Plan Year 2023

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

If you are already a member, please sign in or register on Humana.com to view your issued certificate.

ILHJW3KEN 0123

Important

At Humana, it is important you are treated fairly.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Humana.

Administrative Office:
500 West Main Street
Louisville, Kentucky 40202

Certificate of Coverage
Humana Health Plan Inc.

Group Plan Sponsor:

Group Plan Number:

Effective Date:

Product Name:

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

Bruce Broussard
President

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

"WARNING, LIMITED BENEFITS WILL BE PAID WHEN NON-PARTICIPATING PROVIDERS ARE USED. You should be aware that when you elect to utilize the services of a non-participating provider for a covered service in non-emergency situations, benefit payments to such non-participating provider are not based upon the amount billed. The basis of your benefit payment will be determined according to your policy's fee schedule, usual and customary charge (which is determined by comparing charges for similar services adjusted to the geographical area where the services are performed), or other method as defined by the policy. YOU CAN EXPECT TO PAY MORE THAN THE COINSURANCE AMOUNT DEFINED IN THE POLICY AFTER THE PLAN HAS PAID ITS REQUIRED PORTION. Non-participating providers may bill members for any amount up to the billed charge after the plan has paid its portion of the bill, except for covered services received at a participating health care facility from a non-participating provider that are:

- Ancillary services;
- Items or services furnished as a result of unforeseen, urgent medical needs that arise at the time the item or service is furnished; or
- Items or services received when the facility or the non-participating provider fails to satisfy the notice and consent criteria in the law.

Participating providers have agreed to accept discounted payments for services with no additional billing to the member other than co-insurance and deductible amounts. You may obtain further information about the participating status of professional providers and information on out-of-pocket expenses by calling the toll-free telephone number on your identification card."

UNDERSTANDING YOUR COVERAGE

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

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

Covered and non-covered expenses

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

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

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

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

How your master group contract works

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

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

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

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

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

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 due to *your emergency medical condition*.

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 *master group contract*.

Preauthorization requirements

Preauthorization is required for certain services and supplies. Below is a general category of service and supplies that require *preauthorization*.

- *Inpatient admissions*;
- *Durable medical equipment*;
- *Outpatient advanced imaging* and diagnostic services;
- *Outpatient* therapy services;
- *Inpatient* or *outpatient surgery*;
- Transplants;
- *Bariatric surgeries*;
- Genetic/molecular testing;
- Home health;
- *Infertility* testing and treatment;

- Pain management procedures;
- Cardiac and auditory devices or implants;
- Cancer treatment; and
- *Specialty drugs* when delivered in the physician's office, *outpatient* facility, *urgent care* or home setting.

The detailed list of services and supplies that require *preauthorization* is available on *our* website at www.humana.com or by calling the customer service telephone number on *your* ID card. The list of services and supplies that require *preauthorization* is subject to change. Coverage provided in the past for services or supplies that did not receive or require *preauthorization*, is not a guarantee of future coverage of the same services or supplies. Benefits are not paid at all for services or supplies that are not *covered expenses*.

Your network health care practitioner is responsible for obtaining the appropriate *preauthorization* for services or supplies to be provided by a *network provider*.

You are responsible for informing *your health care practitioner* of the *preauthorization* requirements for services or supplies to be provided by a *non-network provider*. *You* or *your health care practitioner* must contact *us* by telephone, *electronic mail* or in writing to request the appropriate *preauthorization.*

If *you* receive services or supplies from a *non-network provider* for which *preauthorization* is required and not obtained, the benefit payable for any *covered expenses* incurred will be reduced to 50% or by $1,000, whichever is less, after any applicable *deductibles* or *copayments*. The out-of-pocket amounts incurred by *you* due to these benefit reductions will not be used to satisfy any *out-of-pocket limits.*

Your choice of providers affects your benefits

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

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

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

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

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

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

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

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

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

How to find a network provider

You may find a list of *network providers* at www.humana.com. This list is subject to change, however, *we* will provide a 60-day notice when a *network provider* terminates from the network. Please check this list before receiving services from a *qualified provider*. *You* may also call *our* customer service department at the number listed on *your* ID card to determine if a *qualified provider* is a *network provider*, or *we* can send the list to *you.* A *network provider* can only be confirmed by *us*.

How to use your point of service (POS) plan

You may receive services from a *network provider* or *non-network provider* with *your* POS plan without a referral from *your primary care physician.* Refer to the "Preauthorization requirements" provision in this section for any *preauthorization* requirements.

Continuity of care

If *your network provider* is non-renewed or terminated from *our* network, *we* will notify *you* and *your network provider* 60 days prior to the non-renewal or termination. *You* may be eligible to elect continuity of care if *you* are a continuing care patient as of the date the *network provider* terminates or is non-renewed or any of the following events occur:

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

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

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

- 90 days from the date *we* notify *you* the *qualified provider* is termed or non-renewed;
- 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 *master group contract* terminates; or
- The date *you* are no longer a continuing care patient.

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

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

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

If *your* provider under *your* prior *health insurance coverage* is not a *network provider* under this plan, *you* may request continuity of care with the same provider if:

- *You* have a life-threatening *bodily injury* or *sickness* in which case the transitional period is not more than 90 days after *your enrollment date*; or

- *You* have entered the third trimester of pregnancy on *your enrollment date*; and
- *Your* provider agrees in writing to the requirements of Illinois statutes and regulations.

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 or not related to the life-threatening *bodily injury* or *sickness you* received treatment for while covered under *your* prior *health insurance coverage*;
- 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 *non-network hospital* for an *emergency medical condition*. If *your* condition does not allow *you* to call *us* within 48 hours after *your admission*, contact *us* as soon as *your* condition allows. *We* may transfer *you* to a *network hospital* in the service area when *your* condition is stable.

Post-stabilization services

Following stabilization of an *emergency medical condition*, *post-stabilization services* may require *preauthorization*. For more information on services that require *preauthorization*, refer to the "Preauthorization requirements" provision in this section.

When *preauthorization* is required for *post-stabilization services*, *we* will provide access 24 hours a day, 7 days a week to handle such *preauthorization* requests. Benefits for *post-stabilization services* are payable if:

- *Preauthorization* is provided by *us*; or
- The treating *health care practitioner* has two documented good faith efforts, as defined by Illinois law, to contact us to request and obtain *preauthorization* of *post-stabilization services*, and
  - *We* are not accessible; or
  - *We* did not deny the *preauthorization* request within 60 minutes of receipt of the request.

Preauthorization for *post stabilization services* is not required 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.

Seeking urgent care

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

Our relationship with qualified providers

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

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

Independent second opinion

If *we* make a determination that a service proposed by *your primary care physician* is not *medically necessary, you* have the right to an independent second opinion by a *health care practitioner* who holds the same class of license as *your primary care physician.* The reviewing *health care practitioner* will be jointly selected by *you, your primary care physician* and *us.* If the reviewing *health care practitioner* determines the proposed service is *medically necessary, we* will consider the proposed service a *covered expense.*

Our financial arrangements with network providers

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

- Many *network providers* are paid on a discounted fee-for-services basis. This means they have agreed to be paid a set amount for each *covered expense*;

- Some *network providers* may have capitation agreements. This means the *network provider* is paid a set dollar amount each month to care for each *covered person* no matter how many services a *covered person* may receive from the *network provider*, such as a *primary care physician* or a *specialty care physician*;

- *Hospitals* may be paid on a Diagnosis Related Group (DRG) basis or a flat fee per day basis for *inpatient* services. *Outpatient* services are usually paid on a flat fee per service or a procedure or discount from their normal charges.

The certificate

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

COVERED EXPENSES

This "Covered Expenses" section describes the services that will be considered *covered expenses* under the *master group contract* for *preventive services* and medical services for a *bodily injury* and *sickness*. Benefits will be paid as specified in the "How your master group contract works" provision in the "Understanding Your Coverage" section and as shown on the "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 *master group contract* 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.

Covered preventive services for adults include:

- A1C testing for prediabetes, type 1 diabetes, and type 2 diabetes in accordance with prediabetes and diabetes risk factors identified by the United States CDC;
- Abdominal aortic aneurysm one-time screening for men ages 65 to 75 and have ever smoked;
- Alcohol misuse screening and counseling;
- Blood pressure screening for all adults;
- Cholesterol screening for adults of certain ages or at higher risk;
- Colorectal cancer screening for adults 45 years or older and a follow-up colonoscopy when determined to be *medically necessary* by the *health care practitioner*;

- Contraception: Food and Drug Administration – approved female contraceptive methods, female sterilization procedures, natural family planning, and patient education, counseling and exams, as recommended by a health care provider (not including male condoms). Coverage includes follow-up services related to drugs, devices, products and procedures, including but not limited to management of side effects, counseling for continued adherence and device insertion and removal. Coverage also includes 12 months of contraceptives dispensed at one time;

- Depression screening for adults;

- Diabetes type 2 screening for abnormal blood glucose as part of cardiovascular risk assessment in adults aged 40 to 70 years who are overweight or obese;

- Diet counseling for adults at higher risk for chronic disease;

- Falls prevention in older adults: Counseling – exercise therapy to prevent falls in community-dwelling adults aged 65 years or older who are at increased risk for falls;

- Haemophilus influenza type b (HIB): 1 or 3 doses for at risk adults at any age depending on indication;

- Hepatitis B screening for people at high risk, including people in countries with 2% or more hepatitis B prevalence, and U.S. born people not vaccinated as infants and with at least one parent born in a region with 8% or more hepatitis B prevalence;

- Hepatitis C screening for adults at increased risk, and one time for everyone born 1945 - 1965;

- HIV screening for everyone ages 15 to 65, and other ages at increased risk;

- Immunization vaccines for adults – doses, recommended ages, and recommended populations vary:

  - Haemophilus influenza type b (HIB);
  - Hepatitis A;
  - Hepatitis B;
  - Herpes zoster (shingles);
  - Human papillomavirus;
  - Influenza (flu shot);
  - Measles, mumps, rubella;
  - Meningococcal;
  - Pneumococcal;
  - Tetanus, diphtheria, pertussis; and
  - Varicella.

- Lung cancer screening for adults 55-80 at high risk for lung cancer because they are heavy smokers or have quit in the past 15 years;

- Obesity screening and counseling for all adults;

- Pre-exposure prophylaxis (PrEP) with effective antiretroviral therapy for the prevention of HIV *infection* for people at high risk of HIV *infection*;

- Prostate specific antigen (PSA) test and an annual digital rectal examination for a male *covered person* 40 years of age or older;
- Sexually transmitted *infection* (STI) prevention counseling for adults at higher risk;
- Skin cancer prevention behavioral counseling, who have fair skin, about minimizing their exposure to ultraviolet radiation to reduce risk for skin cancer;
- Statin use to prevent cardiovascular disease for men and women ages 40-75 with certain risk factors;
- Syphilis screening for all adults at higher risk;
- Tobacco use screening for all adults and cessation interventions for tobacco users;
- Tuberculosis screening for latent tuberculosis *infection* in populations at increased risk;
- Vitamin D testing in accordance with vitamin D deficiency risk factors identified by the United States CDC; and
- Whole body skin examination for lesions suspicious for skin cancer.

Covered preventive services for women include:

- Anemia screening on a routine basis for pregnant women;
- An annual thorough physical examination of the breast for women 40 years or older, at least every 3 years for women 20 years or older (but less than 40), or as *medically necessary.* This includes but is not limited to a comprehensive clinical breast examination performed by a *health care practitioner* to check for lumps and other changes;
- Breast cancer genetic counseling (BRCA) for women at higher risk;
- *Low-dose mammography* screening as follows:
  - A baseline mammogram for women 35-39;
  - An annual mammogram for women 40 years of age and older;
  - For women under 40 with:
    - A family history of breast cancer or other risk factors, at age intervals considered *medically necessary.*
    - Positive genetic testing or other risk factors.

  Coverage includes:

  - Digital mammography, including breast tomosynthesis;
  - A comprehensive ultrasound screening and magnetic resonance imaging (MRI) of entire breast(s) when mammogram has shown heterogeneous, dense breast tissue, or when *medically necessary*; and

- A screening magnetic resonance imaging (MRI) when *medically necessary* as determined by a *health care practitioner*;

- Breast cancer chemoprevention preventive medications, such as tamoxifen, raloxifene, or aromatase inhibitors, for women at increased risk for breast cancer and low risk for adverse medication side effects;

- Breastfeeding comprehensive support and counseling from trained providers, as well as access to breast pumps, including electric breast pumps, and breastfeeding supplies, for pregnant and nursing women;

- Cervical cancer screening, including cervical smear or pap smear;

- Chlamydia *infection* screening for younger women and other women at higher risk;

- Domestic and interpersonal violence screening and counseling for all women;

- Folic acid supplements for women who may become pregnant;

- Gestational diabetes mellitus screening for pregnant women between 24 to 28 weeks of gestation and at the first prenatal visit for pregnant women identified to be at high risk for diabetes;

- Gestational diabetes mellitus screening in asymptomatic pregnant women after 24 weeks of gestation;

- Gonorrhea screening for all women at higher risk;

- Hepatitis B screening for pregnant women at their first prenatal visit;

- Hepatitis C virus screening for women at high risk for *infection*;

- Human immunodeficiency virus (HIV) screening and counseling for prenatal and sexually active women;

- Human papillomavirus (HPV) DNA test: every 3 years for women with normal cytology results who are 30 or older;

- Osteoporosis screening for women age 60 and over or in younger women whose fracture risk is equal to or greater than that of a 65-year old white woman who has no additional risk factors;

- Preeclampsia screening for pregnant women with blood pressure measurements throughout pregnancy;

- Preeclampsia prevention – Low dose aspirin (81 mg/d) as preventive medication after 12 weeks of gestation in women who are at high risk for preeclampsia;

- Rh incompatibility screening for all pregnant women and follow-up testing for women at higher risk;

- Screening for asymptomatic bacteriuria with urine culture for pregnant women at 12 to 16 weeks' gestation or at their first prenatal visit, if later;
- Sexually transmitted *infection* (STI) counseling for sexually active women;
- Surveillance tests for ovarian cancer for females at risk for ovarian cancer;
- Syphilis screening for all pregnant women or other women at increased risk;
- Tobacco use screening and interventions for all women, and expanded counseling for pregnant tobacco users;
- Urinary tract or other *infection* screening for pregnant women;
- Well-women visits to obtain recommended services.

Covered preventive services for children include:

- Alcohol and drug use assessments for adolescents;
- Autism screening for children at 18 and 24 months;
- Behavioral assessments for children at the following ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years;
- Blood pressure screening for children at the following ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years;
- Cervical dysplasia screening for sexually active females;
- Congenital hypothyroidism screening for newborns;
- Critical congenital heart defect screening for newborns;
- Dental cavities in children from birth through age 5 years – application of fluoride varnish to the primary teeth of all infants and children starting at age of primary tooth eruption and prescribed oral fluoride supplementation starting at age 6 months for children whose water supply is deficient in fluoride;
- Depression screening for adolescents;
- Developmental screening for children under age 3, and surveillance throughout childhood;
- Dyslipidemia screening for children at higher risk of lipid disorders at the following ages: 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years;
- Fluoride chemoprevention supplements for children without fluoride in their water source;
- Gonorrhea preventive medication for the eyes of all newborns;

- Hearing screening for all newborns and for children once between the ages of 11 and 14, once between the ages of 15 and 17 years of age, and once between the ages of 18 and 21;
- Height, weight and body mass index measurements for children at the following ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years;
- Hematocrit or hemoglobin screening for children;
- Hemoglobinopathies or sickle cell screening for newborns;
- Hepatitis B virus *infection*: Screening for hepatitis B virus (HBV) *infection* in persons at high risk for *infection*;
- HIV screening for adolescents at higher risk;
- Hypothyroidism screening for newborns;
- Immunization vaccines for children from birth to age 18 – doses, recommended ages, and recommended populations vary:
  - Diphtheria, tetanus, pertussis;
  - Haemophilus influenza type b;
  - Hepatitis A;
  - Hepatitis B;
  - Hepatitis C virus (HCV);
  - Human papillomavirus;
  - Inactivated poliovirus;
  - Influenza (flu shot);
  - Measles, mumps, rubella;
  - Meningococcal;
  - Pneumococcal;
  - Rotavirus; and
  - Varicella.
- Lead screening for children at risk of exposure;
- Medical history for all children throughout development at the following ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years;
- Obesity screening and counseling;
- Oral health risk assessment for young children at the following ages: 0 to 11 months, 1 to 4 years, 5 to 10 years;
- Phenylketonuria (PKU) screening for this genetic disorder in newborns;
- Sexually transmitted *infection* (STI) prevention counseling and screening for adolescents at higher risk;
- Skin cancer behavioral counseling for children, adolescent, and young adults ages 6 months to 24 years who have fair skin;

- Tobacco use interventions, including education or brief counseling to prevent initiation of tobacco use in school aged children and adolescents;
- Tuberculin testing for children at higher risk of tuberculosis. Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years;
- Vision screening for all children; and
- Whole body skin examination for lesions suspicious for skin cancer.

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

Male sterilization services

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

Diagnostic mammogram screening

We will pay benefits for *covered expenses* incurred by *you* for a diagnostic mammogram screening to evaluate an abnormality and when *medically necessary*, as determined by a *health care practitioner*.

