The actual on exchange policy 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 policy that is issued, the issued policy will control.

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

AZHJG9KEN

INDIVIDUAL HMO MEDICAL CONTRACT
Humana Health Plan, Inc.

Contractholder: [John Doe]

Contract number: [12345]

Effective date: [January 1, 2016] as of 12:01 a.m.

Premium amount: $[xxxx] monthly

PLEASE READ THIS CONTRACT CAREFULLY

We issue coverage on an equal access basis to *covered persons* without regard to race, color, national origin, religion, disability, age, sex, gender identity, or sexual orientation.

Humana Health Plan, Inc. agrees to pay benefits for *services* rendered to *covered persons* who are named in the "Schedule of Benefits", subject to all the terms of this *contract*. *We* reserve the full and exclusive right to interpret the terms of this *contract* to determine the benefits payable hereunder.

This *contract* is issued in consideration of the *contractholder's* application, a copy of which is attached and made a part of this *contract*, and the *contractholder's* payment of premium as provided under this *contract*. **Fraud or intentional misrepresentation of material fact in the application may cause *your contract* to be voided and claims to be reduced or denied.** Please check *your* application for errors and write to *us* if any information is not correct or is incomplete. If *you* purchased *your* coverage through the *marketplace*, please contact the *marketplace* for any information that is not correct or complete.

If *you* purchased *your* coverage through the *marketplace*, this *contract* does not include coverage for pediatric dental *services. You* may purchase additional dental coverage through the *marketplace*.

This *contract* and the insurance it provides become effective 12:01 a.m. (*your* time) on the *effective date* stated above. This *contract* and the insurance it provides terminate at 12:00 midnight (*your* time) on the date of termination. The provisions stated above and on the following pages are part of this *contract*.

Renewability

This *contract* remains in effect at the option of the *contractholder* except as provided in the "Renewability of Insurance and Termination" section of this *contract*.

Right to return contract

You have the right to return this *contract* within 10 calendar days after the day *we* mailed this *contract* to *you*. If *you* choose to return this *contract* to *us* within the 10 day period, *we* will refund any premium that *you* have paid. If *you* return this *contract* within the 10 day period, it will be void and *we* will have no liability under any of the terms or provisions of this *contract*. There will be no coverage for any claims incurred.

[Signature of Officer]

Bruce Broussard
President

ARIZONA
GRIEVANCE AND APPEALS NOTICE

If *you* are not satisfied with the decision made on a claim, *you* may request a review of *our* decision. To begin the appeal process or to obtain a copy of the most current appeal process, contact *us* by telephone or in writing at:

Humana
Grievance and Appeals Department
PO Box 14546
Lexington, KY 40512-4546
Phone: 800-833-6917

Health Care Insurer Appeals Process Information Packet
Humana

CAREFULLY READ THE INFORMATION IN THIS PACKET AND KEEP IT FOR FUTURE REFERENCE. IT HAS IMPORTANT INFORMATION ABOUT HOW TO APPEAL DECISIONS WE MAKE ABOUT YOUR HEALTH CARE.

Getting Information About the Health Care Appeals Process
Help in Filing an Appeal: Standardized Forms and Consumer Assistance From the Department of Insurance

We must send you a copy of this information packet when you first receive your policy, and within 5 business days after we receive your request for an appeal. When your insurance coverage is renewed, we must also send you a separate statement to remind you that you can request another copy of this packet. We will also send a copy of this packet to you or your treating provider at any time upon request. Just call our customer/member services number at 1-(800) 901-1303 to ask.

At the back of this packet, you will find forms you can use for your appeal. The Arizona Insurance Department ("the Department") developed these forms to help people who want to file a health care appeal. You are not required to use them. We cannot reject your appeal if you do not use them. If you need help in filing an appeal, or you have questions about the appeals process, you may call the Department's Consumer Assistance Office at (602) 364-2499 or 1-(800) 325-2548 (outside Phoenix) or call us at 1-(800) 901-1303.

How to Know When You Can Appeal

When we do not authorize or approve a service or pay for a claim, we must notify you of your right to appeal that decision. Your notice may come directly from us, or through your treating provider.

Decisions You Can Appeal

You can appeal the following decisions:

1. We do not approve a service that you or your treating provider has requested.
2. We do not pay for a service that you have already received.
3. We do not authorize a service or pay for a claim because we say that it is not "medically necessary."
4. We do not authorize a service or pay for a claim because we say that it is not covered under your insurance policy, and you believe it is covered.
5. We do not notify you, within 10 business days of receiving your request, whether or not we will authorize a requested service.
6. We do not authorize a referral to a specialist.

Decisions You Cannot Appeal

You cannot appeal the following decisions:

1. You disagree with our decision as to the amount of "usual and customary charges."
2. You disagree with how we are coordinating benefits when you have health insurance with more than one insurer.
3. You disagree with how we have applied your claims or services to your plan deductible.
4. You disagree with the amount of coinsurance or copayments that you paid.
5. You disagree with our decision to issue or not issue a policy to you.
6. You are dissatisfied with any rate increases you may receive under your insurance policy.
7. You believe we have violated any other parts of the Arizona Insurance Code.

If you disagree with a decision that is not appealable according to this list, you may still file a complaint with the Arizona Department of Insurance, Consumer Affairs Division, 2910 N. 44th, Suite 210, Phoenix, AZ 85018.

Who Can File An Appeal?

Either you or your treating provider can file an appeal on your behalf. At the end of this packet is a form that you may use for filing your appeal. You are not required to use this form, and can send us a letter with the same information. If you decide to appeal our decision to deny authorization for a service, you should tell your treating provider so the provider can help you with the information you need to present your case.

Description of the Appeals Process

There are two types of appeals: an expedited appeal for urgent matters, and a standard appeal. Each type of appeal has 3 levels. The appeals operate in a similar fashion, except that expedited appeals are processed much faster because of the patient's condition.

	Expedited Appeals (for urgently needed services you have not yet received)	**Standard Appeals** (for non- urgent services or denied claims)
Level 1	Expedited Medical Review	Informal Reconsideration[1]
Level 2	Expedited Appeal	Formal Appeal
Level 3	Expedited External Independent Medical Review	External Independent Medical Review

We make the decisions at Level 1 and Level 2. An outside reviewer, who is completely independent from our company, makes Level 3 decisions. You are not responsible to pay the costs of the external review if you choose to appeal to Level 3.

[1] You may not obtain Informal Reconsideration of your denied request for payment of a covered service. Instead, you may start the review process by seeking Formal Appeal.

EXPEDITED APPEAL PROCESS FOR URGENTLY NEEDED SERVICES NOT YET PROVIDED

Level 1: Expedited Medical Review

Your request: You may obtain Expedited Medical Review of your denied request for a service that has not already been provided if:

- You have coverage with us,
- We denied your request for a covered service, and
- Your treating provider certifies in writing and provides supporting documentation that the time required to process your request through the Informal Reconsideration and Formal Appeal process (about 60 days) is likely to cause a significant negative change in your medical condition. (At the end of this packet is a form that your provider may use for this purpose. Your provider could also send a letter or make up a form with similar information.) Your treating provider must send the certification and documentation to:

Humana
Grievance and Appeal Department
PO Box 14546
Lexington, KY 40512-4546
Phone: 1-(800) 901-1303
Fax: 1-(920) 339-2112

Our decision: We have 1 business day after we receive the information from the treating provider to decide whether we should change our decision and authorize your requested service. Within that same business day, we must call and tell you and your treating provider, and mail you our decision in writing. The written decision must explain the reasons for our decision and tell you the documents on which we based our decision.

If we deny your request: You may immediately appeal to Level 2.
If we grant your request: We will authorize the service and the appeal is over.
If we refer your case to Level 3: We may decide to skip Level 1 and Level 2 and send your case straight to an independent reviewer at Level 3.

Level 2: Expedited Appeal

Your request: If we deny your request at Level 1, you may request an Expedited Appeal. After you receive our Level 1 denial, your treating provider ***must immediately*** send us a written request (to the same person and address listed above under Level 1) to tell us you are appealing to Level 2. To help your appeal, your provider should also send us any more information (that the provider hasn't already sent us) to show why you need the requested service.

Our decision: We have 3 business days after we receive the request to make our decision.

If we deny your request: You may immediately appeal to Level 3.
If we grant your request: We will authorize the service and the appeal is over.
If we refer your case to Level 3: We may decide to skip Level 2 and send your case straight to an independent reviewer at Level 3.

Level 3: Expedited External, Independent Review

Your request: You may appeal to Level 3 only after you have appealed through Levels 1 and 2. You have only 5 business days after you receive our Level 2 decision to send us your written request for Expedited External Independent Review. Send your request and any more supporting information to:

Humana
Grievance and Appeal Department
PO Box 14546
Lexington, KY 40512-4546
Phone: 1-(800) 901-1303
Fax: 1-(920) 339-2112

Neither you nor your treating provider is responsible for the cost of any external independent review.

The process: There are two types of Level 3 appeals, depending on the issues in your case:

(1) Medical necessity
These are cases where we have decided not to authorize a service because we think the services you (or your treating provider) are asking for, are not medically necessary to treat your problem. For medical necessity cases, the independent reviewer is a provider retained by an outside independent review organization ("IRO"), that is procured by the Arizona Insurance Department, and not connected with our company. The IRO provider must be a provider who typically manages the condition under review.

(2) Contract coverage
These are cases where we have denied coverage because we believe the requested service is not covered under your insurance policy. For contract coverage cases, the Arizona Insurance Department is the independent reviewer.

Medical Necessity Cases

Within 1 business day of receiving your request, we must:

1. Mail a written acknowledgement of the request to the Director of Insurance, you, and your treating provider.
2. Send the Director of Insurance: the request for review; your policy, evidence of coverage or similar document; all medical records and supporting documentation used to render our decision; a summary of the applicable issues including a statement of our decision; the criteria used and clinical reasons for our decision; and the relevant portions of our utilization review guidelines. We must also include the name and credentials of the health care provider who reviewed and upheld the denial at the earlier appeal levels.

Within 2 business days of receiving our information, the Insurance Director must send all the submitted information to an external independent reviewer organization (the "IRO").

Within 72 hours of receiving the information the IRO must make a decision and send the decision to the Insurance Director.

Within 1 business day of receiving the IRO's decision, the Insurance Director must mail a notice of the decision to us, you, and your treating provider.

The decision (medical necessity): If the IRO decides that we should provide the service, we must authorize the service. If the IRO agrees with our decision to deny the service, the appeal is over. Your only further option is to pursue your claim in Superior Court.

Contract Coverage Cases

Within 1 business day of receiving your request, we must:

1. Mail a written acknowledgement of your request to the Insurance Director, you, and your treating provider.
2. Send the Director of Insurance: the request for review, your policy, evidence of coverage or similar document, all medical records and supporting documentation used to render our decision, a summary of the applicable issues including a statement of our decision, the criteria used and any clinical reasons for our decision and the relevant portions of our utilization review guidelines.

Within 2 business days of receiving this information, the Insurance Director must determine if the service or claim is covered, issue a decision, and send a notice to us, you, and your treating provider.

Referral to the IRO for contract coverage cases: The Insurance Director is sometimes unable to determine issues of coverage. If this occurs, the Insurance Director will forward your case to an IRO. The IRO will have 5 business days to make a decision and send it to the Insurance Director. The Insurance Director will have 1 business day after receiving the IRO's decision to send the decision to us, you, and your treating provider.

The decision (contract coverage): If you disagree the with Insurance Director's final decision on a contract coverage issue, you may request a hearing with the Office of Administrative Hearings ("OAH"). If we disagree with the Director's final decision, we may also request a hearing before OAH. A hearing must be requested within 30 days of receiving the Director's decision. OAH must promptly schedule and complete a hearing for appeals from expedited Level 3 decisions.

STANDARD APPEAL PROCESS FOR NON-URGENT SERVICES AND DENIED CLAIMS

Level 1. Informal Reconsideration

Your request: You may obtain Informal Reconsideration of your denied request for a service if:

- You have coverage with us,
- We denied your request for a covered service,
- You do not qualify for an expedited appeal, and
- You or your treating provider asks for Informal Reconsideration within 2 years of the date we first deny the requested service by calling, writing, or faxing your request to:

Humana
Grievance and Appeal Department
PO Box 14546
Lexington, KY 40512-4546
Phone: 1-(800) 901-1303
Fax: 1-(920) 339-2112

Claim for a covered service already provided but not paid for: You may not obtain Informal Reconsideration of your denied request for the payment of a covered service. Instead, you may start the review process by seeking Formal Appeal.

Our acknowledgement: We have 5 business days after we receive your request for Informal Reconsideration ("the receipt date") to send you and your treating provider a notice that we got your request.

Our decision: We have 30 days after the receipt date to decide whether we should change our decision and authorize your requested service. Within that same 30 days, we must send you and your treating provider our written decision. The written decision must explain the reasons for our decision and tell you the documents on which we based our decision.

If we deny your request: You have 60 days to appeal to Level 2.
If we grant your request: The decision will authorize the service and the appeal is over.
If we refer your case to Level 3: We may decide to skip Level 1 and Level 2 and send your case straight to an independent reviewer at Level 3.

Level 2. Formal Appeal

Your request: You may request Formal Appeal if: (1) we deny your request at Level 1, or (2) you have an unpaid claim and we did not provide a Level 1 review. After you receive our Level 1 denial, you or your treating provider must send us a written request within 60 days to tell us you are appealing to Level 2. If we did not provide a Level 1 review of your denied claim, you have 2 years from our first denial notice to request Formal Appeal. To help us make a decision on your appeal, you or your provider should also send us any more information (that you haven't already sent us) to show why we should authorize the requested service or pay the claim. Send your appeal request and information to:

Humana
Grievance and Appeal Department
PO Box 14546
Lexington, KY 40512-4546
Phone: 1-(800) 901-1303
Fax: 1-(920) 339-2112

Our acknowledgement: We have 5 business days after we receive your request for Formal Appeal ("the receipt date") to send you and your treating provider a notice that we got your request.

Our decision: For a denied service that you have not yet received, we have 30 days after the receipt date to decide whether we should change our decision and authorize your requested service. For denied claims, we have 60 days to decide whether we should change our decision and pay your claim. We will send you and your treating provider our decision in writing. The written decision must explain the reasons for our decision and tell you the documents on which we based our decision.

If we deny your request or claim: You have 4 months to appeal to Level 3.
If we grant your request: We will authorize the service or pay the claim and the appeal is over.
If we refer your case to Level 3: We may decide to skip Level 2 and send your case straight to an independent reviewer at Level 3.

Level 3: External, Independent Review

Your request: You may appeal to Level 3 only after you have appealed through Levels 1 and 2. You have 4 months after you receive our Level 2 decision to send us your written request for External Independent Review. Send your request and any more supporting information to:

Humana
Grievance and Appeal Department
PO Box 14546
Lexington, KY 40512-4546
Phone: 1-(800) 901-1303
Fax: 1-(920) 339-2112

Neither you nor your treating provider is responsible for the cost of any external independent review.

The process: There are two types of Level 3 appeals, depending on the issues in your case:

(1) Medical necessity

These are cases where we have decided not to authorize a service because we think the services you (or your treating provider) are asking for, are not medically necessary to treat your problem. For medical necessity cases, the independent reviewer is a provider retained by an outside independent review organization (IRO), procured by the Arizona Insurance Department, and not connected with our company. For medical necessity cases, the provider must be a provider who typically manages the condition under review.

(2) Contract coverage

These are cases where we have denied coverage because we believe the requested service is not covered under your insurance policy. For contract coverage cases, the Arizona Insurance Department is the independent reviewer.

Medical Necessity Cases

Within 5 business days of receiving your request, we must:

1. Mail a written acknowledgement of the request to the Director of Insurance, you, and your treating provider.
2. Send the Director of Insurance: the request for review; your policy, evidence of coverage or similar document; all medical records and supporting documentation used to render our decision; a summary of the applicable issues including a statement of our decision; the criteria used and clinical reasons for our decision; and the relevant portions of our utilization review guidelines. We must also include the name and credentials of the health care provider who reviewed and upheld the denial at the earlier appeal levels.

Within 5 days of receiving our information, the Insurance Director must send all the submitted information to an external independent review organization (the "IRO").

Within 21 days of receiving the information the IRO must make a decision and send the decision to the Insurance Director.

Within 5 business days of receiving the IRO's decision, the Insurance Director must mail a notice of the decision to us, you, and your treating provider.

The decision (medical necessity): If the IRO decides that we should provide the service or pay the claim, we must authorize the service or pay the claim. If the IRO agrees with our decision to deny the service or payment, the appeal is over. Your only further option is to pursue your claim in Superior Court.

Contract Coverage Cases

Within 5 business days of receiving your request, we must:

1. Mail a written acknowledgement of your request to the Insurance Director, you, and your treating provider.
2. Send the Director of Insurance: the request for review; your policy, evidence of coverage or similar document; all medical records and supporting documentation used to render our decision; a summary of the applicable issues including a statement of our decision; the criteria used and any clinical reasons for our decision; and the relevant portions of our utilization review guidelines

Within 15 business days of receiving this information, the Insurance Director must determine if the service or claim is covered, issue a decision, and send a notice to us, you, and your treating provider. If the Director decides that we should provide the service or pay the claim, we must do so.

Referral to the IRO for contract coverage cases: The Insurance Director is sometimes unable to determine issues of coverage. If this occurs, the Insurance Director will forward your case to an IRO. The IRO will have 21 days to make a decision and send it to the Insurance Director. The Insurance Director will have 5 business days after receiving the IRO's decision to send the decision to us, you, and your treating provider.

The decision (contract coverage): If you disagree with the Insurance Director's final decision on a coverage issue, you may request a hearing with the Office of Administrative Hearings ("OAH"). If we disagree with the Director's determination of coverage issues, we may also request a hearing at OAH. Hearings must be requested within 30 days of receiving the coverage issue determination. OAH has rules that govern the conduct of their hearing proceedings.

Obtaining Medical Records

Arizona law (A.R.S. §12-2293) permits you to ask for a copy of your medical records. Your request must be in writing and must specify who you want to receive the records. The health care provider who has your records will provide you or the person you specified with a copy of your records.

Designated Decision-Maker: If you have a designated health care decision-maker, that person must send a written request for access to or copies of your medical records. The medical records must be provided to your health care decision-maker or a person designated in writing by your health care decision-maker unless you limit access to your medical records only to yourself or your health care decision-maker.

Confidentiality: Medical records disclosed under A.R.S. §12-2293 remain confidential. If you participate in the appeal process, the relevant portions of your medical records may be disclosed only to people authorized to participate in the review process for the medical condition under review. These people may not disclose your medical information to any other people.

Documentation for an Appeal

If you decide to file an appeal, you must give us any material justification or documentation for the appeal at the time the appeal is filed. If you gather new information during the course of your appeal, you should give it to us as soon as you get
it. You must also give us the address and phone number where you can be contacted. If the appeal is already at Level 3, you should also send the information to the Department.

The Role of the Director of Insurance

Arizona law (A.R.S. §20-2533(F)) requires "any member who files a complaint with the Department relating to an adverse decision to pursue the review process prescribed" by law. This means, that for appealable decisions, you must pursue the health care appeals process before the Insurance Director can investigate a complaint you may have against our company based on the decision at issue in the appeal.

The appeal process requires the Director to:

1. Oversee the appeals process.
2. Maintain copies of each utilization review plan submitted by insurers.
3. Receive, process, and act on requests from an insurer for External, Independent Review.
4. Enforce the decisions of insurers.
5. Review decisions of insurers.
6. Report to the Legislature.
7. Send, when necessary, a record of the proceedings of an appeal to Superior Court or to the Office of Administrative Hearings (OAH).
8. Issue a final administrative decision on coverage issues, including the notice of the right to request a hearing at OAH.

