The actual off 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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INDIVIDUAL MAJOR MEDICAL POLICY
HUMANA HEALTH BENEFIT PLAN
OF
LOUISIANA, INC.

Policyholder:	Policy Holder
Policy number:	Policyholder Na
Effective date:	99/99/99 as of 12:01 a.m.
Premium amount:	$9999.99 monthly

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

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

Renewability

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

Right to return policy

You have the right to return this *policy* within 10 calendar days of receiving this *policy.* 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.

Notice

Your share of the payment for healthcare *services* may be based on the agreement between *your* health plan and *your* provider. Under certain circumstances, this agreement may allow *your* provider to bill *you* for amounts up to the provider's regular billed charges.

Bruce Broussard
President

Humana.

NOTICE

Continuation of Coverage – Prescription Drugs

You shall have the right to continue the coverage of any *prescription* drug that was approved or covered by *us*, and the coverage of such *prescription* drug shall be at the contracted benefit level until the renewal of the *your* current plan.

Humana.

Prescription Drug Formulary Disclosure

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 healthcare practitioner* will prescribe that *prescription* drug, medicine, or medication for a particular medical condition or *mental illness.*

You can obtain a copy of *our drug list* by visiting *our* Website at www.humana.com or calling the telephone number on *your identification card*. If a specific drug, medicine or medication is not listed on the *drug list, you* may contact *us* orally or in writing with a request to determine whether a specific drug is included on *our drug list. We* will respond to *your* request no later than the third business day after the receipt date of the request.

Modification of coverage

Prescription drug coverage is subject to change. Based on state law, advance written notice is required for the following modifications that affect *prescription* drug coverage:

- Removal of a drug from the *drug list*;
- Requirement that you receive *prior authorization* for a drug;
- An imposed or altered quantity limit;
- An imposed *step therapy* restriction; or
- Moving a drug to a higher cost-sharing level unless a generic alternative to the drug is available.

These types of changes to *prescription* drug coverage will only be made by *us* at renewal of the *policy*. *We* will provide written notice no later than 60 days prior to the effective date of the change.

SUMMARY OF THE LOUISIANA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT AND NOTICE CONCERNING COVERAGE LIMITATIONS AND EXCLUSIONS

Residents of Louisiana who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Louisiana Life and Health Insurance Guaranty Association. The purpose of this association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state, and in some cases, to keep coverage in force. However, the valuable extra protection provided by these insurers through the Guaranty Association is limited. As noted in the disclaimer below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

Disclaimer

The Louisiana Life and Health Insurance Guaranty Association provides coverage of claims under some types of policies if the insurer becomes impaired or insolvent. COVERAGE MAY NOT BE AVAILABLE FOR YOUR POLICY. Even if coverage is provided, there are significant limits and exclusions. Coverage is always conditioned upon residence in this state. Other conditions may also preclude coverage.

Insurance companies and insurance agents are prohibited by law from using the existence of the association or its coverage to sell you an insurance policy.

You should not rely on the availability of coverage under the Louisiana Life and Health Insurance Guaranty Association when selecting an insurer.

The Louisiana Life and Health Insurance Guaranty Association or the Department of Insurance will respond to any questions you may have which are not answered by this document.

Louisiana Life and Health Insurance Guaranty Association
P.O. Drawer 44126
Baton Rouge, LA 70804

Department of Insurance
P.O. Box 94212
Baton Rouge, LA 70804-9214

The state law that provides for this safety-net coverage is called the Louisiana Life and Health Insurance Guaranty Association Act. The following is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change any person's rights or obligations under the Act or the rights or obligations of the Guaranty Association.

COVERAGE

Generally, individuals will be protected by the Life and Health Insurance Guaranty Association if they live in this state and hold a life or health insurance contract, or an annuity, or if they are insured under a group insurance contract, issued by an insurer authorized to conduct business in Louisiana. The beneficiaries, payees or assignees of insured persons are protected as well even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons holding such policies are not protected by this association, if:

1. They are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose Guaranty Association protects insureds who live outside that state);
2. The insurer was not authorized to do business in this state; or
3. Their policy was issued by a nonprofit hospital or medical service organization (the "Blues"), an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange.

The association also does not provide coverage for:

1. Any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
2. Any policy of reinsurance (unless an assumption certificate was issued);
3. Interest rate yields that exceed an average rate;
4. Dividends;
5. Credits given in connection with the administration of a policy by a group contract holder;
6. Employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them); or
7. Unallocated annuity contracts (which give rights to group contract holders, not individuals), unless qualified under 403(b) of the Internal Revenue Code, except that, even if qualified under 403(b), unallocated annuities issued to employee benefit plans protected by the Federal Pension Benefit Guaranty Corporation are not covered.

