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.

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TITLE PAGE (COVER PAGE)

INDIVIDUAL HMO MEDICAL POLICY
HUMANA HEALTH PLAN, INC.

For Claims & Benefit Information
PO Box 14635
Lexington, KY 40512-4635
Toll-Free 1-800-833-6917

For All Other Inquiries
PO Box14642
Lexington, KY 40512-4642
Toll-Free 1-800-223-3659

Policyholder: [John Doe]

Policy number: [12345]

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

Premium amount: $ [xxxx]

PLEASE READ THIS POLICY 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 (Who Pays What)", subject to all the terms of this *policy*.

This *policy* is issued in consideration of the *policyholder's* application, a copy of which is attached and made a part of this *policy*, and the *policyholder's* payment of premium as provided under this *policy*. **Fraud or intentional misrepresentation of a material fact in the application may cause *your* policy 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.

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

Renewability

This *policy* remains in effect at the option of the *policyholder* except as provided in the "Termination/Nonrenewal/Continuation" section of this *policy*.

Right to return policy

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

[Signature of Officer]

Bruce Broussard
President

CONTACT US

As *you* read through this *policy*, *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 *policy* than it does in general usage. Please check the "Definitions" section for the meanings of *italicized* words.

This *policy* 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 policy* carefully before using *your* benefits.

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

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

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

If *you* have any questions about this *policy*, please call the telephone number on *your ID card* or contact *us* at:

Humana
P.O. Box 14635
Lexington, KY 40512-4635
1-800-833-6917
Or
www.humana.com

This *policy* 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 *policy* also requires that a referral be obtained from the *primary care physician* before receiving medical care from any medical care provider other than the *primary care physician*. If a referral is not obtained prior to receiving *services*, such *services* will not be a *covered expense*. See the "How to Access Your Services and Obtain Approval of Benefits" section for a description of these *policy* requirements.

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ELIGIBILITY

Changes to covered persons

You may request a change to the persons covered under *your policy* 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 *us* with the request to have *your dependent* removed from this *policy*.

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

2. **Adding dependents**

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

   If *you* did not purchase *your* coverage through the *marketplace* and a child is born to a *policyholder*, or any *covered person*, a *policyholder* adopts a child, or a child is placed with the *policyholder* for the purpose of adoption or foster care, coverage will be effective for 31 days from the moment of birth or placement. To continue coverage for the child beyond this 31-day period, *we* must be notified of the event in writing and receive any required premium within 60 days.

   If *we* do not receive notice and premium as noted above, 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* child of any age who is medically certified as disabled and dependent upon *you*. Notification of premium due for this coverage will be sent upon *our* receipt of the application.

3. **Effective date of dependent changes**

   a. Coverage for a newborn, foster child or adopted child will be effective on the date of the birth, placement or adoption, provided *you* complete an application and remit the premium within 60 days of the child's date of birth, placement or adoption.
   b. If *we* receive the application and any required premium more than 60 days after the newborn's date of birth or the child's adoption or placement for adoption or foster care, 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. *Civil union*;
   c. Divorce;
   d. Legal separation;
   e. The birth of a natural born child;
   f. The adoption of a child or placement of a child with the *policyholder* for the purpose of adoption;
   g. Placement of a foster child with the *policyholder*;
   h. Death of the *policyholder*; or
   i. For a *covered person* who purchased coverage through a *marketplace*, any other event as determined by the *marketplace*.

2. Coverage under this *policy* terminates due to:
   a. A *dependent* child ceasing to be eligible due to attaining the *limiting age*; or
   b. For a *covered person* who purchased coverage through a *marketplace*, any other event as determined by the *marketplace*.

3. A *covered person* did not enroll for coverage under this *policy* 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, national or lawfully present individual of the United States, lawfully present, and subsequently gaining such lawful status;
   c. Was incarcerated and is no longer incarcerated; or
   d. Any other event as determined by the *marketplace*, for a *covered person* who purchased coverage through a *marketplace*.

4. An individual involuntarily loses existing creditable coverage for any reason other than fraud, misrepresentation, or failure to pay a premium.

5. An individual's enrollment or non-enrollment in a health benefit plan that is unintentional, inadvertent or erroneous and is the result of an error, misrepresentation, or inaction of *us*, the producer, or the *marketplace*.

6. Demonstrating to the Commissioner that the health benefit plan in which the individual is enrolled has substantially violated a material provision of its contract in relation to the individual.

7. A *marketplace* enrollee becoming newly eligible or ineligible for the federal advance payment tax credit or cost-sharing reductions available through the *marketplace*.

8. Gaining access to other creditable coverage as a result of a permanent change in residence.

9. A parent or legal guardian dis-enrolling a *dependent*, or a *dependent* becoming ineligible for the Children's Basic Health Plan.

10. An individual becoming ineligible under the Colorado Medical Assistance Act.

11. An Indian, as defined by section 4 of the Indian Health Care Improvement Act, may enroll in a qualified health plan or change from one qualified health plan to another one time per month.

12. For a *covered person* who purchased coverage through a *marketplace*, any other event as determined by the *marketplace*.

Any person who qualifies for special enrollment must furnish proof of the event that is satisfactory to *us* and may enroll 30 days prior to or within 60 days 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. Except for special effective dates and the option for earlier effective dates as described below, the regular effective dates will be:

1. Between the first and fifteenth day of any month, the *marketplace* must ensure a coverage effective date of the first day of the following month; and
2. Between the sixteenth and the last day of any month, the *marketplace* must ensure a coverage effective date of the first day of the second following month.

Special effective dates will be:

1. In the case of birth, adoption or placement for adoption or foster care, coverage is effective on the date of birth, adoption, or placement for adoption or foster care, but advance payments of the premium tax credit and cost-sharing reductions if applicable, are not effective until the first day of the following month, unless the birth, adoption, or placement for adoption occurs on the first day of the month; and
2. In the case of marriage or a *civil union* or in the case where a qualified *covered person* loses minimum essential coverage, coverage is effective on the first day of the following month.

Option for earlier effective dates will be subject to the *marketplace* demonstrating to the Department of Health and Human Services that *we* agree to provide coverage in a timeframe shorter than discussed above, the *marketplace* may do one or both of the following for all applicable *covered persons*:

1. For a qualified health plan selection received by the *marketplace* from a qualified *covered person* (except in the case of marriage or where a qualified *covered person* loses minimum essential coverage), the *marketplace* may provide a coverage effective date earlier than specified, provided that:
   a. The qualified *covered person* has not been determined eligible for advance payments of the premium tax credit or cost-sharing reductions; or
   b. The qualified *covered person* pays the entire premium for the first partial month of coverage as well as all cost sharing, thereby waiving the benefit of advance payments of the premium tax credit and cost-sharing reduction payments until the first of the next month; or
2. For a qualified health plan section received by the *marketplace* from a qualified *covered person* on a date set by the *marketplace* after the fifteenth of the month, the *marketplace* may provide a coverage effective date of the first of the following month.

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 *policy* 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.

HOW TO ACCESS YOUR SERVICES AND OBTAIN APPROVAL OF BENEFITS

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 *maximum allowable fee*. 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 *policy*.

Selecting a primary care physician

Each *covered person* on this *policy* 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*.

HOW TO ACCESS YOUR SERVICES AND OBTAIN APPROVAL OF BENEFITS

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.

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*.

We do require *preauthorization* for certain *services*. Visit *our* Website at www.humana.com or call the telephone number on *your ID card* for a list of *services* that require *preauthorization*. See the "Utilization Management" section for information on *preauthorization*.

Preauthorization of *services* does not necessarily mean that a provider is in the network. *You* can reduce *your* out-of-pocket expense by ensuring that all providers *you* receive *services* from are *in-network providers*.

Second opinions

We allow a second opinion for a proposed *healthcare service* from an *in- network healthcare practitioner* prior to the treatment. *Preauthorization* and referral from the *primary care physician* may be required before a second opinion is a *covered expense*.

Seeking emergency care services

If *you* are confronted with a life or limb threatening emergency, *you* have the option of dialing the emergency telephone access number 9-1-1 or its local equivalent.

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*.

HOW TO ACCESS YOUR SERVICES AND OBTAIN APPROVAL OF BENEFITS

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.

When *you* are temporarily absent from the service area, *covered expenses* include *hospital, emergency care* or urgent care *services*, and transportation which is *medically necessary* and appropriate under the circumstances to return *you* to an *in-network provider*, subject to the following conditions:

1. The condition could not reasonably have been foreseen;
2. *You* could not reasonably arrange to return to the service area to receive *services* from an *in-network provider*;
3. The temporary absence must be for some purpose other than the receipt of *healthcare services*; and
4. *We* are notified as required herein unless it is shown that it was not reasonably possible to communicate with *us* in such time limit.

We will not deny a claim for *hospital* and *emergency services* necessary to screen and stabilize a *covered person* and will not require *preauthorization* of the *services* if a prudent layperson would have reasonably believed that use of an *in- network healthcare practitioner* would result in a delay that would worsen the *emergency*, or if a provision of Federal, state or local law requires the use of a specific provider.