Receipt of Documents

Any written notice, acknowledgment, request, decision or other written document required to be mailed is deemed received by the person to whom the document is properly addressed on the fifth business day after being mailed. "Properly addressed" means your last known address.

Humana
Grievance and Appeal Department
PO Box 14546
Lexington, KY 40512-4546
Fax: 1-(920) 339-2112

HEALTH CARE APPEAL REQUEST FORM

You may use this form to tell your insurer you want to appeal a denial decision.

Insured Member's Name _____ Member ID # _____
Name of representative pursuing appeal, if different from above _____
Mailing Address _____ Phone # _____
City _____ State _____ Zip Code _____

Type of Denial: ☐ Denied Claim ☐ Denied Service Not Yet Received

Name of Insurer that denied the claim/service: _____

If you are appealing your insurer's decision to deny a service you have not yet received, will a 30 to 60 day delay in receiving the service likely cause a significant negative change in your health? If your answer is "Yes," you may be entitled to an expedited appeal. Your treating provider must sign and send a certification and documentation supporting the need for an expedited appeal.

What decision are you appealing? _____
_____
_____

(Explain what you want your insurer to authorize or pay for.)

Explain why you believe the claim or service should be covered:
_____
_____
_____
_____
_____
_____
_____

(Attach additional sheets of paper, if needed.)

If you have questions about the appeals process or need help to prepare your appeal, you may call the Department of Insurance Consumer Assistance number (602) 364-2499 or 1-(800) 325-2548, or Humana at 1-(800) 901-1303.

Make sure to attach everything that shows why you believe your insurer should cover your claim or authorize a service, including: ☐ Medical records ☐ Supporting documentation (letter from your doctor, brochures, notes, receipts, etc.) **Also attach the certification from your treating provider if you are seeking expedited review.

_____ _____
Signature of insured or authorized representative Date

Please submit completed form to address stated above.

Offered by Humana Health Plan, Inc. or Insured by Humana Insurance Company, Emphesys Insurance Company, HumanaDental Insurance Company or CompBenefits Insurance Company. Please refer to your Benefit Plan Document/Policy for more information in the company providing you benefits.

Humana
Grievance and Appeal Department
PO Box 14546
Lexington, KY 40512-4546
Fax: 1-(920) 339-2112

PROVIDER CERTIFICATION FORM FOR EXPEDITED MEDICAL REVIEWS

(You and your provider may use this form when requesting an expedited appeal.)

A patient who is denied authorization for a covered service is entitled to an expedited appeal if the treating provider certifies and provides supporting documentation that the time period for the standard appeal process (about 60 days) "is likely to cause a significant negative change in the patient's medical condition at issue."

PROVIDER INFORMATION

Treating Physician/Provider _____
Phone # _____ FAX # _____
Address _____
City _____ State _____ Zip Code _____

PATIENT INFORMATION

Patient's Name _____ Member ID # _____
Phone # _____
Address _____
City _____ State _____ Zip Code _____

INSURER INFORMATION

Insurer Name_____
Phone # _____ FAX # _____
Address _____
City _____ State _____ Zip Code _____

- Is the appeal for a service that the patient has already received? ☐ Yes ☐ No
  If "Yes," the patient must pursue the standard appeals process and cannot use the expedited appeals process.
  If "No," continue with this form.
- What service denial is the patient appealing? _____
  _____
- Explain why you believe the patient needs the requested service and why the time for the standard appeal process will harm the patient. _____
  _____
  _____

Attach additional sheets if needed, and include: ☐ Medical records ☐ Supporting documentation

If you have questions about the appeals process or need help regarding this certification, you may call the Department of Insurance Consumer Assistance number (602) 364-2499 or 1 (800) 325-2548. You may also call Humana at 1 (800) 901-1303.

I certify, as the patient's treating provider, that delaying the patient's care for the time period needed for the informal reconsideration and formal appeal processes (about 60 days) is likely to cause a significant negative change in the patient's medical condition at issue.

Provider's Signature _____ Date _____
Please submit completed form to address stated above.

Offered by Humana Health Plan, Inc. or Insured by Humana Insurance Company, Emphesys Insurance Company, HumanaDental Insurance Company or CompBenefits Insurance Company. Please refer to your Benefit Plan Document/Policy for more information in the company providing you benefits.

GUIDE TO YOUR CONTRACT

Contents **Page number**

INTRODUCTION

As *you* read through this *contract*, *you* will notice that certain words and phrases are printed in *italics*. An *italicized* word may have a different meaning in the context of this *contract* than it does in general usage. Please check the "Definitions" section for the meanings of *italicized* words.

This *contract* provides *you* with detailed information regarding *your* coverage. It explains what is covered and what is not covered. It also identifies *your* duties and how much *you* must pay when obtaining *services*. Although *your* coverage is broad in scope it is important to remember that *your* coverage has limitations and exclusions. Be sure to read *your contract* carefully before using *your* benefits.

This *contract* should be read in its entirety. Since many of the provisions of this *contract* are related, *you* should read the entire *contract* to get a full understanding of *your* coverage.

Please note that provisions and conditions of this *contract* apply to *you* and to each of *your covered dependents*.

This *contract* overrides and replaces any health contract or certificate previously issued to *you* by *us*.

If *you* have any questions about this *contract*, please call the telephone number on *your ID card*.

This *contract* requires that each *covered person* select a *primary care physician* who will be responsible for providing primary medical care and helping to guide any care received from other medical care providers. This *contract* also requires that a referral be obtained from the *primary care physician* before receiving non-*emergency* medical care from any medical care provider other than the *primary care physician*, an in-network *urgent care center* or an in-network *retail clinic*. If a referral is not obtained prior to receiving *services*, such *services* will not be a *covered expense*. See the "Access to Care" section for a description of these *contract* requirements.

ACCESS TO CARE

How to find an in-network provider

An online directory of *in-network providers* is available to *you* via www.humana.com at the time *you* apply for coverage. This directory is subject to change at any time. Due to the possibility of *in-network providers* changing status, please check the online directory of *in-network providers* prior to obtaining *services*. If *you* do not have access to the online directory, call the telephone number on *your ID card* prior to *services* being rendered or to request a copy of a directory to be sent to *you* via e-mail or regular U.S. mail.

Use of in-network providers

In-network providers have agreed to provide *covered expenses* at lower costs. A *covered person* must pay any *copayment, deductible* or *coinsurance* they owe to the *in-network provider*. The *in-network provider* will accept a *covered person's copayment, deductible* or *coinsurance* and the amount *we* pay as the full payment for the *covered expenses* incurred. A *covered person* is not responsible for charges over the *net charges*. A *covered person* is responsible for payment of all non-covered *services*.

Be sure to determine if the provider is an *in-network provider* before receiving *services* from them. *We* offer many medical plans, and a provider who participates in one plan may not necessarily be an *in-network provider* for this *contract*.

Selecting a primary care physician

Each *covered person* on this *contract* must choose a *primary care physician* who will be responsible for providing primary medical care and helping to guide any care received from other medical care providers. If a *covered person* fails to select a *primary care physician*, one will be assigned by *us*. A *covered person* may choose an *in-network provider* who practices in the areas of family practice, general practice or internal medicine as their *primary care physician*. An in-network pediatrician may also be chosen as the *primary care physician* for each child.

Role of the primary care physician

A *covered person's primary care physician* is responsible for providing primary medical care and helping to guide any care they receive from other medical care providers, including *specialty care physicians*. Referrals to *specialty care physicians* are required by *us* and must be received prior to *services* being received.

When a primary care physician is not available

When a *covered person's primary care physician* is unavailable, a *covered person* may need to obtain *services* from the *in-network provider* designated by their *primary care physician* to provide patient care when the *primary care physician* is not available. Please be sure to discuss these arrangements with the *primary care physician*.

When a dependent child resides outside the service area

A *dependent* child who resides outside of the service area is eligible for coverage as a *dependent*. However, *covered services* outside the service area are limited to *emergency care* and urgent care. All other *services* including follow-up care for *emergency care* and urgent care *services* must be obtained in the service area under the direction of an *in-network provider*.

ACCESS TO CARE

Seeing a specialist

All medical needs should be discussed with the *primary care physician*. If a *covered person* and their *primary care physician* determine that there is a need to see a *specialty care physician*, *you* and *your primary care physician* should determine the most appropriate in-network *specialty care physician*. In order for *services* received from a *specialty care physician* to be considered *covered expenses* a referral is required. The referral must be approved by *us* prior to the *services* being rendered. *Your primary care physician* should initiate a request for a referral with *us* which includes the name of the *specialty care physician you* will be utilizing. *Services* received without the required *primary care physician* referral or received prior to *our* approval of the referral will not be considered *covered expenses* and no benefits will be payable.

You or any *covered person* under this *contract* may request a standing referral from *us*, to a *specialty care physician* when all of the following conditions are met:

a. The *covered person* has a disease or condition that is life threatening, degenerative, chronic or disabling;
b. The *covered person's primary care physician* or registered nurse practitioner in conjunction with the *specialty care physician* determine that the *covered person*'s health care requires a *specialty care physician's* expertise;
c. The *covered person's primary care physician* or registered nurse practitioner determines that the *covered person's* condition will require ongoing medical treatment for an extended period of time;
d. The standing referral is made by the *covered person's primary care physician* or registered nurse practitioner to a *specialty care physician* who is responsible for providing and coordinating the *covered person's* specialty care;
e. The *specialty care physician* is authorized by *us* to provide *services* under the standing referral; and
f. The *specialty care physician* remains an *in-network provider.*

The number of visits and the time period for which *you* or the *covered person* may receive a standing referral may be limited by *us.*

Open access to specialists

We allow open access to certain *specialty care physicians* without a referral from a *primary care physician* or authorization from *us*. These include obstetrical and gynecological *services* from an in-network *healthcare practitioner*.

ACCESS TO CARE

Seeking emergency care services

If *you* need *emergency care*:

1. Go to the nearest in-network *hospital* emergency room; or
2. Find the nearest *hospital* emergency room if *your* condition does not allow time to locate an in-network *hospital*.

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

If *you* seek *emergency care* at an out-of-network *hospital*, arrangements will be made to transfer *you* to an in-network *hospital* after *your* condition is *medically stable*. *Medically stable* means that *you* can be transported by ambulance with no expected increase in morbidity or mortality, as determined by *us* and *your* attending *healthcare practitioner*.

If *we* deem a transfer is appropriate and the transfer does not take place, benefits will be denied for *your* continued *hospital confinement* at the out-of-network *hospital*. If *you* refuse to be transferred, benefits will denied from the date *your* condition is *medically stable*.

You must see an *in-network provider* for any follow-up care to receive benefits at the *in-network provider* medical payment level as shown on the "Schedule of Benefits". These *services* are subject to any applicable *copayment, deductible,* and *coinsurance*. Follow up care from an *out-of-network provider* will not be covered.

Seeking urgent care services

The steps for seeking urgent care *services* are as follows:

1. Contact the *primary care physician* or the *in-network provider* designated by the *primary care physician* to provide patient care when *the primary care physician* is not available.
2. If the *primary care physician* is unavailable, *you* may go to an *urgent care center* that is an *in-network provider*. *You* can obtain the names of *in-network provider urgent care centers* by accessing our online directory of *in-network providers* on *our* Website at www.humana.com or by calling *us*.
3. *You* must receive any follow-up *services* from the *primary care physician* or an *in-network provider*.
4. *You* must pay any applicable *deductible, copayment,* and *coinsurance* required for urgent care.

Services provided by an out-of-network *urgent care center* are not *covered expenses* under this *contract*.

Use of out-of-network providers

No benefits are available for *services* from an *out-of-network provider* that are not authorized in advance by *us*. If seeing an *out-of-network provider* is determined to be necessary, an authorization must be obtained from *us*. This authorization must be obtained prior to seeking *services*, unless such authorization cannot be reasonably obtained. Only those *services* authorized by *us* to be provided by an *out-of-network provider* will be *covered expenses*. *You* are not responsible for charges in excess of the fee charged by the *out-of-network provider* or the negotiated fee; however *you* are responsible for any applicable *deductible, coinsurance* and/or *copayment* for *covered expenses* received.

ACCESS TO CARE

Not all *healthcare practitioners* who provide *services* at in-network *hospitals* are in-network *healthcare practitioners*. If *services* are provided by out-of-network pathologists, anesthesiologists, radiologists, and emergency room physicians at an in-network *hospital*, *we* will pay for those *services* at the *in-network provider* benefit level. *You* are not responsible for charges in excess of the fee charged by the *out-of-network provider* or the negotiated fee; however *you* are responsible for any applicable *deductible*, *coinsurance* and/or *copayment* for *covered expenses* received. If possible, *you* may want to verify whether *services* are available from in-network *healthcare practitioners*.

It is *your* responsibility to verify the network participation status of all providers prior to receiving all non-emergency *services*. *You* should verify network participation status, only from *us*, by either accessing *your* network information on *our* Website at www.humana.com or calling the telephone number on *your ID card*. Only those *services* preauthorized by *us* to be provided by an *out-of-network provider* will be a *covered expense.*

Our financial arrangements with providers

Many *in-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 *in-network providers* may have capitation agreements. This means the 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 *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 a discount from their normal charges.

Continuity of care

We will allow any new *covered person* whose *healthcare practitioner* is not an *in-network provider*, on written request of the *contractholder*, to continue an active course of treatment with that *healthcare practitioner* during a transitional period after the *effective date* if both of the following apply:

1. The *covered person* has either:
   a. A life threatening disease or condition, in which case the transitional period is not more than 30 days after the *effective date* of the *covered person*; or
   b. Entered the third trimester of pregnancy on or after the *effective date*, in which case the transition period includes the delivery and any related care up to six weeks after the delivery; and

2. The *covered person's healthcare practitioner* agrees in writing to do all of the following:
   a. Accept as payment in full, reimbursement at the rates that are established by *us*, except for any deductible, coinsurance, or copayments. Reimbursement rates will be no greater than the level of reimbursement applicable to similar *services* by *healthcare practitioners* within the network;
   b. Comply with *our* quality assurance and utilization review requirements and provide *us* with any necessary medical information related to the care; and
   c. Comply with *our* policies and procedures including procedures relating to referrals and obtaining *preauthorization* for medical *services* or *prior authorization* for *prescription* drugs, claims handling, and treatment plan approval.

ACCESS TO CARE

We will allow any *covered person* whose *healthcare practitioner* is terminated from the network by *us* except for reasons of medical incompetence or unprofessional conduct, on written request of the *contractholder*, to continue an active course of treatment with that *healthcare practitioner* during a transitional period after the date of the *healthcare practitioner's* termination from the network, if both of the following apply:

1. The *covered person* has either:
   a. A life threatening disease or condition, in which case the transitional period is 30 days after the date of the *healthcare practitioner's* disaffiliation from the network; or
   b. Entered the third trimester of pregnancy on the date of the *healthcare practitioner's* termination, in which case the transition period includes the delivery and any care up to six weeks after the delivery that is related to the delivery; and

2. The *covered person's healthcare practitioner* agrees in writing to do all of the following:
   a. Except for *copayment*, *coinsurance* or *deductible* amounts, continue to accept as payment in full reimbursement at the rates applicable before the beginning of the transitional period;
   b. Comply with *our* quality assurance and utilization review requirements and provide *us* with any necessary medical information related to the care; and
   c. Comply with *our* policies and procedures including procedures relating to referrals and obtaining *preauthorization*, claims handling and treatment plan approval.

Preauthorization for medical services and prior authorization for prescription drugs

All benefits payable under this *contract* must be for medical *services* or *prescription* drugs that are *medically necessary* or for preventive *services* as stated in this *contract*. *Preauthorization* by *us* is required for certain medical *services* and *prior authorization* by *us* is required for certain *prescription* drugs, medicines or medications, including *specialty drugs*. Certain *prescription* drugs, medicines or medication, including *specialty drugs*, may also require *step therapy*. Visit *our* Website at www.humana.com or call the telephone number on *your ID card* to obtain a list of medical *services* that require *preauthorization* or a list of *prescription* drugs, medicines or medications, including *specialty drugs*, that require *prior authorization* and/or *step therapy*. These lists are subject to change. Coverage provided in the past for medical *services* that did not receive or require *preauthorization* and coverage in the past for *prescription* drugs, medicines or medications, including *specialty drugs*, that did not receive or require *prior authorization* and/or *step therapy* is not a guarantee of future coverage of the same medical *service* or *prescription* drug, medicine, medication or *specialty drug*.

Your healthcare practitioner must contact *our* Clinical Pharmacy Review by calling the number on *your ID card* to request and receive *our* approval for *prescription* drugs, medicine or medication including *specialty drugs* that require *prior authorization* and/or *step therapy*. Benefits are payable only if approved by *us*.

You or *your healthcare practitioner* must contact *us* by telephone, *electronically* or in writing to request the appropriate authorization. *Your ID card* will show the *healthcare practitioner* the telephone number to call to request authorization. No benefits are payable for medical *services* or *prescription* drugs that are not *covered expenses*.

GENERAL EXCLUSIONS

Below is a list of limitations and exclusions on *contract* benefits. Please review the entire document, as there may be multiple limitations applying to a particular *service*. These limitations and exclusions apply even if a *healthcare practitioner* has performed or prescribed a medically appropriate *service*. This does not prevent *your healthcare practitioner* from providing or performing the *service*, however, the *service* will not be a *covered expense*.

For the current recommended preventive *services*, including over the counter drugs recommended by the United States Preventive Task Force, please see the Health and Human Services (HHS) website at www.healthcare.gov and the "Preventive Medical Services" provision of this *contract*.