LIMITS ON AMOUNTS OF COVERAGE

The act also limits the amount the association is obligated to pay out. The association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the association will pay a maximum of $300,000 no matter how many policies and contracts there were with the same company, even if they provided different types of coverage. Within this overall $300,000 limit, the association will not pay more than $100,000 in cash surrender values, $100,000 in health insurance benefits, $100,000 in present value of annuities, or $300,000 in life insurance death benefits. Again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverage.

GUIDE TO YOUR POLICY

Contents **Page number**

GUIDE TO YOUR POLICY

INTRODUCTION

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.*

UTILIZATION MANAGEMENT

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.**

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.*

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

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; or
   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.*

UTILIZATION MANAGEMENT

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*; or
   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.

You will be financially responsible for 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 amount, or any portion thereof, will not count toward satisfying any applicable *copayment*, *deductible*, *coinsurance* or *out-of-pocket limit*.

YOUR POLICY BENEFITS

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" and this *policy* section, and according to the "General Exclusions" and "Prescription Drug Exclusions" sections and any amendments that may modify *your* benefits which are part of *your policy.* 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.*

YOUR POLICY BENEFITS

Continuity of care

In the event a *covered* person is in an ongoing course of treatment and their *healthcare practitioner* ceases to be an *in-network provider*, the *covered person* may be eligible for continuity of care for the treatment of:

1. A life threatening illness, until the course of treatment is completed up to a maximum of three months from the date of termination; and
2. A high-risk pregnancy or is past the 24th week of pregnancy, through delivery and postpartum care related to the pregnancy and delivery.

Continuity of care will be provided if the *healthcare practitioner* agrees:

1. To provide medical treatment under the terms of the contract, including without limitation the rates of payment for providing *services*, as those terms existed before termination of the contract; and
2. Not to seek payment from the *covered person* for any *service* provided by the *healthcare practitioner* that the *healthcare practitioner* could not have received from the *covered person* were *the healthcare practitioner* still under contract with *us.*

All terms and provisions of this *policy* are applicable to *covered expenses* provided during the period of continued care by the terminated *healthcare practitioner*.

Continuity of care is not available if:

1. The *healthcare practitioner* was terminated due to suspension, revocation, or restriction of the provider's license to practice in the state of Louisiana by the Louisiana State Medical Board of Medical Examiners or another documented reason related to quality of care;
2. The *covered person* chooses to change *healthcare practitioner;*
3. The *covered person* moves out of the service area; or
4. The *covered person* requires routine monitoring for a chronic condition and the condition is not in an acute phase.

YOUR POLICY BENEFITS

Refer to the "General Exclusions" and "Prescription Drug 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*;
2. When required by *us* to transfer a *covered person* to the nearest appropriate medical facility equipped to provide the *medically necessary services*;
3. To the nearest *hospital* or neonatal special care unit due to *bodily injury*, *sickness*, congenital defect or complications of premature birth for a *newly born* covered *dependent* child; and
4. For the *temporarily medically disabled mother* when accompanying the *newly born* covered *dependent* child if the *healthcare practitioner* has advised that normal travel would be hazardous to her health.

Attention deficit hyperactivity disorder (ADHD)

Covered expenses are *expenses incurred* for the diagnosis and treatment of attention deficit hyperactivity disorder when rendered or prescribed by a *healthcare practitioner* or other appropriate healthcare provider licensed by the state of Louisiana.

Autism spectrum disorders (ASD)

Covered expenses include but are not limited to, assessment, evaluations or tests performed for diagnosis, habilitative or rehabilitative care, pharmacy care (covered under the pharmacy benefit), psychiatric care, psychological care, and therapeutic care. *Covered persons* are eligible for Applied Behavior Analysis as determined by *us*.

Bone mass measurement

Covered expenses are *expenses incurred* for the diagnosis and treatment of osteoporosis for:

1. An estrogen-deficient woman at clinical risk of osteoporosis and considering treatment;
2. A *covered person* receiving long-term steroid therapy or
3. A *covered person* being monitored to assess the response to or efficacy of approved osteoporosis drug therapies.

YOUR POLICY BENEFITS

Cleft lip and cleft palate

Covered expenses are *expenses incurred* for the care and treatment of cleft lip and cleft palate and any *sickness* related to or developed as a result of the condition. Treatment includes:

1. Oral and facial *surgery*, surgical management, and follow-up care;
2. Prosthetic treatment such as obturators, speech appliances, and feeding appliances;
3. Orthodontic treatment and management;
4. Preventive and restorative dentistry to insure good health and adequate dental structures for orthodontic treatment or prosthetic management or therapy;
5. Speech/language evaluation and therapy;
6. Audiological assessments and amplification devices;
7. Otolaryngology treatment and management;
8. Psychological assessment and counseling; and
9. Genetic assessment and counseling for *covered persons* under this *policy*.