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 *policy*.

HOW TO ACCESS YOUR SERVICES AND OBTAIN APPROVAL OF BENEFITS

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*.

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 no greater cost to the *covered person* than if the services were obtained from an *in-network provider* benefit level. Out-of-network *healthcare practitioners* may require payment from *you* for any amount not paid by *us*. If possible, *you* may want to verify whether *services* are available from in-network *healthcare practitioners*.

In any case where there are no *in-network healthcare practitioners* to provide a covered *service*, *we* will arrange for a referral to an *out-of-network healthcare practitioner* with the necessary expertise and ensure that the *covered person* obtains the covered *services* at no greater cost to the *covered person* than if the benefit were obtained 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*. *We* are not responsible for the accuracy or inaccuracy of network participation representations made by any *primary care physician*, *specialty care physician*, *hospital* or other provider whether contracted with *us* or not. This means that even if the in-network *primary care physician*, *specialty care physician* or other provider recommends that *services* be received from another provider or entity, it is *your* responsibility to verify the network participation status of that entity before receiving such *services*. If *you* do not, and the entity is not an *in-network provider* (regardless of what the referring provider may have told *you*), *you* will be responsible for all costs incurred.

Continuity of Care

We and our *in-network healthcare practitioners* will provide at least 60 days written notice to each other before terminating the *in-network healthcare practitioner's* contract without cause. *We* will make a good faith effort to provide written notice of termination within 15 working days after receipt of or issuance of a notice of termination to all *covered persons* that are patients seen on a regular basis by the *in-network healthcare practitioner* whose contract is terminating, regardless of whether the termination was for cause or without cause. Where a contract termination involves a *primary care physician*, all *covered persons* that are patients of that *primary care physician* will also be notified.

A *covered person* may continue receiving care for 60 days from the date a *in-network provider* is terminated without cause when notice has not been provided to the *covered person.*

If this policy is terminated for any reason other than nonpayment of premium, fraud, or abuse, *we* will provide for continued care for a *covered person* being treated at an *in- network hospital* or *healthcare treatment facility* until the *covered person* is discharged.

HOW TO ACCESS YOUR SERVICES AND OBTAIN APPROVAL OF BENEFITS

Preauthorization for medical services and prior authorization for prescription drugs

***Preauthorization* and *prior authorization* is a confirmation and determination of *medical necessity* only and is NOT a guarantee of coverage for or the payment of the medical *service* or *prescription* drug reviewed. For *prescription* drugs, it is a confirmation of the dosage, quantity, and duration as appropriate for the *covered person's* age, diagnosis, and gender. For all medical *services*, it is a confirmation of *medical necessity* only.**

We will not retrospectively deny eligibility for a service for which *preauthorization* has been completed except for:

1. Fraud or abuse, including material misrepresentation about the patient's condition or the cause of the health condition;
2. If this *policy* or coverage is terminated before the *services* are provided; or
3. If the patient is not a *covered person* under this *policy* at the time the *services* are provided.

All benefits payable under this *policy* must be for medical *services* or *prescription* drugs that are *medically necessary* or for preventive *services* as stated in this *policy*. *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*.

The *in-network provider* is solely responsible for obtaining *preauthorization* and *prior authorization*. The *covered person* will not be penalized for failure of the *in-network provider* to obtain *preauthorization* and *prior authorization*. The *in-network provider* 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*.

Reduction of payment

If *preauthorization* or *prior authorization* is not obtained from *us* prior to *services* being rendered the following penalties will apply:

1. No benefits will be paid for:
   a. Any transplant *services* that are not authorized by *us* prior to the transplant evaluation, testing, preparative treatment or donor search;
   b. *Prescription* drugs, medicines, and medications, including *specialty drugs* as identified on the *drug list* on *our* Website at www.humana.com that require *prior authorization*; or
   c. *Services* provided by an *out-of-network provider* except as expressly provided in this *policy*.

2. Benefits will be reduced for otherwise *covered expenses* by $500.00 if authorization is not obtained from *us* prior to *services* being rendered for:
   a. *Durable medical equipment*;
   b. *Services* from:
      i. A *home healthcare provider*;
      ii. *Skilled nursing facility*;
      iii. *Hospice facility*; or
      iv. Other medical *services* and *prescription* drugs, medicines, and medications including *specialty drugs* listed in *our* Website at www.humana.com.

The *in-network provider* may not balance bill for the reduced or denied amounts for failure to obtain *preauthorization* or *prior authorization*. *You* are not responsible for any reduction or penalty due to the failure of the *in-network provider* to obtain the required *preauthorization* or *prior authorization*.

You will be financially responsible for *out-of-network* medical *services* and *prescription* drugs, medicines, and medications, including *specialty drugs* that are not covered under this *policy* due to failure to obtain *preauthorization* or *prior authorization* from *us*. The reduced penalty amount, or any portion thereof, will not count toward satisfying any applicable *copayment*, *deductible*, *coinsurance* or *out-of-pocket limit*. The amount eligible after application of the penalty will count toward satisfying any applicable *copayment*, *deductible*, *coinsurance* or *out-of-pocket limit*.

BENEFITS/COVERAGE

Benefits are payable only if the *services* are *covered expenses*, and subject to specific conditions, exclusions and limitations, and applicable maximums of this *policy*. 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 *policy*.

We will pay benefits for *covered expenses* as stated in the "Schedule of Benefits (Who Pays What)" and this *policy* section, and according to the "Limitations/Exclusions" sections. All benefits *we* pay will be subject to the *maximum allowable fee* and all conditions, exclusions and limitations, and applicable maximums of this *policy*.

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 *maximum allowable fee* 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 *maximum allowable fee* 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 *maximum allowable fee* 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 *maximum allowable fee* for eligible *covered expenses incurred*.
5. *We* will make payment for the remaining eligible *covered expenses* incurred to *you* or *your* servicing provider.

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

BENEFITS/COVERAGE

Refer to the "Limitations/Exclusions" sections in this policy. All terms and provisions of this policy, including the preauthorization and prior authorization requirements specified in this policy are applicable to covered expenses.

Ambulance (licensed air and ground)

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

Expenses incurred for a covered *dependent* for the treatment of *Autism spectrum disorder*: *Covered expenses* include:

1. Evaluation and assessment *services*;
2. Behavioral training and behavior management and applied behavior analysis;
3. Habilitative or rehabilitative care. *Services* for physical, occupational and speech therapy are not applicable to the visit limits in the *policy* if such therapy is *medically necessary* to treat *autism spectrum disorder*;
4. *Prescription* drugs;
5. Psychiatric care;
6. Psychological care, including family counseling; and
7. Therapeutic care.

Cervical cancer vaccine

The full cost of cervical cancer vaccination for all female *covered persons* for whom a vaccination is recommended by the advisory committee on immunization practices of the United States Department of Health and Human Services.

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.

Complications of pregnancy services

Covered expenses are *expenses incurred* for *services* related to a covered *complication of pregnancy* at the point the complication occurs, for any female *covered person.*

Dental anesthesia

General anesthesia, when rendered in a *hospital* or other *healthcare treatment facility*, and associated *hospital* or facility charges for dental care provided to a covered *dependent* child. Such *dependent* child must, in the treating *healthcare practitioner's* opinion, satisfy one or more of the following criteria:

1. The child has a physical, mental, or medically compromising condition;
2. The child has dental needs for which local anesthesia is ineffective because of acute infection, anatomic variations, or allergy;
3. The child is an extremely uncooperative, unmanageable, anxious, uncommunicative child or adolescent with dental needs deemed sufficiently important that dental care cannot be deferred; or
4. The child has sustained extensive orofacial and dental trauma.

Dental services

1. Treatment for a *dental injury* to a *sound natural tooth*. Treatment must begin within 90 days from the date of the *dental injury* and be completed within 12 months from the first date of *service* for treatment of the *dental injury*. *We* limit *covered expenses* to the least expensive *service* that will produce professionally adequate results.
2. Benefits for TMJ (temporomandibular joint) only if determined to be *medically necessary* by a *healthcare practitioner*. The following are considered *covered expenses*:
   a. Diagnostic x-rays and laboratory testing;
   b. Physical therapy; and
   c. *Surgery.*
3. 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; and
   g. Cutting of the tissue in the midline of the tongue (Frenectomy).

Diabetes services

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

1. Routine eye exams;
2. Routine foot care; and
3. Equipment, supplies and outpatient self-management training and education, including medical nutritional therapy 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 for the treatment of diabetes are explained under the "Prescription drug" provision.