Health care practitioner office services

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

Health care practitioner office visit

Covered expenses include:

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

Virtual visit services

We will pay benefits for *covered expenses* incurred by *you,* which includes *telehealth* and *telemedicine,* for *virtual visits* for the diagnosis and treatment of a *sickness* or *bodily injury. Virtual visits* must be for services that would otherwise be a *covered expense* if provided during a face-to-face consultation between a *covered person* and a *health care practitioner*.

Covered expenses include services received from licensed dietitian nutritionists and certified diabetes educators for *diabetes self-management training* and the treatment of diabetes.

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, including *pre-surgical/procedural testing.* A *hospital confinement* must be ordered by a *health care practitioner.*

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

Hospital inpatient services

Covered expenses include:

- Daily semi-private, ward, intensive care or coronary care *room and board* charges for each day of *confinement.* Benefits for a private or single-bed room are limited to the *maximum allowable fee* charged for a semi-private room in the *hospital* while *confined,* unless:
  - The patient's stay in a private *hospital* room is *medically necessary* in terms of generally accepted medical practice; or
  - A private room or single-bed room is the only type of room available.
- Services and supplies, other than *room and board,* provided by a *hospital* while *confined.*

Health care practitioner inpatient services when provided in a hospital

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

Covered expenses include:

- Medical services furnished by an attending *health care practitioner* to *you* while *you* are *hospital confined.*

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

Hospital outpatient services

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

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

Hospital outpatient surgical services

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

Health care practitioner outpatient services when provided in a hospital

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

Covered expenses include:

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

Hospital outpatient non-surgical services

Covered expenses include 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*, including a *dependent* child, for a pregnancy. Please refer to the "Covered Expenses – Behavioral Health" section in this *certificate* for *behavioral health* services during pregnancy and the postpartum period.

Pregnancy benefit

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*; or
- *Abortion* care.

Newborn benefit

Covered expenses include:

- *Hospital confinement* during the first 48 hours or 96 hours following birth, as applicable and listed above for:
  - *Hospital* charges for *routine nursery care*;
  - The *health care practitioner's* charges for circumcision of the newborn child; and
  - The *health care practitioner's* charges for routine examination of the newborn before release from the *hospital*.
- If the covered newborn must remain in the *hospital* past the mother's *confinement*, services and supplies received for:
  - A *bodily injury* or *sickness*;

- Care and treatment for premature birth; and
- Medically diagnosed birth defects and abnormalities.

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

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

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 same benefit level as a *network provider*, as specified in the "Emergency services" benefit in the "Schedule of Benefits" section. The same benefit level means *you* will have no greater cost for *emergency care* provided by a *non-network provider* than if *emergency care* is provided by a *network provider*. 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 same benefit level as a *network provider*, as specified in the "Ambulance services" benefit in the "Schedule of Benefits" section. The same benefit level means *you* will have no greater cost for *ambulance* services for an *emergency medical condition* provided by a *non-network provider* than if *ambulance* services for an *emergency medical condition* are provided by a *network provider*. *You* may be required to pay the *non-network provider* any amount not paid by *us*, as follows:

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

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

Ambulatory surgical center services

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

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

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

Covered expenses include:

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

Durable medical equipment

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

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* purchase the *durable medical equipment* or *diabetes equipment,* any amount paid as rent for such equipment will be credited toward the purchase price.

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

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

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

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

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

Free-standing facility services

Free-standing facility diagnostic laboratory and radiology services

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

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

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

Free-standing facility advanced imaging

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

Home health care services

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

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

Home health care *covered expenses* are limited to:

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

Home health care *covered expenses* do not include:

- Charges for mileage or travel time to and from the *covered person's* home;
- Wage or shift differentials for any representative of a *home health care agency*;
- Charges for supervision of *home health care agencies*;
- Charges for services of a home health aide;

- *Custodial care*; or
- The provision or administration of *self-administered injectable drugs*.

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 and the *covered person* will no longer benefit from standard medical care.

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

Covered expenses include:

- Coordinated home care;
- Medical supplies and dressings;
- Medication;
- Nursing services – skilled and non-skilled;
- Occupational therapy;
- Pain management services;
- Physical therapy;
- *Health care practitioner* visits;
- Social and spiritual services; and
- Respite care service.

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 (TMJ) 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;
- 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:

- Electronic diagnostic modalities;
- Occlusal analysis; or
- Any irreversible procedure, including but not limited to: orthodontics, occlusal adjustment, crowns, onlays, fixed or removable partial dentures, and full dentures.

Physical medicine and rehabilitative services

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

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

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

Habilitative services

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

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

Habilitative services also include other services prescribed by the treating *health care practitioner* pursuant to a treatment plan.

Except as otherwise stated, *habilitative services* apply toward the "Physical medicine and rehabilitative services" maximum number of visits specified in the "Schedule of Benefits." *Habilitative services* provided to a *dependent* child with a *congenital anomaly*, genetic disorder, or early acquired disorder are not subject to any visit limit when all of the following conditions are met:

- A *health care practitioner* has diagnosed the *dependent* child's *congenital anomaly*, genetic disorder, or early acquired disorder.

- Treatment is administered by a *health care practitioner* who is licensed as a: speech-language pathologist; audiologist; occupational therapist; physical therapist; physician; nurse; optometrist; nutritionist; social worker; or psychologist.

- Treatment is *medically necessary* and therapeutic, and is not *experimental, investigational or for research purposes*.

Spinal manipulations/adjustments

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

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

Naprapathic services

We will pay benefits for *covered expenses* incurred by *you* for *naprapathic services* provided by a *naprapath.*

The "Schedule of Benefits" shows the maximum number of visits for *naprapathic 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.

Covered expenses for *specialty drugs* include immune gamma globulin therapy when prescribed by a *health care practitioner* for a *covered person* diagnosed with a primary immunodeficiency, or a pediatric autoimmune neuropsychiatric disorder associated with streptococcal *infections* and/or pediatric acute-onset neuropsychiatric syndrome. Determination of an initial authorization for immune gamma globulin therapy will be no less than three months. After the initial authorization, reauthorization may occur every six months, except for a *covered person* who has been receiving immune gamma globulin therapy for at least two years with sustained beneficial response, then reauthorization will be no less than 12 months unless a more frequent duration has been indicated by the prescribing *health care practitioner*.

Specialty drugs may be subject to *preauthorization* requirements. Refer to the "Understanding Your Coverage (Preauthorization requirements)" 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*.

We may not deny reimbursement for a transplant or *immune effector cell therapy* as *experimental, investigational or for research purposes* unless supported by the determination of the Office of Health Care Technology Assessment within the Agency for Health Care Policy and Research within the federal Department of Health and Human Services that such procedure is either *experimental, investigational* or *for research purposes,* or that there is insufficient data or experience to determine whether an organ transplant or *immune effector cell therapy* is clinically acceptable.

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

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

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

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

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

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

- Acquisition of cell therapy products for *immune effector cell therapy*, acquisition of *stem cells* or solid organs for transplants and associated donor costs, including pre-transplant or *immune effector cell therapy* services, the acquisition procedure, and any complications resulting from the harvest and/or acquisition. This includes evaluation, preparation and delivery of the donor organ, removal of the organ from the donor and transportation of the donor organ to the location of the transplant surgery. Benefits will be limited to the transportation of the donor organ in the United States or Canada. Benefits will only be provided at an in-network approved Human Organ Transplant Coverage Program. Donor costs will be provided as follows:

- If both the donor and recipient have a *policy* with *us*, benefits will be covered by his/her own *policy*;

- If *you* are the recipient of the transplant and the donor is not covered under this *policy* or does not have coverage through any other source, benefits will be provided under this *policy* for both *you* and the donor. Donor costs will not exceed the transplant treatment period and will be charged against *your* benefits; and

- If *you* are the donor for an organ transplant for a recipient not covered under this *policy* and no coverage is available to *you* from any other source, benefits will be provided to *you* under this *policy*. No benefits will be provided to the recipient.

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 50 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 50 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 *master group contract* 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*.

Criminal sexual assault services

We will pay benefits for examination, testing and treatment provided to a *covered person* who is a victim of criminal sexual assault or abuse. Coverage for the exam and testing will be covered in full.

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:

- Treatment for autoimmune encephalitis. Refer to the "Schedule of Benefits – Behavioral Health" and "Covered Expenses – Behavioral Health" sections for *behavioral health* services.
- *Long-term antibiotic therapy* for the treatment of a *tick-borne disease,* including office visits and ongoing testing.
- Blood and blood plasma, which is not replaced by donation; administration of the blood and blood products including blood extracts or derivatives.
- The treatment of end stage renal disease.
- 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.
- *Medically necessary,* wearable non-disposable hearing aids when prescribed by a *health care practitioner* or audiologist for a *covered person,* limited to one per ear every 24 months. Coverage includes related services, such as audiological exams and selection, fitting, and adjustment of ear molds to maintain optimal fit and repairs when *medically necessary.*
- Bone anchored hearing aids.
- 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:

  - Dental braces; or
  - Oral or dental splints and appliances, unless custom made for the treatment of documented obstructive sleep apnea.

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

  - Surgical dressings;
  - Catheters;
  - Colostomy bags, rings and belts; and
  - Flotation pads.

- The initial pair of eyeglasses or contacts needed due to cataract *surgery* or an *accident* if the eyeglasses or contacts were not needed prior to the *accident*.

- Dental treatment only if the charges are incurred for treatment of a *dental injury* to a *sound natural tooth*.

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

- Certain oral surgical operations as follows:

  - Excision of partially or completely impacted teeth;

  - Surgical preparation of soft tissues and excision of bone or bone tissue performed with or without extraction or excision of erupted, partially erupted or completely un-erupted teeth;

  - Excisions of tumors and cysts of the jaws, cheeks, lips, tongue, roof, and floor of the mouth, and related biopsy of bone, tooth or related tissues when such conditions require pathological examinations;

  - Surgical procedures related to repositioning of teeth, tooth transplantation or re-implantation;

  - Services required to correct accidental injuries of the jaws, cheeks, lips, tongue, roof, and floor of the mouth;

  - Reduction of fractures and dislocation of the jaw;

- External incision and drainage of cellulitis and abscess;
- Incision and closure of accessory sinuses, salivary glands or ducts;
- Frenectomy (the cutting of the tissue in the midline of the tongue); and
- Orthognathic *surgery* for a *congenital anomaly*, *bodily injury* or *sickness*.

- Orthodontic treatment for a *congenital anomaly* related to or developed as a result of cleft palate, with or without cleft lip.
- Services for fibrocystic breast conditions.
- *Standard fertility preservation services* when necessary medical treatment may cause *iatrogenic infertility* to a *covered person.*
- Mammogram, except for *preventive services* or considered a diagnostic mammogram screening.
- 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*.

  Expenses for reconstructive *surgery* due to a psychological condition are not considered a *covered expense*, unless the condition(s) described above are also met.
- Treatment to eliminate or provide maximum feasible treatment of nevus flammeus (port-wine stains), including port-wine stains caused by Sturger-Weber syndrome. Treatment includes early intervention including topical, intralesional, or systemic medical therapy and surgery, and laser treatments approved by the United States Food and Drug Administration for *covered persons* aged 18 and younger. These treatments are intended to prevent functional impairment related to visual and oral function, inflammation, bleeding, *infection*, and other medical complications.

  Expenses for the treatment of port-wine stains solely for cosmetic purposes are not considered *covered expenses*.
- Amino-acid based elemental formulas, nutritional supplements and low protein modified foods, regardless of delivery method, for the diagnosis and treatment of an inherited metabolic disease, e.g. phenylketonuria (PKU), eosinophilic disorders, or short bowel syndrome when *medically necessary* and prescribed by a *health care practitioner*.
- Transgender services, for the treatment of gender dysphoria, formerly known as gender identity disorder (GID), including hormone therapy, counseling, and gender reassignment *surgery.*

- Private duty nursing.
- *Palliative care*.
- Following a mastectomy, *medically necessary* length of stay for *inpatient* care and post-discharge office visit to the physician or in home nurse visit provided in the first 48 hours after discharge. For the purposes of this provision, mastectomy means the removal of all or a part of the breast or breast implants for *medically necessary* reasons, as determined by the *health care practitioner*.
- Colorectal examinations and laboratory tests for colorectal cancer as prescribed by a physician and in accordance with the American Cancer Society guidelines on colorectal cancer screening or other colorectal cancer screening guidelines issued by nationally recognized professional medical societies or federal government agencies, including the National Cancer Institute, the Centers for Disease Control and Prevention, and the American College of Gastroenterology.
- Intravenously administered or injected cancer medications used to kill or slow the growth of cancerous cells.
- Pancreatic cancer screening.
- *Comprehensive cancer testing* and *testing of blood or constitutional tissue for cancer predisposition testing* as determined by a *health care practitioner*.
- Biomarker testing for the purposes of diagnosis, treatment, appropriate management, or ongoing monitoring of *your sickness* when the test is supported by medical and scientific evidence.
- Anesthesia charges associated with dental procedures at a *hospital* or *ambulatory surgical center* are a *covered expense* for the following *covered persons*:

  - A child age six or under;
  - An individual who has a medical condition that required hospitalization or general anesthesia for dental care;
  - An individual with a disability; or
  - An individual over age 6 who is determined by a licensed dentist or physician to require such services in order to prevent significant medical risk.

  Anesthesia charges associated with dental procedures at a dental office, oral surgeon's office, *hospital*, or *ambulatory surgical center* are a *covered expense* if the *covered person* has been diagnosed with an *autism spectrum disorder*.

- If *medically necessary*, coverage for bone mass measurement and treatment for osteoporosis.
- If *medically necessary*, pain medication and pain therapy related to the treatment of breast cancer. Pain therapy means pain therapy that is medically based and includes reasonably defined goals, including, but not limited to, stabilizing or reducing pain, with periodic evaluations of the efficacy of the pain therapy against these goals.

- Preventative physical therapy prescribed by a *health care practitioner* licensed to practice medicine in all of its branches for the purpose of treating parts of the body affected by multiple sclerosis. The physical therapy must include reasonably defined goals, including, but not limited to, sustaining the level of function the person has achieved, with periodic evaluation of the efficacy of the physical therapy against those goals.

- Pasteurized donated human breast milk, which may include human milk fortifiers if indicated as prescribed by a *health care practitioner* for:

  - A covered *dependent* under the age of six months when all of the following conditions are met:

    - The milk is obtained from a human milk bank that meets quality guidelines established by the Human Milk Banking Association of North America or is licensed by the Department of Public Health;

    - The covered *dependent's* mother is medically or physically unable to produce maternal breast milk or produce maternal breast milk in sufficient quantities to meet the covered *dependent's* needs or the maternal breast milk is contraindicated;

    - The milk has been determined to be *medically necessary* for the covered *dependent*; and

    - One or more of the following applies to the covered *dependent*:

      - Birth weight is below 1,500 grams;

      - A congenital or acquired condition that places the covered *dependent* at a high risk for development of necrotizing enterocolitis;

      - Infant hypoglycemia;

      - Congenital heart disease;

      - Has had or will have an organ transplant;

      - Sepsis; or

      - Any other serious congenital or acquired condition for which the use of donated human breast milk is *medically necessary* and supports the treatment and recovery of the covered *dependent.*

  - A covered *dependent* six months through 12 months of age when all of the following conditions are met:

    - The milk is obtained from a human milk bank that meets quality guidelines established by the Human Milk Banking Association of North America or is licensed by the Department of Public Health;

- The covered *dependent's* mother is medically or physically unable to produce maternal breast milk or produce maternal breast milk in sufficient quantities to meet the covered *dependent's* needs or the maternal breast milk is contraindicated;

- The milk has been determined to be *medically necessary* for the covered *dependent*; and

- One or more of the following applies to the covered *dependent*:

  - Spinal muscular atrophy;
  - Birth weight was below 1,500 grams and he or she has long-term feeding or gastrointestinal complications related to prematurity;
  - Has had or will have an organ transplant; or
  - A congenital or acquired condition for which the use of donated human breast milk is *medically necessary* and supports the treatment and recovery of the covered *dependent*.

- The following routine foot care services, when *medically necessary*:

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

- *Diabetes self-management training*.

- 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.

- *Bariatric services*.

COVERED EXPENSES - PEDIATRIC DENTAL

This "Covered Expenses – Pediatric Dental" section describes the services that will be considered *covered expenses* for *pediatric dental services* under the *master group contract.* Benefits for *pediatric dental services* will be paid on a *reimbursement limit* basis and as shown in the "Schedule of Benefits – Pediatric Dental," subject to any applicable:

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

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

Definitions

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

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

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

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

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

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

Expense incurred date means the date on which:

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

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

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

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

Reimbursement limit means the maximum fee allowed for *pediatric dental services.* It is the lesser of:

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

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

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

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

Pediatric dental services benefit

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

Class I services

- Periodic oral evaluation. Limited to a maximum of 2 per *year* per patient. In an office or school setting. Completion of a mandated school exam form is considered part of the oral examination.
- Comprehensive oral evaluation. One per lifetime per *provider* or location.
- Limited, problem focused oral evaluations.
- Periodontal evaluations. Limited to a maximum of 1 per *provider* every 3 *years*.
- Cleaning (prophylaxis), including all scaling and polishing procedures. Limited to a maximum of 2 per *year*.
- Intra-oral complete series x-rays (at least 14 films, including bitewings) or panoramic x-ray. Limited to 1 per *provider* every 3 *years*. If the total cost of periapical and bitewing x-rays exceeds the cost of a complete series of x-rays, *we* will consider these as a complete series.
- Bitewing x-rays. Limited to 2 sets per *year*.
- Other x-rays, including intra-oral periapical and occlusal and extra-oral x-rays. Limited to x-rays necessary to diagnose a specific treatment.
- Topical fluoride treatment. Limited to a maximum of 2 per *year*.
- Application of sealants to the occlusal surface of permanent molars that are free of decay and restorations. Limited to a maximum of 1 per tooth per lifetime.
- Installation of space maintainers for retaining space when a primary tooth is prematurely lost. *Pediatric dental services* do not include separate adjustment expenses.