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

1. *Services* which require a *primary care physician* referral if the referral was not approved by *us* prior to the *service* being rendered or a referral was not obtained;
2. *Services* provided by an *out-of-network provider*, except when:
   a. Authorized by *us*;
   b. A referral is obtained from a *primary care physician* and *we* have approved the referral prior to the *service* being rendered; or
   c. The following *services* are *medically necessary* to render *emergency care*;
      i. Licensed ambulance *service*;
      ii. *Services* in a *hospital* emergency room; or
      iii. *Services* in an *urgent care center*;
3. *Services* for care and treatment of non-covered procedures;
4. *Services* incurred before the *effective date* or after the termination date of this *contract*;
5. *Services* not *medically necessary* for diagnosis and treatment of *a bodily injury* or *sickness* or do not meet *our* medical and *pharmacy* coverage policies, claim payment policies or benefit *contract* guidelines, except for the specified routine preventive medical *services*;
6. *Services* performed in association with a *service* that is not covered under this *contract*;
7. Expenses for prophylactic *services* performed to prevent a disease process from becoming evident in the organ tissue at a later date other than a prophylactic mastectomy;
8. *Services* which *are experimental, investigational or for research purposes*, or related to such, whether incurred prior to, in connection with, or subsequent to the *service* which is *experimental, investigational or for research purposes* as determined by *us*. The fact that a *service* is the only available treatment for a condition does not make it eligible for coverage if *we* deem it to be *experimental, investigational or for research purposes*;
9. Complications directly related to a *service* that is not a *covered expense* under this *contract* because it was determined by *us* to be *experimental, investigational or for research purposes* or not *medically necessary*. Directly related means that the complication occurred as a direct result of the *service* that was *experimental, investigational or for research purposes* or not *medically necessary* and the complication would not have taken place in the absence of the *service* that was *experimental, investigational or for research purposes* or not a *medically necessary service*;
10. *Services* exceeding the amount of benefits available for a particular *service*;
11. *Services* for any condition excluded by amendment under this *contract*;
12. *Services* provided when this *contract* is past the premium due date and the required premium is not received within 31 days (90 days if *you* are receiving an Advanced Premium Tax Credit (APTC)) after the premium is due and the *contract* is terminated;
13. *Services* for treatment of complications of non-covered procedures or *services*;

GENERAL EXCLUSIONS

14. *Services* relating to a *sickness* or *bodily injury* incurred as a result of the *covered person* operating a motorized vehicle while intoxicated, as defined by applicable law in the state in which the loss occurred, unless the condition is reported as a result of *mental illness* or *chemical dependency;*
15. *Services* where *sickness* or *bodily injury* was contributed to by the *covered person* being under the influence of illegal narcotics or a controlled substance, unless the condition is reported as a result of *mental illness* or *chemical dependency*, or the controlled substance is administered by or used as prescribed by a *healthcare* practitioner;
16. *Services* relating to a *sickness* or *bodily injury* as a result of:
    a. War or an act of war, whether declared or not;
    b. Taking part in a riot; or
    c. Any act of armed conflict, or any conflict involving armed forces or any authority;
17. *Services*:
    a. For expenses which are not authorized, furnished or prescribed by a *healthcare practitioner* or *healthcare treatment facility*;
    b. For which no charge is made, or for which the *covered person* would not be required to pay if he/she did not have this insurance, unless expenses are received from and reimbursable to the United States government or any of its agencies as required by law;
    c. Furnished by or payable under any plan or law through a government or any political subdivision, unless prohibited by law;
    d. Furnished while a *covered person* is *confined* in a *hospital* or institution owned or operated by the United States government or any of its agencies for any service-connected *sickness* or *bodily injury*;
    e. For expenses received from a *healthcare practitioner* over the *net charges we* would pay for the least costly provider;
    f. Which are not rendered by the billing provider;
    g. Which are not substantiated in the medical records by the billing provider;
    h. Provided by a *family member* or person who resides with the *covered person*; or
    i. Rendered by a standby *health*care *practitioner*, surgical assistant, assistant surgeon, physician's assistant, *nurse* or certified operating room technician unless *medically necessary*;
18. Any expenses, including *healthcare practitioner* expenses, which are incurred if a *covered person* is admitted to a *hospital* on a Friday or Saturday unless:
    a. The *hospital* admission is due to *emergency care*; and
    b. Treatment or *surgery* is performed on that same day;
19. *Hospital inpatient services* when the *covered person* is in *observation status*;
20. Cosmetic *services*, or any complication therefrom;
21. *Custodial care* and *maintenance care*;
22. Ambulance *services* for routine transportation to, from or between medical facilities and/or a *healthcare practitioner's* office except as expressly provided in this *contract*;
23. Medical or surgical procedures that are not *medically necessary* except elective tubal ligation and vasectomy;
24. Elective medical or surgical abortion unless:
    a. The pregnancy would endanger the life of the mother;
    b. The pregnancy is a result of rape or incest;
    c. Necessary to avert substantial and irreversible impairment of a major bodily function of the woman having the abortion;
25. Reversal of sterilization;
26. *Infertility services* except as expressly provided in the "Infertility services" provision of the "Your Contract Benefits" section of this *contract*;
27. Sexual dysfunction;
28. Sex change *services*, regardless of any diagnosis of gender role or psychosexual orientation problems;

GENERAL EXCLUSIONS

29. Vision examinations or testing for the purposes of prescribing corrective lenses except for routine eye screenings that are covered under preventive medical *services*; radial keratotomy; refractive keratoplasty; or any other *surgery* or procedure to correct myopia, hyperopia or stigmatic error; orthoptic treatment (eye exercises); or the purchase or fitting of eyeglasses or contact lenses, unless specified in this *contract*;
30. Dental *services*, appliances or supplies for treatment of the teeth, gums, jaws or alveolar processes including, but not limited to, excision of partially or completely unerupted impacted teeth except as expressly stated in this *contract*, any oral *surgery*, *endodontic services* or *periodontics*, preoperative and post operative care, implants and related procedures, orthodontic procedures except as expressly provided in this contract, and any dental *services* related to a *bodily injury* or *sickness* except as expressly provided in this *contract*;
31. *Pre-surgical/procedural testing* duplicated during a *hospital confinement*;
32. Surgical procedures for the removal of excess skin and/or fat in conjunction with or resulting from weight loss or a weight loss *surgery*;
33. Treatment of nicotine habit or addiction other than:
    a. Screening and cessation interventions for tobacco use; and
    b. FDA approved smoking cessation aids, prescription and over-the-counter medications with a *prescription* from a *healthcare practitioner*;
34. Educational or vocational training or therapy, *services*, and schools including but not limited to videos and books; nutritional therapy except as expressly provided in this *contract*;
35. Except as expressly provided in this *contract*, foot care *services* including but not limited to:
    a. Shock wave therapy of the feet;
    b. Treatment of weak, strained, flat, unstable or unbalanced feet;
    c. Hygienic care, and the treatment of superficial lesions of the feet, such as corns, calluses or hyperkeratosis;
    d. Tarsalgia, metatarsalgia or bunion treatment, except *surgery* which involves exposure of bones, tendons or ligaments;
    e. Cutting of toenails, except removal of nail matrix; and
    f. Arch supports, heel wedges, lifts, shoe inserts, the fitting or provision of foot orthotics or orthopedic shoes, unless *medically necessary* because of diabetes or hammertoe;
36. Hair prosthesis except as expressly provided in this *contract*, hair transplants or implants;
37. Hearing care that is routine, including but not limited to exams and tests except for routine hearing screenings that are covered under preventive medical *services*, any artificial hearing device, cochlear implant, auditory prostheses or other electrical, digital, mechanical or surgical means of enhancing, creating or restoring auditory comprehension, except as expressly provided in the "Hearing aids" provision of the "Your Contract Benefits" section of this *contract*;
38. *Services* rendered in a premenstrual syndrome clinic or holistic medicine clinic;
39. Transplant *services* except as expressly provided in this *contract*;
40. Charges for growth hormones;
41. Over the counter medical items or supplies that can be provided or prescribed by a *healthcare practitioner* but are also available without a written order or prescription except for drugs prescribed for use for a covered preventive medical *service* as recommended by the United States Preventive Task Force or smoking cessation aids*;*
42. Immunizations including those required for foreign travel for *covered persons* of any age except as expressly provided in this *contract*;

43. Treatment for any jaw joint problem (other than temporomandibular joint disorder), including but not limited to, craniomaxillary disorder, craniomandibular disorder, head and neck neuromuscular disorder or other conditions of the joint linking the jaw bone and skull to correct any of the above;
44. Genetic testing, counseling or *services* except for BRCA screening, counseling, and appropriate testing as recommended by the Health Resources and Services Association (HRSA), or unless *medically necessary* for the purpose of determining an appropriate course of treatment;
45. *Sickness* or *bodily injury* for which medical payments/personal injury protection (PIP) coverage exists under any automobile, homeowner, marine, aviation, premise or any other similar coverage whether such coverage is in effect on a primary, secondary or excess basis. This exclusion applies up to the available limit under the other coverage regardless of whether a claim is filed with the medical payments/PIP carrier. Whether medical payment or expense coverage is payable under another coverage is to be determined as if the coverage under this *contract* did not exist;
46. *Covered expense* to the extent of any amount paid by Workers' Compensation, "no-fault" and automobile medical payments for the bodily injuries or losses which necessitated such benefits;
47. Expense for employment, school, sports or camp physical examinations or for the purpose of obtaining insurance, or premarital tests or examinations;
48. *Services* received in an emergency room unless required because of *emergency care*;
49. Any expense including related complications incurred for *services* received outside of the United States except as required by law for *emergency care services*;
50. *Services* received during an inpatient stay when the stay is primarily related to behavioral, social maladjustment, lack of discipline or other antisocial actions which are not specifically the result of *mental health*;
51. *Services* and supplies which are:
    a. Rendered in connection with *mental illnesses* not classified in the International Classification of Diseases of the U.S. Department of Health and Human Services;
    b. Extended beyond the period necessary for evaluation and diagnosis of learning and behavioral disabilities or for mental retardation; and
    c. Marriage counseling;
52. *Services* rendered for:
    a. Immunotherapy for recurrent abortion;
    b. Chemonucleolysis (non-surgical treatment for a bulging disc that involves the injection of an enzyme in an intervertebral disc with the goal of dissolving the inner part of the disc);
    c. Biliary lithotripsy (procedure using high energy shock waves to fragment gall stones);
    d. Home uterine activity monitoring;
    e. Sleep therapy;
    f. Light treatment for Seasonal Affective Disorder (S.A.D.);
    g. Immunotherapy for food allergy;
    h. Prolotherapy (injection of an irritant solution);
    i. Hyperhidrosis (excessive sweating); and
    j. Sensory integration therapy;
53. Expenses incurred for a sickness or bodily injury arising out of, or in the course of, any employment for wage or profit if the covered person is insured, or is required to be insured by Workers' Compensation;
54. *Court-ordered mental health services* unless *medically necessary*;
55. Expenses for alternative medicine, including medical diagnosis, treatment, and therapy. Alternative medicine *services* includes, but is not limited to:
    a. Acupressure;
    b. Acupuncture;
    c. Aromatherapy;
    d. Ayurveda;

e. Biofeedback, except as expressly provided in the "Mental health" provision in the "Your Contract Benefits" section of this *contract*;
f. Faith healing;
g. Guided mental imagery;
h. Herbal medicine;
i. Holistic medicine;
j. Homeopathy;
k. Hypnosis;
l. Macrobiotic;
m. Massage therapy;
n. Naturopathy;
o. Ozone therapy;
p. Reflexotherapy;
q. Relaxation response;
r. Rolfing;
s. Shiatsu;
t. Yoga;
u. Herbs, nutritional supplements, and alternative medicines; and
v. Chelation therapy;

56. Private-duty nursing, except as expressly provided in the "Healthcare treatment facility services" provision of this *contract*;
57. Living expenses, travel, transportation, except for the following:
    a. As expressly provided in the "Ambulance services" in the "Schedule of Benefits" and the "Ambulance services" provision in the "Your Contract Benefits" section of this *contract*;
    b. As expressly provided in the "Transplant services" provision in the "Your Contract Benefits" section of this *contract*; or
    c. Travel expenses incurred as a result of travelling outside the service area to obtain out-of-network *services*;
58. Expenses for *services* (whether or not prescribed by a *healthcare practitioner*) that are primarily and customarily used for a non-medical purpose or used for environmental control or enhancement including but not limited to:
    a. Common household items such as air conditioners, air purifiers, water purifiers, vacuum cleaners, waterbeds, hypoallergenic mattresses or pillows or exercise equipment;
    b. Scooters or motorized transportation equipment, escalators, elevators, ramps, modifications or additions to living/working quarters or transportation vehicles;
    c. Personal hygiene equipment including bath/shower chairs, transfer equipment or supplies or bed side commodes;
    d. Personal comfort items including cervical pillows, gravity lumbar reduction chairs, swimming pools, whirlpools or spas or saunas;
    e. Medical equipment including blood pressure monitoring devices, PUVA lights and stethoscopes;
    f. Expenses for any membership fees or program fees paid by a *covered person*, including but not limited to:
        i. Health clubs;
        ii. Health spas;
        iii. Aerobic and strength conditioning;
        iv. Work-hardening programs and weight loss or similar programs; and
        v. Any related material or products related to these programs;
    g. Communication system, telephone, television or computer systems and related equipment or similar items or equipment; and
    h. Communication devices except after surgical removal of the larynx or a diagnosis of permanent lack of function of the larynx.

YOUR CONTRACT BENEFITS

Benefits are payable only if the *services* are *covered expenses*, and subject to specific conditions, exclusions and limitations, and applicable maximums of this *contract*. A *covered expense* is deemed to be incurred on the date a *covered service* is performed or furnished.

If *you* incur non-*covered expenses*, whether from an *in-network provider* or *out-of-network provider*, *you* are responsible for making the full payment to the healthcare provider. The fact that a *healthcare practitioner* has performed or prescribed a medically appropriate *service* or the fact that it may be the only available treatment for a *bodily injury* or *sickness*, does not mean that the *service* is covered under this *contract*.

We will pay benefits for *covered expenses* as stated in the "Schedule of Benefits" and this *contract* section, and according to the "General Exclusions" and "Prescription Drug Exclusions" sections and any amendments that may modify *your* benefits which are part of *your contract*. All benefits *we* pay will be subject to the *net charges* and all conditions, exclusions and limitations, and applicable maximums of this *contract*.

Upon a *covered person* receiving a *service*, *we* will determine if such *service* qualifies as a *covered expense*. After determining that the *service* is a *covered expense*, *we* will pay benefits as follows:

1. *We* will determine the total *net charges* for eligible *covered expenses* incurred related to a particular *service*.
2. If *you* are required to pay a *copayment we* will subtract that amount from the *net charges* for eligible *covered expenses* incurred.
3. If *you* are required to meet a *deductible* and *you* have not met the *deductible* requirement, *we* will subtract any amounts *you* are required to pay as part of *your deductible* from the *net charges* for the eligible *covered expenses* incurred.
4. If *you* have not yet incurred enough *coinsurance* expenses, if applicable, to equal the amount of the *out-of-pocket limit we* will subtract any *coinsurance* amounts *you* must pay from the *net charges* for eligible *covered expenses incurred*.
5. *We* will make payment for the remaining eligible *covered expenses* incurred to *you* or *your* servicing provider.

The amount *you* are responsible to pay for a *covered expense* rendered by a provider is only the applicable *copayment*, *coinsurance* or *deductible*.

Refer to the "General Exclusions" and "Prescription Drug Exclusions" sections in this contract. All terms and provisions of this contract, including the preauthorization and prior authorization requirements specified in this contract are applicable to covered expenses.

Ambulance (licensed air, ground and water)

Licensed ambulance service as follows:

1. From the scene of a medical emergency to the nearest appropriate medical facility equipped to provide treatment for *emergency care*; and
2. When required by *us* to transfer a *covered person* to the nearest appropriate medical facility equipped to provide the *medically necessary services*.

Autism spectrum disorder services

Covered expenses for the treatment of autism spectrum disorders include applied behavioral analysis (ABA) therapy.

No benefits will be provided for, or on account of:

1. Sensory integration;
2. LOVAAS therapy; or
3. Music therapy

Bariatric surgery

Bariatric *surgery* for a *covered person* who is 18 years of age or older or has reached full expected skeletal growth if all of the following criteria are met:

1. The *covered person* must have a body-mass index (BMI) greater than or equal to 35;
2. Have at least one co-morbidity related to obesity;
3. Had previous unsuccessful medical treatment for obesity including active participation within the last two years in one weight-management program supervised by a *healthcare practitioner* for a minimum of six months without significant gaps. The weight-management program must include monthly documentation of weight, dietary program and physical activity (exercise program). This information must be documented in the *covered person's* medical records.

The following bariatric procedures are considered *covered expenses* if the above requirements have been met and the *services* are performed at an approved Center of Excellence facility:

1. Open roux-en-y gastric bypass (RYGBP);
2. Laparoscopic roux-en-y gastric bypass (RYGBP);
3. Laparoscopic adjustable gastric banding (LABB);
4. Open biliopancreatic diversion with duodenal switch (BPD/DS); and
5. Laparoscopic biliopancreatic diversion with duodenal switch (BPD/DS).

No benefits will be provided for, or on account of:

1. Open vertical banded gastroplasty;
2. Laparoscopic vertical banded gastroplasty;
3. Open sleeve gastrectomy;
4. Laparoscopic sleeve gastrectomy; or
5. Open adjustable gastric banding.

Clinical trial

Routine costs for a *covered person* participating in an approved Phase I, II, III or IV clinical trial.

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

Routine costs do not include *services* that are:

1. *Experimental, investigational or for research purposes*;
2. Provided only for data collection and analysis that is not directly related to the clinical management of the *covered person*; or
3. 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:

1. Referred by a *healthcare practitioner*; or
2. 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 treatment of cancer or a life-threatening condition and is:

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

Dental services

1. Treatment for a *dental injury* to a *sound natural tooth*. Treatment must begin within six months from the date of the *dental injury*. *We* limit *covered expenses* to the least expensive *service* that *we* determine will produce professionally adequate results.
2. Certain oral surgical operations:
   a. 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;
   b. *Services* required to correct accidental injuries of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
   c. Reduction of fractures and dislocation of the jaw;
   d. External incision and drainage of abscess;
   e. External incision of cellulites;
   f. Incision and closure of accessory sinuses, salivary glands or ducts;
   g. Cutting of the tissue in the midline of the tongue (Frenectomy); and
3. Anesthesia and inpatient hospitalization for dental or oral *surgery* for a *covered person* with a hazardous medical condition which includes:
   a. Heart problems;
   b. Diabetes;
   c. Hemophilia;
   d. Dental extractions due to cancer related conditions;
   e. Probability of an allergic reaction; or
   f. Any other condition that could increase the danger of anesthesia;

4. Orthognathic *surgery* and related orthodontia *services* and appliances that change the occlusion of the teeth; and
5. Orthodontia for the treatment of congenital or developmental malformations, including but not limited to, when related to or developed as a result of cleft palate, with or without cleft lip.

The following Current Dental Terminology codes apply to orthodontia *services*:

D8010 Limited orthodontic treatment of the primary dentition
D8020 Limited orthodontic treatment of the transitional dentition
D8030 Limited orthodontic treatment of the adolescent dentition
D8050 Interceptive orthodontic treatment of the primary dentition
D8060 Interceptive orthodontic treatment of the transitional dentition
D8070 Comprehensive orthodontic treatment of the transitional dentition
D8080 Comprehensive orthodontic treatment of the adolescent dentition
D8210 Removable appliance therapy
D8220 Fixed appliance therapy
D8660 Pre-orthodontic treatment visit
D8670 Periodic orthodontic treatment visit (as part of contract)
D8680 Orthodontic retention (removal of appliances, construction and placement of retainer(s)

Diabetes services

The following *services* for a *covered person* with diabetes:

1. Routine eye exams;
2. Routine foot care; and
3. Outpatient self-management training and education prescribed by a *healthcare practitioner* for the treatment of:
   a. Insulin-dependent diabetes;
   b. Insulin-using diabetes;
   c. Gestational diabetes; and
   d. Non-insulin using diabetes.

Prescription drugs and supplies for the treatment of diabetes are explained under the "Prescription drug" and "Durable medical equipment and medical supplies" provisions.

Durable medical equipment and medical supplies

The following equipment, appliances, or devices specifically designed and intended for the care and treatment of a *bodily injury* or *sickness*:

1. Non-motorized wheelchair;
2. *Hospital* bed;
3. Ventilator;
4. Hospital type equipment;
5. Oxygen and rental of equipment for its administration;
6. Initial internal or external permanent prosthetic devices or supplies, including, but not limited to, limbs and eyes. The prosthetic devices for a lost limb or absent limb must be necessary to provide or to restore their minimal basic function. Replacement of prosthetic devices is a *covered expense* when the replacement is due to pathological changes, growth or when necessary due to wear;
7. Orthotics used to support, align, prevent or correct deformities. *Covered expense* does not include replacement orthotics, dental braces or oral and dental splints and appliances unless custom made for the treatment of documented obstructive sleep apnea;

8. Initial contact lenses or eyeglasses following cataract *surgery*;
9. Casts, splints (other than dental), trusses, braces (other than orthodontic), and crutches;
10. Wigs following cancer treatment (not to exceed one per lifetime);
11. The following special supplies up to a 30-day supply for the initial order or a subsequent refill, when prescribed by the *healthcare practitioner*:
    a. Surgical dressings;
    b. Catheters;
    c. Colostomy and ostomy supplies including but not limited to: bags, rings, belts, pouches, face plates, irrigation sleeves, catheters, skin barriers, gauze, adhesive, adhesive remover, deodorant and pouch covers;
    d. Flotation pads; and
    e. Equipment prescribed by a *healthcare practitioner* for the treatment of diabetes including insulin pumps and podiatric appliances;
12. Other *durable medical equipment*. Visit *our* Website at www.humana.com or call the telephone number on *your ID card* to obtain a list of *durable medical equipment*.