Durable medical equipment and medical supplies

The following equipment 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. 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;
7. Initial contact lenses or eyeglasses following cataract *surgery*;
8. Casts, splints (other than dental), trusses, braces (other than orthodontic), and crutches;
9. Wigs following cancer treatment (not to exceed one per lifetime);
10. Rental or purchase of a breast pump for lactating mothers;
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 bags, rings, and belts;
    d. Flotation pads;
    e. Equipment prescribed by a *healthcare practitioner* for the treatment of diabetes; and
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 *maximum allowable fee* for a standard item that is a *covered expense*, serves the same purpose and is *medically necessary*. Any expense that exceeds the *maximum allowable fee* 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, or on account of:

1. Repair or maintenance of the *durable medical equipment* or orthotic devices necessitated by misuse or loss;
2. Experimental and research braces;
3. More than one orthotic device for the same part of the body, except for covered replacements, spare devices, or alternate use devices; or
4. Duplicate or similar rentals of *durable medical equipment*, as determined by *us*.

Early intervention services

Expenses incurred for eligible *early intervention services* are payable by the Trust set up by the Colorado Department of Human Services for an *eligible child* from birth to age three years.

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.

If *emergency services* are obtained through an *out-of-network provider*, benefits will be provided at the in-network medical payment level in order to stabilize the *covered person* until a transfer can be made to an *in-network provider* as shown on the "Schedule of Benefits (Who Pays What)" 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 (Who Pays What)" subject to any applicable *copayment*, *deductible*, and *coinsurance*.

Habilitative services

Habilitative services ordered and performed by a *healthcare practitioner* for a *covered person* with a disabling condition, 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 (Who Pays What)".

Health education services

Health education appointments to support understanding of chronic diseases. Benefits include training on self-care topics including stress management and nutrition.

Healthcare treatment facility services

1. Daily room and board up to the semi-private room rate for each day of *confinement*;
2. *Confinement* in a critical care or intensive care unit;
3. Private duty nursing when determined to be *medically necessary* by the *healthcare practitioner*;
4. Operating room;
5. Ancillary *services* (such as surgical dressings, supplies, casts, and splints);
6. Blood and blood plasma which is not replaced by donation;
7. Administration of blood and blood products including blood extracts or derivatives;
8. *Advanced imaging*, pulmonary function studies, cardiac catheterization, electrocardiogram (EKG), and electroencephalogram (EEG);
9. Other *healthcare treatment facility* charges;
10. Drugs and medicines that are provided or administered to the *covered person* while *confined* in a *hospital* or *skilled nursing facility*;

11. 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
12. *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. Second surgical opinions;
4. *Surgery*. If several *surgeries* are performed during one operation, *covered services* will be subject to the *maximum allowable fee* for the most complex procedure. For each additional procedure *we* will allow:
   a. 50% of *maximum allowable fee* for the secondary procedure; and
   b. 25% of *maximum allowable fee* 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 *maximum allowable fee* for the procedure;
5. 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*;
6. Surgical *services rendered by* a physician assistant (P.A.), registered nurse (R.N.), 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*;
7. Anesthesia administered by a *healthcare practitioner* or certified registered anesthetist attendant to a *surgery*;
8. *Services* of a pathologist;
9. *Services* of a radiologist;
10. Allergy injections, therapy, testing, and serum. Therapy and testing for treatment of allergies must be approved by the American Academy of Allergy, Asthma, and Immunology or the Department of Health and Human Services or any of its offices or agencies; and
11. 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 expense during a *healthcare practitioner's* office visit for charges incurred for *advanced imaging*, pulmonary function studies, cardiac catheterization, electrocardiogram (EKG), electroencephalogram (EEG) are not subject to the office visit *copayment*. Benefits will be provided at the medical payment level as shown on the "Schedule of Benefits (Who Pays What)" subject to any applicable *deductible* and *coinsurance*.

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

Hearing aids for minor children

Hearing aids for minor *dependent* children who have a hearing loss that has been verified by a *healthcare practitioner* who is a licensed audiologist. The *hearing aids* must be medically appropriate to meet the needs of the *dependent* child according to accepted professional standards. *Covered expenses* include the purchase of the following:

1. Initial *hearing aids* and replacement *hearing aids* not more frequently than every five years;
2. A new *hearing aid* when alterations to the existing hearing aid cannot adequately meet the needs of the child; and
3. *Services* and supplies including, but not limited to, the initial assessment, fitting, adjustments, and auditory training that is provided according to accepted professional standards.

Home healthcare

Services provided by a *home healthcare agency* at the *covered person's* home. All home healthcare *services* must be provided on a part-time or intermittent basis in conjunction with a *home healthcare plan*.

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*.

These *services* are subject to an annual visit limit as shown on the "Schedule of Benefits (Who Pays What)".

Hospice care

1. Room and board for short-term inpatient care in a *hospice facility*, when it is for management of acute pain or for an acute phase of chronic symptoms;
2. Other *services*;
3. Intermittent and 24 hour on-call professional nursing *services* provided by or under the supervision of a registered nurse (R.N.);
4. Intermittent and 24 hour on-call social or counseling services 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 terminally ill *covered person* or his/her *immediate family members* 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 counseling;
7. Nutritional counseling by a nutritionist or dietician;
8. Rental or purchase of *durable medical equipment*;
9. Transportation;
10. Physical, occupational and speech therapy regardless of whether the purpose is to maintain or improve functional capacity;

11. Homemaker services and volunteer services including;
    a. Preparation of meals and routine household care, housecleaning and household maintenance; and
    b. Teaching, and providing the *hospice patient* and his/her *immediate family member*s with household management techniques to promote self-care, independent living and nutrition;
12. Certified *nurse* aid *services* or nursing services delegated to other assistants as permitted by the state;
13. Medical supplies, drugs, and medicines prescribed by a *healthcare practitioner* for *palliative care*; and
14. Bereavement *services* for the family members of the deceased *hospice patient* for the 12-month period following death.

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. Sitter or companion services; 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.

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 those hours fall after 8 p.m., coverage will continue until 8 a.m. the following morning. 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* during the first week of life is also covered, subject to the terms of this *policy*; and
3. Postpartum care.

Mental health (including biologically based mental illness)

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 include psychological testing. *Services* for neuropsychological testing are explained under the "Healthcare practitioner services" provision.

Inpatient care for mental health

Covered expenses are *expenses incurred* for:

1. *Inpatient services* including room and board; and
2. *Healthcare practitioner* visits.

Outpatient care and office services for mental health

Covered expenses while not *confined* in a *hospital* or *healthcare treatment facility* are *expenses incurred* for:

1. Office exams or consultations including laboratory tests and x-rays; and
2. Therapy.

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

1. A halfway house; or
2. *Court-ordered mental health services* unless *medically necessary*.

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; or
   c. *Healthcare practitioner* charges for routine examination of the newborn before release from the *hospital*;
2. *Bodily injury* or *sickness*;
3. Care and treatment for premature birth; and
4. Medically diagnosed birth defects and abnormalities.

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 services" provision.

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

Medically necessary 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*.

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 (Who Pays What)".

Outpatient therapies for dependent children

Physical, occupational, and speech therapy for the care and treatment of congenital defects and birth abnormalities for a covered *dependent* child from the child's third birthday to the child's sixth birthday. Therapy visits may be distributed as medically appropriate throughout the yearly term of the *policy*, without regard to whether the condition is acute or chronic and without regard to whether the purpose of the therapy is to maintain or to improve functional capacity.

Prescription drugs

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

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. Compounded drugs in any dosage form that are included on the *drug list*;
4. Insulin and *diabetic supplies*;
5. 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*);
6. *Self-administered injectable drugs* approved by *us*;
7. Drugs, medicines or medications on the Preventive Medication Coverage *drug list* with a *prescription* from a *healthcare practitioner*;

8. Enteral formulas and nutritional supplements for the treatment of phenylketonuria (PKU), inherited enzymatic disorders caused by single gene defects, other inherited metabolic diseases, or as otherwise determined by *us*;
9. Off-label indications recognized through peer-reviewed medical literature;
10. Spacers and/or peak flow meters for the treatment of asthma; and
11. Prescribed orally administered anticancer medication that has been approved by the Federal Food and Drug Administration and is used to kill or slow the growth of cancerous cells.

Regardless of any other provisions of this *policy*, *we* may decline coverage or, if applicable, exclude from the *drug list* any and all *prescriptions* until the conclusion of a review period not to exceed six months following FDA approval for the use and release of the *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 (Who Pays What)", after any applicable *deductible* is met.

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

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*.

About our drug list

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

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 entity (IRE).

The IRE'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.

Preventive medical services

Services for well child and adult care preventive medical *services*. Preventive medical *services* under this *policy* 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 *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 *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. Currently the Food and Drug Administration (FDA) has approved 18 different methods of contraception. All FDA approved methods of contraception are covered without cost sharing as required by Federal and state law;
3. 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;
4. Evidence-informed preventive care and screenings provided for in the Health Resources and Services Administration (HRSA) guidelines for infants, children, adolescents, and women;
5. Current recommendations of the USPSTF regarding breast cancer screening, mammography, and prevention (does not include recommendations issued in or around November 2009); and
6. Prostate cancer screening including Prostate Antigen test (PSA) and digital rectal exam for a male *covered person* who is:
   a. Age 50 and older; or
   b. Age 40 to 50 and at an increased risk of developing prostate cancer as determined by the *healthcare practitioner*.