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

Class II services

- Restorative services as follows:
  - Amalgam restorations (fillings). Limited to 1 per *year* per tooth, per surface.
  - Composite restorations (fillings) on anterior teeth. Limited to 1 per *year* per patient per tooth, per surface.
  - Pin retention per tooth in addition to restoration that is not in conjunction with core build-up.
  - Re-cementing of inlays, onlays, crowns, and bridges.
  - Non-cast pre-fabricated stainless steel, esthetic stainless steel, resin crowns, metal/porcelain, and porcelain crowns on primary teeth that cannot be adequately restored with amalgam or composite restorations. One per 5 *years* per patient per tooth.
- Miscellaneous services as follows:
  - *Palliative dental care* for a *dental emergency* for the treatment of pain or an *accidental dental injury* to the teeth and supporting structures. *We* will consider the service a separate benefit only if no other service, except for x-rays and problem focused oral evaluation is provided during the same visit.
  - Diagnostic consultations provided by a *dentist* or *health care practitioner* not providing the treatment subject to *clinical review*.
  - Sedative filling.

Class III services

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

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

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

- Periodontic services as follows:

  - Periodontal scaling and root planning. One per 2 *years* per patient per quadrant. One full month service is covered every 2 *years*.

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

  - Periodontal maintenance (at least 30 days following periodontal therapy), unless a cleaning (prophylaxis) is performed on the same day visit.

  - Periodontal and osseous surgical procedures, including bone replacement, tissue regeneration and/or graft procedures. Limited to a maximum of 1 per 2 *years* and 4 quadrants per visit. If more than one surgical procedure is performed on the same day, only the most inclusive procedure will be considered a *pediatric dental service*.

  - Occlusal adjustments when performed in conjunction with a periodontal surgical procedure. Limited to a maximum of 1 per 2 *years* and 4 quadrants per visit.

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

- Endodontic procedures as follows:

  - Root canal therapy, including root canal treatments and root canal fillings for permanent teeth and primary teeth. Limited to a maximum of 1 per tooth per lifetime. Any test, intraoperative x-rays, laboratory or any other follow-up care is considered integral to root canal therapy.

  - Retreatment of previous root canal therapy. Limited to a maximum of 1 per tooth per lifetime. Any test, intraoperative x-rays, exam, laboratory or any other follow-up care is considered integral to root canal therapy.

  - Periradicular surgical procedures for permanent teeth, including apicoectomy, root amputation, tooth reimplementation, bone graft, and surgical isolation. Limited to a maximum of 1 per tooth per lifetime.

  - Partial pulpotomy for apexogenesis for permanent teeth. Limited to a maximum of 1 per tooth per lifetime.

- Vital pulpotomy for primary teeth. Limited to a maximum of 1 per tooth per lifetime.

- Pulp debridement, pulpal therapy (resorbable) for permanent and primary teeth. Limited to a maximum of 1 per tooth per lifetime.

- Full mouth debridement to enable comprehensive evaluation and diagnosis, limited to 2 per *year*.

- Apexification/recalcification for permanent and primary teeth. Limited to a maximum of 1 per tooth per lifetime.

- Prosthodontics services as follows:

  - Denture adjustments during the six-month period following delivery of new prosthesis.

  - Initial placement of bridges, complete dentures (upper and lower), partial dentures (upper and lower), and immediate dentures. Limited to 1 per 5 *years* per patient. *Pediatric dental services* include pontics, inlays, onlays, and crowns. One per 5 *years* per patient per tooth.

  - Replacement of bridges, complete dentures, and partial dentures. Replacement of immediate dentures is limited to 1 per lifetime. *Pediatric dental services* include the replacement of the existing prosthesis if:

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

  - Tissue conditioning.

  - Denture relines or rebases. One per 2 *years* per patient.

  - Post and core build-up in addition to partial denture retainers with or without core build up. Limited to1 per tooth every 5 *years*.

- The following simple oral surgical services as follows each is limited to one per tooth per lifetime:

  - Extraction of coronal remnants of a deciduous tooth limited to once per tooth per lifetime.
  - Extraction of an erupted tooth or exposed root for permanent and primary teeth limited to once per tooth per lifetime.

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

  - Pain control, unless the *covered person* has a documented allergy to local anesthetic.
  - Anxiety.

- Fear of pain.
- Pain management.
- Emotional inability to undergo a surgical procedure.

Class IV services

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

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

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

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

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

Integral service

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

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

Pretreatment plan

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

- A list of services to be performed using the American Dental Association terminology and codes;
- *Your dentist's* written description of the proposed treatment;

- Pretreatment x-rays supporting the services to be performed;
- Itemized cost of the proposed treatment; and
- Any other appropriate diagnostic materials that *we* may request.

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

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

Pretreatment plan process and timing

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

Alternate services

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

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

Limitations and exclusions

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

- Any expense arising from the completion of forms.
- Any expense due to *your* failure to keep an appointment.
- Any expense for a service *we* consider *cosmetic*, unless it is due to an *accidental dental injury*.
- Expenses incurred for:
  - Precision or semi-precision attachments;
  - Overdentures and any endodontic treatment associated with overdentures;

- Other customized attachments;
- Any services for 3D imaging (cone beam images);
- Temporary and interim dental services; or
- Additional charges related to materials or equipment used in the delivery of dental care.

- Charges for services rendered:

  - In a dental facility or *health care treatment facility* sponsored or maintained by the *employer* under this plan or an employer of any *covered person* covered by the *master group contract*; or
  - By an employee of any *covered person* covered by the *master group contract.*

  For the purposes of this exclusion, *covered person* means the *employee* and the *employee's dependents* enrolled for benefits under the *master group contract* and as defined in the "Glossary" section.

- Any service related to:

  - Altering vertical dimension of teeth or changing the spacing or shape of the teeth;
  - Restoration or maintenance of occlusion;
  - Splinting teeth, including multiple abutments, or any service to stabilize periodontally weakened teeth;
  - Replacing tooth structures lost as a result of abrasion, attrition, erosion, or abfraction; or
  - Bite registration or bite analysis.

- *Infection* control, including but not limited to, sterilization techniques.

- Expenses incurred for services performed by someone other than a *dentist*, except for scaling and teeth cleaning and the topical application of fluoride, which can be performed by a licensed dental hygienist. The treatment must be rendered under the supervision and guidance of the *dentist* in accordance with generally accepted dental standards.

- Any *hospital*, surgical or treatment facility, or for services of an anesthesiologist or anesthetist.

- *Prescription* drugs or pre-medications, whether dispensed or prescribed.

- Any service that:

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

- Repair and replacement of orthodontic appliances.

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

COVERED EXPENSES - PEDIATRIC DENTAL (continued)

- Replacement of any lost, stolen, damaged, misplaced or duplicate major restoration, prosthesis or appliance.
- Any caries susceptibility testing, laboratory tests, saliva samples, anaerobic cultures, sensitivity testing or charges for oral pathology procedures.

COVERED EXPENSES - PEDIATRIC VISION CARE

This "Covered Expenses – Pediatric Vision Care" section describes the services that will be considered *covered expenses* for *pediatric vision care* under the *master group contract.* Benefits for *pediatric vision care* will be paid on a *reimbursement limit* basis and as shown in the "Schedule of Benefits – Pediatric Vision Care," subject to any applicable:

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

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

Definitions

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

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

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

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

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

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

- The fee established by comparing charges for similar services or *materials* to a national database adjusted to the geographical area where the services or procedures were performed or *materials* provided;

- At *our* choice, the fee established by using a national Relative Value Scale. Relative Value Scale means a methodology that values procedures and services relative to each other that includes, but is not limited to, a scale in terms of difficulty, work, risk, as well as the material and outside costs of providing the service, as adjusted to the geographic area where the services or procedures were performed or *materials* provided;

- In the case of services rendered by or *materials* obtained from providers with whom *we* have agreements, the fee that *we* have negotiated with that provider;

- The fee based on rates negotiated with one or more *network providers* for the same or similar services or *materials*;

- The fee based on the provider's costs for providing the same or similar services or *materials* as reported by the provider in the most recent, publicly available *Medicare* cost report submitted annually to the Centers for Medicare & Medicaid Services; or

- The fee based on a percentage of the fee *Medicare* allows for the same or similar services or *materials* provided in the same geographic area.

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

Severe vision problems mean the best-corrected acuity is:

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

Pediatric vision care benefit

We will pay benefits for *covered expenses* provided by a licensed physician or optometrist operating within the scope of his or her license, or a dispensing optician, incurred by a *covered person* for *pediatric vision care*. *Covered expenses* for *pediatric vision care* are:

- *Comprehensive eye exam.*

COVERED EXPENSES - PEDIATRIC VISION CARE (continued)

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

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

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

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

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

- *Low vision* services include the following:

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

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

COVERED EXPENSES - PEDIATRIC VISION CARE (continued)

- Laser Vision Correction: Lasik and PRK:

  - *You* are entitled to a discount of up to 25% off provider's usual and customary fees, or a 5% discount on any advertised special. To ensure the discount is applied correctly, *you* must call the toll-free number on the back of *your* identification card. A customer service representative will assist in coordinating Laser Vision Correction services.

Limitations and exclusions

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

- In no event will benefits exceed the lesser of the limits of the *master group contract*, shown in the "Schedule of Benefits – Pediatric Vision Care" or in the "Schedule of Benefits" of this *certificate.*

- *Materials* covered by the *master group contract* that are lost, stolen, broken, or damaged will only be replaced at normal intervals as specified in the "Schedule of Benefits – Pediatric Vision Care."

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

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

COVERED EXPENSES - BEHAVIORAL HEALTH

This "Covered Expenses – Behavioral Health" section describes the services that will be considered *covered expenses* for *mental health services, serious mental illness* services, and *chemical dependency* services under the *master group contract.* Benefits will be paid as specified in the "How your master group contract works" provision of the "Understanding Your Coverage" section and as shown in the "Schedule of Benefits – Behavioral Health." 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 *master group contract* apply. *Preauthorization* only applies to *substance use disorders* if a *health care practitioner* or *health care treatment facility* fail to notify *us* of the initiation of treatment as required by Illinois law.

Acute inpatient services

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

Acute inpatient health care practitioner services

We will pay benefits for *covered expenses* incurred by *you* for *mental health services, serious mental illness* services, and *chemical dependency* services provided by a *health care practitioner*, including *virtual visits* and tele-psychiatry, 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, serious mental illness* services, and *chemical dependency* services.

Emergency care provided by *non-network providers* will be covered at the same benefit level as a *network provider*, as specified in the "Emergency services" benefit in the "Schedule of Benefits" or "Schedule of Benefits – Behavioral Health" sections of this *certificate.* The same benefit level means *you* will have no greater cost for *emergency care* provided by a *non-network provider* than if *emergency care* is provided by a *network provider*. 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.*

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, serious mental illness* services, and *chemical dependency* services.

Outpatient services

We will pay benefits for *covered expenses* incurred by *you* for *mental health services, serious mental illness* 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, virtual visits,* electroconvulsive therapy, tele-psychiatry, 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, serious mental illness* 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, serious mental illness* 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*.

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 "Understanding Your Coverage (Preauthorization requirements)" 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*.

Psychiatric collaborative care model services

We will pay benefits for *covered expenses* incurred by *you* through a *psychiatric collaborative care model* for *mental health services* and *serious mental illnesses*.

Autism spectrum disorders

We will pay benefits for the diagnosis and treatment of *medically necessary autism spectrum disorders*.

Covered expenses include the following services received from a *qualified provider*:

- Psychiatric care;
- Psychological care;

- Habilitative or rehabilitative care (counseling and treatment programs intended to develop, maintain, and restore the functioning of an individual); and
- Therapeutic care (including behavioral, speech, occupational, and physical therapies) addressing the following areas:

  - Self-care and feeding;
  - Pragmatic, receptive, and expressive language;
  - Cognitive functioning;
  - Applied behavioral analysis, intervention, and modification;
  - Motor planning; and
  - Sensory processing.

Autism spectrum disorders are payable as shown on the "Schedule of Benefits – Behavioral Health." *We* will not deny a service that would otherwise be a *covered expense* based on the location of the *qualified provider*.

COVERED EXPENSES - INFERTILITY

This "Covered Expenses – Infertility" section describes the services that will be considered *covered expenses* for *infertility* under the *master group contract.* Benefits will be paid as specified in the "How your master group contract works" provision of the "Understanding Your Coverage" section and as shown in the "Schedule of Benefits – Infertility." Refer to the "Schedule of Benefits" for any service not specifically listed in the "Schedule of Benefits – Infertility." Benefits are subject to any applicable:

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

All terms used in this benefit have the same meaning given to them in this *certificate*, unless otherwise specifically defined in this benefit. Refer to the "Limitations and Exclusions" provision in this section and the "Limitations and Exclusions" section listed in this *certificate* for *infertility services* not covered by the *master group contract.* All terms and provisions of the *master group contract* apply.

Definitions

Donor means an oocyte donor or sperm donor who is covered under this *master group contract.*

Infertility means a disease, condition or status characterized by:

- A *covered person's* inability to reproduce either as an individual or with the *covered person's* partner without medical intervention;
- A *health care practitioner's* determination based on the age, medical history, sexual and reproductive history, physical findings, or diagnostic testing results of the *covered person*; or
- The failure to establish a pregnancy or to carry a pregnancy to live birth after:

  - 12 months of regular, *unprotected sexual intercourse* for a woman age 35 or younger; or
  - Six months of regular, *unprotected sexual intercourse* for a woman over 35 years of age.

  Conception, which results in a miscarriage, does not restart the timeframes above.

Infertility services mean:

- Diagnosis and treatment of *infertility* including uterine embryo lavage, embryo transfer, artificial insemination, low tubal ovum transfer, injectable medication and infertility drugs.

- In vitro fertilization, intracytoplasmic sperm injection, gamete intrafallopian tube transfer or zygote intrafallopian tube transfer, if the following conditions have been met:

  - The *covered person* is unable to attain or sustain a pregnancy through less costly *infertility* treatments covered by *us.* This requirement will be waived in the event that the *covered person's* physician determines that the *covered person* has a medical condition that renders less costly *infertility* treatments useless;

- The *covered person* has not undergone four complete oocyte retrievals in a *year*; except, if a live birth follows a completed oocyte retrieval, two more completed oocyte retrievals will be covered. *We* will cover one attempt at fertilized egg implantation per oocyte harvest procedure. If an oocyte donor is used, then the completed oocyte retrieval performed on the *donor* will count against the *covered person* as one completed oocyte retrieval.

- The procedures are performed at medical facilities that conform to the American Society for Reproductive Medicine guidelines for in vitro fertilization clinics or minimum standards for programs of in vitro fertilization.

- Medical expenses of a *donor* for procedures utilized to retrieve oocytes or sperm, as well as a subsequent procedure to transfer the oocytes or sperm to the covered recipient.

Surrogate means a woman who carries a pregnancy for a woman who has infertility coverage as specified in this *master group contract.*

Unprotected sexual intercourse means sexual union without the use of any process, device or method that prevents conception, including but not limited to, oral contraceptives, chemicals, physical or barrier contraceptives, natural abstinence or voluntary permanent surgical procedures.

Health care practitioner office services

We will pay the following benefits for *covered expenses* incurred by *you* for *health care practitioner* office for *infertility services.*

Health care practitioner office visit

Covered expenses for *infertility services* include:

- Office visits.
- Diagnostic laboratory and radiology.
- Injections.
- *Surgery*, including anesthesia.
- Second surgical opinions.

Hospital services

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

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

COVERED EXPENSES - INFERTILITY (continued)

Hospital inpatient services

Covered expenses for *infertility services* 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*, unless:

  - The patient's stay in a private *hospital* room is medically necessary in terms of generally accepted medical practice; or
  - A private room or single-bed room is the only type of room available.

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

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

Hospital outpatient surgical services

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

Additional covered expenses

We will pay benefits for *medically necessary infertility services* rendered to a *donor* or *surrogate* on behalf of a *covered person* diagnosed with *infertility*. Such services include procedures to obtain and transfer eggs, sperm or embryos, physical examinations, laboratory screenings, psychological screenings, and *prescription* drugs. These *infertility services* will be paid based upon the location of the services and the type of provider.