If the equipment and device include comfort or convenience items or features that exceed what is *medically necessary* in the situation or needed to treat the condition, reimbursement will be based on the *net charges* for a standard item that is a *covered expense*, serves the same purpose and is *medically necessary*. Any expense that exceeds the *net charges* for the standard item that is a *covered service* is the *covered person's* responsibility. For example, the reimbursement for a motorized wheelchair will be limited to the reimbursement for a standard wheelchair, when a standard wheelchair adequately accommodates the condition.

If the *covered person* chooses to upgrade the equipment or device, they will be responsible for the price difference between the cost of the standard item and the cost of the upgraded item.

Costs for these items will be limited to the lesser of the rental cost or the purchase price, as decided by *us*. If *we* determine the lesser cost is the purchase option, any amount paid as rent for such *durable medical equipment* shall be credited toward the purchase price.

No benefits will be provided for duplicate or similar rentals of *durable medical equipment*, as determined by *us*.

Emergency services

1. A *hospital* for the emergency room and ancillary *services*; and
2. An emergency room *healthcare practitioner* for *outpatient services* for treatment and stabilization of an emergency medical condition including psychiatric stabilization and assessment.

If *emergency services* are obtained through an *out-of-network provider*, benefits will be provided at the in-network medical payment level as shown on the "Schedule of Benefits" subject to any applicable *copayment*, *deductible*, and *coinsurance*.

If *you* need *emergency services*:

1. Go to the nearest in-network *hospital* emergency room; or
2. Find the nearest *hospital* emergency room if *your* condition does not allow time to locate an in-network *hospital*.

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

If *you* seek *emergency services* at an out-of-network *hospital*, arrangements will be made to transfer *you* to an in-network *hospital* after *your* condition is *medically stable*. *Medically stable* means that *you* can be transported by ambulance with no expected increase in morbidity or mortality, as determined by *us* and *your* attending *healthcare practitioner*.

If *we* deem a transfer is appropriate and the transfer does not take place, benefits will be denied for *your* continued *hospital confinement* at the out-of-network *hospital*. If *you* refuse to be transferred, benefits will be denied from the date *your* condition is *medically stable*.

You must see an *in-network provider* for any follow-up care to receive benefits at the *in-network provider* medical payment level as shown on the "Schedule of Benefits" subject to any applicable *copayment*, *deductible*, and *coinsurance.*

Family planning services

1. Medical history;
2. Physical examination;
3. Related laboratory tests;
4. Medical supervision in accordance with generally accepted medical practice;
5. Information and counseling on contraception;
6. Implanted/injected contraceptives; and
7. After appropriate counseling, medical s*ervices* connected with surgical therapies (vasectomy or tubal ligation).

Services and supplies under this provision include those not covered under the “Preventive services” provision.

Habilitative services

Habilitative services ordered and performed by a *healthcare practitioner* for a *covered person* with a developmental delay or defect or congenital anomaly, to learn or improve skills and functioning for daily living for the following:

1. Physical therapy *services*;
2. Occupational therapy *services*;
3. Spinal manipulations, adjustments, and modalities;
4. Speech therapy or speech pathology *services*; and
5. Audiology *services*.

No benefits will be provided for, or on account of group physical, occupational or speech therapy *services*.

These *services* are subject to an annual visit limit as shown on the "Schedule of Benefits".

Healthcare treatment facility services

1. Daily room and board for each day of *confinement* up to the semi-private room rate or private room rate when *medically necessary*;
2. *Confinement* in a critical care or intensive care unit;
3. Operating room;
4. Ancillary *services* (such as surgical dressings, supplies, casts, and splints);
5. Blood and blood plasma which is not replaced by donation;
6. Administration of blood and blood products including blood extracts or derivatives;
7. Other *healthcare treatment facility* charges;
8. Drugs and medicines that are provided or administered to the *covered person* while *confined* in a *hospital* or *skilled nursing facility*;
9. Private duty nursing during *confinement* if skilled nursing *services* are not available from the *healthcare treatment facility*;
10. Regularly scheduled treatment such as dialysis, chemotherapy, inhalation therapy or radiation therapy in a *healthcare treatment facility* as ordered by the *covered person's healthcare practitioner*; and
11. *Outpatient services* in a *hospital* or *free standing surgical facility*. The *covered expense* will be limited to the average semi-private room rate when the *covered person* is in *observation status.*

Healthcare practitioner services

1. *Healthcare practitioner* visits;
2. Diagnostic laboratory and radiology tests;
3. Neuropsychological tests;
4. Second surgical opinions;
5. *Surgery*. If several *surgeries* are performed during one operation, *covered services* will be subject to 100% of the *net charges* for the most complex procedure. For each additional procedure *we* will allow:
   a. 50% of *net charges* for the secondary procedure; and
   b. 25% of *net charges* for the third and subsequent procedures.

   If two surgeons work together as primary surgeons performing distinct parts of a single reportable procedure, *we* will allow each surgeon 62.5% of the fee for the procedure;
6. Surgical *services* rendered by a surgical assistant and/or assistant surgeon when *medically necessary*. Surgical assistants and/or assistant surgeon will be allowed at 20% of the *covered expense* for *surgery*;
7. Surgical *services rendered by* a physician assistant (P.A.), registered nurse (R.N.), nurse practitioner (N.P.) or a certified operating room technician when *medically necessary*. Physician assistants (P.A.), registered nurses (R.N.), and certified operating room technicians will be allowed at 10% of the *covered expense* for the *surgery*;
8. Anesthesia administered by a *healthcare practitioner* or certified registered anesthetist attendant to a *surgery*;
9. *Services* of a pathologist;
10. *Services* of a radiologist;
11. Counseling regarding preventive medications;
12. Allergy injections, therapy, testing, and serum. Therapy and testing for treatment of allergies must be approved by the American Academy of Allergy and Immunology or the Department of Health and Human Services or any of its offices or agencies; and
13. Injections other than allergy.

A *healthcare practitioner's* office visit includes only the following *services* performed on the same day or during the same encounter:

1. Taking a history;
2. Performing an examination;
3. Making a diagnosis or medical decision; and
4. Administering allergy shots.

Covered expenses incurred for *advanced imaging*, pulmonary function studies, cardiac catheterization, elektrocardiogram (EKG), electroencephalogram (EEG) are applied separately and are not considered part of the office visit.

Services for *mental health* are explained under the "Mental health" provision.

Hearing aids

Covered expenses for hearing aids for the following *services*:

1. New or replacement hearing aids no longer under warranty;
2. Cleaning or repair; and
3. Batteries for cochlear implants.

No benefits will be provided for, or on account of:

1. Cochlear implants; and
2. Batteries for hearing aids.

Home healthcare

Services provided by a licensed *home healthcare agency* at the *covered person's* home prescribed by a *healthcare practitioner* in lieu of *hospital services* provided that the *hospital services* would have been covered under this *contract*.

No benefits will be provided for, or on account of:

1. Charges for mileage or travel time to and from the *covered person's* home;
2. Wage or shift differentials for any representative of a *home healthcare agency*;
3. Charges for supervision of *home healthcare agencies*;
4. Charges for services of a home health aide;
5. *Custodial care*; and
6. Provision or administration of *self-administered injectable drugs*.

Hospice care

Covered expenses for *services* provided under a *hospice care program* furnished in a *hospice facility* or in the *covered person's* home by a *hospice care agency*. A *healthcare practitioner* must certify that the *covered person* is terminally ill with a life expectancy of six months or less:

1. Room and board in a *hospice facility*, when it is for management of acute pain or for an acute phase of chronic symptom management;
2. Other *services*;
3. Part-time nursing care provided by or supervised by a *nurse*;
4. Counseling for the *hospice patient* and his/her *immediate family members* by a licensed clinical social worker or pastoral counselor;

5. Medical social services for the *hospice patient* or his/her *immediate family members* under the direction of a *healthcare practitioner* including:
   a. Assessment of social, emotional, and medical needs and the home and family situation; and
   b. Identification of the community resources available;
6. Psychological and dietary counseling;
7. Physical therapy;
8. Part-time home health aide *services*; and
9. Medical supplies, drugs, and medicines prescribed by a *healthcare practitioner* for *palliative care*.

No benefits will be provided for, or on account of:

1. Private-duty nursing when *confined* in a *hospice facility*;
2. *Services* relating to a *confinement* that is not for management of acute pain control or other treatment for an acute phase of chronic symptom management;
3. Funeral arrangements;
4. Services by volunteers or persons who do not regularly charge for their services;
5. Financial or legal counseling, including estate planning or drafting of a will;
6. Homemaker or caretaker services, including:
   a. Sitter or companion services;
   b. Housecleaning;
   c. Household maintenance; and
7. *Services* of a social worker other than a licensed clinical social worker.

For this benefit only, *immediate family member* is considered to be the *covered person's* parent, *domestic partner*, spouse, and children or step-children.

Infertility

Covered expenses include *services* for the diagnosis and evaluation of the cause of infertility.

No benefits will be provided for, or on account of *services* or *prescription* drugs once the *covered person* has been diagnosed with infertility.

Maternity services

1. Prenatal care;
2. A minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated caesarean section delivery. 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 *healthcare practitioner*, a post-discharge office visit to the *healthcare practitioner* or a *home healthcare visit* within the first 48 hours after discharge is also covered, subject to the terms of this *contract*;
3. Postpartum care; and
4. Expenses for the birth mother of a child who is legally adopted by the *contractholder* if:
   a. The child is adopted by the *contractholder* within one year of birth;
   b. The *contractholder* is legally obligated to pay the costs of birth;
   c. All limitations have been met and any *deductible, copayments* or *coinsurance* have been paid by the *contractholder*; and
   d. The *contractholder* has notified *us* of his or her acceptance to adopt the child within 60 days after their acceptance or within 60 days after a change in his or her insurance contract, plan or company.

This benefit is in excess of any other coverage the natural mother may have for maternity benefits except for eligible persons under Arizona Health Care Cost Containment.

If other coverage does exist, the agency, attorney or individual arranging the adoption must make arrangements for the other insurance to pay the costs that may be covered under that contract and shall advise the *contractholder* in writing of the existence and extent of coverage. The *contractholder* must notify us of the extent of the other coverage.

We will not pay any costs in excess of the amount *we* would have been obligated to pay if the birth mother and child had received the maternity and newborn care directly from *us*.

Medical Food Products

Covered expenses are *expenses incurred* for medical food products when prescribed by a *healthcare practitioner* for the treatment of an inherited metabolic disorder to prevent serious mental or physical impairment or to promote optimal growth, health and metabolic stability.

Mental health

Covered expenses are charges made by a:

1. *Healthcare practitioner*;
2. *Partial hospitalization* program;
3. *Residential treatment center*;
4. *Hospital*; or
5. *Healthcare treatment facility*. A *healthcare treatment facility* does not include a halfway house.

Covered expenses are *expenses incurred* for:

1. *Inpatient services* including room and board;
2. *Healthcare practitioner* visits and counseling;
3. Office exams or consultations including laboratory tests and x-rays;
4. Medication management when provided in conjunction with a consultation;
5. Electroconvulsive therapy (ECT);
6. Detoxification, including medical detoxification;
7. Biofeedback for the purpose of pain management;
8. Therapy; and
9. Psychological testing (s*ervices* for neuropsychological testing are explained under the "Healthcare practitioner services" provision)

No benefits will be provided for, or on account of:

1. A halfway house; or
2. *Court-ordered mental health services* unless *medically necessary* or as expressly stated in this *contract*.

Newborn services

Covered expenses for a covered *dependent* newborn child include the following:

1. Routine well newborn care for the first 48 hours or 96 hours following birth for:
   a. *Hospital* charges for *routine nursery care*;
   b. *Healthcare practitioner's* charges for circumcision of the newborn child; and
   c. *Healthcare practitioner's* charges for routine examination of the newborn before release from the *hospital*;
2. *Bodily injury* or *sickness*;
3. Care and treatment for premature birth;
4. Medically diagnosed birth defects and abnormalities; and
5. Expenses for a child who is legally adopted by the *contractholder* if:
   a. The child is adopted by the *contractholder* within one year of birth;
   b. The *contractholder* is legally obligated to pay the costs of birth;
   c. All limitations have been met and any *deductible, copayments* or *coinsurance* have been paid by the *contractholder*; and
   d. The *contractholder* has notified us of his/her acceptance to adopt the child within 60 days after their acceptance or within 60 days after a change in his/her insurance contract, plan or company.

   This benefit is in excess of any other coverage the natural mother may have for maternity benefits except for eligible persons under Arizona Health Care Cost Containment.

   If other coverage does exist, the agency, attorney or individual arranging the adoption must make arrangements for the other insurance to pay the costs that may be covered under that contract and shall advise the *contractholder* in writing of the existence and extent of coverage. The *contractholder* must notify *us* of the extent of the other coverage.

   We will not pay any costs in excess of the amount *we* would have been obligated to pay if the birth mother and child had received the maternity and newborn care directly from *us*.

Services for routine well newborn care for the first 48 hours or 96 hours following birth are explained under the "Newborn services" provision. *Services* for routine well newborn and well-baby care after the first 48 hours or 96 hours following birth are explained under the "Preventive medical services" and the "Well baby care" provisions.

Nutritional evaluation and counseling

Nutritional evaluation and counseling *services* when dietary adjustment has a therapeutic role in the management of a diagnosed chronic condition including but not limited to:

1. *Morbid obesity*;
2. Diabetes;
3. Cardiovascular disease;
4. Hypertension;
2. Kidney disease;
3. Eating disorders;
4. Gastrointestinal disorders;
5. Food allergies; and
6. Hyperlipidemia.

Occupational coverage

Services provided in connection with a *sickness* or *bodily injury* arising out of, or sustained in the course of any occupation, employment or activity for compensation, profit or gain.

Services are only covered when a *covered person* is not entitled to file a claim for Workers' Compensation or similar benefits and the *covered person* is recognized under state law as:

1. A sole proprietor in a proprietorship;
2. A partner in a partnership; or
3. An executive officer in a corporation.

Benefits will not be provided for, or on account of a *sickness* or *bodily injury* eligible for benefits under Workers' Compensation, Employers Liability or similar laws even when a claim for benefits is not filed.

Outpatient therapies and rehabilitative services

Outpatient services ordered and performed by a *healthcare practitioner* for the following:

1. *Services* for:
   a. Documented loss of physical function;
   b. Pain; or
   c. Developmental delay or defect;
2. Physical therapy *services*;
3. Occupational therapy *services*;
4. Spinal manipulations, adjustments, and modalities;
5. Speech therapy or speech pathology *services*;
6. Cognitive rehabilitation *services*;
7. Audiology therapy *services*;
8. Radiation therapy *services*;
9. Pulmonary rehabilitation *services*;
10. Chemotherapy; and
11. Cardiac rehabilitation *services*.

The expectation must exist that the therapy will result in a measurable improvement in the level of functioning within a reasonable period of time and the therapy is not considered *maintenance care*, as determined by *us*.

No benefits will be provided for, or on account of group physical, occupational or speech therapy *services*.

These *services* are subject to an annual visit limit as shown on the "Schedule of Benefits".

Prescription drugs

Benefits may be subject to *dispensing limits*, *prior authorization* or *step therapy* requirements, if any. Medication management programs are subject to change and are maintained and updated as medications are FDA approved within the defined therapeutic class and as clinical evidence requires.

Covered *prescription* drugs that are included on the *drug list* are:

1. Drugs, medicines, medications or *specialty drugs* that under Federal or state law may be dispensed only by *prescription* from a *healthcare practitioner*;
2. Drugs, medicines, medications or *specialty drugs* that are included on the *drug list*;
3. Insulin and *diabetic supplies*;
4. Hypodermic needles or syringes or other methods of delivery when prescribed by a *healthcare practitioner* for use with insulin or *self-administered injectable drugs*. (Hypodermic needles, syringes, and other methods of delivery used in conjunction with covered drugs may be available at no cost to the *covered person*);
5. *Self- administered injectable drugs* approved by *us*;
6. Oral chemotherapy drugs. Coverage for oral chemotherapy drugs will be administered the same as for intravenously administered or injected chemotherapy drugs.
7. Drugs, medicines or medications, including FDA approved and over-the-counter smoking cessation aids, on the Preventive Medication Coverage *drug list* with a *prescription* from a *healthcare practitioner*;
8. Growth hormones when there is a laboratory confirmed diagnosis of growth hormone deficiency, or as otherwise determined by *us*;
9. Off-label use of *prescription* drugs for the treatment of cancer if the *prescription* drug has been recognized as safe and effective for the treatment of that specific type of cancer either by the FDA, one or more of the standard medical reference compendia, or peer reviewed literature;
10. Formulas and nutritional supplements including the following:
    a. Enteral formulas and nutritional supplements for the treatment of phenylketonuria (PKU) or other inherited metabolic diseases, or as otherwise determined by *us*; and
    b. Amino acid-based formula for the treatment of eosinophilic gastrointestinal disorder if:
        i. The treatment is supervised by a licensed h*ealthcare practitioner*; and
        ii. The *covered person* risks mental or physical impairment without the formula; and
11. Spacers and/or peak flow meters for the treatment of asthma.

Regardless of any other provisions of this *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 *prescription* into the market.

If the dispensing *pharmacy's* charge is less than the *prescription* drug *copayment*, the *covered person* will be responsible for the dispensing *pharmacy* charge amount.

The amount paid by *us* to the dispensing *pharmacy* may not reflect the ultimate cost to *us* for the drug. A covered person's cost share is made on a per *prescription* fill or refill basis and will not be adjusted if *we* receive any retrospective volume discounts or *prescription* drug rebates.

Some retail *pharmacies* participate in *our* program which allows a *covered person* to receive a 90-day supply of a *prescription* fill or refill except for *specialty drugs* or *self-administered injectable drugs* which are limited to a maximum of a 30-day supply. The cost is three times the applicable *copayment* and/or *coinsurance* as shown on the "Schedule of Benefits", after any applicable *deductible* is met.

No benefits are available for prescriptions purchased at an *out-of-network pharmacy*.

Humana's Pharmacy and Therapeutics Committee determines inclusion and exclusion of *prescription* drugs on the *drug list* on a yearly basis. *Prescription* drugs may be included or excluded based on safety, efficacy, cost, or availability of therapeutic alternatives. *Prescription* drugs may also be excluded based on lack of medical necessity.

Visit *our* Website at www.humana.com or call the telephone number on *your ID card* to obtain the *drug lists*.

Pharmacy standard exception requests

If a clinically appropriate drug is not included on *our drug list*, a *covered person* may contact *us* by phone, electronically or in writing to request coverage of that specific drug or specialty drug (a standard exception request). A standard exception request may be initiated by a *covered person*, their appointed representative, or the prescribing *healthcare practitioner* by calling the telephone number on the ID card or visiting our Website at www.humana.com. *We* will respond to a standard exception request no later than the 72 hours after the receipt date of the request.

As part of the standard exception request, the prescribing *healthcare practitioner* should include an oral or written statement that provides justification to support the need for the prescribed drug not included on our *drug list* to treat the *covered person*'s condition, including a statement that:

1. All covered drugs on the *drug list* on any tier will be or have been ineffective;
2. Would not be as effective as the drug not included on the *drug list*; or
3. Would have adverse effects.

If *we* grant a standard exception request for coverage of a prescribed drug that is not on *our drug list*, *we* will cover the prescribed 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, a *covered person* has the right to an independent review of *our* decision, as described below in the "Pharmacy external exception request" provision.

Pharmacy expedited exception request

If a clinically appropriate drug is not included on our *drug list*, an expedited exception request based on exigent circumstances may be initiated by a *covered person*, their appointed representative, or their prescribing *healthcare practitioner* by calling the telephone number on the *ID card* or 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:

1. Suffering from a health condition that may seriously jeopardize their life, health, or ability to regain maximum function; or
2. Undergoing a current course of treatment using a drug not included on the *drug list*.