Prosthetic devices

Expenses incurred for prosthetic devices and supplies, including but not limited to limbs and eyes, and are limited to the most appropriate model that adequately meets the *covered person's* medical needs, as determined by the attending *healthcare practitioner*. *Preauthorization and notification* is required to be considered a *covered expense*.

Repairs and replacement are a *covered expense*:

1. Unless necessitated by misuse or loss;
2. If not covered by the manufacturer; or
3. If due to pathological changes or growth.

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 *policy*.

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;
4. Treatment for congenital hemangioma (port wine stains) of the face and neck for a *covered person* age 18 years and under;

5. Because of a congenital *sickness* or anomaly of a *dependent* child that resulted in a functional defect; and
6. Oral and facial *surgery* for a *covered person* born with a cleft-lip and/or cleft palate including:
   a. Surgical management and follow-up care by plastic surgeons or oral surgeons;
   b. Prosthetic treatment such as obturators, speech appliances, and feeding appliances;
   c. Orthodontic treatment;
   d. Prosthodontic treatment;
   e. Habilitative speech therapy;
   f. Otolaryngology treatment; and
   g. Audiological assessments and treatment.

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 *policy* 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:

1. Provided in lieu of care in a *hospital*; or
2. For the same condition that required *confinement* 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, and speech therapy;
3. Pulmonary rehabilitation programs; and
4. 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 (Who Pays What)".

Special services program

Home visits provided by a *healthcare practitioner* with specific training in end-of-life issues for a *covered person* who has been diagnosed with a terminal illness with a life expectancy of one year or less, but is not yet ready for hospice care. This program provides a *covered person* and their family to become more familiar with hospice-type services, helps bridge the gap between diagnosis and preparing for end of life and provides spiritual or emotional care.

Specialty drug 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* 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.

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 *policy* 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.

Tobacco cessation

Services for a *coverage person* age 18 and older as follows:

1. Nicotine replacement therapy including transdermal patches, gum and lozenges;
2. Smoking cessation classes; and
3. Tapes.

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 *policy* benefits and are subject to other applicable provisions of this *policy*.

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 *policy* benefits and other provisions of this *policy* 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 *policy*;
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 100 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 100 miles from the transplant facility.

Direct non-medical costs include:

1. Transportation to and from the *hospital* where the *transplant* is performed; and
2. Temporary lodging at a prearranged location when requested by the *hospital* and approved by *us*.

All direct, non-medical costs for the *covered person* receiving the *transplant* and the designated caregiver(s) or support person(s) are limited to a combined maximum coverage per transplant as shown on the "Schedule of Benefits (Who Pays What)".

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 *policy*.

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 (Who Pays What)" subject to any applicable *copayment, deductible,* and *coinsurance*.

BENEFITS/COVERAGE

PEDIATRIC VISION CARE COVERED EXPENSES

This section describes the *services* that will be considered *covered expenses* for pediatric vision care *services* under this *policy*. Benefits we pay for pediatric vision care *services* will be based on the *reimbursement limit* and as shown in the "Schedule of Benefits (Who Pays What)" section of this *policy* 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 "Limitations/Exclusions" sections in this *policy*. All terms and provisions of this *policy*, including *preauthorization* requirements specified in this *policy*, are applicable to the pediatric vision care *covered expenses*.

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

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 *policy*. If a *covered person* selects a frame that is not included in the frame selection this *policy* 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; or
4. *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.

LIMITATIONS/EXCLUSIONS

GENERAL EXCLUSIONS

Below is a list of limitations and exclusions on *policy* 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* please see the Health and Human Services (HHS) Website at www.healthcare.gov and the "Preventive Medical Services" provision of this *policy*.

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*; 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 *policy*;
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 *policy* guidelines, except for the specified routine preventive medical *services*;
6. *Services* performed in association with a *service* that is not covered under this *policy*;
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 *policy* 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. Expenses in excess of the *maximum allowable fee* for the *service*;
11. *Services* exceeding the amount of benefits available for a particular *service*;
12. *Services* provided when this *policy* is past the premium due date and payment is not received (refer to the “Grace period” provision in the “Member Payment Responsibility” section of this *policy*);
13. *Services* for treatment of complications of non-covered procedures or *services*;

14. *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;
    c. Engaging in an illegal occupation; or
    d. Any act of armed conflict, or any conflict involving armed forces or any authority;
15. *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. Which are not rendered by the billing provider;
    f. Which are not substantiated in the medical records by the billing provider; or
    g. Rendered by a standby *health*care *practitioner*, surgical assistant, assistant surgeon, physician's assistant, *nurse* or certified operating room technician unless *medically necessary*;
16. 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;
17. *Hospital inpatient services* when the *covered person* is in *observation status*;
18. Cosmetic *services*, or any complication therefrom;
19. *Custodial care* and *maintenance care*;
20. Ambulance *services* for routine transportation to, from or between medical facilities and/or a *healthcare practitioner's* office except as expressly provided in this *policy*;
21. Medical or surgical procedures that are not *medically necessary* except elective tubal ligation and vasectomy;
22. Elective medical or surgical abortion unless:
    a. The pregnancy would endanger the life of the mother; or
    b. The pregnancy is a result of rape or incest;
23. Reversal of sterilization;
24. *Infertility services*;
25. Sexual dysfunction;
26. 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 *policy*;
27. 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 *policy*, any oral *surgery*, *endodontic services* or *periodontics*, preoperative and post operative care, implants and related procedures, orthodontic procedures, orthognathic *surgery*, and any dental *services* related to a *bodily injury* or *sickness* except as expressly provided in this *policy*;
28. *Pre-surgical/procedural testing* duplicated during a *hospital confinement*;

LIMITATIONS/EXCLUSIONS

29. Any treatment for obesity, which includes *morbid obesity*, regardless of any potential benefits for co-morbid conditions, including but not limited to:
    a. Surgical procedures for *morbid obesity*; or
    b. *Services* for complications related to any *services* rendered for weight reduction;
30. Surgical procedures for the removal of excess skin and/or fat in conjunction with or resulting from weight loss or a weight loss *surgery*;
31. Hypnosis for the treatment of nicotine habit or addiction;
32. Educational or vocational training or therapy, *services*, and schools including but not limited to videos and books; nutritional therapy except for treatment of diabetes;
33. Except as expressly provided in this *policy*, 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;
34. Hair prosthesis except as expressly provided in this *policy*, hair transplants or implants;
35. 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, other than *hearing aids* for a covered *dependent* child;
36. *Services* rendered in a premenstrual syndrome clinic or holistic medicine clinic;
37. Transplant *services* except as expressly provided in this *policy*;
38. Charges for growth hormones;
39. 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*;
40. Immunizations including those required for foreign travel for *covered persons* of any age except as expressly provided in this *policy*;
41. Treatment for any jaw joint problem, including but not limited to, temporomandibular joint disorder (except as expressly provided in this *policy*), craniomaxillary disorder, craniomandibular disorder, head and neck neuromuscular disorder or other conditions of the joint linking the jaw bone and skull or any orthognathic *surgery* to correct any of the above;
42. Genetic testing, counseling or *services* except for BRCA screening, counseling, and appropriate testing as recommended by the Health Resources and Services Association (HRSA), unless *medically necessary* as determined by *our* medical guidelines;
43. *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 *policy* did not exist;
44. *Covered expense* to the extent of any amount received from others for the *bodily injuries* or losses which necessitated such benefits. Amounts received from others specifically includes, without limitation, liability insurance, Workers' Compensation, uninsured motorists, underinsured motorists, "no-fault" and automobile medical payments;
45. Expense for employment, school, sports or camp physical examinations or for the purpose of obtaining insurance, or premarital tests or examinations;

46. *Services* received in an emergency room unless required because of *emergency care*;
47. Any expense including related complications incurred for *services* received outside of the United States except as required by law for *emergency care services*;
48. *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*;
49. *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 *medically necessary* for evaluation and diagnosis of learning and behavioral disabilities or for mental retardation; and
    c. Marriage counseling;
50. *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;
51. *Services* or supplies 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, whether or not benefits are available under Workers' Compensation except as expressly provided in this *policy*. Without limiting this exclusion, this applies whether or not a *covered person* has Workers' Compensation coverage;
52. *Court-ordered mental health services* unless *medically necessary*;
53. 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;
    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;

54. Private-duty nursing, except as expressly provided in the “Healthcare treatment facility” provision in the “Benefits/Coverage” section of this *policy*;
55. Living expenses, travel, transportation, except as expressly provided in the "Ambulance services" provision or "Transplants" provision in the "Benefits/Coverage" section of this *policy*; and
56. 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.

LIMITATIONS/EXCLUSIONS

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* please see the Health and Human Services (HHS) Website at www.healthcare.gov and the Preventive Medical Services provision of this *policy*.