Exclusions

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

- Reversal of voluntary sterilization;

COVERED EXPENSES - INFERTILITY (continued)

- Payment for medical services rendered to a *surrogate* for purposes of childbirth, other than *medically necessary infertility services*;

- Costs associated with cryopreservation and storage of sperm, eggs, and embryos, except when a necessary medical treatment may directly or indirectly cause *iatrogenic infertility* to a *covered person*; provided, subsequent procedures of a medical nature necessary to make use of the cryo preserved substance will not be similarly excluded if deemed non-experimental and non-investigational;

- Selected termination of an embryo; provided that where the life of the mother would be in danger were all embryos to be carried to full term, the termination is covered;

- Non-medical costs of an egg or sperm *donor*;

- Travel costs for travel within one hundred (100) miles of *your* home address as filed with *us.* Travel costs not *medically necessary*, not mandated or required by *us.*

- *Infertility* treatments deemed experimental in nature as determined by the written determination of the American Society for Reproductive Medicine. Except, where *infertility* treatment includes elements which are not experimental in nature along with those which are, to the extent services may be delineated and separately charged, those services which are not experimental in nature will be covered.

COVERED EXPENSES - PHARMACY SERVICES

This "Covered Expenses – Pharmacy Services" section describes *covered expenses* under the *master group contract* 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*. *We* will apply any third-party payments, financial assistance, discount, product vouchers, or any other reduction in out-of-pocket expenses made by *you* or on *your* behalf for *prescription* drugs toward *your deductible, copayment, cost sharing* responsibility, or *out-of-pocket limit*.

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 *master group contract* apply, including *prior authorization* requirements specified in the "Schedule of Benefits – Pharmacy Services" of this *certificate*.

Coverage description

We will cover *prescription* drugs on *our drug list* 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. *We* follow criteria established by the American Society of Addiction Medicine for any *prior authorization* and/or *step therapy* requirements applied to drugs, medicines or medications to treat *substance use disorders*.

Covered *prescription* drugs include:

- 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*.
- Immunosuppressant drugs to prevent the rejection of transplanted organs and tissues after a covered transplant.
- Drug therapies for *infertility*.
- Drugs for medically assisted treatment of *substance use disorders*.
- Opioid antagonists, including intranasal opioid reversal agents for opioid medically assisted treatment.
- Topical anti-inflammatory pain mediation approved by the FDA for acute and chronic pain.
- Insulin. *Your cost share* for a 30-day supply of a covered *prescription* insulin medication obtained from a *network pharmacy* will not exceed $100 per *prescription* fill or refill.
- *Diabetes supplies*.
- *Self-administered injectable drugs*.

- Epinephrine injectors.
- Inhalants.
- Topical eye medication.
- 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.
- 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 *master group contract, 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.

Prescription synchronization

We will cover a *prescription* dispensed by a *pharmacy* for less than a 30-day supply, when requested by *you,* to synchronize *your prescriptions* that treat a permanent or long-term *sickness* or *bodily injury.* Synchronizing *your prescriptions* is to align the dispensing of multiple *prescriptions* by a *pharmacy*. *Your* prescribing *health care practitioner* or the *pharmacist* will determine if synchronizing the fill or refill of *your prescription* is in *your* best interest. Synchronization of *prescription* refills is provided if all the following conditions are met:

- The *prescriptions* are a *covered expense* or approved by a formulary exceptions process;
- The *prescriptions* have available refill quantities at the time of synchronization;
- The *prescription* is not a Schedule II, III, or IV controlled substance;
- *You* meet all *prior authorization* or *step therapy* criteria specific to the *prescription* at the time of synchronization;
- The *prescriptions* are of a formulation that can be safely split into short-fill periods to achieve synchronization; and
- The *prescriptions* do not have special handling or sourcing needs that require a designated pharmacy to fill or refill the *prescription*.

The *cost share* for a partial supply of a *prescription* will be prorated when dispensed to synchronize *your prescriptions.*

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*. *We* follow criteria established by the American Society of Addiction Medicine for any *prior authorization* and/or *step therapy* requirements applied to drugs, medicines or medications to treat *substance use disorders*. Placement on the *drug list* does not guarantee *your health care practitioner* will prescribe that *prescription* drug, medicine or medication for a particular medical condition. *You* can obtain a copy of *our drug list* by visiting *our* website at www.humana.com or calling the customer service telephone number on *your* ID card.

Modification of prescription drug coverage

Prescription drug coverage is subject to change.

- The FDA approves new drugs throughout the *year*, *we* add some new drugs to the *drug list* on a monthly basis and certain drugs may be moved to a lower cost-sharing level on a monthly basis.
- Based on state law, advanced notice is required for the following modifications:
  - Removal of a drug from the *drug list*;
  - Requirement that *you* receive *prior authorization* for a drug;

- An imposed *step-therapy* restriction; or
- Moving a drug to a higher cost-sharing level unless a generic alternative to the drug is available.

These types of changes to *prescription* drug coverage will only be made by *us* annually. *We* will provide written notice no later than 60 days prior to the *effective date* of the change. Advance notice requirements are applied uniformly to all covered drugs including immunosuppressant drugs.

Access to medically necessary contraceptives

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

Access to non-formulary drugs

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

Non-formulary drug standard exception request

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

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

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

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

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

Non-formulary drug expedited exception request

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

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

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

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

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

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

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

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

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

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

Non-formulary drug exception request external review

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

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

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

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

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

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

Step therapy exception request

An exception for any clinically appropriate *prescription* drug can be requested by *you* or *your* appointed representative when *step therapy*:

- Has been ineffective in the treatment of *your* disease or medical condition;
- Is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance; or
- Has caused or, based on sound medical evidence, is likely to cause an adverse reaction or harm to *you.*

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

- 24 hours for an expedited request.
- 72 hours for a standard request.

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

- The required *prescription* drug is contraindicated;
- *You* have tried the required *prescription* drug and the *health care practitioner* submits evidence of failure or intolerance;
- *You* are stable on a *prescription* drug selected by *your health care practitioner* for the medical condition under consideration; or
- The *prescription* drug is for the treatment of stage 4 advanced metastatic cancer and coverage is consistent with best practices for the treatment of stage 4 advanced metastatic cancer, supported by peer-reviewed medical literature.

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 Appeal Procedures" section of this *certificate.*

Dose restriction exception request

An exception for any clinically appropriate *prescription* drug can be requested by *you* or *your* appointed representative when the number of doses available under a dose restriction for the *prescription* drug:

- Has been ineffective in the treatment of *your* disease or medical condition; or
- Is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance.

We will respond to an exception request within:

- 24 hours after receipt of an expedited exception request.
- 72 hours after receipt of a standard exception request.

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

- The reason for the denial; and
- The right to appeal *our* decision as described in the "Complaint and Appeal Procedures" provision in this *certificate.*

LIMITATIONS AND EXCLUSIONS

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

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

- Treatments, services, supplies, or *surgeries* that are not *medically necessary*, except *preventive services*.
- A *sickness* or *bodily injury* arising out of any employment for wage, gain or profit for which the *employer* provides Workers' Compensation or similar coverage. If a Workers' Compensation or similar law requires coverage for the employment, this exclusion applies whether or not *you* have Workers' Compensation coverage.
- Care and treatment given in a *hospital* owned or run by any government entity, unless *you* are legally required to pay for such care and treatment. However, care and treatment provided by military *hospitals* to *covered persons* who are armed services retirees and their *dependents* are not excluded.
- Any service furnished while *you* are *confined* in a *hospital* or institution owned or operated by the United States government or any of its agencies for any military service-connected *sickness* or *bodily injury*.
- Services, or any portion of a service, for which no charge is made.
- Services, or any portion of a service, *you* would not be required to pay for, or would not have been charged for, in the absence of this coverage.
- Any portion of the amount *we* determine *you* owe for a services that the provider waives, rebates or discounts, including *your copayment, deductible* or *coinsurance*.
- *Sickness* or *bodily injury* for which *you* are in any way paid or entitled to payment or care and treatment by or through a government program.
- Any service not ordered by a *health care practitioner*.
- Any service not rendered by the billing provider.
- Any service not substantiated in the medical records of the billing provider.
- Any amount billed for a professional component of an automated:
  - Laboratory service; or
  - Pathology service.
- Education or training, except for *diabetes self-management training* and *habilitative services.*

LIMITATIONS AND EXCLUSIONS (continued)

- 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, device, medical treatment, or procedure which is *experimental, investigational or for research purposes*.

- Vitamins, except for *preventive services* with a *prescription* from a *health care practitioner*, dietary supplements, and dietary formulas, except enteral formulas, nutritional supplements or low protein modified food products for the treatment of an inherited metabolic disease, e.g. phenylketonuria (PKU).

- Over-the-counter, non-prescription medications, except for all FDA approved medications for the treatment of tobacco dependence, unless for drugs, medicines or medications or supplies on the Preventive Medication Coverage *drug list* with a *prescription* from a *health care practitioner*.

- Over-the-counter medical items or supplies that can be provided or prescribed by a *health care practitioner* but are also available without a written order or *prescription*, except for *preventive services*.

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

- *Prescription* drugs and *self-administered injectable* drugs, except: 1) as specified in the "Covered Expenses – Pharmacy Services" section in this *certificate*; or 2) unless administered to *you*:

  a) While an *inpatient* in a *hospital*, *skilled nursing facility*, *health care treatment facility*, or *residential treatment facility*;
  b) By the following, when deemed appropriate by *us*:

  - A *health care practitioner*:

    - During an office visit; or
    - While an *outpatient*; or

  - A *home health care agency* as part of a covered *home health care plan*.

- Certain *specialty drugs* administered by a *qualified provider* in a *hospital's outpatient* department, except as specified in the "Access to non-formulary drugs" provision in the "Covered Expenses - Pharmacy Services" section of this *certificate*.

- Services received in an emergency room, unless required because of *emergency care* or charges for examination and testing for criminal sexual assault.

- 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*.
- In vitro fertilization unless for *infertility services*.
- Reversal of elective sterilization.
- Services for or in connection with a transplant or *immune effector cell therapy* if:
  - The expense relates to storage of cord blood and stem cells, unless it is an integral part of a transplant approved by *us*.
  - Not approved by *us*, based on *our* established criteria.
  - Expenses are eligible to be paid under any private or public research fund, government program except *Medicaid*, or another funding program, whether or not such funding was applied for or received.
  - The expense relates to the transplantation of any non-human organ or tissue, unless otherwise stated in the *master group contract*.
  - The expense relates to the donation or acquisition of an organ or tissue for a recipient who is not covered by *us*.
- Services provided for:
  - Immunotherapy for recurrent abortion;
  - Chemonucleolysis;
  - Sleep therapy;
  - Light treatments for Seasonal Affective Disorder (S.A.D.);
  - Immunotherapy for food allergy;
  - Prolotherapy; or
  - Sensory integration therapy.
- *Cosmetic surgery* related services and supplies, except for the correction of *congenital anomalies* or for conditions resulting from *bodily injury*, *infection* or other disease of the involved part.
- Hair prosthesis, hair transplants or implants and wigs.
- Dental services, appliances or supplies for treatment of the teeth, gums, jaws, or alveolar processes, including but not limited to, any *oral surgery*, *endodontic services* or *periodontics*, implants and related procedures, orthodontic procedures, and any dental services related to a *bodily injury* or *sickness* unless otherwise stated in this *certificate*.
- The following types of care of the feet, unless otherwise stated in this *certificate*:
  - 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.

- *Custodial care* and *maintenance care*.

- Any loss that in any way results from or is 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). *We* will not exclude *medically necessary* services that are a result of or related to an injury while a *covered person* is intoxicated or under the influence of any narcotic, regardless of whether the intoxicant or narcotic is administered on the advice of a *health care practitioner*.

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

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

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

  - Common household items including air conditioners, air purifiers, water purifiers, vacuum cleaners, waterbeds, hypoallergenic mattresses or pillows, or exercise equipment;
  - Motorized transportation equipment (e.g. scooters), escalators, elevators, ramps, or modifications or additions to living/working quarters or transportation vehicles;
  - Personal hygiene equipment including bath/shower chairs, transfer equipment or supplies or bed side commodes;
  - Personal comfort items including cervical pillows, gravity lumbar reduction chairs, swimming pools, whirlpools, spas, or saunas;
  - Medical equipment including:

    - Blood pressure monitoring devices, unless prescribed by a *health care practitioner* for *preventive services* and ambulatory blood pressure monitoring is not available to confirm diagnosis of hypertension;

  - PUVA lights; and
  - Stethoscopes;
- Communication systems, telephone, television, or computer systems and related equipment or similar items or equipment;
- Communication devices, except after surgical removal of the larynx or a diagnosis of permanent lack of function of the larynx.

- 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.
- Weight loss products or services, except *bariatric 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.
- *Alternative medicine*, except *naprapathic services* provided under the "Covered Expenses" section in this *certificate.*
- Acupuncture, unless:
  - The treatment is *medically necessary*, appropriate and is provided within the scope of the acupuncturist's license; and
  - *You* are directed to the acupuncturist for treatment by a licensed physician.
- Services rendered in a premenstrual syndrome clinic or holistic medicine clinic.
- Services of a midwife, unless the midwife is licensed.
- Vision examinations or testing for the purposes of prescribing corrective lenses, except *comprehensive eye exams* provided under the "Covered Expenses – Pediatric Vision Care" section in this *certificate.*
- Orthoptic/vision training (eye exercises).
- Radial keratotomy, refractive keratoplasty or any other *surgery* or procedure to correct myopia, hyperopia or stigmatic error.

LIMITATIONS AND EXCLUSIONS (continued)

- The purchase or fitting of eyeglasses or contact lenses, except as:

  - The result of an *accident* or following cataract *surgery* as stated in this *certificate*.
  - Otherwise specified in the "Covered Expenses – Pediatric Vision Care" section in this *certificate.*

- Services and supplies which are:

  - Rendered in connection with mental illnesses not classified in the 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 disorder.

- Marriage counseling, unless related to *mental health services.*

- Expenses for:

  - Employment;
  - School;
  - Sport;
  - Camp;
  - Travel; or
  - The purposes of obtaining insurance, unless performed during a *covered person's* wellness visit.

- 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 *master group contract.* Coverage will be extended as described in the "Extension of Benefits" section, as required by state law.

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

LIMITATIONS AND EXCLUSIONS - PHARMACY SERVICES

This "Limitations and Exclusions – Pharmacy Services" section describes the limitations and exclusions under the *master group contract* 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*.
- *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.

  The following will not be excluded:

  - *Long-term antibiotic therapy* for the treatment of a *tick-borne disease* if the drug has been approved by the FDA.
  - Drugs for the treatment of cancer will not be excluded on the basis that the drug has been prescribed for the treatment of a type of cancer for which the drug has not been approved by the FDA. The drug must be approved by the FDA and must be recognized for the treatment of the specific cancer for which the drug has been prescribed in any one of the following established reference compendia:
    - The American Medical Association Drug Evaluations;
    - The American Hospital Formulary Service Drug Information;
    - The United States Pharmacopeia Drug Information; or
    - If not in the compendia, the drug must be recommended for that particular type of cancer in formal clinical studies for which results have been published in at least two peer reviewed professional medical journals published in the United States or Great Britain.
- Any drug prescribed for a *sickness* or *bodily injury* not covered under the *master group contract*.

LIMITATIONS AND EXCLUSIONS - PHARMACY SERVICES (continued)

- Any drug, medicine or medication that is either:

  - Labeled "Caution - limited by federal law to investigational use;" or
  - *Experimental, investigational or for research purposes,*

  even though a charge is made to *you.*

- Allergen extracts.

- Therapeutic devices or appliances, including, but not limited to:

  - Hypodermic needles and syringes (except when prescribed by a *health care practitioner* for use with insulin and *self-administered injectable drugs*, whose coverage is approved by *us*);
  - Support garments;
  - Test reagents;
  - Mechanical pumps for delivery of medications; and
  - Other non-medical substances.

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

- 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.

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

- Any drug used for the purpose of weight loss.

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

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

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

  - Insulin; and

  - Drugs, medicines or medications and supplies on the Preventive Medication Coverage *drug list,* including over-the-counter FDA approved tobacco cessation mediations, when obtained from a *network pharmacy* with a *prescription* from a *health care practitioner*.

LIMITATIONS AND EXCLUSIONS - PHARMACY SERVICES (continued)

- 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.

- Any drug prescribed for impotence and/or sexual dysfunction, unless *medically necessary.*

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

- The administration of covered medication(s).

- *Prescriptions* that are to be taken by or administered to *you* 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* to be dispensed by or administered in a *pharmacy*;
  - 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.

LIMITATIONS AND EXCLUSIONS - PHARMACY SERVICES (continued)

- Any portion of a *prescription* fill or refill that:
  - Exceeds *our* drug-specific *dispensing limit*;
  - Exceeds the duration-specific *dispensing limit*;
  - Is dispensed to a *covered person*, whose age is outside the drug-specific age limits; or
  - Is refilled early, except for *prescription* refills of an inhalant or a topical ophthalmic medication. Early refills will not be denied for:
    - An inhalant, used to enable a *covered person* to breathe when suffering from asthma or other life-threatening bronchial ailments, if the inhalant has been ordered or prescribed by the treating *health care practitioner* and is medically appropriate.
    - A topical ophthalmic medication when:
      - The medication is to treat a chronic eye condition;
      - The refill is requested by the *covered person* prior to the last day of the prescribed dosage period and after at least 75% of the predicted days of use; and
      - The prescribing *health care practitioner* on the original *prescription* that refills are permitted and the early refills requested by the *covered person* do not exceed the total number of refills prescribed.
- Any drug for which *we* require *prior authorization* or *step therapy* and it is not obtained.
- Any drug for which a charge is customarily not made.
- Any drug, medicine or medication received by *you*:
  - Before becoming covered; or
  - After the date *your* coverage has ended.
- Any costs related to the mailing, sending or delivery of *prescription* drugs.
- Any intentional misuse of this benefit, including prescriptions purchased for consumption by someone other than *you.*
- Any *prescription* fill or refill for drugs, medicines or medications that are lost, stolen, spilled, spoiled, or damaged.
- Drug delivery implants and other implant systems or devices.
- Any amount *you* paid for a *prescription* that has been filled, regardless of whether the *prescription* is revoked or changed due to adverse reaction or change in dosage or *prescription*.
- *Prescriptions* filled at a *non-network pharmacy*, except for *prescriptions* required during an emergency.