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

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

If *we* grant an expedited exception based on exigent circumstances for coverage of the prescribed drug that is not on *our drug list*, *we* will provide access to the prescribed drug:

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

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

If *we* deny an expedited exception request, a *covered person* has the right to an independent review of our decision as described below in the "Pharmacy external exception request" provision.

Pharmacy external exception request

If *we* deny a request for a standard exception or an expedited exception, a *covered person*, their appointed representative, or the prescribing *healthcare practitioner* may initiate an external exception request for the original exception request and the denial of that request to be reviewed by an independent review organization (IRO).

The IRO's decision to either uphold or reverse the denial of the original exception request will be provided orally or in writing to the *covered person*, their appointed representative or the prescribing *healthcare practitioner* no later than:

1. 24 hours after receipt of an external exception review request if the original exception request was expedited.
2. 72 hours after receipt of an external exception review request if the original exception request was standard.

If a *covered person* requests a *brand-name drug* when a *generic drug* is available, the *covered person's cost share* is greater. The *covered person* is responsible for the applicable *brand-name drug copayment* or *coinsurance* and 100% of the difference between the amount *we* would have paid the dispensing *pharmacy* for the *brand-name drug* and the amount *we* would have paid the dispensing *pharmacy* for the *generic drug*. If the prescribing *healthcare practitioner* determines that the *brand-name drug* is *medically necessary*, the *covered person* is only responsible for the applicable *copayment* or *coinsurance* of the *brand-name drug limit*. If the *cost share* that is applicable to a *covered person's* claim is waived by the *pharmacy* or a provider, the *covered person* is required to inform *us*. Any amount thus waived and not paid by the *covered person* would not apply to any *out-of-pocket limit*.

Preventive medical services

Services for well child and adult care preventive medical *services*. Preventive medical *services* under this *contract* are the recommended preventive *services* identified on the Department of Health and Human Services (HHS) Website at www.healthcare.gov on the date a *covered person* receives *services*. The recommended preventive medical *services* are subject to change. A *covered person* may obtain the current list of preventive *services* at www.healthcare.gov or by calling the telephone number on *your ID card* prior to receiving a preventive medical *service*.

Covered expenses for preventive medical *services* include the following:

1. Evidence-based items or *services* that have in effect a rating of A or B in the current recommendations of the U.S. Preventive Services Task Force (USPSTF);
2. Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control (CDC) that are listed on the Immunization Schedules of the CDC;
3. Current recommendations of the Health Resources and Services Administration (HRSA) including:
    a. Evidence-informed preventive care and screenings provided for in the Health Resources and Services Administration (HRSA) guidelines for infants, children, adolescents, and women; and
    b. Breast feeding counseling, *services* and supplies including rental or purchase of breast pumps for each birth. Refer to the "Durable medical equipment" provision which explains how coverage is determined;
4. Current recommendations of the USPSTF regarding breast cancer screening, mammography, and prevention (does not include recommendations issued in or around November 2009);
5. Routine mammograms for a female *covered person* including the following:
    a. A baseline mammogram from ages 35 through 39; and
    b. A mammogram every year for a woman 40 years of age and over; and
6. An annual prostate specific antigen (PSA) screening and digital rectal exam for a male *covered person* who is:
    a. Age 40 and older; or
    b. For males under age 40 who are:
        i. At higher risk due to family history or previous borderline PSA levels; or
        ii. African-American.

Reconstructive surgery

Reconstructive surgery is payable only if the *sickness* or *bodily injury* necessitating the *reconstructive surgery* procedure would have been a *covered expense* under this *contract*.

We will provide benefits for *covered expenses incurred* for the following:

1. To restore function for conditions resulting from a *bodily injury*;
2. That is incidental to or follows a covered *surgery* resulting from *sickness* or a *bodily injury* of the involved part if trauma, infection or other disease occurred;
3. Following a *medically necessary* mastectomy. *Reconstructive surgery* includes all stages and revisions of reconstruction of the breast on which the mastectomy has been performed, reconstruction of the other breast to establish symmetry, and physical complications in all stages of mastectomy, including lymphedemas and at least two external postoperative prostheses; and
4. Because of a congenital defect or birth abnormality of a *dependent* child that resulted in a functional defect.

No benefits are available for *surgery* or treatment to change the texture or appearance of the skin or to change the size, shape or appearance of facial or body features (including but not limited to a *covered person's* nose, eyes, ears, cheeks, chin, chest or breasts).

Cosmetic *services* and *services* for complications from cosmetic *services* are not covered regardless of whether the initial *surgery* occurred while the *covered person* was covered under this *contract* or under any prior coverage.

Skilled nursing facility and rehabilitation services

Covered expenses include those *incurred* for daily room and board, general nursing *services* for each day of *confinement*, and *rehabilitation services,* rendered while *confined* in a *sub-acute rehabilitation facility* or *skilled nursing facility*, provided the *covered person* is under the regular care of a *healthcare practitioner* who has reviewed and approved the *confinement*.

Services in a *sub-acute rehabilitation facility* or *skilled nursing facility* must be provided in lieu of care in a *hospital*.

Coverage for *sub-acute rehabilitation facility* or *skilled nursing facility* will cease when measurable and significant progress toward expected and reasonable outcomes has been achieved or has plateaued as determined by *us*.

Rehabilitation services include but are not limited to:

1. Treatment of complications of the condition that required an inpatient *hospital* stay;
2. Physical therapy, occupational therapy, respiratory therapy, and speech therapy; and
3. The evaluation of the need for the *services* listed above.

Confinement in a *skilled nursing facility* is limited to an annual maximum as shown on the "Schedule of Benefits".

Specialty and oral chemotherapy drugs medical benefit

Benefits may be subject to *dispensing limits, prior authorization* or *step therapy* requirements, if any.

Covered *specialty drugs* included on *our specialty drug list* or oral chemotherapy drugs when given during a:

1. *Healthcare practitioner's* office visit;
2. *Home healthcare visit*;
3. *Hospital*;
4. *Free-standing surgical facility* visit;
5. *Urgent care center* visit;
6. *Skilled nursing facility*;
7. Emergency room; or
8. Ambulance.

Coverage for oral chemotherapy drugs will be administered the same as for intravenously administered or injected chemotherapy drugs.

No benefits will be provided for, or on account of:

1. Any amount exceeding the *default rate* for *specialty drugs*; or
2. *Specialty drugs* for which coverage is not approved by *us*.

Telehealth and telemedicine services

Covered expenses are expenses incurred for *medically necessary telehealth* and *telemedicine services* provided to a *covered person* which are:

1. For the purpose of diagnosis, consultation or treatment; and
2. Delivered through the use of a two-way telephonic and/or video-enabled, *electronic* communication between the *covered person* and *healthcare practitioner*.

Benefits are available for *telehealth* and *telemedicine services*, provided both of the following conditions are met:

1. The *services* would be covered under this *contract* if they were delivered during an in person consultation between the *covered person* and a *healthcare practitioner* instead of by *telehealth* or *telemedicine*; and
2. The *distant site* at which the *healthcare practitioner* is providing the *service* cannot be the same site as the *originating site* where the *covered person* is located at the time the *service* is being furnished.

Services provided through *telehealth* or *telemedicine* or that result from a *telehealth* or *telemedicine* consultation must comply with the following as applicable:

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

No benefits will be provided for internet only *services* that lack a video component unless coverage for such *services* is mandated by state or Federal law.

Temporomandibular joint disorder (TMJ)

Covered expenses are *services* recognized by a *healthcare practitioner* as effective and appropriate for TMJ disorder which is the result of:

a. An accident;
b. Trauma;
c. Congenital defect;
d. Developmental defect; or
e. Pathology.

Covered expenses include intra-oral splints that stabilize the jaw joint.

Transplant services

We will pay benefits for *covered expenses* incurred by a *covered person* for a transplant that is preauthorized and approved by *us*. *We* must be notified of the initial transplant evaluation and given a reasonable opportunity to review the clinical results to determine if the transplant will be covered. A *covered person* or their *healthcare practitioner* must contact *our* Transplant Management Department by calling the telephone number on the *ID card* when in need of a transplant. *We* will advise the *healthcare practitioner* once coverage of the requested transplant is approved by *us*. Benefits are payable only if the transplant is approved by *us*.

Covered expense for a transplant includes 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:

1. Heart;
2. Lung(s);
3. Liver;
4. Kidney;
5. *Bone marrow*;
6. Pancreas;
7. Auto-islet cell;
8. Intestine;
9. Multivisceral;
10. Any combination of the above listed transplants; and
11. Any transplant not listed above required by state or Federal law.

Multiple transplantations performed simultaneously are considered one transplant *surgery*.

Corneal transplants and porcine heart valve implants are tissues which are considered part of regular *contract* benefits and are subject to other applicable provisions of this *contract*.

The following are *covered expenses* for an approved transplant and all related complications:

1. *Hospital* and *healthcare practitioner services*; and
2. Acquisition for transplants and associated donor costs, including pre-transplant *services*, the acquisition procedure, and any complications resulting from the acquisition. Donor costs for post-discharge *services* and treatment of complications for or in connection with acquisition for an approved transplant will not exceed the transplant treatment period of 365 days from the date of *hospital* discharge following acquisition.

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

No benefits will be provided for, or on account of:

1. Transplants which are *experimental, investigational or for research purposes*;
2. Expenses related to the donation or acquisition of an organ for a recipient who is not covered by *us*;
3. Expenses that 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;

4. Expenses related to a transplant for which *we* do not approve coverage based on *our* established criteria;
5. Expenses related to the transplantation of any non-human organ or tissue except as expressly provided in this *contract*;
6. Expenses related to donor costs that are payable in whole or in part by any other medical plan, insurance company, organization or person other than the donor's family or estate;
7. Expenses related to the storage of cord blood and stem cells unless it is an integral part of a transplant approved by *us*; or
8. Expenses related to a transplant performed outside of the United States and any care resulting from that transplant.

Transplant transportation and lodging

Direct non-medical costs for:

1. The *covered person* receiving the transplant if he/she lives more than 60 miles from the transplant facility; and
2. One designated caregiver or support person (two, if the *covered person* receiving the transplant is under 18 years of age), if they live more than 60 miles from the transplant facility.

Direct non-medical costs include:

1. Transportation to and from the *hospital* where the *transplant* is performed;
2. Temporary lodging; and
3. Food while at the *hospital* or travelling to and from the *hospital* where the transplant is performed.

Urgent care services

Services in an *urgent care center* for a *sickness* or *bodily injury* that develops suddenly and unexpectedly outside of a *healthcare practitioner's* normal business hours and requires immediate treatment but that does not endanger the *covered person's* life or pose serious bodily impairment to a *covered person*.

If a *covered person* needs urgent care, they should go to the nearest in-network *urgent care center* to receive the *in-network provider* benefit level. If *services* are received at an *out-of-network provider*, no benefits will be provided except as expressly stated in this *contract*.

You must see an *in-network provider* for any follow-up care to receive benefits at the *in-network provider* medical payment level as shown on the "Schedule of Benefits" subject to any applicable *copayment, deductible,* and *coinsurance*.

Well baby care

Services include well baby visits and care up to 47 months of age, including immunizations which are not included under the "Preventive services" or "Newborn services" provision.

PRESCRIPTION DRUG EXCLUSIONS

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

For the current recommended preventive *services*, including over the counter drugs recommended by the United States Preventive Task Force, please see the Health and Human Services (HHS) Website at www.healthcare.gov and the "Preventive medical services" provision of this *contract*.

Unless specifically stated otherwise, no benefits will be provided for, or on account of, the following items obtained from a *pharmacy*:

1. Contraceptives, including oral and transdermal, whether medication or device, when prescribed for purpose(s) other than to prevent pregnancy;
2. Growth hormones for idiopathic short stature or any other condition unless there is a laboratory confirmed diagnosis of growth hormone deficiency, or as otherwise determined by *us*;
3. Drugs which are not included on the *drug lists*;
4. Dietary supplements except enteral formulas and nutritional supplements for the treatment of phenylketonuria (PKU) or other inherited metabolic disease or amino acid-based formulas for the treatment of eosinophilic gastrointestinal disorder;
5. Nutritional products;
6. Drugs and/or ingredients not approved by the FDA, including bulk compounding ingredients;
7. Minerals;
8. 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*;
9. *Legend drugs* which are not deemed *medically necessary* by *us*;
10. Any drug prescribed for a *sickness* or *bodily injury* not covered under this *contract*;
11. Any drug prescribed for intended use other than for:
    a. Indications approved by the FDA;
    b. Off-label indications recognized through peer-reviewed medical literature;
12. Any amount exceeding the *default rate*;
13. Any drug, medicine or medication that is either:
    a. Labeled "Caution-limited by Federal law to investigational use"; or
    b. *Experimental, investigational or for research purposes*, even though a charge is made to the *covered person*;
14. Allergen extracts;
15. The administration of covered medication(s);
16. *Specialty drugs* for which coverage is not approved by *us*;
17. Therapeutic devices or appliances, including but not limited to:
    a. Hypodermic needles and syringes except when prescribed by a *healthcare practitioner* for use with insulin, and *self-administered injectable drugs* whose coverage is approved by *us*;
    b. Support garments;
    c. Test reagents;
    d. Mechanical pumps for delivery of medication; and
    e. Other non-medical substances;
18. Anorectic or any drug used for the purpose of weight control;
19. Abortifacients (drugs used to induce abortions);
20. Any drug used for cosmetic purposes, including but not limited to:
    a. Dermatologicals or hair growth stimulants; or
    b. Pigmenting or de-pigmenting agents;

PRESCRIPTION DRUG EXCLUSIONS

21. Any drug or medicine that is:
    a. Lawfully obtainable without a *prescription* (over-the-counter drugs), except insulin and drugs or medicines on the Preventive Medication Coverage *drug list*; or
    b. Available in *prescription* strength without a *prescription*;
22. Compounded drugs in any dosage form except when prescribed for pediatric use for children through 19 years of age or as otherwise determined by *us*;
23. *Infertility services* including medications, except as expressly stated in the "Infertility services" provision of the "Your Contract Benefits" section of this *contract*;
24. Any drug prescribed for impotence and/or sexual dysfunction;
25. Any drug, medicine or medication that is consumed or injected at the place where the *prescription* is given or dispensed by the *healthcare practitioner* (these drugs are covered under the "Healthcare practitioner services" provision);
26. *Prescriptions* that are to be taken by or administered to the *covered person*, in whole or in part, while he/she is a patient in a facility where drugs are ordinarily provided by the facility on an inpatient basis by the facility. Inpatient facilities include, but are not limited to:
    a. *Hospital*;
    b. *Skilled nursing facility*; or
    c. *Hospice facility*;
27. Injectable drugs, including but not limited to:
    a. Immunizing agents unless otherwise determined by *us*;
    b. Biological sera;
    c. Blood; or
    d. Blood plasma.
28. *Prescription* fills or refills:
    a. In excess of the number specified by the *healthcare practitioner*; or
    b. Dispensed more than one year from the date of the original order;
29. 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 a *covered person* to receive a 90-day supply of a *prescription* fill or refill;
30. 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 a *covered person* to receive a 30-day supply of a *prescription* fill or refill;
31. Any portion of a *specialty drug prescription* fill or refill that exceeds a 30-day supply, unless otherwise determined by *us*;
32. Any drug for which *we* require *step therapy* and it is not obtained;
33. Any drug for which a charge is customarily not made;
34. Any portion of a *prescription* fill or refill that:
    a. Exceeds *our* drug specific *dispensing limit*;
    b. Is dispensed to a *covered person* whose age is outside the drug specific age limits defined by *us*;
    c. Is refilled early, as defined by *us*; or
    d. Exceeds the duration-specific *dispensing limit*;
35. Any drug, medicine or medication received by the *covered person*:
    a. Before becoming covered under this *contract*; or
    b. After the date the *covered person's* coverage under this *contract* has ended;
36. Any costs related to the mailing, sending or delivery of *prescription* drugs;
37. Any intentional misuse of this benefit, including *prescriptions* purchased for consumption by someone other than the *covered person*;

PRESCRIPTION DRUG EXCLUSIONS

38. Any *prescription* fill or refill for drugs, medicines or medications that are lost, stolen, spilled, spoiled or damaged;
39. Any amount the *covered person* 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*; and
40. *Prescription drugs* filled or refilled at an *out-of-network pharmacy*.

PEDIATRIC VISION CARE BENEFIT

This section describes the *services* that will be considered *covered expenses* for pediatric vision care *services* under this *contract*. Benefits we pay for pediatric vision care *services* will be based on the *net charges* and as shown in the "Schedule of Benefits–Pediatric Vision Covered Expenses" section of this *contract* subject to:

1. The *deductible*, if applicable;
2. Any *copayment*, if applicable;
3. Any *coinsurance* percentage;
4. Any *out-of-pocket limit*; and
5. Any *benefit maximum*.

Refer to the "Pediatric vision care exclusions" provision below, the "General Exclusions" and the "Prescription Drug Exclusions" sections in this *contract*. All terms and provisions of this *contract*, including *preauthorization* requirements specified in this *contract*, are applicable to the pediatric vision care *covered expenses*.

All terms used in this section have the same meaning given to them in this *contract* unless otherwise specifically defined in this section.

Pediatric vision care covered expenses

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

1. *Comprehensive eye exam*;
2. Prescription lenses;
3. Frames available from a selection of covered frames. The *in-network provider* will show the *covered person* the selection of frames covered by this *contract*. If a *covered person* selects a frame that is not included in the frame selection this *contract* covers, the *covered person* is responsible for the difference in cost between the *in-network provider* reimbursement amount for covered frames and the retail price of the frame selected;
4. Elective contact lenses available from a selection of covered contact lenses, *contact lens fitting and follow-up*. The *in-network provider* will inform the *covered person* of the contact lens selection covered by this *contract*. If a *covered person* selects a contact lens that is not part of the contact lens selection this *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 this *contract* and the cost of the contact lens selected;
5. *Medically necessary* contact lenses under the following circumstances when *preauthorization* is obtained:
    a. Visual acuity cannot be corrected to 20/70 in the better eye except by use of contact lenses;
    b. Anisometropia greater than 3.50 diopters and aesthenopia or diplopia, with glasses;
    c. Keratoconus;
    d. Monocular aphakia or binocular aphakia where the doctor certifies contact lenses are *medically necessary* for safety and rehabilitation to a productive life; and
    e. High ametropia of either +10D or -10D in any meridian; or
6. *Low vision services* includes the following when *preauthorization* is obtained:
    a. Low vision supplementary testing; or
    b. Low vision aids include only the following:
        i. Spectacle-mounted magnifiers;
        ii. Hand-held and stand magnifiers;
        iii. Hand held or spectacle-mounted telescopes; or
        iv. Video magnification.

PEDIATRIC VISION CARE BENEFIT

Pediatric vision care exclusions

In addition to the "General Exclusions" section and the "Prescription Drug Exclusion" section of this *contract* and any limitations specified in the "Schedule of Benefits– Pediatric Vision Covered Expenses" section of this *contract*, benefits for *pediatric vision care* are limited as follows:

1. In no event will benefits exceed the lesser of the limits shown in the "Schedule of Benefits–Pediatric Vision Covered Expenses" section of this *contract.*
2. *Materials* covered by this *contract* that are lost, or stolen. Broken or damaged *materials* will only be replaced at normal intervals as specified in the "Schedule of Benefits–Pediatric Vision Covered Expenses" section of this *contract*.
3. Basic cost for lenses and frames covered by the *contract*.