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, or if *medically necessary* and appropriate for the condition;
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;
5. Nutritional products;
6. Drugs and/or ingredients not approved by the FDA;
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 *policy*;
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 (this is covered under the Durable medical equipment and medical supplies provision); 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;
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 not listed on the *drug list*;
23. *Infertility services* including medications;
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;
    d. Blood plasma; or
    e. *Self-administered injectable drugs* or *specialty drugs* for which *prior authorization* has not been obtained from *us*;
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 *prior authorization* or *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 *policy*; or
    b. After the date the *covered person's* coverage under this *policy* 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*;

LIMITATIONS/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*.

LIMITATIONS/EXCLUSIONS

PEDIATRIC VISION CARE EXCLUSIONS

In addition to the "Limitations/Exclusions" sections of this *policy* and any limitations specified in the "Schedule of Benefits (Who Pays What) section of this *policy*, 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 *policy*.
2. *Materials* covered by this *policy* 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 *policy*.
3. Basic cost for lenses and frames covered by the *policy*.

Refer to all "Limitations/Exclusions" sections of this *policy* 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 *policy* as a *covered expense* or in the "Schedule of Benefits– Pediatric Vision Covered Expenses" section of this *policy*;
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*.

MEMBER PAYMENT RESPONSIBILITY

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

If coverage was not purchased through a *marketplace*, a grace period of 31 days will be granted for the payment of each premium falling due after the first premium, during which this coverage shall continue in force. Premium for the grace period is due upon termination of coverage.

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.

Return of premium

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

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

CLAIMS PROCEDURE

Assignment of benefits

Assignment of benefits may be made by *you*, to assign payments due under this *policy* directly to the healthcare provider by submitting a written request to *us*.

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* of any additional information *we* need to process the claim.

Cost of legal representation

We will pay the costs of *our* legal representation in matters related to *our* recovery rights under this *policy*. 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 *policy* 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 *policy* 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 *policy* 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 PROCEDURE

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 *policy*, 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 there is other valid coverage, not with this insurer, providing benefits for the same loss on a provision of service basis or on an expense incurred basis and of which this insurer has not been given written notice prior to the occurrence or commencement of loss, the only liability under any expense incurred coverage of this *policy* shall be for such proportion of the loss as the amount which would otherwise have been payable hereunder plus the total of like amounts under all such other valid coverages for the same loss of which this insurer had notice bears to the total like amounts under all valid coverages for such loss, and for the return of such portion of the premiums paid as shall exceed the pro rata portion for the amount so determined. For the purpose of applying this provision when other coverage is on a provision of service basis, the "like amount" of such other coverage shall be taken as the amount which the services rendered would have cost in the absence of such coverage.

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

CLAIMS PROCEDURE

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

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 *policy*.

Within 30 days of *our* receipt of the claim, *we* will send a written request to the healthcare provider, the *policyholder* or *covered person* of what additional information is needed to resolve the claim, including any additional medical or other information related to the claim. The healthcare provider, *policyholder* or *covered person* receiving the request for additional information, shall submit the information to us within 30 calendar days after receipt of the request.

If *we* do not receive the necessary information within 30 calendar days of the receipt of the request, *we* may deny any pending or subsequent claims for which the information is requested. The denied claim is subject to resubmittal of the claim or the appeals process.
However, *your* claims will not be reduced or denied nor will this *policy* 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 *policy*, 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 *policy*;
3. Made to *you* and/or any party on *your* behalf, based on fraud or an intentional misrepresentation of a material fact; 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 as often as *we* deem reasonably necessary to determine *policy* benefits. *We* also have the right to make an autopsy in case of death, unless prohibited by law. These procedures will be conducted at *our* expense.

Time of payment of claims

If no additional information is required (a clean claim) upon *our* receipt of a claim, payments due under this *policy* will be paid, settled or denied within 30 calendar days of *our* receipt of a claim submitted *electronically*, and within 45 calendar days for a claim submitted by any other means. If additional information was required in order to resolve the claim, *we* will pay, settle or deny the claim no later than 90 calendar days following receipt of the claim.

CLAIMS PROCEDURE

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*. If *we* pay *you* directly, *you* are then responsible for all payments to the *out-of-network provider*(s). *You* may request that *we* direct a payment of selected medical benefits to the healthcare provider on whose charge the claim is based. *We* will then pay the healthcare provider directly. Such payments will not constitute the assignment of any legal obligation to the *out-of-network provider*. *We* will honor any assignment of benefits made by *you*.

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.

GENERAL POLICY PROVISIONS

Conformity with state statutes

Any provisions which are in conflict with the laws of the state in which this *policy* 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 policy* 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 *policy*. The third party service providers are solely responsible to *you* for the provision of any such goods and/or services. *We* are not responsible for any such goods and/or services, nor are *we* liable if vendors refuse to honor such discounts. 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 *policy*, 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 *policy*, 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 policy* may not include a copy of *your* application.

No modification or amendment to this *policy* 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 *policy*. No agent has authority to modify this *policy*, waive any of the *policy* provisions, extend the time for premium payment, or bind *us* by making any promise or representation.

Incontestability

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

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 *policy* which relate to a *covered person's* eligibility for coverage under this *policy*.

GENERAL POLICY 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 when a new application of the *covered person* is completed.

Legal action

No action at law or in equity may be brought to recover on this *policy* prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this *policy*. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

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 *policy* 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 *policy* 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 policy*. If *you* have any questions concerning *your* coverage, please call the telephone number on *your ID card*.

GENERAL POLICY PROVISIONS

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*.

Non-duplication of benefits

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

GENERAL POLICY PROVISIONS

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.

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 *policy*;
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.

Our right of subrogation

If *we* provide benefits for a loss incurred by a *covered person* due to an accident or injury *we* have the right to recover those benefits from any party that is responsible for the medical expenses or benefits related to that accident or injury.

As a condition to receiving benefits from *us*, the *covered person* agrees to transfer to *us* any rights they may have to make a claim, take legal action or recover any expenses paid for benefits covered under this *policy*. *We* will be subrogated to the *covered person's* rights to recover from any funds paid or payable as a result of a personal injury claim or any reimbursement of expenses by:

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

We may enforce our subrogation rights by asserting a claim to any coverage to which *you* may be entitled.

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

Right of reimbursement

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

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

If after the *effective date* of this *policy*, any *covered person* recovers payment from and releases any legally responsible person, their insurer, or an uninsured motorist, underinsured motorist, medical payment/expense, Workers' Compensation, no-fault or other similar insurer from liability for future medical expenses relating to a *sickness* or *bodily injury*, *we* shall have a continuing right to reimbursement from *you* or that *covered person* to the extent of the benefits *we* provided with respect to that *sickness* or *bodily injury*. This right, however, shall apply only to the extent of such payment and to the reasonable value of *services* and benefits provided under a managed care agreement and only to the extent not limited or precluded by law in the state whose laws govern this policy, including any whole or similar rule.

The obligation to reimburse *us* in full exists, regardless of whether the settlement, compromise or judgment designates the recovery as including or excluding medical expenses. The obligation to reimburse *us* in full also exists regardless of whether the amounts received or payable to *you* or the *covered person* are sufficient to fully compensate *you* or the *covered person* for the *sickness* or *bodily injury*.

Assignment of recovery rights

This *policy* 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 *policy*. 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 *policy* 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.

Workers' compensation

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

If benefits are paid by *us* and *we* determine that the benefits were for treatment of 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 *policy*, *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*.

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 *policy* or change any of the terms of this *policy*. *Our* agreement with the third parties and the program may be terminated at any time, although insurance benefits will be subject to applicable state and Federal laws.

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 *policy*, *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 *policy*.

If *you* choose to obtain services from a *non-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 a *non-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 *policy* 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.

TERMINATION/NONRENEWAL/CONTINUATION

Reasons we will terminate your policy

This *policy* is renewable at the option of the *policyholder*, except for the conditions stated below. *We* will terminate *your policy* 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*. Coverage will remain in effect during the 31-day grace period. If premium is not received within the 31-day grace period, *we* will terminate *your policy* at the end of the grace period. If coverage was purchased through an exchange and *you* received advance payment of the premium tax credit and have paid at least one month of premium, *you* have three months 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 first month of the grace period;
2. *You* or a *covered person* commit fraud or make an intentional misrepresentation of a material fact. Termination will be effective at 12:01 a.m. local time at the *policyholder's* state of residence on the date the fraud or intentional misrepresentation of a material fact occurred. A 30-day advance written notice of the termination will be provided;
3. *You* cease to be a resident in the state in which this *policy* was issued;
4. *You* request termination of the *policy*, including enrolling in another health insurance plan during *open enrollment*. The request may be given verbally, *electronically*, or in writing. Termination will be effective on later of the date request by *you* or the date *we* receive *your* notice to cancel. If this *policy* is being replaced by another qualified health plan, the termination date of this *policy* is the day prior to the effective date of the new qualified health plan;
5. *We* cease to offer a type of policy or cease to do business in the individual medical insurance market, as allowed or required by state or Federal law; or
6. If coverage was purchased through a *marketplace*:
   a. *You* cease to be eligible for coverage through a *marketplace*; or
   b. This *policy* 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. Termination will be effective at 12:01 a.m. local time at the *covered person's* state of residence on the date the intentional misrepresentation of a material fact occurred. A 30-day advance written notice of the termination will be provided;
3. When the *policyholder's* coverage under this *policy* terminates; or
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.