ELIGIBILITY AND EFFECTIVE DATES

Eligibility date

Employee eligibility date

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

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

Dependent eligibility date

Each *dependent* is eligible for coverage on:

- The date the *employee* is eligible for coverage, if he or she has *dependents* who may be covered on that date;
- The date of the *employee's* marriage or becoming a *partner to a civil union* or a *domestic partner*, if the *employer* includes *domestic partners* on the Employer Group Application 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*;
- The date the *employee* gains temporary care of a foster child; 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 *master group contract* may enroll for coverage as specified in the enrollment provisions outlined below.

Employee enrollment

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

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

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

Dependent enrollment

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

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

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

Newborn and adopted dependent enrollment

A newborn *dependent* will be covered from the moment 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.

ELIGIBILITY AND EFFECTIVE DATES (continued)

Special enrollment

Special enrollment is available if the following apply:

- *You* have a change in family status due to:
  - Marriage;
  - Divorce;
  - Becoming a *partner to a civil union* or a *domestic partner*, if the *employer* includes *domestic partners* on the Employer Group Application;
  - 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;
  - Gaining temporary care of a foster child; and
  - You enroll within 31 days after the *special enrollment date*; or

- You are an *employee* or *dependent* eligible for coverage under the *master group contract,* and:
  - 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 *master group contract*; and
  - You enroll within 31 days after the *special enrollment date*; or

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

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

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

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

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

Dependent special enrollment

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

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

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

Open enrollment

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

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

Effective date

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

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.*

The *effective date* of coverage for a foster child is the date the *employee* gains temporary care of the child, if the foster child is not a *late applicant*.

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

Open enrollment effective date

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

Retired employee coverage

Retired employee eligibility date

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

Retired employee enrollment

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

Retired employee effective date

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

Effects of Medicare

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 and described in the "Coordination of Benefits" section of this *certificate.*

REPLACEMENT OF COVERAGE

Applicability

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

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

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

Deductible credit

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

- Incurred in the same calendar year the *master group contract* first becomes effective; and
- Was 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 *group plan sponsor's* Prior Plan on the day that it ended, any period of time that the *employee* satisfied will be applied to the appropriate *waiting period* under the *master group contract*, if any. The *employee* will then be eligible for coverage under the *master group contract* when the balance of the *waiting period* has been satisfied.

Out-of-pocket limit

Any medical expense 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 *master group contract* if the medical expense was incurred in the same calendar year the *master group contract* first becomes effective.

TERMINATION PROVISIONS

Termination of coverage

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

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

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

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

Otherwise, coverage terminates on the earliest of the following:

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

Termination for cause

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

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

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

Reinstatement

If the required premium is not paid by the end of the grace period and the *master group contract* is terminated, the *master group contract* may be reinstated at *our* option.

Reinstatement must be submitted in writing by the *group plan sponsor* within 45 days of the termination date, is subject to *our* approval and payment of any overdue premiums.

EXTENSION OF BENEFITS

Extension of coverage for total disability

We extend limited coverage if:

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

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

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

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

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

CONTINUATION

Continuation options in the event of termination

If coverage terminates:

- It may be continued as described in the "State continuation of coverage" provision; or
- It may be continued as described in the "Continuation of coverage for dependents due to divorce, death or retirement of the employee" provision, if applicable; or
- It may be continued as described in the "Continuation for dependent children" provision, if applicable; or
- It may be continued under the continuation provisions as provided by the Consolidated Omnibus Budget Reconciliation Act (COBRA), if applicable.

A complete description of the "State continuation of coverage," "Continuation of coverage for dependents," and "Continuation for dependent children" provisions follow.

State continuation of coverage

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

If *your* medical coverage under the *master group contract* terminates due to loss of employment, or reduction in normal working hours, *you* may continue medical coverage for *you* and *your* covered *dependents* if:

- *You* were covered under the *master group contract* for at least three consecutive months prior to termination; and
- *You* are not eligible for *Medicare* or other group coverage.

However, *you* and *your dependents* are NOT eligible for continuation of medical coverage if *you* were discharged from *your* employment due to commission of a felony or a theft in connection with *your* work and for which the *employer* was in no way responsible, provided that *you* have admitted to commission of the felony or theft or have been convicted or received an order of supervision by a court of competent jurisdiction for such act.

Enrollment

The *group plan sponsor* will notify *you* in writing of *your* right to continue coverage. If *you* elect to continue coverage *you* must notify the *group plan sponsor* in writing within 30 days following the later of:

- The date *your* coverage would otherwise terminate; or
- The date *you* received written notification of *your* right to continue coverage.

Under no circumstances will *you* be eligible to elect continuation of coverage more than 60 days after the date *your* coverage would have otherwise terminated.

CONTINUATION (continued)

If *you* elect to continue coverage *you* must pay the total monthly premium in advance to the *group plan sponsor*. The premium for continuing *your* coverage will be the rate that would have been applicable to the *group plan sponsor* for *your* group coverage during the continuation period.

If *you* do not choose to continue *your* group medical coverage, or if *you* do and it terminates, *you* have the right to exercise the Medical Conversion Privilege described in this *certificate.* However, if *you* do not elect to continue coverage and instead utilize the Medical Conversion Privilege, *you* thereby waive the right to continue coverage. The Medical Conversion Privilege is available to *your* covered dependents while *you* are insured under this continuation privilege.

Termination

Medical coverage may be continued until the earliest of the following:

- 12 months after the date *your* coverage would otherwise have terminated;
- The end of any month for which *you* fail to make timely payment of premiums, or timely payment of premiums is not made on *your* behalf by the *group plan sponsor*. The *group plan sponsor* is responsible for sending *us* the premium payments for those individuals who choose to continue their coverage. If the *group plan sponsor* fails to make proper payment of the premiums to *us, we* are relieved of all liability for any coverage that was continued and the liability will rest with the *group plan sponsor*;
- The date the *group* coverage terminates in its entirety. If group coverage is replaced, coverage will continue under the new master group contract;
- The date on which the *covered person* is, or could be, covered under *Medicare*;
- The date on which the *covered person* is eligible or is covered for similar benefits under another group plan;
- For *your dependent,* the date he or she no longer meets the definition of *dependent.*

If the *employee* returns to *active status* while insured under this continuation privilege, he or she must reenroll for *employee* coverage.

Continuation of coverage for dependents due to divorce, death or retirement of the employee

Continuation of coverage is available for *dependents* that are no longer eligible for the coverage provided by the *master group contract* because of:

- The death of the covered *employee*;
- The retirement of the covered *employee*; or
- The severance of the family relationship through legal annulment, dissolution of marriage or divorce.

CONTINUATION (continued)

You may continue medical coverage for *you* and *your* covered *dependents* if *you*:

- Give the *group plan sponsor* written notice within 30 days after the date *your* coverage would have otherwise terminated;
- Elect to continue group medical coverage within 30 days after receipt of written notice of *your* right to continue coverage; and
- Pay the total monthly premium in advance to the *group plan sponsor*. The premium for continuing *your* coverage will be the rate that would have been applicable to the *group plan sponsor* for *your* group coverage during the continuation period. In the case that coverage would be continued for more than 2 years, an additional administrative fee may be charged, but it will not exceed 20% of the total costs of administration.

Termination

If the former spouse has not attained the age of 55 at the time the continued coverage begins, coverage may be continued until the earliest of the following:

- Two years after the date the continued coverage began;
- The date the former spouse remarries;
- The end of any month for which *you* fail to make timely payment of premiums, or timely payment of premiums is not made on *your* behalf by the *group plan sponsor*;
- The date coverage would have terminated under the terms of the existing *master group contract*, if the *employee* and former spouse were still married to each other; except that the continued coverage shall not be modified or terminated during the first 120 days following the divorce or death of the *employee* unless the *master group contract* is modified or terminated as to all *employees*;
- The date the *group* coverage terminates in its entirety. If group coverage is replaced, coverage will continue under the new master group contract;
- The date the former spouse first becomes an insured employee under any other group health plan after the date of election of continued coverage; or
- For a dependent child, the date no longer qualified as a dependent.

If the former spouse or retiree's spouse has attained the age of 55 at the time the continued coverage begins, coverage may be continued until the earliest of the following:

- The date the former spouse or retiree's spouse remarries;
- The end of any month for which *you* fail to make timely payment of premiums, or timely payment of premiums is not made on *your* behalf by the *group plan sponsor*;

- The date coverage would have terminated, except due to the retirement of an *employee*, under the terms of the existing *master group contract*, if the *employee* and former spouse were still married to each other; except that the continued coverage shall not be modified or terminated during the first 120 days following the divorce, death or retirement of the *employee* unless the *master group contract* is modified or terminated as to all *employees*;

- The date the *group* coverage terminates in its entirety. If group coverage is replaced, coverage will continue under the new master group contract;

- The date the former spouse or retiree's spouse first becomes an insured employee under any other group health plan after the date of election of continued coverage; or

- For a dependent child, the date no longer qualified as a *dependent*; or

- The date the former spouse or retiree's spouse reaches the qualifying age or otherwise becomes eligible for *Medicare*.

Continuation for dependent children

If *your* (the covered *dependent* child's) medical coverage under this *master group contract* terminates, either due to death of the *employee* or due to attaining the limiting age as stated in this *certificate*, *you* may continue medical coverage if *you* (or the responsible adult acting on *your* behalf):

- Give the *group plan sponsor* written notice within 30 days after the date *your* coverage would otherwise terminate;

- Elect to continue group medical coverage within 30 days after receipt of written notice of *your* right to continue coverage; and

- Pay the total monthly premium in advance to the *group plan sponsor*. The premium for continuing *your* coverage will be the rate that would have been applicable to the *group plan sponsor* for *your* group coverage during the continuation period.

Termination

Coverage may be continued until the earliest of the following:

- Two years after the date the continued coverage began;
- The end of any month for which *you* fail to make timely payment of premiums, or timely payment of premiums is not made on *your* behalf by the *group plan sponsor*;
- The date coverage would have terminated under the terms of the existing *master group contract* if *you* were still an eligible *dependent* of the *employee*; or
- The date *you* first become an insured employee under any other group health plan after the date of election of continued coverage.

COORDINATION OF BENEFITS

Applicability

This "Coordination of Benefits" (COB) provision applies when a *covered person* has health care coverage under more than one *plan*. The order of benefit determination rules below determine which *plan* will pay as the *primary plan*. The *primary plan* pays first without regard to the possibility another *plan* may cover some expenses. A *secondary plan* pays after the *primary plan* and may reduce the benefits it pays so that payments from all *plans* do not exceed 100% of the total *allowable expense*.

Definitions

The following definitions are used exclusively in this provision.

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

Plan includes:

- Individual or group insurance coverage, health maintenance organization (HMO) contracts, closed panel or other forms of group or group-type coverage (whether insured or uninsured);
- Medical care components of long-term care contracts, such as skilled nursing care;
- Medical benefits under individual or group automobile contracts, including "No Fault" and Medical Payments coverages; and
- *Medicare* or other governmental benefits, as permitted by law.

Plan does not include:

- Hospital indemnity benefits;
- Accident only coverage;
- Specified disease or specified accident coverage;
- Limited benefit health coverage;
- School accident-type coverages that cover students for accidents only, including athletic injuries, either on a 24-hour basis or on a "to and from school" basis;
- Benefits provided in long-term care insurance policies for non-medical services, for example, personal care, adult day care, homemaker services, assistance with activities of daily living, respite care and custodial care, or for contracts that pay a fixed daily benefit without regard to expenses incurred or the receipt of services;
- Medicare supplement policies;
- A state plan under *Medicaid*;

- Coverage under other governmental plans, unless permitted by law; or
- Disability income protection coverage.

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

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

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

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

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

- If a *covered person* is confined in a private *hospital* room, the difference between the cost of a semi-private room in the *hospital* and the private room is not an *allowable expense*, unless:
  - The patient's stay in a private *hospital* room is medically necessary in terms of generally accepted medical practice; or
  - A private room is the only type of room available.
- If a person is covered by two or more *plans* that compute their benefits payments on the basis of usual and customary fees, any amount in excess of the highest usual and customary fees for a specific benefit is not an *allowable expense*.
- If a person is covered by two or more *plans* that provide benefits or services on the basis of negotiated fees, any amount in excess of the highest of the fees is not an *allowable expense*.
- If a person is covered by one *plan* that calculates its benefits or services on the basis of usual and customary fees and another *plan* that provides its benefits or services on the basis of negotiated fees, the *primary plan's* payment arrangement shall be the *allowable expense* for all *plans*.
- The amount a benefit is reduced by the *primary plan* because a *covered person* does not comply with the *plan* provisions. Examples of these provisions are second surgical opinions, precertification of admissions and preferred provider arrangements.

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

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

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

Order of determination rules

General

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

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

Rules

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

- **Non-dependent or *dependent*.** The *plan* that covers the person other than as a *dependent*, for example as an *employee*, member, subscriber or retiree is *primary* and the *plan* that covers the person as a *dependent* is *secondary*. However, if the person is a *Medicare* beneficiary and, as a result of federal law, *Medicare* is *secondary* to the *plan* covering the person as a *dependent*; and *primary* to the *plan* covering the person as other than a *dependent* (e.g. retired *employee*); then the order of benefits between the two *plans* is reversed so that the *plan* covering the person as an *employee*, member, subscriber or retiree is *secondary* and the other *plan* is *primary*.

COORDINATION OF BENEFITS (continued)

- **Dependent child covered under more than one *plan***. The order of benefits when a child is covered by more than one *plan* is:

  - The *primary plan* is the *plan* of the parent whose birthday is earlier in the year if:

    - The parents are married;
    - The parents are not separated (whether or not they have been married); or
    - A court decree awards joint custody without specifying that one parent has the responsibility to provide health care coverage.

  - If both the parents have the same birthday, the *plan* that covered either of the parents longer is *primary*.

  - If the specific terms of a court decree state that one parent is responsible for the child's health care expenses or health care coverage and the *plan* of that parent has actual knowledge of those terms, that *plan* is *primary*. This rule applies to *claim determination periods* or plan years commencing after the *plan* is given notice of the court decree.

  - If the parents are not married, or are separated (whether or not they ever have been married) or are divorced, the order of benefits is:

    - The *plan* of the *custodial parent*;
    - The *plan* of the spouse of the *custodial parent*;
    - The *plan* of the non-*custodial parent*; and then
    - The *plan* of the spouse of the non-*custodial parent.*

- **Young adult/Dependent**. For a *dependent* child who has coverage under either or both parents' plans and also has his or her own coverage as a *dependent* under a spouse's plan, the **longer or shorter length of coverage** applies. In the event the *dependent* child's coverage under the spouse's plan began on the same date as the *dependent* child's coverage under either or both parents' plans, the order of benefits shall be determined by applying the birthday rule to the *dependent* child's parent or parents and the *dependent's* spouse.

- **Active or inactive *employee***. The *plan* that covers a person as an *employee*, who is neither laid off nor retired, is *primary*. The same would hold true if a person is a *dependent* of a person covered as a retiree and an *employee.* If the other *plan* does not have this rule, and if, as a result, the *plans* do not agree on the order of benefits, this rule is ignored.

- **Continuation coverage**. If a person whose coverage is provided under a right of continuation provided by federal or state law also is covered under another *plan*, the *plan* covering the person as an *employee*, member, subscriber or retiree (or as that person's *dependent*) is *primary*, and the continuation coverage is *secondary*. If the other *plan* does not have this rule, and if, as a result, the *plans* do not agree on the order of benefits, this rule is ignored.

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

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

Effects on the benefits of this plan

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

The difference between the benefit payments that this *plan* would have paid had it been the *primary plan*, and the benefit payments that it actually paid or provided shall be recorded as a benefit reserve for the *covered person* and used by this *plan* to pay an *allowable expense*, not otherwise paid during the *claim determination period*. As each claim is submitted, this *plan* will determine:

- Its obligation to pay or provide benefits under its contract;
- Whether a benefit reserve has been recorded for the *covered person*; and
- Whether there are any unpaid *allowable expenses* during the *claim determination period*.

If there is a benefit reserve, the *secondary plan* will use the *covered person's* benefit reserve to pay up to 100% of total *allowable expenses* incurred during the *claim determination period*. At the end of the *claim determination period*, the benefit reserve returns to zero. A new benefit reserve must be created for each new *claim determination period*.

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

Right to receive and release needed information

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

Facility of payment

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

Right of recovery

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

CLAIMS

Notice of claim

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

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

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

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

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

Written notice of claim should be submitted to *us* within 20 days of the occurrence or commencement of any loss. The forms necessary for filing proof of loss are available at www.humana.com. When requested by *you*, *we* will send *you* the forms for filing proof of loss. If the requested forms are not sent to *you* within 15 days, *you* will have met the proof of loss requirements by sending *us* a written or *electronic* statement of the nature and extent of the loss containing the above elements within the time limit stated in the "Proof of loss" provision.