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

1. Orthoptic or vision training and any associated supplemental testing;
2. Two or more multiple pair of glasses, in lieu of bifocals or trifocals;
3. Medical or surgical treatment of the eye, eyes or supporting structure;
4. Any *services* and/or *materials* required by an *employer* as a condition of employment;
5. Safety lenses and frames;
6. Contact lenses, when benefits for frames and lenses are received;
7. Oversized 61 and above lens or lenses;
8. Cosmetic items;
9. Any *services* or *materials* not listed in this *contract* as a *covered expense* or in the "Schedule of Benefits– Pediatric Vision Covered Expenses" section of this *contract*;
10. Expenses for missed appointments;
11. Any charge from a providers' office to complete and submit claim forms;
12. Treatment relating to or caused by disease;
13. Non-prescription *materials* or vision devices;
14. Costs associated with securing *materials*;
15. Pre- and post-operative *services*;
16. Orthokeratology;
17. Routine maintenance of *materials*;
18. Refitting or change in lens design after initial fitting;
19. Artistically painted lenses;
20. Premium lens options;
21. *Pediatric vision care* not obtained from an *in-network provider* designated by *us*; or
22. *Services* provided by an *out-of-network provider*.

Definitions

The following terms are specific to *pediatric vision care* benefits:

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; additional biomicroscopy with and without lens.

Covered person under this section means a person who is eligible and enrolled for benefits provided under this *contract* through the end of the month in which he/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.

Materials means frames, and lenses and lens options, and/or contact lenses.

Pediatric vision care means the *services* and *materials* specified in the "Pediatric vision care covered expense" provision in this *contract* for a *covered person*.

Severe vision problems mean the best-corrected acuity is:

1. 20/200 or less in the better eye with best conventional spectacle or contact lens prescription;
2. A demonstrated constriction of the peripheral fields in the better eye to 10 degrees or less from the fixation point; or
3. The widest diameter subtends an angle less than 20 degrees in the better eye.

CLAIMS

Assignment of benefits

Assignment of benefits may be made only with *our* consent. An assignment is not binding until *we* receive and acknowledge in writing the original or copy of the assignment before payment of the benefit. *We* do not guarantee the legal validity or effect of such assignment.

Completing the claim form

We do not require completion of a standard claim form to process benefits. After *we* receive notice informing *us* of the claim, *we* will notify the *covered person* within 15 days of any additional information *we* need to process the claim. If *we* do not request the information within 15 days, *you* will be deemed to have met the requirements for providing proof of loss.

Cost of legal representation

We will pay the costs of *our* legal representation in matters related to *our* recovery rights under this *contract*. The costs of legal representation incurred by or on behalf of a *covered person* shall be borne solely by *you* or the *covered person*. *We* shall not be obligated to share any costs of legal representation with *you* or the *covered person* under a common fund or similar doctrine unless *we* were given notice of the claim and an opportunity to protect *our* own interests at least 60 days prior to the settlement of the claim and *we* either failed or declined to do so.

Duplicating provisions

If any charge is described as covered under two or more benefit provisions, *we* will pay only under the provision allowing the greater benefit. This may require *us* to make a recalculation based upon both the amounts already paid and the amounts due to be paid. *We* have no obligation to pay for benefits other than those this *contract* provides.

Non-duplication of Medicare benefits

We will not duplicate benefits for expenses that are paid by Medicare as the primary payer.

If the *covered person* is enrolled in Medicare, the benefits available under this *contract* will be coordinated with Medicare, with Medicare as the primary payer. Before filing a claim with *us*, the *covered person* or the provider must first file a claim with Medicare. After filing the claim with Medicare, the *covered person* or the provider must send a copy of the itemized bill and a copy of the Explanation of Medicare Benefits to *us*.

If the *covered person* is eligible for Medicare benefits but not enrolled, benefits under this *contract* will be coordinated to the extent benefits otherwise would have been payable under Medicare.

In all cases, coordination of benefits with Medicare and the provisions of Title XVIII of the Social Security Act as amended will conform with Federal Statutes and Regulations.

Medicare means Title XVIII, Parts A, B, C, and D of the Social Security Act, as enacted or amended.

CLAIMS

Notice of claim

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

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

1. Name of the *covered person* who incurred the *covered expenses*;
2. Name and address of the provider;
3. Diagnosis;
4. Procedure or nature of the treatment;
5. Place of *service*;
6. Date of *service*; and
7. Billed amount.

For *services* received from a foreign provider, the information to be submitted by a *covered person* along with their complete claim includes but is not limited to:

1. Proof of payment to the foreign provider for the *services* provided;
2. Complete medical information and/or records;
3. Proof of travel to the foreign country such as airline tickets or passport stamps; and
4. The foreign provider's fee schedule if the provider uses a billing agency.

Other insurance coverage

If the *covered person* has insurance coverage with another insurer and did not inform *us* of this coverage on the application or such coverage is acquired after the *effective date* of this *contract*, *we* will only pay benefits for *covered expenses* that exceed the benefits payable under the other coverage.

When a *covered person* is covered by more than one plan which provides medical benefits or *services*, benefits under this *contract* may be reduced so that the benefits for the *services you* received from all the other plans does not exceed 100 percent of the *covered expense*.

If the other coverage has a similar provision and the amount of benefits is not determined according to the preceding paragraph, *we* will pay *covered expenses* at the proportionate amount. The proportionate amount means the ratio that the total amount of *covered expense* compared to the total amount of benefits payable under all other coverage, regardless of any limits imposed in other plans.

In no event will *our* payment be larger than the amount that would have been payable without this provision.

CLAIMS

Proof of loss (Information we need to process your claim)

The *covered person* must complete and submit all claim information that *we* request in order for *us* to pay the claim within 90 days after the date of loss. This information must be given *electronically* or in writing. *We* may need to obtain additional information to determine if the *expense incurred* is a *covered expense*. The information *we* may need includes but is not limited to:

1. Authorizations for the release of medical information including the names of all providers from whom the *covered person* received *services*;
2. Medical information and/or records from any provider;
3. Information about other insurance coverage; and
4. Any information *we* need to administer the terms of this *contract*.

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

However, *your* claims will not be reduced or denied nor will this *contract* be terminated if it was not reasonably possible to give such proof. In any event, written or *electronic* notice must be given within 15 months after the date written or *electronic* proof of loss is otherwise required under this *contract*, except if *you* were legally incapacitated.

Right to request overpayments

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

1. Made in error;
2. Made to *you* and/or any party on *your* behalf, where *we* determine that such payment made is greater than the amount payable under this *contract*;
3. Made to *you* and/or any party on *your* behalf, based on fraudulent or misrepresented information; or
4. 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 any *deductible* or *out-of-pocket limit*.

Right to require medical examinations

We have the right to have the *covered person* examined or autopsied, unless prohibited by law. These procedures will be conducted as often as *we* deem reasonably necessary to determine *contract* benefits, at *our* expense.

Time of payment of claims

Payments due under this *contract* will be paid after *our* receipt of complete written or *electronic* proof of loss and within the time required by applicable Federal or state law.

To whom benefits are payable

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

All benefit payments for *services* rendered by an *out-of-network provider* are payable to the *covered person*. Assignment of benefits is prohibited; however, *you* may request that *we* direct a payment of selected medical benefits to the healthcare provider on whose charge the claim is based. If *we* consent to this request, *we* will pay the healthcare provider directly. Such payments will not constitute the assignment of any legal obligation to the *out-of-network provider*. If *we* decline this request, *we* will pay *you* directly, and *you* are then responsible for all payments to the *out-of-network provider*(*s*).

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/her, such payment will be made to his/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/her custody and support.

If the *covered person* is deceased, payment will be made, at *our* option, to any one of the following:

1. *You* in the case of a covered *dependent*;
2. *Your* spouse;
3. A provider; or
4. *Your* estate.

Any payment made by *us* in good faith will fully discharge *us* of any liability to the extent of such payment.

RECOVERY RIGHTS

Your obligation to assist in the recovery process

The *covered person* is obligated to assist *us* and *our* agents in order to protect *our* recovery rights by:

1. Promptly notifying *us* that *you* have asked anyone other than *us* to make payment for *your* injuries;
2. Obtaining *our* consent before releasing any party from liability for payment of medical expenses;
3. Providing *us* with a copy of any relevant information, including legal notices, arising from the *covered person's* injury and its treatment and delivering such documents as *we* or *our* agents reasonably require to secure *our* recovery rights;
4. Taking all action to assist *our* enforcement of recovery rights and doing nothing after loss to prejudice *our* recovery rights; and
5. Agreeing to not attempt to avoid *our* recovery rights by designating all (or any disproportionate part) of any recovery as exclusively for "pain and suffering".

If the *covered person* fails to cooperate with *us*, *we* shall be entitled to recover from *you* any payments made by *us* from *you*.

Other insurance/non-duplication of benefits

We will not provide duplicate coverage for benefits under this *contract* when a person is covered by *us* and has, or is entitled to:

1. Receive benefits;
2. Recovery for damages; or
3. Settlement proceeds, as a result of their *bodily injuries* from any other coverage including, but not limited to:
   a. First party uninsured or underinsured motorist coverage;
   b. Any no-fault insurance;
   c. Medical payment coverage (auto, homeowners or otherwise);
   d. Workers' Compensation settlement or awards;
   e. Other group coverage (including student plans); or
   f. Direct recoveries from liable parties, premises medical pay or any other insurer providing coverage that would apply to pay *your* medical expenses.

Benefits will be determined as described in the "Other insurance coverage" provision.

Where there is such coverage or other recovery sources, *we* will not duplicate other sources of recovery available to *you* or the *covered person*, and shall be considered secondary, except where specifically prohibited. Where duplicate sources of recovery exist, *we* shall have the right to be repaid from whoever has received the overpayment from *us* to the extent of the duplication with other sources of recovery.

We will not duplicate coverage under this *contract* whether or not *you* or the *covered person* has made a claim under the other applicable coverage or recovery sources.

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

RECOVERY RIGHTS

Right to request information

The *covered person* must cooperate with *us* and when asked, assist *us* by:

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

If the *covered person* fails 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.

Assignment of recovery rights

This *contract* contains an exclusion for *sickness* or *bodily injury* for which there is medical payments/personal injury protection (PIP) coverage provided under any automobile, homeowner, marine, aviation, premises or other similar coverage.

If the *covered person's* claim against the other insurer is denied or partially paid, *we* will process such claim according to the terms and conditions of this *contract*. If payment is made by *us* on the *covered person's* behalf, *you* and the *covered person* agree that any right the *covered person* has against the other insurer for medical expenses *we* pay will be assigned to *us*.

If benefits are paid under this *contract* and *you* or the *covered person* recovers under any automobile, homeowners, marine, aviation, premises, or similar coverage, *we* have the right to recover from *you*, the *covered person* or whomever *we* have paid an amount equal to the amount *we* paid.

RECOVERY RIGHTS

Workers' compensation

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

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

We will 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*. *We* are not required to contribute to attorney fees or recovery expenses under a Common Fund or similar doctrine.

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

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

As a condition to receiving benefits from *us*, *you* and the *covered person* hereby agree that, in consideration for the coverage provided by this *contract*, *we* will be notified of any Workers' Compensation claim the *covered person* makes, and that *you* or the *covered person* 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 the *covered person*.

PREMIUM PAYMENT

Your duty to pay premium

You must pay the required premium to *us* as it becomes due. If *you* don't pay *your* premium on time, *we* will terminate coverage.

The first premium is due on the date specified by *us*. Subsequent premiums are due on the date *we* assign. All premiums are payable to *us*.

Grace period

You have 31 days from the premium due date to remit the required funds. If premium is not paid *we* will terminate the insurance as of the last day of the premium period for which premium was paid.

If coverage was purchased through a *marketplace* and *you* are receiving an Advanced Premium Tax Credit (APTC), *you* have 90 days from the premium due date to remit the required funds provided *you* have paid at least one month of premium. If premium is not paid *we* will terminate the insurance on the last day of the first month of the grace period.

Changes to your premium

Premium may change when:

1. *Dependents* are added or deleted;
2. Benefits and/or coverage is increased or decreased;
3. The *covered person* moves to a different zip code or county;
4. A misstatement or omission is made on the application resulting in the proper amount due not being charged;
5. A new set of rates applies to this *contract*;
6. Any *covered person's* age increases; or
7. Any *covered person's* rating classification changes.

We will notify *you* of any premium change. Advanced notice will be provided in accordance with state and Federal requirements prior to premium rate changes due to items 5 through 7 above.

Your payment of premium will stand as proof of *your* agreement to the change.

Return of premium

In no event, except for the following reasons will premium be returned:

1. The *contractholder* returns the *contract* as described in the "Right to return contract" provision on the cover of this *contract*;
2. *Rescission* of coverage as described in the "Incontestability" provision in the "General Provisions" section; or
3. The *contractholder* requests coverage to end and premium has been paid past the date in which the termination is being requested.

CHANGES TO THE CONTRACT

Your rights to make changes to the contract

You have several rights to make changes to *your contract*.

Changes in benefits

You may make a change in benefits during an *open enrollment period* or when qualifying for a special enrollment.

If *you* purchased *your* coverage through the *marketplace you* will need to contact the *marketplace* to request a change in benefits.

Change in residence

We must be notified of any change in *your* resident address. If *you* purchased *your* coverage through the *marketplace*, please also notify the *marketplace* of the change in *your* resident address.

At least 14 days prior to *your* move, call or write *us* informing *us* of *your* new address and phone number. When *we* receive this information, *we* will inform *you* of any changes to *your contract* on such topics as new networks, benefits, and premium. If *you* move outside of this *contract's* service area *we* will terminate this *contract*. See the "Renewability of Insurance and Termination" section for the events that will cause this *contract* to end. Such change will be effective on or after *your* move date on the date *we* assign.

We have the right to change *your* resident address in *our* records upon *our* receipt of an address change from the United States Postal Service.

Changes to covered persons

You may request a change to the persons covered under *your contract* due to certain changes in *your* family.

1. **Removing dependents**

   If *you* purchased *your* coverage through the *marketplace you* will need to contact the *marketplace* and request to have *your dependent* removed from this *contract*.

   If *you* did not purchase *your* coverage through the *marketplace* and wish to remove a *covered person* from *your contract*, simply call the telephone number on *your ID card*.

CHANGES TO THE CONTRACT

2. Adding dependents

If *you* purchased *your* coverage through the *marketplace you* will need to contact the *marketplace* and request to have *your dependent* added to this *contract*.

If *you* did not purchase *your* coverage through the *marketplace*, *you* will need to do the following to have *your dependent* added to this *contract*:

a. If a child is born to a *contractholder*, or any *covered person*, or a *contractholder* adopts a child or a child is placed with the *contractholder* for the purpose of adoption, coverage is effective for 31 days from the moment of birth or placement. *We* must be notified of the event in writing and receive any required premium within 60 days to continue coverage beyond the first 31 days.
b. If a child is placed with the *contractholder* for the purpose of foster care, *we* must be notified of the event in writing and receive any required premium within 60 days of placement. Coverage will be effective on the date of placement.
c. If there is an administrative or court order that requires *you* to provide coverage for a *dependent* child, coverage for the child will be effective from the date of application by the child's other parent or pursuant to the Public Health and Safety Title of Arizona Code. *We* must be notified of the event in writing and receive any required premium within 60 days of application.

If *we* do not receive notice and premium for the first 60 days and forward, the child must wait to enroll for coverage during the next *open enrollment period* unless such child becomes eligible for a *special enrollment* as specified in the "Special enrollment" provision.

For a *dependent* not falling under the previous paragraphs the *dependent* must wait to enroll for coverage during the next *open enrollment period*, unless the *dependent* becomes eligible for a *special enrollment* as specified in the "Special enrollment" provision.

Upon *our* receipt of the completed application and premium, an *effective date* will be assigned. A *dependent* child is eligible to apply if they are under age 26 or an unmarried *dependent* over the age of 26 who is permanently mentally or physically handicapped and incapable of self-sustaining employment.

3. Effective date of dependent changes

a. Coverage for a newborn, foster child, adopted child, or a child for which the *covered person* is required to cover as a result of an administrative or court order will be effective as outlined above.
b. If *we* receive the application and any required premium more than 60 days after the newborn's date of birth, the child's adoption or placement for adoption or foster care, or the application by the other parent for coverage under an administrative or court order, such child will not be eligible for coverage until the next *open enrollment period*.
c. For changes for other *dependents*, the *dependent* will not be eligible for coverage until the next *open enrollment period* or until qualifying for a special enrollment.

Special enrollment

A *special enrollment period* is available if the following apply:

1. A *covered person* has a change in family status due to:
   a. Marriage;
   b. Divorce;
   c. Legal separation;
   d. The birth of a natural born child;
   e. The adoption of a child or placement of a child with the *contractholder* for the purpose of adoption;
   f. Placement of a foster child with the *contractholder*;
   g. A child is required to be covered as a result of an administrative or court order;
   h. Death of the *contractholder*; or
   i. For a *covered person* who purchased coverage through a *marketplace*, any other event as determined by the *marketplace*.

   The *covered person* must furnish proof of the event that is satisfactory to *us* and enroll within 60 days of the date of the special enrollment event.

2. An individual or *dependent* did not enroll for coverage when first eligible due to:
   a. Being covered under an employer sponsored health insurance plan and coverage under that plan terminates;
   b. Not a citizen of the United States, lawfully present, and subsequently gaining such lawful status;
   c. Was incarcerated and is no longer incarcerated;
   d. A change of permanent residence; or
   e. The loss of minimal essential coverage.

   The individual must furnish proof of the event that is satisfactory to *us* and enroll within 60 days of the date of the special enrollment event.

3. An individual or *dependent* did not enroll for coverage through the *marketplace* when first eligible due to:
   a. Being newly eligible for cost-sharing reductions or advanced premium tax credits;
   b. Enrollment or non-enrollment in a *Qualified Health Plan* was unintentional, inadvertent or erroneous and is the result of the error, misrepresentation, or inaction of a *marketplace* or Health and Human Services (HHS) employee;
   c. A *Qualified Health Plan* substantially violated a material provision of its contract;
   d. The individual is an American Indian or Alaskan Native as defined by Section 4 of the Indian Health Care Improvement Act may enroll in a *Qualified Health Plan* or change *Qualified Health Plans* one time per month; or
   e. Exceptional circumstances or any other event as determined by the *marketplace*, for an individual who purchased coverage through the *marketplace*.

   The individual must furnish proof of the event to the *marketplace*.

4. Coverage under this *contract* terminates due to:
   a. A *dependent* child ceasing to be eligible due to attaining the *limiting age*;
   b. The individual moves outside of the service area for this *contract*; or
   c. For a *covered person* who purchased coverage through a *marketplace*, any other event as determined by the *marketplace*.

The *covered person* must furnish proof of the event that is satisfactory to *us* and enroll within 60 days of the date of the special enrollment event.

The *effective date* of coverage for a *covered person* who requests coverage due to a special enrollment event will be assigned.

A *special enrollment period* is not available if coverage terminated due to non-payment of premium or coverage is *rescinded*.

Open enrollment

An *open enrollment period* is the opportunity for a *dependent* who did not enroll under this *contract* when first eligible to enroll for coverage. The *open enrollment period* is also the opportunity for a *covered person* to change to a different health insurance plan.

The request to enroll must be received by *us* during the *open enrollment period*. If enrollment is requested after the *open enrollment period*, the *covered person* and/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.
The *effective date* of coverage when enrolling during an *open enrollment period* will be assigned.

Our rights to make changes to the contract

We have the right to make certain changes to *your contract.*

Changes we will make without notice to you

Changes to this *contract* can be made by *us* at any time without prior consent of, or notice to *you*, when the changes are corrections due to clerical errors or clarifications that do not change benefits.

Changes where we will notify you

1. A 60-day notice will be provided for:
   a. An increase in benefits without any increase in premium; or
   b. Clarifications that do not reduce benefits but modify material content.