TERMINATION/NONRENEWAL/CONTINUATION

You must notify *us* as soon as possible if *your dependent* no longer meets the eligibility requirements of this *policy*. 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*.

Your duty to notify us

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

Fraud

You or a *covered person* knowingly and with intent to defraud or mislead, 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 *policy*.

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a *policyholder* or claimant for the purpose of defrauding or attempting to defraud the *policyholder* or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the department of regulatory agencies.

If *you* or the *covered person* knowingly and with intent to defraud or mislead, commits fraud against *us*, or makes an intentional misrepresentation of a material fact, *we* reserve the right to rescind coverage under this *policy* 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*.

APPEALS AND COMPLAINTS

Definitions

Adverse benefit determination means a denial, reduction, or termination of, or a failure to provide or make a payment (in whole or in part) for a pre-service or post-service benefit, including:

1. A determination that an item or *service* is *experimental, investigational or for research purposes* or not *medically necessary*;
2. A determination that the benefit is not appropriate, effective, or efficient;
3. A determination that the benefit is not provided in or at the appropriate health care setting or level of care;
4. A determination of *your* eligibility for coverage under the *policy*;
5. A determination that the benefit is not covered;
6. Any rescission of coverage or termination of coverage not attributed to a failure to pay premiums that is applied retroactively.

Appeal is a request for reconsideration of an *adverse benefit determination.*

Commissioner means the Commissioner of the Colorado Division of Insurance.

Complaint means a written communication primarily expressing a *grievance.*

De minimis means any minor error or omission that does not substantively impact the rights of a *covered person* to request an external review of an *adverse benefit determination*.

Designated representative means:

1. *Your healthcare practitioner* or a person *you* have given written consent to represent *you*;
2. A person authorized by law to provide substituted consent for *you*, including a guardian, agent under power of attorney or a proxy; or designee of the Colorado Department of Health Care Policy and Financing; or
3. A *healthcare practitioner* with knowledge of *your* medical condition in urgent care situations.

Expedited* (*external*) *review means a review following completion of procedures for expedited internal review of an *adverse benefit determination* involving a situation where the timeframe of the standard independent external review procedures would seriously jeopardize the life or health of the *covered person* or would jeopardize the *covered person's* ability to regain maximum function. Expedited review is available if the *adverse benefit determination* concerns an admission, availability of care, continued stay or healthcare *services* for which the *covered person* received *emergency care* has not been discharged from the *healthcare treatment facility*.

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

Grievance means a circumstance regarded as a cause for protest, including the protest of an *adverse benefit determination*.

***Independent Review Entity* (*IRE*)** means an entity assigned by the *commissioner* to conduct an independent external review of an *adverse benefit determination* and a *final adverse benefit determination*.

Prospective review means *utilization review* conducted prior to an admission or course of treatment.

Retrospective review means *utilization review* conducted after *services* have been provided to the *covered person,* but does not include the review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding or adjudication for payment, also known as a 'post-service review'.

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

1. Could seriously jeopardize the life or health of the *covered person* or the ability of the *covered person* to regain maximum function;
2. In the opinion of a physician with knowledge of the *covered person's* medical condition, would subject the *covered person* to severe pain that cannot be adequately managed without the service that is the subject of the claim; or
3. For persons with a disability, create an imminent and substantial limitation of their existing ability to live independently.

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

Utilization review means a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures, or settings.

Contact information

You may contact the *commissioner* for assistance at any time using the contact information below:

Colorado Division of Insurance
1560 Broadway, Suite 850
Denver, CO 80202

Telephone Numbers:
303-894-7490 - Consumer Information
800-930-3745 - Toll Free outside Denver

APPEALS AND COMPLAINTS

Internal appeals

First level review

You or *your designated representative* must *appeal* an *adverse benefit determination* within 180 calendar days or next business day following the 180 days after receiving written notice of the denial (or partial denial). A request for a first level review of an *adverse benefit determination* may be made by *you* or *your designated representative* by means of written application to *us* or by mail, postage prepaid to the address below:

HUMANA
GRIEVANCE AND APPEALS OFFICE
P.O. BOX 14546
LEXINGTON, KY 40512-4546

The first level review is for medical necessity, experimental or investigational or contractual determination, when *you* or *your designated representative* have provided evidence from a medical professional that there is a reasonable medical basis that the contractual determination does apply to a denied benefit. The first level review will be evaluated by a *healthcare practitioner* who shall consult with an appropriate clinical peer or peers. The *healthcare practitioner* and clinical peer(s) shall not have been involved in the initial *adverse benefit determination*; however, a person previously involved may answer questions.

We will notify *you* or *your designated representative* of the decision no later than:

1. 30 days after the date *we* received the request for the first level review; or
2. 60 days after the date *we* received the request for the post service review of a post service contractual determination when *you* or *your designated representative* have not provided evidence from a medical professional that there is a reasonable medical basis that the contractual determination does not apply to the denied benefit.

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

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

You or *your designated representative* may submit written comments, documents, records and other material relating to the *adverse benefit determination* for consideration and may receive, upon request, reasonable access to, and copies of all documents, records and other relevant information.

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

Expedited internal appeal

We will establish written procedures for the expedited review of urgent care requests of grievances involving an *adverse benefit determination. We* will also provide an expedited review to a request for a benefit for a *covered person* who has received *emergency care* but has not been discharged from a *health care treatment facility*. The procedures shall allow a *covered person* to request an expedited review under this section orally or in writing. The procedures shall also allow the *covered person* to identify health care providers to whom *we* will send a copy of the review decision. A *covered person* requesting an *expedited* (*external*) *review* may request such review concurrently with a request for an expedited internal review.

An expedited review shall be available to, and may be initiated by, the *covered person* or the provider acting on behalf of the *covered person.*

In an expedited review, all necessary information, including *our* decision, shall be transmitted between *us* and the *covered person* or the provider acting on behalf of the *covered person* by telephone, facsimile or similar expeditious method available.

Expedited appeal evaluations:

1. Expedited appeals shall be evaluated by an appropriate clinical peer or peers in the same or similar specialty as would typically manage the case under review. (For the purposes of this section, the clinical peers shall be called “the reviewers”.) The clinical peer or peers shall not have been involved in the initial *adverse benefit determination.*

2. In conducting a review under this section, the reviewer or reviewers shall take into consideration all comments, documents, records and other information regarding the request for services submitted by the *covered person* without regard to whether the information was submitted or considered in making the initial *adverse benefit determination.*

In an expedited review, *we* will make a decision and notify the *covered person* or the provider acting on the *covered person's* behalf as expeditiously as the *covered person's* medical condition requires, but in no event more than seventy-two (72) hours after the review is commenced. If the expedited review is a concurrent review determination, the service shall be continued without liability to the *covered person* until the *covered person* has been notified of the determination.

We will provide written confirmation of its decision concerning an expedited review within three (3) calendar days of providing notification of that decision, if the initial notification was not in writing.

In any case where the expedited review process does not resolve a difference of opinion between *us* and the *covered person* or the provider acting on behalf of the *covered person*, the *covered person* or the provider acting on behalf of the *covered person* may request an independent external review.

We will not provide an expedited review for retrospective *adverse benefit determinations*.

Exhaustion of remedies

Upon completion of the internal appeals process under this section, *you* or *your designated representative* will have exhausted his or her administrative remedies under the plan. If *we* fail to adhere to all requirements of the internal appeal process, except for failures that are based on *de minimis* violations, the claim shall be deemed to have been denied and *you* or *your designated representative* may request an external review.

After exhaustion of remedies, *you* or *your designated representative* may pursue any other legal remedies available.

External review

Within four months or the next business day following the four months after *you* or *your designated representative* receives notice of an *adverse benefit determination* and after the completion of exhaustion of the internal appeal process, *you* or *your designated representative* may file a written request for an external review.

A request for an external review may be made if an *adverse benefit determination* has been made when *we* have denied a request for an alternate standard or a waiver of a standard that would otherwise be applicable to an individual under a wellness and prevention program that offers incentives or rewards for satisfaction of a standard related to a health risk factor.

A request for an external review may be made if an *adverse benefit determination* has been made involving a recommended or requested medical service that is experimental or investigational if the treating *health care practitioner* certifies that the recommended or requested health care service or treatment will be less effective if not started immediately, and the treating *health care practitioner* certifies:

1. That the standard health care services has not improved the *covered person's* condition or are not medically appropriate; or
2. There is no standard health care service or treatment available that is covered by the carrier that is more beneficial to the *covered person* than the recommended or requested health care services or treatment, and that the *health care practitioner* is a board certified or board eligible *health care practitioner* qualified to practice in the area of medicine appropriate to treat the *covered person's* condition.

Please refer to the provision titled 'Expedited external review' if the *adverse benefit determination* involves an *urgent-care claim* or an ongoing course of treatment.