Proof of loss

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

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

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. *Your qualified provider* may access *our* claims processing edits and claims payment policies on *our* website at www.humana.com by clicking on "For Providers" and "Claims Resources."

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

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

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

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

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

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

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

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

Right to require medical examinations

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

To whom benefits are payable

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

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 if for the amount *we* owe if:

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

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

Except as specified 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.

In the event of the *covered person's* death, benefits shall be payable to the designated beneficiary. If no such designation exists, benefits will be payable to the estate of the *covered person.*

We will rely upon an affidavit to determine benefit payment, unless *we* receive written notice of valid claim before payment is made. The affidavit will release *us* from further liability. Any payment made by *us* in good faith will fully discharge *us* to the extent of such payment.

Time of payment of claims

Payments due under the *master group contract* will be paid no more than 30 days after receipt of written or *electronic* proof of loss.

If *we* fail to make payment within 30 days after *our* receipt of complete proof of loss, *we* will pay interest at a rate of 9% per year from the 30th day.

Right to request overpayments

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

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

We reserve the right to adjust any amount applied in error to the *deductible, out-of-pocket limit* or *copayment limit*, if any. In no event will *we* attempt to recover any *copayment, deductible* or *coinsurance* amounts paid by *you* and/or any part on *your* behalf.

Right to collect needed information

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

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

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

Exhaustion of time limits

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

Recovery rights

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

Duty to cooperate in good faith

You are obligated to cooperate with *us* and *our* agents in order to protect *our* recovery rights. Cooperation includes promptly notifying *us you* may have a claim, providing *us* relevant information, and signing and delivering such documents as *we* or *our* agents reasonably request to secure *our* recovery rights. *You* agree to obtain *our* consent before releasing any party from liability for payment of medical expenses.

You agree to provide *us* with a copy of any summons, complaint or any other process served in any lawsuit in which *you* seek to recover compensation for *your* injury and its treatment.

You 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.

Duplication of benefits/other insurance

We will not provide duplicate coverage for benefits under the *master group contract* 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* and shall be considered secondary, except where specifically prohibited. 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.

We will not duplicate coverage under the *master group contract* whether or not *you* have made a claim under the other applicable coverage.

Workers' compensation

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

If benefits are paid by *us*, and 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. In no event will *we* attempt to recover any *copayment, deductible* or *coinsurance* amounts paid by *you* and/or any part on *your* behalf.

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

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

- The Workers' Compensation carrier does not accept responsibility to provide benefits;
- There is no final determination that *bodily injury* or *sickness* was sustained in the course of, or resulted from, *your* employment;

- The amount of Workers' Compensation due to medical or health care is not agreed upon or defined by *you* or the Workers' Compensation carrier; or
- Medical or health care benefits are specifically excluded from the Workers' Compensation settlement or compromise.

As a condition to receiving benefits from *us*, *you* hereby agree, in consideration for the coverage provided by the *master group contract*, *you* will notify *us* of any Workers' Compensation claim *you* make, and *you* agree to reimburse *us* as described above. If *we* are precluded from exercising *our* recovery rights to recover from funds that are paid by Workers' Compensation or similar coverage *we* will exercise *our* right to recover against *you.* In no event will *we* attempt to recover any *copayment, deductible* or *coinsurance* amounts paid by *you* and/or any part on *your* behalf.

Right of subrogation

We are assigned the right to recover from the negligent third party, or his or her insurer, including self-insured entities, to the extent of the benefits *we* paid for that *sickness* or *bodily injury*. *You* are required to furnish any information or assistance, or provide any documents that *we* may reasonably require in order to exercise *our* rights under this provision. This provision applies whether or not the third party admits liability. *We* shall have first priority to recover benefits *we* have paid from any funds that are paid or payable as a result of any *sickness* or *bodily injury*, regardless of whether available funds are sufficient to fully compensate *you* for *your sickness* or *bodily injury.*

Right of reimbursement

If a *covered person* recovers expenses for a *sickness* or *bodily injury* that occurred due to the negligence of a third party, *we* have the right to first reimbursement for all benefits *we* paid from any and all damages collected from the negligent third party for those same expenses whether by action at law, settlement, or compromise, by the *covered person* (or the *covered person's* parents if the *covered person* is a minor), or the *covered person's* legal representative as a result of that *sickness* or *bodily injury*. *You* agree to furnish any information, or provide any documents that *we* may reasonably require in order to exercise *our* rights under this provision. This provision applies whether or not the third party admits liability. In no event will *we* attempt to recover any *copayment, deductible* or *coinsurance* amounts paid by *you* and/or any part on *your* behalf.

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 share the cost of legal fees or expenses incurred by *you* under any Common Fund or similar doctrine unless *we* were given timely notice of the claim and an opportunity to protect *our* own interests and *we* failed or declined to do so.

COMPLAINT AND APPEAL PROCEDURES

Definitions

The following definitions are used exclusively in this provision:

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 of *your* eligibility to participate in the plan or health insurance coverage;
- A determination that the benefit is not covered;
- The imposition of a source-of-injury exclusion, network exclusion, or other limitation on otherwise covered benefits; or
- A determination that a benefit is experimental or investigational or not *medically necessary* or appropriate.

An *adverse benefit determination* also includes any rescission of coverage.

In addition, an *adverse benefit determination,* also includes an *adverse determination.*

Adverse determination means:

- A determination by *us* that a request for a benefit under this *master group contract* does not meet *our* requirements for medical necessity, appropriateness, healthcare setting, level of care, or effectiveness or is determined to be experimental or investigational, and the requested benefit is denied, reduced, or terminated, or full payment is not made for the benefit;

- Claims protected under the Federal No Surprises Act; or

- A rescission of coverage determination due to intentional fraud or misrepresentation. This does not include a cancellation or discontinuance of coverage that is attributable to a failure to timely pay required premiums.

Appeal means a formal request, either orally or in writing, for reconsideration of an *adverse benefit determination.*

Authorized representative (AR) means:

- A person to whom a *covered person* has given written consent to represent the *covered person*;

- A person authorized by law to provide substituted consent for a *covered person*;

- The *covered person's* family member when the *covered person* is unable to provide consent;

- A *health care practitioner* when the *covered person's master group contract* requires that a request for a benefit under the *covered person's master group contract* be initiated by their *health care practitioner*; or in the case of an urgent care request, a *health care practitioner* with knowledge of the *covered person's* medical condition.

Concurrent review means a review conducted during a *covered person's* stay or course of treatment in a *health care treatment facility*, the *health care practitioner's* office or other inpatient or outpatient healthcare setting.

Director means the Director of the Department of Insurance.

Final adverse determination means an *adverse determination* involving a *covered expense* that has been upheld by *us*, or *our* designee utilization review organization, at the completion of *our* internal *appeal* process.

Grievance means a written complaint from a *covered person* or their *authorized representative* expressing dissatisfaction with any administrative aspect of the plan, including a previous problem that is not resolved to the satisfaction of the *covered person* or their *authorized representative*, other than a claim or service denial.

Independent review organization (IRO) means an organization, approved by the Illinois Department of Insurance that conducts independent external reviews of *adverse determinations* and *final adverse determinations.*

Postpartum means the 12-month period after a *covered person* has delivered a baby.

Prospective review means a review conducted prior to an admission, the provision of a healthcare service or a course of treatment in accordance with *our* requirement that the healthcare service or course of treatment be preauthorized.

Retrospective review means any review of a request for a benefit that is not a *concurrent review* or *prospective review* request. *Retrospective review* does not include the review of a claim that is limited to error of documentation or accuracy of coding.

Contact information

You or *your authorized representative* have the right to file a complaint with the Illinois Department of Insurance at:

Illinois Department of Insurance
Office of Consumer Health Insurance
320 W. Washington Street
Springfield, IL 62767
Toll-free phone: 1-866-445-5364
Fax: 217-558-2083
Email: consumer_complaints@ins.state.il.us
https://mc.insurance.illinois.gov/messagecenter.nsf

Grievance process

You, *your authorized representative*, or provider acting on *your* behalf may submit a *grievance* at any time to:

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

Once a *grievance* is filed, *we* acknowledge receipt in writing within 3 business days of receipt. A grievance specialist will review the *grievance. You* will be notified of a final decision not later than 60 days after *our* receipt of the *grievance.*

Internal appeal process

All *appeals* for reconsideration of an *adverse benefit determination* may be submitted to us orally or in writing.

Any *appeal* involving medical necessity or services denied as experimental or investigational will, be reviewed by a physician who:

- Holds an active, unrestricted medical license;
- Is in the same or similar specialty that typically manages the medical condition, procedure or treatment;
- Is knowledgeable of and has experience providing the services under *appeal*;
- Was not directly involved in making the *adverse benefit determination* subject to the *appeal*; and
- Will consider all known clinical aspects of the service under review, including, but not limited to, a review of all pertinent medical records and any medical literature provided to *us* by the *covered person's* health are professional or provider.

Standard internal review

A *covered person* is eligible for an internal review if the *covered person* received notice of an *adverse benefit determination.* The *covered person* or their *authorized representative*, or *health care practitioner* acting on the *covered person's* behalf may request an internal *appeal* within 180 days after the date of the explanation of a denial of a claim for benefits in which to *appeal* the denial to:

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

Toll-free phone: 1-800-901-1303
Standard Appeals Fax: 1-888-556-2128
Expedited Appeals Fax: 1-920-339-2112

Website: www.humana.com
Appeal Email address: HumanaResolution@humana.com

An internal appeal request may be submitted by email, however this is not a secure channel to send personal or confidential information. By emailing an appeal request, the *covered person*, their *authorized representative*, or *health care practitioner* acting on the *covered person's* behalf accepts the risk that personal or confidential information may be compromised. Please use fax or mail to submit any personal or confidential information.

The deadlines for filing an *appeal* or external review request are not postponed or delayed by *health care practitioner appeals* UNLESS the *health care practitioner* is acting as an *authorized representative* for the *covered person*, i.e., the *covered person* should be filing internal *appeals* independently and concurrently unless the *health care practitioner* has been designated in writing as the *authorized representative*.

For *appeals* related to healthcare services other than for *services* which could significantly increase the risk to a *covered person's* health, *we* will request information that is needed to evaluate the *appeal* within three business days of receipt of *your appeal*. *We* will make *our* decision on the *appeal* within 15 business days after receipt of the required information, but not more than:

- 30 days after the request was filed for a *concurrent review* or *prospective review*; or
- 60 days after the request was filed for a *retrospective review*.

We will notify *you* or *your authorized representative*, and any *health care practitioner* who recommended the healthcare service involved with a written or electronic notice (must ensure documents received and provide paper copy upon request). *You* have one level of internal review. Upon completion of the standard internal review process, *you* will have exhausted *your* internal *appeal* rights. If *we* have denied *your appeal* for medical necessity, experimental or investigational, *you* have the right to request an external review of *our* decision by an *IRO*, who is not associated with *us*, by submitting a written request for an *external review* to the Illinois Department of Insurance. Please see the "Standard external review" provision for detailed instructions.

Expedited (urgent) internal review

If the *appeal* relates to an expedited (urgent) healthcare service, including but not limited to procedures or treatments ordered by a *health care practitioner*, the denial of which could significantly increase the risk to the *covered person's* health, the *covered person* may be entitled to an *appeal* on an expedited basis. Before authorization of benefits for an *ongoing course of treatment* is terminated or reduced, *we* will provide the *covered person* or the *covered person's authorized representative* with notice and an opportunity to *appeal*.

Upon receipt of an expedited (urgent) pre-service or concurrent *appeal*, *we* will notify the party filing the *appeal*, as soon as possible, but no more than 24 hours after submission of the *appeal*, of all the information needed to review the *appeal*. **Additional information (from the *covered person*, the *covered person's authorized representative* or the *health care practitioner*) must be submitted within 24 hours of the request**. *We* will render a decision on the *appeal* within 24 hours after *we* receive the requested information. *We* will render a decision no later than 24 hours from receipt for medical necessity *adverse determinations* involving a pregnant or *postpartum covered person* receiving treatment for *mental health services, serious mental illness* services, *chemical dependency* services, and detoxification. For ongoing treatment involving a pregnant or *postpartum covered person* receiving treatment for *mental health services, serious mental illness* services, and *chemical dependency* services, coverage will continue through the day following the date *our* decision is made.

If the *covered person* or the *covered person's authorized representative* filed a request for an expedited internal review of an *adverse determination* and has not received notice of *our* decision within 48 hours of such request, except to the extent the *covered person* or the *covered person's authorized representative* requested or agreed to a delay, then the *covered person* or the *covered person's authorized representative* may file a request for external review and will be considered to have exhausted *our* internal *appeal* process.

If an *adverse determination* concerns a denial of coverage is based on a determination that the recommended or requested healthcare service or treatment is experimental or investigational, and the *covered person's health care practitioner* certifies in writing that the recommended or requested healthcare service or treatment that is the subject of the request would be significantly less effective if not promptly initiated, then the *covered person* or the *covered person's authorized representative* may request an expedited external review at the same time the *covered person* or the *covered person's authorized representative* files a request for an expedited internal *appeal* involving an *adverse determination.* The *IRO* assigned to conduct the expedited external review will determine whether the *covered person* is required to complete the expedited review of the *appeal* prior to conducting the expedited external review.

External review process

Standard external review

An external review is a review of an adverse determination or *final determination* involving denials for medical necessity, experimental or investigational, conducted by an *IRO* approved by the *Director*.

The *covered person* or their *authorized representative* must file a written request for external review with the Department of Insurance within four months following receipt of *our* notice of an *adverse determination* or *final adverse determination*. **The *covered person*, the *covered person's authorized representative* or the *health care practitioner* may submit additional information or documentation with the request for external review** at:

Illinois Department of Insurance
External Review Unit
320 W. Washington Street, 4th Floor
Springfield, IL 62767
Toll-free phone: 1-877-850-4740
Fax: 217-557-8495
Email: doi.externalreview@illinois.gov
Website: https://mc.insurance.illinois.gov/messagecenter.nsf

The *covered person* or their *authorized representative* also have the right to file a complaint with the Illinois Department of Insurance at:

Illinois Department of Insurance
Office of Consumer Health Insurance
320 W. Washington Street
Springfield, IL 62767
Toll-free phone: 1-866-445-5364
Fax: 217-558-2083
Email: consumer_complaints@ins.state.il.us
Website: https://mc.insurance.illinois.gov/messagecenter.nsf

If the *covered person* has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the *covered person* or would jeopardize the *covered person's* ability to regain maximum function, then the *covered person* or the *covered person's authorized representative* may file a request for an expedited external review.

If the *adverse determination* or *final adverse determination* is related to a *mental health service* or *substance use disorder*, *we* will notify *you*, *your authorized representative* and *health care practitioner* in writing of *your* right to request an external review within 24 hours following the *adverse determination* or *final adverse determination*.

If a *final adverse determination* concerns an admission, availability of care, continued stay, or healthcare service for which the *covered person* received *emergency care*, but has not been discharged from a *health care treatment facility*, then the *covered person* or the *covered person's authorized representative* may request an expedited external review.

If a *final adverse determination* concerns a denial of coverage based on a determination that the recommended or requested healthcare service or treatment is experimental or investigational, and the *covered person's health care practitioner* certifies in writing that the recommended or requested healthcare service or treatment that is the subject of the request would be significantly less effective if not promptly initiated, then the *covered person* or the *covered person's authorized representative* may request an expedited external review.

An external review request will not be granted until the internal *appeal* process outlined above has been exhausted.

A *covered person* will also be considered to have exhausted *our* internal *appeal* process if:

- The *covered person* or their *authorized representative* has filed an *appeal* under *our* internal *appeal* process and has not received a written decision on the *appeal* 30 days following the date the *covered person* or their *authorized representative* files an *appeal* of an *adverse determination*, that involves a *concurrent review* or *prospective review* request or 60 days following the date the *covered person* or their *authorized representative* files an *appeal* of an *adverse determination* that involves a *retrospective review* request, except to the extent the *covered person* or their *authorized representative* requested or agreed to a delay;

- The *covered person* or their *authorized representative* filed a request for an expedited internal review of an *adverse determination* and has not received a decision on the request from *us* within 48 hours, except to the extent the *covered person* or their *authorized representative* and *health care practitioner* requested or agreed to a delay;

- *We* agree to waive the exhaustion requirement;

- The *covered person* has a medical condition in which the timeframe for completion of an expedited internal review of an *appeal* involving an *adverse determination*, a *final adverse determination*, or a standard external review would seriously jeopardize the life or health of the *covered person* or would jeopardize the *covered person's* ability to regain maximum function; or

- An *adverse determination* concerns a denial of coverage based on a determination that the recommended or requested healthcare service or treatment is experimental or investigational, and the *covered person's health care practitioner* certifies in writing that the recommended or requested healthcare service or treatment that is the subject of the request would be significantly less effective if not promptly initiated. In such cases, the *covered person* or the *covered person's authorized representative* may request an expedited external review at the same time the *covered person* or the *covered person's authorized representative* files a request for an expedited internal *appeal* involving an *adverse determination*. The *IRO* assigned to conduct the expedited external review will determine whether the *covered person* is required to complete the expedited review of the *appeal* prior to conducting the expedited external review; or

- *We* have failed to comply with applicable State and federal law governing internal claims and *appeals* procedures.