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.

YOUR POLICY BENEFITS

Dental services

Covered expenses are *expenses incurred* for:

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 *we* determine will produce professionally adequate results;
2. General anesthesia and associated *services* from a *hospital* or *healthcare treatment facility* in conjunction with dental care, excluding temporomandibular joint (TMJ) disorders, provided when a *covered person* has a mental or physical condition that requires such *services*;
3. Dental *service* when specifically required for a *covered person* who has been diagnosed with head or neck cancer. Benefits are limited to *services* needed for preparation for or follow-up to radiation therapy involving the mouth;
4. Certain oral surgical operations:
    a. Excisions of tumors and cysts of the jaws, cheeks, lips, gums, 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 and of sound natural teeth;
    c. Reduction of fractures and dislocation of the jaw;
    d. External incision and drainage of abscess;
    e. External incision of cellulites;
    f. Incision and closure of accessory sinuses, salivary glands or ducts;
    g. Cutting of the tissue in the midline of the tongue (Frenectomy);
    h. Extraction of impacted teeth; and
    i. Excision of exastoses or tori of the jaws and hard palate;
5. Anesthesia for the above *services* or procedures when rendered by an oral surgeon;
6. Anesthesia for the above *services* or procedures when rendered by a dentist who holds all required permits or training to administer such anesthesia;
7. Anesthesia when rendered in a *hospital* setting and for associated *hospital* charges when a *covered person's* mental or physical condition requires dental treatment to be rendered in a *hospital* setting. Anesthesia benefits are not available for treatment rendered for temporomandibular joint (TMJ) disorders; and
8. Dental *services* when specifically required for a *covered person* who has been diagnosed with head or neck cancer. Benefits are limited to *services* needed for preparation for or follow-up to radiation therapy involving the mouth.

Services rendered by a dentist who is an *out-of-network provider* will be reimbursed at the *in-network provider* benefit level.

YOUR POLICY BENEFITS

Diabetes services

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

1. Routine eye exams;
2. Routine foot care; and
3. Outpatient self-management training and education, 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.

Dietician services

Services for outpatient visits to a registered dietician. Dietician visits for diabetics are payable under the "Diabetes services" provision. These *services* are subject to an annual visit limit as shown on the "Schedule of Benefits".

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. Initial permanent prosthetic devices, supplies and *services* including, but not limited to, limbs and eyes. The prosthetic devices for a lost limb or absent limb must be necessary to provide or to restore their minimal basic function. Replacement of prosthetic devices is a *covered expense* when the replacement is due to pathological changes or growth;
7. Orthotics used to support, align, prevent or correct deformities. *Covered expense* does not include replacement orthotics, dental braces (unless *medically necessary*) or oral and dental splints and appliances unless custom made for the treatment of documented obstructive sleep apnea;
8. Initial contact lenses or eyeglasses following cataract *surgery*;
9. Casts, splints (other than dental), trusses, braces (other than orthodontic unless *medically necessary*), and crutches;
10. Wigs following cancer treatment (not to exceed one per lifetime);
11. The following special supplies up to a 30-day supply for the initial order or a subsequent refill, when prescribed by the *healthcare practitioner*:
    a. Surgical dressings;
    b. Catheters;
    c. Colostomy 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*.

YOUR POLICY BENEFITS

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 prosthetic devices necessitated by loss or damage due to neglect or misuse; or
2. Duplicate or similar rentals of *durable medical equipment*, as determined by *us*.

Emergency services

Expenses incurred for *emergency services*, including *services* necessary to screen, evaluate, and stabilize a medical condition for:

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 as shown on the "Schedule of Benefits" subject to any applicable *copayment, deductible*, and *coinsurance*.

We will not retrospectively deny or reduce payment for *emergency services* unless *our* payment for the *services* was based on the following:

1. Fraud, clerical error, or a material omission or misrepresentation;
2. Any payment reduction due to applicable copayment, *coinsurance*, or *deductible* which may be the responsibility of the *covered person*; or
3. Cases in which the *covered person's* condition does not meet the definition of *emergency care*, unless the *covered person* was referred to the emergency department by their *healthcare practitioner*.

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.

