nursery care*.

### S

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



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## GLOSSARY (continued)

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

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

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

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

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

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

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

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

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

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*.



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## GLOSSARY (continued)

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

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

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

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

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

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

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

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

## T

**Telehealth** means services, other than *telemedicine*, provided via telephonic or *electronic* communications. *Telehealth* services must comply with the following, as applicable:

- Federal and state licensure requirements;
- Accreditation standards; and
- Guidelines of the American Telemedicine Association or other qualified medical professional societies to ensure quality of care.

**Telemedicine** means audio and video real-time interactive communication between a *covered person* at an *originating site* and a *health care practitioner* at a *distant site*. *Telemedicine* services must comply with the following, as applicable:

- Federal and state licensure requirements;

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## GLOSSARY (continued)

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- Accreditation standards; and
- Guidelines of the American Telemedicine Association or other qualified medical professional societies to ensure quality of care.

### U

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

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

### V

### W

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

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

### X

### Y

***Year*** means the period of time which begins on any January 1st and ends on the following December 31st. When *you* first become covered by the *policy*, the first *year* begins for *you* on the *effective date* of *your* insurance and ends on the following December 31st.

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

### Z

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## GLOSSARY – PHARMACY SERVICES

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

### A

### 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

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## GLOSSARY – PHARMACY SERVICES (continued)

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### G

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

### H

### I

### J

### K

### L

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

**Level 1 drugs** mean a category of *prescription* drugs, medicines or medications within the *drug list* that are designated by *us* as level 1.

**Level 2 drugs** mean a category of *prescription* drugs, medicines or medications within the *drug list* that are designated by *us* as level 2.

**Level 3 drugs** mean a category of *prescription* drugs, medicines or medications within the *drug list* that are designated by *us* as level 3.

**Level 4 drugs** mean a category of *prescription* drugs, medicines or medications within the *drug list* that are designated by *us* as level 4.

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## GLOSSARY – PHARMACY SERVICES (continued)

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### M

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

### N

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

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

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

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

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

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

### O

### P

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

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

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

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## GLOSSARY – PHARMACY SERVICES (continued)

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**Prior authorization** means the required prior approval from *us* for the coverage of certain *prescription* drugs, medicines or medications, including *specialty drugs*. The required prior approval from *us* for coverage includes the dosage, quantity and duration, as *medically necessary* for the *covered person*.

### Q

### R

### S

**Specialty pharmacy** means a *pharmacy* that provides covered *specialty pharmacy* services, as defined by *us*, to *covered persons*.

**Step therapy** means a requirement for *you* to first try certain drugs, medicines or medications or *specialty drugs* to treat *your* medical condition before *we* will cover another *prescription* drug, medicine, medication or *specialty drug* for that condition.

### T

### U

### V

### W

### X

### Y

### Z

SAMPLE

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