Within one business day after the date of receipt of a request for external review, the *Director* will send a copy of the request to *us*.

Within three business days following the date *we* receive the external review request, *we* will complete a preliminary review of the request to determine whether:

- The individual is or was a *covered person* under this *master group contract* at the time the *services* was requested or provided;

- The *service* that was the subject of the *adverse determination* or *final adverse determination* is a covered *service* under the *master group contract*, but *we* have determined that the *service* is not a covered *service*, except in the case of *our* determination that the service or treatment is experimental or investigational for a particular medical condition and which is not explicitly excluded under the plan;

- In the case of an *adverse determination* or *final adverse determination* of treatment that is experimental or investigational:

  - *Your health care practitioner* has certified that one of the following situations is applicable:

    - Standard health care services or treatments have not been effective in improving *your* condition;

- Standard health care services or treatments are not medically appropriate for *you*; or
- There is no available standard health care service or treatment covered by *us* that is more beneficial than the recommended or requested health care service or treatment.

- *Your health care practitioner*:

  - Has recommended a health care service or treatment that the *health care practitioner* certifies, in writing, is likely to be more beneficial to *you*, in their opinion, than any available standard health care services or treatments; or

  - Who is a licensed, board certified or board eligible physician qualified to practice in the area of medicine appropriate to treat *your* condition, has certified in writing that scientifically valid studies using accepted protocols demonstrate that the health care service or treatment requested by *you* that is the subject of the *adverse determination* or *final adverse determination* is likely to be more beneficial to *you* than any available standard health care services or treatments;

- The *covered person* has exhausted *our* internal *appeal* process unless the *covered person* is not required to exhaust the *appeal* process; and

- The *covered person* has provided the necessary information and forms required to process an external review.

Within one business day after *we* complete our preliminary review, *we* will notify the *Director* and the *covered person* or their *authorized representative* in writing whether their request is complete and eligible for external review. If the request:

- Is not complete, *we* will inform the *Director* and the *covered person* or their *authorized representative* in writing and include in the notice what information or materials are required to make the request complete; or

- Is not eligible for external review, *we* will notify the *Director* and the *covered person* or their *authorized representative* in writing and include in the notice the reason it is not eligible for an external review. The *covered person* or their *authorized representative* may *appeal* the determination that the external review request is ineligible by filing a complaint with the *Director*. The *Director* may determine that a request is eligible for external review and require it be referred for an external review. The decision by the *Director* will be in accordance with the terms of this *master group contract*, unless it is inconsistent with applicable law.

Within one business day of receiving notice that a request is eligible for external review, the *Director* will:

- Assign an *IRO* from the list of approved *independent review organizations* compiled and maintained by the *Director* and notify *us* of the assigned *IRO*; and

- Provide a notice to the *covered person* or their *authorized representative* in writing of the acceptance of the request for external review and the name of the *IRO*. **The notice will include a statement advising the *covered person* or their *authorized representative* may, within five business days following the receipt of the notice, submit in writing to the assigned *IRO* any additional information from the *covered person*, the *covered person's authorized representative* or the *health care practitioner* that the *IRO* will consider with conducting the external review**. The *IRO* is not required to but may accept and consider additional information submitted after five business days.

In the case of treatment that is experimental or investigational, within one business day after the receipt of the notice of assignment to conduct the external review, the *IRO* shall select one or more clinical reviewers, as it determines is appropriate to conduct the external review.

All clinical reviewers assigned by the *IRO* to conduct external reviews shall be physicians or other appropriate health care providers who meet the following qualifications:

- Be an expert in the treatment of *your* medical condition that is the subject of the external review;
- Be knowledgeable about the recommended health care service or treatment through recent or current actual clinical experience treating patients with *your* same or similar medical condition;
- Hold a non-restricted license in a state of the United States and, for physicians, a current certification by a recognized American medical specialty board in the area or areas appropriate to the subject of the external review;
- Have no history of disciplinary actions or sanctions, including loss of staff privileges or participation restrictions, that have been taken or are pending by any hospital, governmental agency or unit, or regulatory body that raise a substantial question as to the clinical reviewer's physical, mental, or professional competence or moral character; and
- Through clinical experience in the past 3 years, are experts in the treatment of *your* condition and knowledgeable about the recommended or requested health care service or treatment.

Neither *you*, *your authorized representative*, nor *us* shall choose or control the choice of the physicians or other health care professionals to be selected to conduct the external review. Each clinical reviewer shall provide a written opinion to the *IRO* on whether the recommended or requested health care service or treatment should be covered. In reaching an opinion, clinical reviewers are not bound by any decisions or conclusions reached during *our* utilization review process or *our* internal *appeal* process.

Within five business days upon receipt of the notice, *we* will provide the *IRO* with any documents and information considered in making the *adverse determination* or *final adverse determination.* If *we* fail to provide the *IRO* with the documents and information within 5 business days:

- It will not delay the conduct of the external review; and

- The assigned *IRO* may terminate the external review and make a decision to reverse the *adverse determination* or *final adverse determination.* The *IRO* will notify the *Director*, *us* and the *covered person* or their *authorized representative* within one business day of their decision to reverse the *adverse determination* or *final adverse determination*.

Upon receipt of *our* information, the assigned *IRO*, or each clinical reviewer will review all the information and documentation and any other information submitted in writing by the *covered person* or their *authorized representative*.

The *IRO*, or each clinical reviewer in the case of treatment that is experimental or investigational, will consider the following in reaching a decision:

- The *covered person's* pertinent medical records;
- The *covered person's health care practitioner's* recommendation;
- Consulting reports from appropriate *health care practitioners* and other documents submitted by *us*, the *covered person* or their *authorized representative* and the treating *health care practitioner*;
- The coverage under the *master group contract* to ensure the *IRO's* decision is not contrary to the terms of the *master group contract,* unless the terms are inconsistent with applicable law;
- In the case of treatment that is experimental or investigational, whether:
  - The recommended or requested health care service or treatment has been approved by the federal Food and Drug Administration, if applicable, for the condition; or
  - Medical or scientific evidence or evidence-based standards demonstrate that the expected benefits of the recommended or requested health care service or treatment is more likely than not to be beneficial to the *covered person* than any available standard health care service or treatment and the adverse risks of the recommended or requested health care service or treatment would not be substantially increased over those of available standard health care services or treatments.
- The most appropriate medical guidelines, which include applicable evidence-based standards and any other guidelines developed by the federal government, national or professional medical societies, boards and associations;
- Applicable clinical review criteria developed and used by *us*;
- The opinion of the *IRO's* clinical reviewer(s) after considering the above items; and
- In the case of *medically necessary* determination for *substance use disorders*, the patient placement criteria established by the America Society of Addiction Medicine.

The *IRO* will forward the information submitted by the *covered person* or their *authorized representative* to *us* within one business day. Upon receipt of this additional information, *we* may reconsider *our adverse determination* or *final adverse determination.* The external review will not be delayed or terminated if *we* reconsider *our adverse determination* or *final adverse determination*. Within one business day, or immediately in the case of treatment that is experimental or investigational, of *our* decision to reverse *our adverse determination* or *final adverse determination, we* will notify the *Director*, assigned *IRO*, and the *covered person* or their *authorized representative* in writing of *our* decision. Upon receipt of this notice, the assigned *IRO* will terminate the external review.

Within five days after receipt of all necessary information, but in no event more than 45 days after the date of receipt of the request for an external review for an *adverse determination* or *final adverse determination* involving treatment that is not *medically necessary* or involving treatment that is experimental or investigational, the assigned *IRO* will provide written notice of its decision to uphold or reverse the *adverse determination* or *final adverse determination* to the *Director, us* and the *covered person* or their *authorized representative*. In reaching a decision, the assigned *IRO* is not bound by a claim determination reached prior to the submission of information to the *IRO*. The *IRO* will include in the notice:

- A general description of the reason for the request for external review;
- The date the *IRO* received the assignment from the *Director* to conduct the external review;
- The time period during which the external review was conducted;
- References to the evidence or documentation, including the evidence-based standards considered in reaching its decision;
- The date of its decision;
- The principal reason(s) for its decision, including any evidence-based standards that were a basis for the decision; and
- The rationale for its decision.

Upon our receipt of a notice of a decision reversing *our adverse determination* or *final adverse determination, we* will immediately approve the coverage of the *services* that were the subject of the *adverse determination* or *final adverse determination.*

Expedited external review

An expedited external review may not be provided for retrospective adverse or *final adverse determinations.*

A *covered person* or a *covered person's authorized representative* may file a request for an expedited external review with the *Director* in writing, including any additional information or documentation:

- Immediately after the date of receipt of a notice prior to a *final adverse determination*;
- Immediately after the date of receipt of a notice upon *final adverse determination*; or
- If *we* fail to provide a decision on request for an external internal *appeal* within 48 hours.

- Following a medical necessity *adverse determination* notification from *us* involving *substance use disorders*, unless the *health care practitioner* or facility has determined continued treatment is no longer *medically necessary.* The request for the expedited external review will be considered to have exhausted *our* internal *appeal* process.

Upon receipt of a request for an expedited external review, the *Director* will immediately send a copy of the request to *us.* Immediately upon *our* receipt of the request for an expedited external review, *we* will determine whether the request meets the reviewability requirements as follows:

- The individual is or was a *covered person* under this *master group contract* at the time the *services* was requested or provided;

- The *service* that was the subject of the *adverse determination* or *final adverse determination* is a covered *service* under the *master group contract*, but *we* have determined that the *service* is not a covered *service*, except in the case of *our* determination that the service or treatment is experimental or investigational for a particular medical condition and which is not explicitly excluded under the plan;

- In the case of an *adverse determination* or *final adverse determination* of treatment that is experimental or investigational:

  - *Your health care practitioner* has certified that one of the following situations is applicable:

    - Standard health care services or treatments have not been effective in improving *your* condition;
    - Standard health care services or treatments are not medically appropriate for *you*; or
    - There is no available standard health care service or treatment covered by *us* that is more beneficial than the recommended or requested health care service or treatment.

  - *Your health care practitioner*:

    - Has recommended a health care service or treatment that the *health care practitioner* certifies, in writing, is likely to be more beneficial to *you*, in their opinion, than any available standard health care services or treatments; or

    - Who is a licensed, board certified or board eligible physician qualified to practice in the area of medicine appropriate to treat *your* condition, has certified in writing that scientifically valid studies using accepted protocols demonstrate that the health care service or treatment requested by *you* that is the subject of the *adverse determination* or *final adverse determination* is likely to be more beneficial to *you* than any available standard health care services or treatments; and

- The *covered person* has provided the necessary information and forms required to process an expedited external review.

In such cases, the following provisions will apply:

- *We* will immediately notify the *Director*, a *covered person* or a *covered person's authorized representative* of its eligibility determination;

- *We* will provide notice of initial determination including a statement informing the *covered person* or a *covered person's authorized representative* they may *appeal our* initial determination that the external review request is ineligible for review by filing a complaint with the *Director*;

- The *Director* may determine that a request is eligible for expedited external review notwithstanding, *our* initial determination that the request is ineligible and require that it be referred for external review. The *Director's* decision will be made in accordance with the terms of this *master group contract*, unless such terms are inconsistent with applicable law.

Upon receipt of the notice that the request meets the reviewability requirements, the *Director* will immediately assign an *independent review organization.*

The following provisions will apply:

- The assignment of an approved *IRO* to conduct an external review will be made from those approved *independent review organizations* qualified to conduct an external review;

- The *Director* will immediately notify *us* of the name of the assigned *IRO*. Immediately upon this receipt but in no case more than 24 hours after receiving such notice, *we* will provide or transmit all necessary documents and information considered in making the *adverse determination* or *final adverse determination* to the assigned *IRO* electronically, by telephone or facsimile or any other available expeditious method;

- If *we* fail to provide the documents and information within 24 hours after receiving notice from the *Director*, the assigned *IRO* may terminate the external review and make a decision to reverse the *adverse determination* or *final adverse determination*;

- Within one business day after making the decision to terminate the external review and make a decision to reverse the *adverse determination* or *final adverse determination*, the *IRO* will notify the *Director*, *us*, and the *covered person* or a *covered person's authorized representative* of its decision to reverse the *adverse determination* or *final adverse determination*;

- In addition to the documents and information provided by *us* and any documents and information provided by the *covered person* or a *covered person's authorized representative*, the *IRO*, to the extent the information or documents are available and the *IRO* considers them appropriate, will consider this information in reaching its decision; and

- As expeditiously as the *covered person's* medical condition or circumstances requires, but in no event more than 72 hours after the date of receipt of the request for an expedited external review for an *adverse determination* or *final adverse determination* involving treatment that is not *medically necessary* (5 days for an expedited external review for an *adverse determination* or *final adverse determination* involving treatment that is experimental or investigational), the assigned *IRO* will:

  - Make a decision to uphold or reverse the *final adverse determination*; and
  - Provide notice to the *Director*, *us*, the *covered person*, the *covered person's health care practitioner* or a *covered person's authorized representative* of the decision.

If the notice provided is not in writing, then the assigned *IRO* will provide written confirmation of their decision within 48 hours to the *Director*, *us*, and the *covered person* or a *covered person's authorized representative.* In reaching a decision, the assigned *IRO* is not bound by any decisions or conclusions reached during *our* utilization review process or *our* internal *appeal* process.

Upon receipt of notice of a decision reversing the *adverse determination* or *final adverse determination*, *we* will immediately approve the coverage that was the subject of the *adverse determination* or *final adverse determination.*

If the assigned *IRO* upholds a medical necessity *adverse determination* involving *substance use disorders*, *we* will pay benefits for *covered expenses* through the day following the determination of the *IRO*.

Internal Review

Type of Notice or Extension	**Timing**
If *your grievance* or *appeal* is complete, *we* will notify *you* of *our* decision within:	15 days of receipt of *appeal*
If *your grievance* or *appeal* is incomplete, *we* will notify *you* for required information within:	3 business days of receipt of *appeal*
We will make *our* decision of *appeal* within:	15 business days, but no more than 30 days after receipt of required information for a *concurrent review* or *prospective review* (60 days a for *retrospective review*, 24 hours for an expedited (urgent) pre-service or *concurrent review*, and medical necessity *adverse determinations* for pregnant or *postpartum covered person* receiving treatment for *mental health services*, *serious mental illness* services, and *chemical dependency* services)
We will make *our* decision of a *grievance* within:	15 business days from the receipt of information, but no more than 60 day from the receipt of the request.

External Review

Type of Notice or Extension	Timing
We will complete a preliminary review following receipt of the external review request from the *Director* within:	3 business days
We will notify *you* advising if the request is eligible for external review within:	1 day upon completion of *our* preliminary review
Director will provide notice of assignment of *independent review organization* within:	1 business day
We will provide *IRO* with required documentation within:	5 business days of receiving notice of *IRO* assignment
You may provide *IRO* with additional information within:	5 business days of receiving notice of *IRO* assignment
IRO will notify of their decision of the review within:	5 business days but no more than 45 days for a review involving treatment that is not *medically necessary* or involving treatment that is experimental or investigational)

Expedited External Review

Type of Notice or Extension	Timing
We will notify *you* advising if the request is eligible for external review:	Immediately upon receipt of the *Director's* notice of the external review request
We will provide *IRO* with required documentation within:	24 hours upon *Director's* notice of assignment of *IRO*
If *we* fail to provide documents to *IRO* in 24 hour timeline, *IRO* may make decision to reverse *adverse determination.* The decision by the *IRO* will be made within:	1 business day
IRO will provide notice of decision within:	72 hours of external review request for a review involving treatment that is not *medically necessary* (5 days for a review involving treatment that is experimental or investigational)
If *IRO* notice was not provided in writing, *IRO* will provide written confirmation of decision within:	48 hours
If *adverse determination* is reversed, we will provide coverage:	Immediately upon receipt of *IRO* decision

Legal actions and limitations

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

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

WELLNESS PROGRAMS

The wellness programs are designed and have been shown to improve health and prevent disease for those participating by encouraging healthy behavior and assisting in managing *your* health. These programs may be accessed by registering at *our* website at www.humana.com. Participation in these programs may include:

"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.

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.

By participating in these wellness activities, *you* will accumulate points that may be used toward obtaining rewards.

As permitted under applicable state and federal laws, the rewards can include, but are not limited to:

- Payment for all or a portion of a participatory wellness program;
- Merchandise;
- Gift cards;
- Debit cards;
- Discounts;
- Contributions to *your* health spending account;
- Premium discounts or credits toward premium;
- A reduction in *copayments*, *deductibles* or *coinsurance*.

Such insurance premium or benefit rewards may be made available at the individual or *group* health plan level.

We offer directly, or enter into agreements with third parties who administer participatory or health-contingent wellness programs that encourage healthy behavior. In the event *our* agreement with a third party terminates, *your* reward points will not be affected and will still be redeemable for rewards with another contracted third party.

The rewards may be taxable income. *You* may consult a tax advisor for further guidance. The rewards will not exceed the limits under state and federal law. For additional information on how to redeem points for rewards, please go to *our* website at www.humana.com.