2. If *we* determine that *you* or a *covered person* have misrepresented any information, not including a medical condition, *we* shall have the right, in *our* sole discretion, to:
   a. Reform *your contract* and reissue the correct form of coverage *you* would have received had the misrepresentation not been made; or
   b. Continue *your* present coverage and collect the difference in premium which would have been assessed had the misrepresentation not been made.

   We will notify *you* with a 60-day notice of this change in coverage and/or premium and request *your* acceptance of the change(s). *We* will apply all premium paid to the new coverage and shall collect any difference in the premium due to the change(s).

We can also make changes to *your contract* on the premium due date or upon separate notice, provided *we* send *you* a written explanation of the change. All such changes will be made in accordance with state law. *Your* payment of premium will stand as proof of *your* agreement to the change.

RENEWABILITY OF INSURANCE AND TERMINATION

Reasons we will terminate your contract

This *contract* is renewable at the option of the *contractholder*, except for the conditions stated below. *We* will terminate *your contract* at the end of the billing period in which the following events occur unless stated otherwise:

1. The required premium was due to *us* and not received by *us*. Termination will be effective on the last day for which the premium was paid;
2. *You* or a *covered person* commit fraud or make an intentional misrepresentation of a material fact, as determined by *us*. Termination will be effective at 12:01 a.m. local time at the *contractholder's* state of residence on the date the misrepresentation occurred. A 30-day advance written notice of the termination will be provided;
3. *You* cease to be a resident in the service area, as determined by *us*. Call the telephone number on *your ID card* for this *contract's* service area;
4. *You* cease to be a resident in the state in which this *contract* was issued;
5. *You* request termination of the *contract*. The request may be given verbally, *electronically*, or in writing. Termination will be effective on the later of:
   a. The date requested by *you*; or
   b. The date we received your notice to cancel;
6. *We* cease to offer a type of contract. A 90 day advanced notice will be provided prior to the discontinuance of coverage;
7. *We* cease to do business in the individual medical insurance market, as allowed or required by state or Federal law. A 180 day advanced notice will be provided prior to the discontinuance of coverage; or
8. If coverage was purchased through a *marketplace*:
   a. *You* cease to be eligible for coverage through a *marketplace*; or
   b. This *contract* ceases to be a *qualified health plan* and is decertified by a *marketplace*.

   The *marketplace* will initiate the termination and notify *us* of the event. The termination date will be assigned.

Reasons we will terminate coverage for a covered person

We will terminate coverage for a *covered person* at the end of the billing period in which the following events occur unless stated otherwise:

1. When the *covered person* no longer qualifies as a *dependent* or meets eligibility criteria;
2. The *covered person* commits fraud or makes an intentional misrepresentation of a material fact, as determined by *us*. Termination will be effective at 12:01 a.m. local time at the *covered person's* state of residence on the date the misrepresentation occurred. A 30-day advance written notice of the termination will be provided;
3. When the *contractholder's* coverage under this *contract* terminates;
4. If coverage was purchased through a *marketplace*, the *covered person* ceases to be eligible for coverage through a *marketplace*. The *marketplace* will initiate the termination and notify *us* of the event. The termination date will be assigned; or
5. The administrative or court order requiring coverage expires or the *dependent* is enrolled in comparable health coverage through another insurer with no lapse in coverage. The *covered person* must furnish written proof of the event satisfactory to *us.*

You must notify *us* as soon as possible if *your dependent* no longer meets the eligibility requirements of this *contract*. Notice should be provided to *us* within 31 days of the change. If there is an overpayment of *your* premium prior to the change to *your dependent* eligibility, *we* will apply any overpayments as a credit to *your* next premium payment unless *you* request a refund by providing written notice to *us*.

RENEWABILITY OF INSURANCE AND TERMINATION

Your duty to notify us

You are responsible to notify *us* of any of the events stated above in "Reasons we will terminate your contract" and "Reasons we will terminate coverage for a covered person" provisions which would result in termination of this *contract* or a *covered person*.

Fraud

You or a *covered person* commit fraud against *us* when *you* or a *covered person* make an intentional misrepresentation of a material fact by not telling *us* the correct facts or withholding information which is necessary for *us* to administer this *contract*.

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 is committing insurance fraud. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

If *you* or the *covered person* commits fraud against *us*, as determined by *us*, *we* reserve the right to rescind coverage under this *contract* as of the date fraud is committed or as of the date otherwise determined by *us*. *We* will provide a 30-day advance written notice that coverage will be *rescinded*. *You* have the right to appeal the *rescission*. *We* will also provide information to the proper authorities and support any criminal charges which may be brought. Further, *we* reserve the right to seek any civil remedies which may be available to *us*.

GENERAL PROVISIONS

Conformity with state statutes

Any provisions which are in conflict with the laws of the state in which this *contract* is issued are amended to conform to the minimum requirements of those laws.

Discount program

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

Entire contract

The rules governing *our* agreement to provide *you* with health insurance in exchange for *your* premium payment are based upon several written documents: this *contract*, riders, amendments, endorsements, and the application. All statements made by *you* or a *covered person* are considered to be representations, not warranties. This means that the statements are made in good faith. No statement or omission will void this *contract*, reduce the benefits it provides or be used in defense to a claim unless it is contained in a written or *electronic* application and a copy is furnished to the person making such statement or his/her beneficiary. If coverage was purchased through a *marketplace, your contract* may not include a copy of *your* application.

No modification or amendment to this *contract* will be valid unless approved by the President, Secretary or a Vice-President of *our* Company. The approval must be endorsed on or attached to this *contract*. No agent has authority to modify this *contract*, waive any of the *contract* provisions, extend the time for premium payment, or bind *us* by making any promise or representation.

Incontestability

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

After a *covered person* is insured without interruption for two years, *we* cannot contest the validity of their coverage except for:

1. Nonpayment of premium; or
2. Any fraud or intentional misrepresentation of a material fact made by the *covered person*.

At any time, *we* may assert defenses based upon provisions in this *contract* which relate to a *covered person's* eligibility for coverage under this *contract*.

GENERAL PROVISIONS

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

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

Legal action

No lawsuit with respect to benefits under this *contract* may be brought:

1. Until 60 days after written proof of loss is provided which is satisfactory to us; or
2. Prior to the date the *covered person* has exhausted their appeal rights.

Misstatement of age or gender

If *you* or the *covered person* has provided *us* with information in error, and after *we* investigate the matter *we* also determine it was an error, *we* will not end *contract* coverage. However, *we* will adjust premium or claim payment based on this new information.

Our relationship with providers

In-network providers and *out-of-network providers* are not *our* agents, employees or partners. *In-network providers* are independent contractors. *We* do not endorse or control the clinical judgment or treatment recommendation made by *in-network providers* or *out-of-network providers*.

Nothing contained in this *contract* or any agreement or reimbursement document shall, nor is it intended to, interfere with communication between *you* and health care providers regarding *your* medical condition or treatment options. *Healthcare practitioners* and other providers are acting on *your* behalf when requesting authorizations and ordering *services*. All decisions related to patient care are the responsibility of the patient and the treating *healthcare practitioner*, regardless of any coverage determination(s) *we* have made or will make. *We* are not responsible for any misstatements made by any provider with regard to the scope of *covered expenses* and/or non-covered expenses under *your contract*. If *you* have any questions concerning *your* coverage, please call the telephone number on *your ID card*.

Rewards Program

From time to time *we* may enter into agreements with third parties who administer Rewards programs that may be available to a *covered person.* Through these programs, a *covered person* may earn rewards by:

1. Completing certain activities such as wellness, educational, or informational programs; or
2. Reaching certain goals such as lowering blood pressure or becoming smoke free.

The rewards may include non-insurance benefits such as merchandise, gift cards, debit cards, discounts or contributions to *your* health spending account. *We* are not responsible for any rewards that are non-insurance benefits or for a *covered person's* receipt of such reward.

The rewards may also include insurance benefits such as credits toward premium or a reduction in *copayments, deductibles* or *coinsurance*, as permitted under applicable state and Federal laws.

The rewards may be taxable income. A *covered person* may consult a tax advisor for further guidance.

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

Please call the telephone number listed on the *ID card* or in the marketing literature issued by the Rewards program administrator for a possible alternative activity if:

1. It is unreasonably difficult for a *covered person* to reach certain goals due to their medical condition; or
2. The *covered person's health care practitioner* advises them not to take part in the activities needed to reach certain goals.

The Rewards program administrator or *we* may require proof in writing from the *covered person's health care practitioner* that their medical condition prevents them from taking part in the available activities.

The decision to participate in these programs or activities is voluntary and a *covered person* may decide to participate anytime during the year. Refer to the marketing literature issued by the Rewards program administrator for their program's eligibility, rules and limitations.

Shared savings program

We have a Shared Savings Program that may allow *you* to share in discounts *we* have obtained from *out-of-network providers*. However, it will be *our* sole discretion on a case by case basis whether *we* will apply the Shared Savings Program.

As a *covered person under* this *contract, you* are free to obtain *services* from *in-network providers or out-of-network providers*. **If *you* chose to receive *services* from an *out-of-network provider* there is no coverage for any *services* received except when authorized by *us*.**

We cannot guarantee that *services* rendered by *out-of-network providers* will be discounted. The *out-of-network provider* discounts in the Shared Savings Program may not be as favorable as *in-network provider* discounts.

In most cases, to maximize *your* benefit design and reduce your non-covered expenses, please access *in-network providers* associated with this *contract*.

If *you* choose to obtain services from an *out-of-network provider*, it is not necessary for *you* to inquire about a provider's status in advance. When processing *your* claim, *we* will automatically determine if that provider is participating in the Shared Savings Program and calculate any applicable *copayment, deductible* and/or *coinsurance* on the discounted amount. *Your* Explanation of Benefits statement will reflect any savings with a remark code used to reference the Shared Savings Program.

However, if *you* would like to inquire in advance to determine if an *out-of-network provider* participates in the Shared Savings Program, please call the telephone number on *your ID card*. Please note provider arrangements in the Shared Savings Program are subject to change without notice. *We* cannot guarantee that the provider from whom *you* received treatment is still participating in the Shared Savings Program at the time treatment is received. Discounts are dependent upon availability and cannot be guaranteed.

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

Workers' compensation

This *contract* does not cover *sickness* or *bodily injury* arising out of, or sustained in the course of, any occupation, employment or activity for compensation, profit or gain and is not issued as a substitute for Workers' Compensation or occupational disease insurance except as provided for under the "Occupational coverage" provision.

DEFINITIONS

The following are definitions of terms as they are used in this *contract*. Defined terms are printed in *italic* type wherever found in this *contract*.

Advanced imaging for the purpose of this definition, includes Magnetic Resonance Imaging (MRI), Magnetic Resonance Angiography (MRA), Positron Emission Tomography (PET), Brain Electrical Activity Mapping (BEAM), Electrical Capacitance Tomography (ECT), Single Photon Emission Computed Tomography (SPECT), Computed Tomography (CT) imaging, and *nuclear medicine*.

Benefit maximum means the limit set on the amount of *covered expenses* that *we* will pay on behalf of a *covered person* for some *services*. *We* will not make benefit payments in excess of the *benefit maximum* for the *covered expenses* and time periods shown on the "Schedule of Benefits".

Bodily injury means bodily damage other than *sickness*, including all related conditions and recurrent symptoms, resulting from sudden, violent, external physical trauma which could not be avoided or predicted in advance. The *bodily injury* must be the direct cause of the loss, independent of disease, bodily infirmity or any other cause. Bodily damage resulting from infection or muscle strain due to athletic or physical activity is considered a *sickness* and not a *bodily injury*.

Bone marrow 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 or from a matched related or unrelated donor or cord blood. The term *bone marrow* includes the harvesting, the transplantation and the integral chemotherapy components.

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*.

Calendar year means the period of time beginning on any January 1st and ending on the following December 31st. The first *calendar year* begins for a *covered person* on the date benefits under this *contract* first become effective for that *covered person* and ends on the following December 31st.

Chemical dependency means the abuse of, or psychological or physical dependence on, or addiction to alcohol or a controlled substance as classified in the Diagnostic and Statistical Manual of Mental Disorders.

Coinsurance means the amount of *covered expense*, expressed as a percentage, a *covered person* must pay toward the cost *incurred* for each separate *prescription* fill or refill dispensed by a *pharmacy* and for all other medical *services*, in addition to any applicable *copayments* and *deductibles*. This percentage is shown in the "Schedule of Benefits". Charges paid as *coinsurance* do not apply to any responsibility for *copayments* or *deductibles*.

Confined/confinement means the status of being a resident patient in a *hospital* or *healthcare treatment facility* receiving *inpatient services*. *Confinement* does not mean detainment in *observation status*. Successive *confinements* are considered to be one *confinement* if they are:

1. Due to the same *bodily injury* or *sickness*; and
2. Separated by fewer than 30 consecutive days when the *covered person* is not *confined*.

DEFINITIONS

Contract means this document, together with any amendments, and endorsements which describe the agreement between *you* and *us*.

Contractholder means the person to whom this *contract* is issued and whose name is shown on the cover of this *contract* and the "Schedule of Benefits".

Copayment/Copay means a specified dollar amount shown on the "Schedule of Benefits", to be paid by a *covered person* toward the cost of each separate *prescription* fill or refill dispensed by a *pharmacy* and for certain medical benefits specified in this *contract* each time a *covered service* is received, regardless of any amounts that may be paid by *us*. *Copayments*, if any, do not apply toward any applicable *deductible*.

Cosmetic surgery means *surgery*, procedure, injection, medication or treatment primarily designed to improve appearance, self-esteem or body image and/or to relieve or prevent social, emotional or psychological distress.

Cost share means any applicable *copayment*, *deductible*, and/or *coinsurance* percentage that must be paid by the *covered person* per *prescription* drug fill or refill. Any expense that exceeds the *default rate* will not apply to any *covered person's cost share* responsibility.

Court-ordered means involuntary placement in *mental health* treatment as a result of a judicial directive.

Covered expense means a *medically necessary service* incurred by a *covered person* which was ordered by a *healthcare practitioner*. To be a *covered expense*, the *service* must not be *experimental, investigational or for research purposes* or otherwise excluded or limited by this *contract* or by any amendment.

Covered person means anyone enrolled to receive *contract* benefits as a *covered person*. Refer to the "Schedule of Benefits" for a complete list.

Custodial care means *services* given to a *covered person* if:

1. The *covered person* needs *services* that include, but are 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; or
2. The *services* are required to primarily maintain and not likely to improve the *covered person's* condition.

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

1. The *covered person* is under the care of a *healthcare practitioner*;
2. The *services* are prescribed by a *healthcare practitioner* to support or maintain the *covered person's* condition;
3. *Services* are being provided by a *nurse*; or
4. The *services* involve the use of skills which can be taught to a layperson and do not require the technical skills of a *nurse*.

DEFINITIONS

Deductible means the amount of *covered expense* that a *covered person*, either individually or combined as a covered family, must pay in a *calendar year* and is responsible to pay in addition to any applicable *copayments* or *coinsurance* before *we* pay medical or *prescription* drug benefits under this *contract*. This amount will be applied on a *calendar year* basis and will vary for medical *services*, *prescription* drug *services*, and for *services* obtained by *in-network providers* and *out-of-network providers*. The *deductible* is shown on the "Schedule of Benefits".

One or more of the following *deductibles* may apply to *covered expenses* as shown on the "Schedule of Benefits":

1. **Family medical deductible.** The amount of medical *covered expense* that a *covered person*, either individually or combined as a covered family, must pay each *calendar year* in addition to any applicable *copayment* and/or *coinsurance* before *we* pay medical benefits under this *contract*. These expenses do not apply toward any other *deductible* stated in this *contract*.
2. **Family prescription drug deductible.** The amount of *prescription* drug *covered expense* that a *covered person*, either individually or combined as a covered family, must pay each *calendar year* in addition to any applicable *copayment* and/or *coinsurance* before *we* pay *prescription* drug benefits under this *contract*. These expenses do not apply toward any other *deductible* stated in this *contract*.

Default rate means the fee based on rates negotiated by *us* or other payers with one or more *in-network providers* in a geographic area determined by *us* for the same or similar *prescription* fill or refill.

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.

Dependent means *your domestic partner* or legally recognized spouse, *your* natural born child, step-child, legally adopted child, foster child upon placement in the home whose age is less than the *limiting age* or a child placed for adoption whose age is less than the *limiting age*, a child whose age is less than the *limiting age* and for whom *you* have received a court or administrative order to provide coverage, or *your* adult child who meets the following conditions:

1. Is beyond the *limiting age* of a child;
2. Is unmarried;
3. Is permanently mentally or physically handicapped; and
4. Incapable of self-sustaining employment.

Each child, other than the child who qualifies because of a court or administrative order, must meet all of the qualifications of a *dependent* as determined by *us*.

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 condition as defined in the 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.

Dependent does not mean a:

1. Grandchild, unless such child is born to a *dependent* while covered under this *contract*;
2. Great grandchild; or
3. Child who has not yet attained full legal age but who has been declared by a court to be emancipated.

Diabetic supplies means:

1. Blood glucose monitors and test strips;
2. Visual reading and urine test strips;
3. Lancets and lancet devices;
4. Insulin and insulin analogs;
5. Injection aids;
6. Syringes;
7. Prescriptive agents for controlling blood sugar levels;
8. Prescriptive non-insulin injectable agents for controlling blood sugar levels;
9. Glucagon emergency kits; and
10. Alcohol swabs.

Dispensing limit means the monthly drug dosage limit and/or the number of months the drug usage is commonly prescribed to treat a particular condition, as determined by *us*.

Distant site means the site at which the *healthcare practitioner* delivering the *services* is located at the time the *service* is provided via a telecommunications system.

Domestic partner means an individual of the same or opposite gender who resides with *you* 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 *yours* at any one time. *You* and *your domestic partner* must each be at a minimum 18 years of age, competent to contract, and may not be related by blood to a degree of closeness which would prohibit legal marriage in the state in which *you* and *your domestic partner* both legally reside. *We* reserve the right to require an affidavit from *you* and *your domestic partner* attesting that the domestic partnership has existed for a minimum period of six months and, periodically thereafter, to require proof that the *domestic partner* relationship continues to exist.

Drug list (drug formulary) means a list of covered *prescription* drugs, medicines, medications, and supplies specified by *us*. The *drug list* identifies categories of drugs, medicines or medications and supplies by applicable levels, if any, and indicates applicable *dispensing limits*, *specialty drug* designation and/or any *prior authorization* or *step therapy* requirements. Visit *our* Website at www.humana.com or call the telephone number on *your ID card* to obtain the *drug lists*. The *drug lists* are subject to change without notice.

Durable medical equipment means equipment which meets the following criteria:

1. It can withstand repeated use;
2. It is primarily and customarily used to serve a medical purpose rather than being primarily for comfort or convenience;
3. It is usually not useful to a person except to treat a *bodily injury* or *sickness*;
4. It is *medically necessary* and necessitated by the *covered person's bodily injury* or *sickness*;
5. It is not typically furnished by a *hospital* or *skilled nursing facility*; and
6. It is prescribed by a *healthcare practitioner* as appropriate for use in the home.

DEFINITIONS

Effective date means the first date all the terms and provisions of this *contract* apply. It is the date that appears on the cover of this *contract* or on the date of any amendment or endorsement.

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

Emergency care means s*ervices* for a *bodily injury* or *sickness* that develops suddenly and unexpectedly and if not treated immediately would:

1. Endanger the *covered person's* life; or
2. Cause serious bodily impairment to the *covered person*.

Emergency care does not mean any *service* for the convenience of the *covered person* or the provider of treatment or *services*.

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

1. Root canal therapy and root canal fillings;
2. Periradicular *surgery* (around the root of the tooth);
3. Apicoectomy;
4. Partial pulpotomy; or
5. Vital pulpotomy.