The request for an external review must:

1. Be submitted to *us* in writing;
2. Include a signed consent, authorizing *us* to disclose protected health information, including medical records pertinent to the external review; and
3. Include a completed "Request for Independent External Review of Carrier's Final Adverse Determination" form.

If *we* receive an incomplete request for an external review that does not meet *our* filing procedures, *we* will notify *you* or *your designated representative* of the failure to file a complete request for external review as soon as possible, but no later the (5) five calendar days following the receipt of the incomplete request.
You or *your designated representative* may contact *us* at the following:

HUMANA
GRIEVANCE AND APPEALS OFFICE
P.O. BOX 14546
LEXINGTON, KY 40512-4546

Upon receipt of a complete request for an external review, *we* will provide a copy of the request to the *commissioner* within two business days.

If a decision is made to reverse the *adverse benefit determination* based on new or additional information submitted, *we* will notify *you* or *your designated representative* within one business day of the reversal.

Within two business days from the time the *commissioner* receives a request, the *commissioner* will select an *IRE* to conduct the external review. Within one business day of that selection, *we* will notify *you* or *your designated representative* of the entity assigned.

Within two business days of receipt of the notice from *us*, *you* or *your designated representative* may provide the *commissioner* with documentation regarding potential conflict of interest of the *IRE* assigned. If the *commissioner* determines the *IRE* presents a conflict of interest, the *commissioner* will, within one business day, assign another *IRE* to conduct the external review.

Within five business days of receipt of the notice from *us*, *you* or *your designated representative* may provide additional information to the *IRE* that shall be considered during the review.

Within five business days from the date the *commissioner* notifies *us* of the *IRE* assigned *we* will provide the *IRE* with the documents and information considered in making the *adverse benefit determination*. Within two business days of receipt of the documentation the *IRE* will provide *you* or *your designated representative* with an index of all materials submitted to them.

The *IRE* will notify *you* or *your designated representative*, *your* health care provider and *us* of any additional medical information required. Within five business days of the request, *you*, *your designated representative* or *your healthcare practitioner* must submit the additional information or an explanation of why the additional information is not being submitted to the *IRE* and *us*.

Within 45 calendar days after the date the *IRE* receives the request for an external review, the *IRE* will notify *you* or *your designated representative* of its determination.

Upon receipt of the decision to reverse the *adverse benefit determination we* will:

1. For concurrent and *prospective reviews*, approve the coverage within one business day;
2. For *retrospective reviews*, approve the coverage within five business days; and
3. Provide *you* or *your designated representative* written notice of the approval within one business day of our approval of coverage.

An external review decision is binding on *us* and on *you* except to the extent *you* have other remedies available under Federal or state law and *we* have other remedies available under Federal or state law; however the determination of the *IRE* will create a rebuttable presumption in any subsequent action. *You* or *your designated representative* may not file a subsequent request for external review involving *our* adverse determination for which *you* have already received an external review decision.

Expedited external review

You or *your designated representative* may request an expedited external review in writing:

1. At the same time *you* request an expedited internal appeal of an *adverse benefit determination* for an *urgent-care claim* or when *you* are receiving an ongoing course of treatment; or
2. When *you* receive an *adverse benefit determination* or *final adverse benefit determination* of:
   a. An *urgent-care claim*. The request must include a physician's certification that *your* medical condition meets the criteria; or
   b. An admission, availability of care, continued stay or health care *service* for which *you* received emergency *services*, but *you* have not been discharged from the facility.

If *we* received an incomplete request for an expedited external review that does not meet *our* filing procedures, *we* will notify *you* or *your designated representative* of the failure to file a complete request for an expedited external review as soon as possible, but no later that 24 hours following the receipt of the incomplete request.

If the request qualifies for an expedited external review, an *IRE* will be assigned. *You* or *your designated representative* will be notified of the determination with 72 hours of the receipt of the request.

Within one business day from the time the *commissioner* receives a request, the *commissioner* will select an *IRE* to conduct the external review. Within one business day of that selection *we* will notify *you* of the entity assigned.

Immediately upon receipt of the notification, *we* will provide the *IRE* with the documents and information considered in making the *adverse benefit determination*.

If the *IRE* reverses *our* final *adverse benefit determination*, *we* will immediately approve the coverage that was the subject of the final *adverse benefit determination*.

Legal actions and limitations

No lawsuit with respect to plan benefits may be brought after the expiration of three years after the latter of:

1. The date on which *we* first denied the service or claim; paid less than *you* believe appropriate; or failed to timely pay the claim; or
2. 180 days after a final determination of a timely filed *appeal*.

INFORMATION ON POLICY AND RATE CHANGES

Your rights to make changes to the policy

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

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* and *us* 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 policy* on such topics as new networks, benefits, and premium. See the "Termination/Nonrenewal/Continuation" section for the events that will cause this *policy* to end. Such change will be effective 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 a third party.

Our rights to make changes to the policy

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

Changes we will make without notice to you

Changes to this *policy* 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.

INFORMATION ON POLICY AND RATE CHANGES

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 intentionally misrepresented any material information concerning a condition, *we* shall have the right, in *our* sole discretion, to:
   a. Reform *your policy* and reissue the correct form of coverage *you* would have received had the intentional misrepresentation of a material fact not been made; or
   b. Continue *your* present coverage and collect the difference in premium which would have been assessed had the intentional misrepresentation of a material fact 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). Failure to timely provide *us* with *your* acceptance of the change(s) will result in *rescission* of coverage. *We* will provide *you* with a 30-day notice prior to *rescission* of coverage.

We can also make material changes to *your policy* which increase or decrease coverage on the premium due date or upon separate notice, provided *we* send *you* a written explanation 60 days prior to the change. All such material changes will be made in accordance with state law. *Your* payment of premium will stand as proof of *your* agreement to the change.

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 *policy*;
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.

DEFINITIONS

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

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

Autism spectrum disorders includes the following neurological disorders: autistic disorder, asperger's disorder, and atypical autism as a diagnosis within pervasive developmental disorder not otherwise specified, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, at the time of the diagnosis.

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 (Who Pays What)".

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 *policy* 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.

Civil union means a relationship established by two eligible persons that entitles them to receive the benefits and protections and be subject to the responsibilities of spouses.

DEFINITIONS

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 (Who Pays What)". Charges paid as *coinsurance* do not apply to any responsibility for *copayments* or *deductibles*.

Complications of pregnancy means:

1. Acute nephritis;
2. Nephrosis;
3. Cardiac decompensation;
4. Hyperemesis gravidarum;
5. Puerperal infection;
6. Pre-eclampsia (toxemia);
7. Eclampsia;
8. Abruptio placenta;
9. Placenta previa;
10. Missed or threatened abortion;
11. Ectopic pregnancy;
12. Endometritis;
13. Hydatidiform mole;
14. Chorionic carcinoma;
15. Pre-term labor;
16. Spontaneous termination of pregnancy which occurs during a period of gestation in which a viable birth is not possible; or
17. Gestational diabetes.

Complications of pregnancy does not mean:

1. False labor;
2. Occasional spotting;
3. Rest prescribed during the period of pregnancy;
4. Morning sickness;
5. Conditions associated with the management of a difficult pregnancy, but which do not constitute a distinct *complication of pregnancy*;
6. Prolonged labor;
7. Cessation of labor;
8. Breech baby;
9. Fetal distress;
10. Edema; or
11. Complicated delivery.

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

Copayment/Copay means a specified dollar amount shown on the "Schedule of Benefits (Who Pays What)", 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 *policy* 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* expense, based on the *maximum allowable fee* for *services* incurred by a *covered person* which were 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 *policy* or by any amendment.

Covered person means anyone eligible to receive *policy* benefits as a *covered person*. Refer to the "Schedule of Benefits (Who Pays What)" 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*.

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 *policy*. 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 (Who Pays What)".

DEFINITIONS

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

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 medial benefits under this *policy*. These expenses do not apply toward any other *deductible* stated in this *policy*.

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 *policy*. These expenses do not apply toward any other *deductible* stated in this *policy*.

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, a partner in a *civil union*, *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; and
3. Is medically certified as disabled and dependent upon *you*.

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

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 *policy*;
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. Test strips for blood glucose monitors;
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 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.

Early intervention services means *services* that are authorized through an *eligible child's individualized family service plan*.

DEFINITIONS

Effective date means the first date all the terms and provisions of this *policy* apply. It is the date that appears on the cover of this *policy* 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.

Eligible child means an infant or toddler from birth to age three years, who is a covered *dependent* child and has significant delays in development or has a diagnosed physical or mental condition which has a high probability of resulting in significant delays in development, and who is eligible for *services* under Colorado statute.

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 *maximum allowable 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 *policy*;
5. Is identified as not covered by the Centers for Medicare and Medicaid Services (CMS) Medicare Coverage Issues Manual, a CMS Operational Policy Letter or a CMS National Coverage Decision except as required by state or Federal law;
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, *domestic partner*, a partner in a *civil union*, or *you* or *your* spouse's, *domestic partner's*, or *civil union'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 or otherwise authorized by the appropriate state agency, to diagnose or treat a *bodily injury* or *sickness*, and who provides *services* within the scope of that license.