WELLNESS PROGRAMS (continued)

The Wellness programs may be terminated in accordance with the termination provision of the *policy*. The decision to participate in these wellness programs or 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.

MISCELLANEOUS PROVISIONS

Entire contract

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

Additional group plan sponsor responsibilities

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

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

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

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

Beneficiary designation

The *covered person* designating a beneficiary retains the right to change the designation unless he/she makes that designation irrevocable.

Certificates

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

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

MISCELLANEOUS PROVISIONS (continued)

Incontestability

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

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

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

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

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

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

Fraud

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

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

Clerical error or misstatement

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

Modification of master group contract

The *master group contract* may be modified by *us,* upon renewal of the *master group contract,* as permitted by state and federal law. The *group plan sponsor* will be notified in writing or *electronically* as follows:

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

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

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

Discontinuation of coverage

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

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

If *we* cease doing business in the *small employer* or the large *employer* group market, the *group plan sponsors*, *covered persons* and the Commissioner of Insurance will be notified of such discontinuation at least 180 days prior to the date of discontinuation of such coverage. Upon the payment of a claim under the *policy*, any premium then due and unpaid or covered by any note or written order may be deducted therefrom.

Premium contributions

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

Premium rate change

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

Assignment

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

Emergency declarations

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

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

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

Conformity with statutes

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

GLOSSARY

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

A

Abortion means the use of any instrument, medicine, drug, or any other substance or device to terminate the pregnancy of a *covered person* known to be pregnant with an intention other than to increase the probability of a live birth, to preserve the life or health of the child after live birth, or to remove a dead fetus.

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

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

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

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

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

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

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

Acute treatment services means 24-hour medically supervised addiction treatment for *chemical dependency* including evaluation, withdrawal management, biopsychosocial assessment, individual and group counseling, psychoeducational groups, and discharge planning.

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.

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

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

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

Ancillary services mean *covered expenses* that are:

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

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

Autism spectrum disorders means pervasive development disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, including:

- Autism;
- Asperger's disorder; and
- Pervasive developmental disorder (not otherwise specified).

B

Bariatric services mean the *bariatric surgery* and the post-discharge services following a *bariatric surgery preauthorized* by *us* based on established criteria.

Bariatric surgery means gastrointestinal *surgery* to promote weight loss for the treatment of *morbid obesity.*

Behavioral health means *mental health services, serious mental illness* services, and *chemical dependency* services.

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

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

C

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

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

Civil union means a legal relationship between two persons, of either the same or opposite sex, established pursuant to Illinois state law.

Clinical stabilization services mean 24-hour treatment for *chemical dependency* following *acute treatment services.* Coverage includes intensive education, counseling regarding the nature of the addiction and its consequences, relapse prevention, outreach to families and significant others, and planning for the *covered person* beginning to engage in recovery from their addiction.

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

Common diagnostic screenings and tests means the following laboratory services to diagnose a *sickness*:

- Cyanocobalamin (Vitamin B-12);
- Folic acid; serum;
- Basic metabolic panel (Calcium, total). This panel must include:
  - Calcium, total;
  - Carbon dioxide (bicarbonate);
  - Chloride;
  - Creatinine;
  - Glucose;
  - Potassium;
  - Sodium; and
  - Urea nitrogen (BUN);
- Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count;
- Comprehensive metabolic panel. This panel must include:
  - Albumin;
  - Bilirubin, total;
  - Calcium, total;
  - Carbon dioxide (bicarbonate);
  - Chloride;
  - Creatinine;
  - Glucose;
  - Phosphatase, alkaline;
  - Potassium;
  - Protein, total;
  - Sodium;
  - Transferase, alanine amino (ALT) (SGPT);
  - Transferase, aspartate amino (AST) (SGOT); and
  - Urea nitrogen (BUN);
- Sedimentation rate, erythrocyte; non-automated;
- Glucose; quantitative, blood (except reagent strip);
- Gonadotropin, chorionic (hCG); qualitative;
- Hemoglobin; glycosylated (A1C);
- Ferritin;
- Iron;

- Iron binding capacity;
- Hepatic function panel. This panel must include:
  - Albumin;
  - Bilirubin, total;
  - Bilirubin, direct;
  - Phosphatase, alkaline;
  - Protein, total;
  - Transferase, alanine amino (ALT) (SGPT); and
  - Transferase, aspartate amino (AST) (SGOT);
- Lipid panel. This panel must include:
  - Cholesterol, serum, total;
  - Lipoprotein, direct measurement, high density cholesterol (HDL cholesterol); and
  - Triglycerides;
- Lithium;
- Antibody; borrelia burgdorferi (Lyme disease);
- Testosterone; free;
- Testosterone; total;
- Thyroid stimulating hormone (TSH);
- Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; automated, with microscopy;
- Culture, bacterial; quantitative colony count, urine;
- Vitamin D, 25 hydroxy, includes fraction(s), if performed.

Comprehensive cancer testing includes, but is not limited to, the following forms of testing:

- Targeted cancer gene panels;
- Whole-exome genome testing;
- Whole-genome sequencing;
- RNA sequencing; and
- Tumor mutation burden.

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

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

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

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

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

Covered expense means:

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

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

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

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

Custodial care means services given to *you* if:

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

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

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

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

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

D

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

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

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

Dependent means a covered *employee's*:

- Legally recognized spouse, *domestic partner* if the *employer* includes *domestic partners* on the Employer Group Application, *partner to a civil union*, or *party to a marriage*, so long as the relationship is valid and recognized under state law;

- Natural born child, step-child, legally adopted child, child who is in *your* custody under an interim court order prior to finalization of adoption or placement of adoption vesting temporary care, regardless of whether a final order granting adoption is ultimately issued, or any child for which *you* are a court appointed legal guardian, including a foster child for which the *employee* gains temporary care, whose age is less than the limiting age, including children of a spouse, *partner to a civil union* or *party to a marriage*;

- Child whose age is less than the limiting age and for whom the *employee* has received a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN) to provide coverage, if the *employee* is eligible for family coverage until:

  - Such QMCSO or NMSN is no longer in effect; or
  - The child is enrolled for comparable health coverage, which is effective no later than the termination of the child's coverage under the *master group contract*; or

- Military veteran: Unmarried natural born child, step-child, legally adopted child, foster child for which the *employee* has gained temporary care, whose age is less than the limiting age if he or she:

  - Is an Illinois resident; and

  - Served as a member of the active or reserve components of the U.S. Armed Forces, including the National Guard; and

  - Received a release or discharge other than a dishonorable discharge; and

  - Submits proof of services using a DD-214 (Member 4 or 6) form, otherwise known as a "Certificate of Release or Discharge from Active Duty." This form is issued by the federal government to all veterans. For more information on how to obtain a copy of a DD-214, the veteran can call the Illinois Department of Veterans' Affairs at 1-800-437-9824 or the U.S. Department of Veterans' Affairs at 1-800-827-1000.

If the *employer* includes *domestic partners*, and the *employer* does not make specific reference to exclude dependents of *domestic partners*, *dependent* also means a covered *employee's*:

- *Domestic partner's* natural born child, step-child, legally adopted child, or child placed for adoption, regardless of whether a final order granting adoption is ultimately issued, or any child for which the *domestic partner* is court appointed legal guardian, including a foster child for which temporary care is granted, whose age is less than the limiting age;

- *Domestic partner's* child whose age is less than the limiting age and for whom the *domestic partner* has received a QMCSO or NMSN to provide coverage, if the *employee* is eligible for family coverage until:

  - Such QMCSO or NMSN is no longer in effect; or
  - The *domestic partner's* child who is enrolled for comparable health coverage, which is effective no later than the termination of the child's coverage under the *master group contract.*

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

Except as specified above, *dependent* does not mean a grandchild, great grandchild or foster child, including where the grandchild, great grandchild or foster child meets all of the qualifications of a dependent as determined by the Internal Revenue Service.

The coverage for each *dependent* child is subject to the following limiting age(s):

- The end of the month that he or she attains the age of 26; or
- The birthday that he or she attains the age of 30, if such child has met the eligibility criteria for a military veteran as specified above.

Each *dependent* child is covered to the limiting age, regardless if the child is:

- Married;

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

We shall continue to provide coverage for a *dependent* college student who takes a *medically necessary leave of absence* or reduces his or her course load to part-time status because of a catastrophic *sickness* or *bodily injury.* Continuation of insurance under the *master group contract* shall terminate 12 months after notice of the *sickness* or *bodily injury* or until the coverage would have otherwise terminated pursuant to the terms and conditions of the *master group contract,* whichever comes first. The need for part-time status or *medically necessary leave of absence* must be supported by a clinical certification of need from a *health care practitioner*.

You must furnish satisfactory proof to *us*, upon *our* request, that the above conditions continuously exist. If satisfactory proof is not submitted to *us*, the child's coverage will not continue beyond the last date of eligibility.

A covered *dependent* child, who attains the limiting age while covered under the *master group contract,* remains eligible if the covered *dependent* child is:

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

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

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

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

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

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

Distant site means the location of a *health care practitioner* 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.

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

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

E

Effective date means the date *your* coverage begins under the *master group contract.*

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

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

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

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

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

- Placing the health of that individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment to bodily functions;
- Serious dysfunction of any bodily organ or part;
- Inadequately controlled pain; or
- With respect to a pregnant woman who is having contractions:

  - Inadequate time to complete a safe transfer to another *hospital* before delivery; or
  - A transfer to another *hospital* may pose a threat to the health or safety of the woman or unborn child.

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

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

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

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

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

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

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

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

- 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*, *your* legally recognized spouse, *domestic partner* if the *employer* includes *domestic partners* on the Employer Group Application, or *partner to a civil union*, or *party to a marriage.* It also means the children, brother, sister, or parent of *you*, *your* legally recognized spouse, *your partner to a civil union*, *party to a marriage*, or *domestic partner* if the *employer* does not make specific reference to exclude *dependents* of *domestic partners.*

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

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

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

G

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

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

H

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

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

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

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

Health status-related factor means any of the following:

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

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*.

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

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

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

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

I

Iatrogenic infertility means an impairment of fertility by *surgery*, radiation, chemotherapy, or other medical treatment affecting reproductive organs or processes.

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.

Infection means bacterial infections, except infections which result from an accident injury, or infection which results from accidental, involuntary, or unintentional ingestion of a contaminated substance.

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.

L

Late applicant means an *employee* or *dependent* who requests enrollment for coverage under the *master group contract* 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.*

Long-term antibiotic therapy means the administration of oral, intramuscular, or intravenous antibiotics singly or in combination for periods of time in excess of four weeks.

Low-dose mammography means the x-ray examination of the breast using equipment dedicated specifically for mammography, including the x-ray tube, filter, compression device, and image receptor, with radiation exposure delivery of less than 1 rad per breast for 2 views of an average size breast. The term also includes digital mammography.

M

Maintenance care means services and supplies furnished mainly to:

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

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

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

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

- The fee charged by the provider for the services;

- The fee that has been negotiated with the provider whether directly or through one or more intermediaries or shared savings contracts for the services;

- The fee established by *us* by comparing rates from one or more regional or national databases or schedules for the same or similar services from a geographic area established by *us*;

- The fee based upon rates negotiated by *us* or other payors with one or more *network providers* in a geographic area established 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.

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.

Medically necessary leave of absence means a leave of absence for a *dependent* child, who is no longer enrolled for sufficient course credits to maintain full-time status as defined by an accredited secondary school, college or university, or licensed technical school, or had any other change in enrollment at such institution.

The *medically necessary leave of absence* must:

- Begin due to a *bodily injury* or *sickness*;
- Be determined necessary by the *dependent* child's *health care practitioner*, who must send *us* written certification; and
- Cause the *dependent* child to lose full-time student status as defined in the definition of "*dependent.*"

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

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

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

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

N

Naprapath means a duly licensed *naprapath.*

Naprapathic services mean a drugless method of treating neuro-musculoskeletal conditions by manipulating muscles, tendons, and ligaments.

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*.

Ongoing course of treatment means the treatment of a condition or disease that requires repeated health care services pursuant to a plan of treatment by a *health care practitioner* because of the potential for changes in the *covered person's* therapeutic regimen.

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

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

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

Originating site means the location of a *covered person* at the time a *telehealth* 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 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.

Partner to a civil union means an individual of the same or opposite sex who is in a relationship that is legally recognized by the applicable governmental authority and has the same rights and responsibilities as a covered *dependent*, spouse or family member under this *certificate*; and is included in any use of the terms "spouse," "family," "immediate family," "dependent," or "next of kin," or other terms that refer to the spousal relationship under this *certificate*.

Party to a marriage means an individual of the same or opposite sex who is in a marriage that is legally recognized by the applicable governmental authority and has the same rights and responsibilities as a covered *dependent*, spouse or family member under this *certificate*; and is included in any use of the terms "spouse," "family," "immediate family," "dependent," or "next of kin," or other terms that refer to the spousal relationship under this *certificate*.

Pediatric dental services mean the following services:

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

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

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

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

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

Pre-surgical/procedural testing means:

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

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

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

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

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

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

- Services with an A or B rating in the current recommendations of the USPSTF.

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

For the recommended *preventive services* that apply to *your* plan *year*, refer to the www.healthcare.gov website or call the customer service telephone number on *your* ID card. Refer to the "Preventive services" provision in the "Covered Expenses" section which includes *preventive services* covered by the *master group contract.*

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

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

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

Psychiatric collaborative care model means an evidence-based, integrated *behavioral health* service delivery method, which includes a formal collaborative arrangement among a primary care team consisting of a primary care provider, a care manager, and a psychiatric consultant, and includes but is not limited to, the following services:

- Care directed by the primary care team;
- Structured care management;
- Regular assessments of clinical status using validated tools; and
- Modification of treatment for *mental health services* and *serious mental illnesses,* as appropriate.

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*;
  - Provide *preventive services*;
  - Provide *pediatric dental services*; or
  - Provide *pediatric vision care*;

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

R

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

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

Residential treatment facility means an institution that:

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

- Provides a multidisciplinary treatment plan in a controlled environment, under the supervision of a physician who is able to provide treatment on a daily basis;

- Provides supervision and treatment by a Ph.D. psychologist, licensed therapist, psychiatric nursing staff or registered nurse;

- Provides programs such as social, psychological, family counseling and rehabilitative training, age appropriate for the special needs of the age group of patients, with focus on reintegration back into the community; and

- Provides structured activities throughout the day and evening.

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

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

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

Serious mental illness means the following psychiatric illnesses as defined by the American Psychiatric Association in the Diagnostic and Statistical Manual (DSM):

- Schizophrenia;
- Paranoid and other psychotic disorders;
- Bipolar disorders (hypomanic, manic, depressive and mixed);
- Major depressive disorders (single episodes or recurrent);
- Schizoaffective disorders (bipolar or depressive);
- Pervasive development disorders;
- Obsessive-compulsive disorders;
- Depression in childhood and adolescence;
- Panic disorders;
- Post-traumatic stress disorders (acute, chronic, or with delayed onset); and

- Eating disorders, including but not limited to, anorexia nervosa, bulimia nervosa, pica, rumination disorder, avoidant/restrictive food intake disorder, other specified feeding or eating disorder (OSFED), and any other eating disorder contained in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.

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

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

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

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

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

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

Sound natural tooth means a tooth that:

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

Special enrollment date means the date of:

- Change in family status after the *eligibility date*;
- Loss of other coverage under another group health plan or other *health insurance coverage*;
- COBRA exhaustion;
- Loss of coverage under *your employer's* alternate plan;

- Termination of *your Medicaid* coverage or *your* Children's Health Insurance Program (CHIP) coverage as a result of loss of eligibility; or
- Eligibility for a premium assistance subsidy under *Medicaid* or CHIP.

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

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

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

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

Standard fertility preservation services means procedures based upon current evidence-based standards of care established by the American Society for Reproductive Medicine, the American Society of Clinical Oncology, or other national medical associations that follow current evidence-based standards of care.

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.

Substance use disorder means the following mental disorders as defined in the most current edition of the Diagnostic and Statistical Manual of Mental Disorders:

- Substance abuse disorders;
- Substance dependent disorders; and
- Substance induced disorders.

Surgery means procedures categorized as Surgery in either the:

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

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

- Excision or incision of the skin or mucosal tissues;
- Insertion for exploratory purposes into a natural body opening;

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

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

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

Testing of blood or constitutional tissue for cancer predisposition testing includes, but is not limited to, the following forms of testing:

- Targeted cancer gene panels;
- Whole-exome genome testing; and
- Whole-genome sequencing.

Tick-borne disease means a disease caused when an infected tick bite transmits an infectious agent (bacteria, viruses, or parasites) that can cause illness, including, but not limited to, the following:

- A severe infection with borrelia burgdorferi;
- A late stage, persistent, or chronic infection or complications related to such an infection;
- An infection with other strains of borrelia or a tick-borne disease that is recognized by the United States Centers for Disease Control and Prevention; and
- The presence of signs or symptoms compatible with acute infection of borrelia or other tick-borne diseases.

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

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

U

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

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

V

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

W

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

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

Y

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

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

GLOSSARY – PHARMACY SERVICES

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

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 *deductible, 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.

Drug list means a list of covered *prescription* drugs, medicines or medications and supplies specified by *us.*

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.*

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."

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.

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 *master group contract.* These expenses do not apply toward any other *deductible*, if any, stated in the *master group contract.*

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.*

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.

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