Expense incurred means the fee charged for *services* which are *medically necessary* to treat the condition. The date a *service* is rendered is the *expense incurred* date.

Experimental, investigational or for research purposes means any procedure, treatment, supply, device, equipment, facility or drug (all *services*) determined by *our* Medical Director or his/her designee to:

1. Not be a benefit for diagnosis or treatment of a *sickness* or a *bodily injury*;
2. Not be as beneficial as any established alternative; or
3. Not show improvement outside the investigational setting.

A drug, biological product, device, treatment or procedure that meets any one of the following criteria, as determined by *us*, will be considered *experimental, investigational or for research purposes*:

1. Cannot be lawfully marketed without the final approval of the United States Food and Drug Administration (FDA) for the particular *sickness* or *bodily injury* and which 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 Pharmacopoedia-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 Federal or state law;

2. Is a device required to receive Premarket Approval (PMA) or 510K approval by the FDA, but has not received a PMA or 510K approval;
3. 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;
4. Is the subject of a National Cancer Institute (NCI) Phase I, II or III trial, or any trial not recognized by NCI regardless of the Phase except as expressly provided in this *contract*;
5. Is identified as not covered by the Centers for Medicare and Medicaid Services (CMS) Medicare Coverage Issues Manual, a CMS Operational Contract Letter or a CMS National Coverage Decision except as required by state or Federal law;
6. The FDA has determined the device to be contraindicated for the particular *sickness* or *bodily injury* for which the device has been prescribed; or
7. The treatment, *services* or supplies are:
   a. Not as effective in improving health outcomes and not as cost effective as established technology; or
   b. Not usable in appropriate clinical contexts in which established technology is not employable.

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

Free-standing surgical facility means any licensed public or private establishment which has permanent facilities that are equipped and operated primarily for the purpose of performing outpatient *surgery*.

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

Habilitative services means *services* that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't 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.

Healthcare practitioner means a practitioner, professionally licensed by the appropriate state agency, to diagnose or treat a *bodily injury* or *sickness*, and who provides *services* within the scope of that license. A *healthcare practitioner's services* are not covered if the practitioner resides in the *covered person's* home or is a *family member*.

Healthcare treatment facility means only a facility, institution or clinic duly licensed by the appropriate state agency, and is primarily established and operating within the scope of its license. *Healthcare treatment facility* does not include a halfway house.

DEFINITIONS

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

1. It must primarily provide skilled nursing *services* and other therapeutic *services* under the supervision of *healthcare practitioners* or registered nurses;
2. It must be operated according to established processes and procedures by a group of professional medical people, including *healthcare practitioners* and *nurses*;
3. It must maintain clinical records on all patients; and
4. It must be licensed by the jurisdiction where it is located, if licensure is required. It must be operated according to the laws of that jurisdiction which pertains to agencies providing home healthcare.

Home healthcare plan means a plan of healthcare established with a home healthcare provider. The *home healthcare plan* must consist of:

1. Care by or under the supervision of a *healthcare practitioner* and not for *custodial care*;
2. Physical, speech, occupational, and respiratory therapy;
3. Medical social work and nutrition *services*; or
4. Medical appliances, equipment, and laboratory *services*, if *expenses incurred* for such supplies would have been *covered expenses* during a *confinement*.

A *healthcare practitioner* must:

1. Review and approve the *home healthcare plan*;
2. Certify and verify that the *home healthcare plan* is required in lieu of *confinement* or a continued *confinement*; and
3. Not be related to the *home healthcare agency* by ownership or contract.

Home healthcare visit means home healthcare *services* provided by any one *healthcare practitioner* for four consecutive hours or any portion thereof.

Hospice care agency means an agency which:

1. Has the primary purpose of providing hospice *services* to *hospice patients*;
2. Is licensed and operated according to the laws of the state in which it is located; and
3. Meets the following requirements:
   a. Has obtained any required certificate of need;
   b. Provides 24-hour-a-day, seven-day-a-week service, supervised by a *healthcare practitioner*;
   c. Has a full-time administrator;
   d. Keeps written records of *services* provided to each patient; and
   e. Has a coordinator who:
      i. Is a *nurse*; and
      ii. Has four years of full-time clinical experience, of which at least two were involved in caring for terminally ill patients; and
4. Has a licensed social service coordinator.

DEFINITIONS

Hospice care program means a coordinated, interdisciplinary program provided by a hospice designed to meet the special physical, psychological, spiritual, and social needs of a terminally ill *covered person* and his/her *immediate family members*, by providing *palliative care* and supportive medical, nursing, and other *services* through at-home or *inpatient* care. A hospice must:

1. Be licensed by the laws of the jurisdiction where it is located and run as a hospice as defined by those laws; and
2. Provide a program of treatment for a least two unrelated individuals who have been medically diagnosed as having no reasonable prospect for cure for their *sickness* or *bodily injury*, and as estimated by their *healthcare practitioners*, are expected to live less than six months as a result of that *sickness* or *bodily injury*.

For purposes of the Hospice Care benefit only, *immediate family member* is considered to be the *covered person's* parent, spouse, *domestic partner*, and children or step-children.

Hospice facility means a licensed facility or part of a facility which:

1. Principally provides hospice care;
2. Keeps medical records of each patient;
3. Has an ongoing quality assurance program;
4. Has a *healthcare practitioner* on call at all times;
5. Provides 24-hour-a-day skilled nursing *services* under the direction of a registered nurse; and
6. Has a full-time administrator.

Hospice patient means a terminally ill or injured person who has six months or less to live, as certified by a *healthcare practitioner*.

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

1. It must provide, for a fee, medical care and treatment of sick or injured patients on an inpatient basis;
2. 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;
3. Care and treatment must be given by and supervised by *healthcare practitioners*. Nursing *services* must be provided on a 24-hour basis and must be given by or supervised by registered nurses;
4. It must be licensed by the laws of the jurisdiction where it is located;
5. It must be operated as a *hospital* as defined by those laws; and
6. It must not be primarily a:
   a. Convalescent, rest or nursing home; or
   b. Facility providing custodial or educational care.

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

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

ID cards means cards each *covered person* receives which contain *our* address, telephone number, group number and other coverage information.

Infertility services means any diagnostic evaluation, treatment, supply, medication or *service* given to achieve pregnancy or to achieve or maintain ovulation. This includes, but is not limited to:

1. Artificial insemination;
2. In vitro fertilization;
3. GIFT;
4. ZIFT;
5. Tubal ovum transfer;
6. Embryo freezing or transfer;
7. Sperm storage or banking;
8. Ovum storage or banking;
9. Embryo or zygote banking;
10. Diagnostic and/or therapeutic laparoscopy;
11. Hysterosalpingography;
12. Ultrasonography;
13. Endometrial biopsy; and
14. Any other assisted reproductive techniques or cloning methods.

In-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 a *covered person's* home or healthcare provider.

In-network provider means a *hospital*, *healthcare treatment facility*, *healthcare practitioner* or other 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 *covered persons* for this *contract* and for the *services* received.

Inpatient services are *services* rendered to a *covered person* during their *confinement*.

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

Level one drug means a category of *prescription* drugs, medicines or medications within the *drug list* that are designated by *us* as level one. Visit *our* Website at www.humana.com or call the telephone number on *your ID card* for a description of the drugs in this category.

Level two drug means a category of *prescription* drugs, medicines or medications within the *drug list* that are designed by *us* as level two. Visit *our* Website at www.humana.com or call the telephone number on *your ID card* for a description of the drugs in this category.

Level three drug means a category of *prescription* drugs, medicines or medications within the *drug list* that are designated by *us* as level three. Visit *our* Website at www.humana.com or call the telephone number on *your ID card* for a description of the drugs in this category.

Level four drug means a category of *prescription* drugs, medicines or medications within the *drug list* that are designated by *us* as level four. Visit *our* Website at www.humana.com or call the telephone number on *your ID card* for a description of the drugs in this category.

Level five drug means a category of *prescription* drugs, medicines or medications within the *drug list* that are designated by *us* as level five. Visit *our* Website at www.humana.com or call the telephone number on *your ID card* for a description of the drugs in this category.

Lifetime maximum benefit means the maximum dollar amount or day/visit limit for which benefits are payable for certain *covered expenses* incurred by a *covered person* while this *contract* is in effect as shown on the "Schedule of Benefits" and does not apply to essential health benefits.

Limiting age means a covered *dependent* child's 31st birthday (26th birthday if coverage was purchased through a *marketplace*).

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*.

Maintenance care means *services* furnished mainly to:

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

Marketplace (or Exchange) means a governmental agency or nonprofit entity that meets the applicable Federal or state standards and makes *qualified health plans* available to qualified individuals. This term includes an *exchange* serving the individual market regardless of whether the *exchange* is established and operated by a state (including a regional *exchange* or subsidiary *exchange*) or by the Federal government as defined by the Affordable Care Act.

Medically necessary or medical necessity means healthcare *services* that a *healthcare practitioner* exercising prudent clinical judgment would provide to his/her patient for the purpose of preventing, evaluating, diagnosing, or treating a *sickness* or *bodily injury* or its symptoms. The fact that a *healthcare practitioner* may prescribe, authorize or direct a *service* does not of itself make it *medically necessary* or covered under this *contract*. Such healthcare *service*, treatment or procedure must be:

1. In accordance with nationally recognized standards of medical practice;
2. Clinically appropriate in terms of type, frequency, extent, setting, and duration and considered effective for the patient's *sickness* or *bodily injury*;
3. Not primarily for the convenience of the patient or *healthcare practitioner* or other healthcare provider; and
4. Not more costly than an alternative *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*.

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 *healthcare practitioners* practicing in relevant clinical areas, and any other relevant factors.

Mental health means *mental illness* and *chemical dependency*.

Mental illness means a mental, nervous, behavioral or emotional condition of any type as classified in the Diagnostic and Statistical Manual of Mental Disorders. This is true regardless of the original cause of the disorder.

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

1. 40 kilograms or greater per meter squared (kg/m^2); or
2. 35 kilograms or greater per meter squared (kg/m^2) with an associated co-morbid condition such as hypertension, type II diabetes, or joint disease that is treatable, if not for the obesity.

Net charges means the total amount billed by the provider, less any amounts such as:

1. Those negotiated by contract, directly or indirectly, between *us* and the provider; or
2. Adjustments related to *our* claims processing edits.

Nuclear medicine means radiology in which radioisotopes (compounds containing radioactive forms of atoms) are introduced into the body for the purpose of imaging, evaluating organ function or localizing disease or tumors.

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

Observation status means a stay in a *hospital* or *healthcare treatment facility* if the *covered person*:

1. Has not been admitted as a resident inpatient;
2. Is physically detained in an emergency room, treatment room, observation room or other such area; or
3. Is being observed to determine whether a *confinement* will be required.

Open enrollment period means the period during which:

1. A *dependent* who did not enroll for coverage under this *contract* when first eligible or during a *special enrollment period* can enroll for coverage; or
2. A *covered person* has an opportunity to enroll in another health insurance plan.

Visit *our* Website at www.humana.com for information on the *open enrollment period*.

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

Out-of-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 a *covered person's* home or healthcare provider.

Out-of-network provider means a *hospital*, *healthcare treatment facility*, *healthcare practitioner*, or other provider who has not been designated by *us* as an *in-network provider* for this *contract* and for the *services* received.

Out-of-pocket limit means the amount of *covered expense* a *covered person*, either individually or combined as a covered family, must pay each *calendar year* for medical *services* or *prescription* drugs covered under this *contract*. This amount does not include:

1. Amounts over the *default rate*;
2. Non-covered *services*; or
3. Other *contract* limits.

There may be separate individual and family medical, *prescription* drug, *in-network provider* and *out-of-network provider out-of-pocket limits*. **See the "Schedule of Benefits" for the specific amounts.**

Outpatient services means *services* that are rendered to a *covered person* while they are not *confined* as a registered inpatient. *Outpatient services* include, but are not limited to, *services* provided in:

1. A *healthcare practitioner's* office;
2. A *hospital* outpatient setting;
3. A *free-standing surgical facility*;
4. A licensed birthing center; or
5. An independent laboratory or clinic.

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 *services* provided in an outpatient program by a *hospital* or *healthcare treatment facility* in which patients do not reside for a full 24-hour period.

1. For a comprehensive and intensive interdisciplinary psychiatric treatment for a minimum of five hours a day, five days per week;
2. That provides for social, psychological, and rehabilitative training programs with a focus on reintegration back into the community and admits children, adolescents, and adults who must have a treatment program designed to meet the special needs of that age range; and
3. That has *healthcare 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:

1. *Custodial care*; or
2. Day care.

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

1. Periodontal maintenance;
2. Scaling and tooth planning;
3. Gingivectomy;
4. Gingivoplasty; or
5. Osseous *surgery*.

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

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

Preauthorization means the determination by *us*, or *our* designee, of the *medical necessity* of a *service* prior to it being provided. *Preauthorization* is not a determination that a *service* is a *covered expense* and does not guarantee coverage for or the payment of *services* reviewed.

Prescription means a direct order written by a *healthcare practitioner* for the preparation and use of a drug, medicine, or medication. The *prescription* must be given to a *pharmacist* for a *covered person's* benefit and used for the treatment of a *bodily injury* or *sickness* which is covered under this *contract* or for drugs, medicines or medications on the *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 *healthcare practitioner*.

The *prescription* must include at least:

1. The name of the *covered person;*
2. The type and quantity of the drug, medicine or medication prescribed and the directions for its use;
3. The date the *prescription* was prescribed; and
4. The name and address of the prescribing *healthcare practitioner*.

Pre-surgical/procedural testing means:

1. 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 procedures; and
2. The tests must be for the same *bodily injury* or *sickness* causing the *covered person* to be *confined* to a *hospital* or to have the outpatient *surgery* or procedure.

DEFINITIONS

Primary care physician means an in-network *healthcare 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 *healthcare practitioner* in one of the following specialties:

1. Family Medicine;
2. Internal Medicine; and
3. Pediatrics.

An Obstetrician/Gynecologist and Nurse Practitioner will be considered as *primary care physicians* if the following conditions are met:

1. The *healthcare practitioners* have signed an agreement with *us* as a *primary care physician*; and
2. A *covered person* has selected the Obstetrician/Gynecologist or Nurse Practitioner as their *primary care physician*.

Review the "Provider Directory" on *our* Website at www.humana.com or call the telephone number on *your ID card* to obtain a list of Obstetrician/Gynecologists and Nurse Practitioners who are considered *primary care physicians*.

Prior authorization means the required prior approval from *us* for the coverage of *prescription* drugs, medicines, or medications or *specialty drugs*, including the dosage, quantity, and duration, as appropriate for a *covered person's* diagnosis, age, and gender. Certain *prescription* drugs, medicines, medications or *specialty drugs* may require *prior authorization* and/or *step therapy*. Visit *our* Website at www.humana.com or call the telephone number on *your ID card* to obtain a list of *prescription* drugs, medicines, medications, and *specialty drugs* that require *prior authorization* and/or *step therapy*.

Qualified health plan means a health plan that is certified and meets the standards issued or recognized by each *marketplace* through which the plan is offered as defined by the Affordable Care Act, section 1301.

Reconstructive surgery means *surgery* performed on an abnormal body structure caused by congenital defects, developmental abnormalities, trauma, infection, tumor or disease in order to improve function.

Rehabilitation services means specialized treatment for *sickness* or a *bodily injury* which meets all of the following requirements:

1. Is a program of *services* provided by one or more members of a multi-disciplinary team;
2. Is designed to improve the patient's function and independence;
3. Is under the direction of a qualified *healthcare practitioner*;
4. Includes a formal written treatment plan with specific attainable and measurable goals and objectives; and
5. May be provided in either an inpatient or outpatient setting.

Rescission/rescinded means a cancellation or discontinuance of coverage that has a retroactive effect. Coverage under this *contract* will be *rescinded* when a *covered person* performs an act, practice or omission that constitutes fraud or makes an intentional misrepresentation of a material fact prohibited by the terms of this plan or coverage, as determined by *us*.

Residential treatment center means an institution which:

1. Is licensed as a 24-hour residential, intensive, inpatient facility, although NOT licensed as a *hospital*;
2. Provides a multidisciplinary treatment plan in a controlled environment, with periodic supervision of a licensed *healthcare practitioner* or Ph.D. psychologist; and
3. Provides programs such as social, psychological, and rehabilitative training, age appropriate for the special needs of the age group of patients, with a focus on reintegration back into the community.

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 *healthcare 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).

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

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

Services means procedures, *surgeries*, consultations, advice, diagnosis, referrals, treatment, supplies, drugs, devices or technologies.

Sickness means disturbance in function or structure of the *covered person's* body which causes physical signs or symptoms which, if left untreated, will result in a deterioration of the health state of the structure or system(s) of the *covered person's* body.

Skilled nursing facility means a facility that provides continuous skilled nursing *services* on an inpatient basis for persons recovering from a *sickness* or a *bodily injury*. The facility must meet all of the following requirements:

1. Be licensed by the state to provide skilled nursing *services*;
2. Be staffed by an on call *healthcare practitioner* 24 hours per day;
3. Provide skilled nursing *services* supervised by an on duty registered nurse 24 hours per day;
4. Maintain full and complete daily medical records for each patient; and
5. Not primarily a place for rest, for the aged, for *custodial care* or to provide care for *mental health* although these *services* may be provided in a distinct section of the same physical facility. The facility may also provide extended care which would not be covered under this *contract*.

Sound natural tooth means a tooth that:

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

Special enrollment period means a 60-day period of time during which a *covered person* or *dependent* who has a qualifying event may enroll for coverage outside of an *open enrollment period*.

Specialty care physician means an in-network *healthcare practitioner* who has received training in a specific medical field and is not a *primary care physician*.

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

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

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

Step therapy means a type of *prior authorization*. *We* may require a *covered person* to follow certain steps prior to *our* coverage of some medications including *specialty drugs*. *We* may also require a *covered person* to try similar drugs, medicines or medications, including *specialty drugs* that have been determined to be safe, effective, and more cost effective for most people that have the same condition as the *covered person*. Alternatives may include over-the-counter drugs, *generic drugs*, and *brand-name drugs*.

Sub-acute medical care means a short-term comprehensive inpatient program of care for a *covered person* who has a *sickness* or a *bodily injury* that:

1. Does not require the *covered person* to have a prior admission as an inpatient in a *healthcare treatment facility*;
2. Does not require intensive diagnostic and/or invasive procedures; and
3. Requires *healthcare practitioner* direction, intensive nursing care, significant use of ancillaries, and an outcome-focused, interdisciplinary approach using a professional medical team to deliver complex clinical interventions.

DEFINITIONS

Sub-acute rehabilitation facility means a facility that provides *sub-acute medical care* for *rehabilitation services* for *sickness* or a *bodily injury* on an inpatient basis. This type of facility must meet all of the following requirements:

1. Be licensed by the state in which the *services* are rendered to provide *sub-acute medical care* for *rehabilitation services*;
2. Be staffed by an on call *healthcare practitioner* 24 hours per day;
3. Provide nursing *services* supervised by an on duty registered nurse 24 hours per day;
4. Maintain full and complete daily medical records for each patient; and
5. Not primarily provide care for *mental health* although these *services* may be provided in a distinct section of the same physical facility. The facility may also provide extended care or *custodial care* which would not be covered under this *contract*.

Surgery means surgical procedures as categorized in the Current Procedural Terminology (CPT) Manuals published by the American Medical Association. The term *surgery* includes, but is not limited to:

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

Telehealth means an audio and video real-time interactive communication between the patient and *distant site healthcare practitioner*.

Telemedicine means *services* other than *telehealth services* which are provided via telephonic or *electronic* communications.

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

We, us or **our** means or otherwise refers to the insurer as shown on the cover page of this *contract*.

You/your means the *contractholder*.

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