DEFINITIONS

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.

Hearing aid means amplification technology that optimizes audibility and listening skills in the environment commonly experienced by the covered *dependent* child including a wearable instrument or device designed to aid or compensate for impaired human hearing.

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.

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*, partner in a *civil union,* 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.

Individualized family service plan (IFSP) means a written plan that authorizes *early intervention services* to an *eligible child* and the child's family.

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 *policy* 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 *policy* is in effect as shown on the "Schedule of Benefits (Who Pays What)".

Limiting age means a covered *dependent* child's 26th birthday.

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.

Maximum allowable fee for a *covered expense*, other than *emergency care services* provided by *out-of-network providers* in a *hospital's* emergency department, is the lesser of:

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

Maximum allowable fee for a covered expense for emergency care *services* provided by *out-of-network providers* in an emergency department is an amount equal to the greatest of:

1. The fee negotiated with *in-network providers*;
2. The fee calculated using the same method to determine payments for *out-of-network provider services*; or
3. The fee paid by Medicare for the same *services*.

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

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 *policy*. 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 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.

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 *policy* 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 *policy* 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 *policy*. This amount does not include:

1. Amounts over the *maximum allowable fee*;
2. Transplant *services* from a *out-of-network provider*;
3. Amounts over the *default rate*;
4. Utilization management or *prescription* drug penalties;
5. Non-covered *services*; or
6. Other *policy* 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 (Who Pays What)" 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 and adolescents 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*.

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

Policyholder means the person to whom this *policy* is issued and whose name is shown on the cover of this *policy* and the "Schedule of Benefits (Who Pays What)".

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 *policy* 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.

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.

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 *policy* 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 *policy*.

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.

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 *policy*.

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.

DEFINITIONS

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

Well-child visits means a visit to a *healthcare practitioner* that includes the following elements:

1. Age appropriate physical exam;
2. History;
3. Anticipatory guidance and education, including but not limited to examining family functioning and dynamics, injury prevention counseling, dietary issues and age appropriate behaviours;
4. Growth and developmental assessment; and
5. Safety and health education counseling.

You/your means the *policyholder*.

DEFINITIONS

PEDIATRIC VISION CARE DEFINITIONS

The following are definitions of terms as they are used in this *policy*. Defined terms are printed in *italic* type wherever found in this *policy*. All terms used in this section have the same meaning given to them in this *policy* unless otherwise specifically defined in this section.

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 *policy* 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 *policy* for a *covered person*.

Reimbursement limit is the maximum fee allowed for a *covered expense*. It is the lesser of:

1. The actual cost for covered *services* or *materials*;
2. The fee most often charged in the geographical area where the *service* was performed or *materials* provided;
3. The fee most often charged by the provider;
4. The fee determined by comparing charges for similar *services* or *materials* to a national database adjusted to the geographical area where the *services* or procedures were performed or *materials* provided;
5. At *our* choice the fee determined by using a national Relative Value Scale. Relative Value Scale means a methodology that values procedures and *services* relative to each other that includes, but is not limited to, a scale in terms of difficulty, work, risk, as well as the *material* and outside costs of providing the *service*, as adjusted to the geographic area where the *services* or procedures were performed or *materials* provided;
6. In the case of *services* rendered by or *materials* obtained from providers with whom *we* have agreements, the fee that *we* have negotiated with that provider;
7. The fee based on rates negotiated with one or more *in-network providers* for the same or similar *services* or *materials*;

8. The fee based on the provider's costs for providing the same or similar *services* or *materials* as reported by the provider in the most recent, publicly available Medicare cost report submitted annually to the Centers for Medicare and Medicaid Services; or
9. The fee based on a percentage of the fee Medicare allows for the same or similar *services* or *materials* provided in the same geographic area.

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.

HUMANA®

OFFERED BY
HUMANA HEALTH PLAN, INC.

NOTICE OF PROTECTION PROVIDED BY
LIFE AND HEALTH INSURANCE PROTECTION ASSOCIATION

This notice provides a **brief summary** of the Life and Health Insurance Protection Association ("the Association") and the protection it provides for policyholders. This safety net was created under Colorado law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your life, annuity or health insurance company becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Colorado law, with funding from assessments paid by other insurance companies.

The basic protections provided by the Association are:

- Life Insurance
  - $300,000 in death benefits
  - $100,000 in cash surrender or withdrawal values
- Health Insurance
  - $500,000 in hospital, medical and surgical insurance benefits
  - $300,000 in disability insurance benefits
  - $300,000 in long-term care insurance benefits
  - $100,000 in other types of health insurance benefits
- Annuities
  - $250,000 in withdrawal and cash values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $300,000. Special rules may apply with regard to hospital, medical and surgical insurance benefits.

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also various residency requirements and other limitations under Colorado law.

To learn more about the above protections, as well as protections relating to group contracts or retirement plans, please visit the Association's website http://colorado.lhiga.com, email jkelldorf@aol.com or contact:

Colorado Life and Health *Insurance Protection Association* *P. O. Box 36009* *Denver, CO 80236* *(303) 292-5022*	*Colorado Division of Insurance* *1560 Broadway, Suite 850* *Denver, CO 80202* *(303) 894-7499*

Insurance companies and agents are not allowed by Colorado law to use the existence of the Association or its coverage to encourage you to purchase any form of insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and Colorado law, then Colorado law will control.

HUMANA HEALTH PLAN, INC.

Service Area

No *network providers* are actively maintained other than in the counties listed below. This list may change depending on network adequacy.

Health Maintenance Organization (HMO)

Adams
Arapahoe
Boulder
Broomfield
Denver
Douglas
El Paso
Jefferson
Larimer
Teller
Weld

Out-of-network providers **may balance bill** ***you*** **for the difference between the amount paid by** ***us*** **and the** ***out-of-network provider's*** **billed charges, if:**

a. *You* knowingly seek services from an *out-of-network provider* because *you* are required to travel a reasonable distance beyond the established geographic area requirements for an adequate network in order to receive services from a *network provider*; and
b. The *out-of-network provider* is reimbursed for an amount less than the billed charges.

FEDERAL PATIENT PROTECTION AND AFFORDABLE CARE ACT NOTICES

Choice of Primary Care Provider

This plan may require or allow the designation of a Primary Care Provider (PCP). You have the right to designate any PCP who participates in our network and who is available to accept you or your family members. For information on how to select a PCP, and for a list of PCPs, contact the telephone number on the back of your Identification Card or refer to our Website, www.humana.com .

For children, you may designate a pediatrician as the PCP.

Direct Access to Obstetricians and Gynecologists

You do not need prior authorization from the plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, visit www.humana.com or contact the phone number listed on the back of your ID card.

NOTICES REQUIRED BY STATE LAW

Cancer Screenings

At Humana, we believe cancer screenings provide important preventive care that supports our mission: to improve the lives of the people we serve and the health of our communities. We cover cancer screenings as described below.

Pap Tests

All Plans provide coverage under the preventive care benefits for a routine annual Pap test and the related office visit. Payment for the routine Pap test is based on the Plan's provisions for preventive care service. Payment for the related office visit is based on the Plan's preventive care provisions.

Mammogram Screenings

All Plans provide coverage under the preventive care benefits for routine screening or diagnostic mammogram regardless of age. Payment for the mammogram screening benefit is based on the Plan's provisions for preventive care.

Prostate Cancer Screenings

All Plans provide coverage under the preventive care benefits for routine prostate cancer screening for men. Payment for the prostate cancer screening is based on the Plan's provisions for preventive care.

Colorectal Cancer Screenings

Several types of colorectal cancer screening methods exist. All Plans provide coverage for routine colorectal cancer screenings, such as fecal occult blood tests, barium enema, sigmoidoscopies and colonoscopies. Depending on the type of colorectal cancer screening received, payment for the benefit is based on where the services are rendered and if rendered as a screening or medical procedure. Colorectal cancer screenings are covered under preventive care as long as the services provided are for a preventive screening. Payment for preventive colorectal cancer screenings is based on the Plan's provisions for preventive care.

The information above is only a summary of the benefits described. The Policy includes important additional information about limitations, exclusions and covered benefits. The "Schedule of Benefits (Who Pays What)" section includes additional information about Copayments, Deductibles and Coinsurance. If you have any questions, please call Customer Service at the number on the back of your Identification Card.

Pediatric Dental Services

This policy does not include coverage of pediatric dental services as required under The Patient Protection and Affordable Care Act, Pub, L. 111-148 and the Health Care and Education Reconciliation Act of 2010, Pub, L.111-152. Coverage of pediatric dental services is available for purchase in the State of Colorado, and can be purchased as a stand-alone plan. Please contact your insurance carrier, agent, or Connect for Health Colorado to purchase either a plan that includes pediatric dental coverage, or an Exchange-certified stand-alone dental plan that includes pediatric dental coverage.