YOUR POLICY BENEFITS

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 reduced or denied for *your* continued *hospital confinement* at the out-of-network *hospital*. If *you* refuse to be transferred, benefits will be denied from the date *your* condition is *medically stable.*

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

Also see the "Choice of providers" provision in the "General Provisions" section for information on how benefits will be paid for certain out-of-network *healthcare practitioners* providing *services* at an in-network *healthcare treatment facility.*

Habilitative services

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

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

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

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. Operating room;
4. Ancillary *services* (such as surgical dressings, supplies, casts, and splints);
5. Blood and blood plasma which is not replaced by donation;
6. Administration of blood and blood products including blood extracts or derivatives;
7. Other *healthcare treatment facility* charges;
8. Drugs and medicines that are provided or administered to the *covered person* while *confined* in a *hospital* or *skilled nursing facility*;
9. 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
10. *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.*

YOUR POLICY BENEFITS

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. *Perioperative services*, including those rendered by a registered *nurse* first assistant;
11. Allergy injections, therapy, testing, and serum. Therapy and testing for treatment of allergies must be approved by the American Academy of Allergy and Immunology or the Department of Health and Human Services or any of its offices or agencies; and
12. 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" subject to any applicable *deductible* and *coinsurance*.

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

Also see the "Choice of providers" provision in the "General Provisions" section for information on how benefits will be paid for certain out-of-network *healthcare practitioners* providing *services* at an in-network *healthcare treatment facility*.

YOUR POLICY BENEFITS

Hearing aids

Covered expenses are *expenses incurred* for hearing aids for covered *dependent* children under age 18 if the hearing aids are fitted and dispensed by a licensed audiologist or licensed hearing aid specialist following medical clearance by a *healthcare practitioner* and an audiological evaluation medically appropriate to the age of the *dependent* child. Hearing aids must be received from an *in-network provider*.

Hearing impaired transliterator services

Covered expenses for a hearing interpreter/translator for a hearing impaired *covered person* when *services* are used in connection with treatment or diagnostic consultations performed by a *healthcare practitioner*.

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*.

Hospice care

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

1. Room and board in a *hospice facility*, when it is for management of acute pain or for an acute phase of chronic symptom management;
2. Other *services*;
3. Part-time nursing care provided by or supervised by a *nurse* for up to eight hours per day;
4. Counseling for the *hospice patient* and his/her *immediate family members* by a licensed clinical social worker or pastoral counselor;
5. Medical social services for the *hospice patient* or his/her *immediate family members* under the direction of a *healthcare practitioner* including:
   a. Assessment of social, emotional, and medical needs and the home and family situation; and
   b. Identification of the community resources available;
6. Psychological and dietary counseling;
7. Physical therapy;
8. Part-time home health aide services for up to eight hours in any one day; and
9. Medical supplies, drugs, and medicines prescribed by a *healthcare practitioner* for *palliative care*.

YOUR POLICY BENEFITS

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

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

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

Low protein food products

Covered expenses are *expenses incurred* for *low protein food products* for treatment of inherited metabolic diseases if the *low protein food products* are *medically necessary* and, are obtained from a source approved by *us.*

Lymphedema

Covered expenses are *expenses incurred* for the diagnosis, evaluation, and treatment of lymphedema. Coverage includes benefits for equipment and supplies, complex decongestion therapy, and self-management training and education if determined to be *medically necessary* and provided by a licensed *healthcare practitioner* practicing within the scope of their license. Gradient compression garments are covered only with a prescription and when custom fit for the *covered person.*

Maternity services

1. Prenatal care;
2. A minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated caesarean section delivery. If an earlier discharge is consistent with the most current protocols and guidelines of the American College of Obstetricians and Gynecologists or the American Academy of Pediatrics and is consented to by the mother and the attending *healthcare practitioner*, a post-discharge office visit to the *healthcare practitioner* or a *home healthcare visit* within the first 48 hours after discharge is also covered, subject to the terms of this *policy*; and
3. Postpartum care.

YOUR POLICY BENEFITS

Mental health

Covered expenses are charges made by a:

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

Covered expenses 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; and
   c. *Healthcare practitioner's* charges for routine examination of the newborn before release from the *hospital*;
2. *Bodily injury* or *sickness*;
3. Care and treatment for premature birth; 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 medical services" provision.

YOUR POLICY BENEFITS

Occupational coverage

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

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

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

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

Outpatient therapies and rehabilitative services

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

1. *Services* for:
   a. Documented loss of physical function;
   b. Pain; or
   c. Developmental delay or defect;
2. Physical therapy *services*;
3. Occupational therapy *services*;
4. Spinal manipulations, adjustments, and modalities;
5. Massage and physical therapy rendered in connection with the treatment of dislocation, subluxation, or misplacement of vertebrae and/or strains and sprains of soft tissue related to the spine;
6. Speech therapy or speech pathology *services*;
7. Cognitive rehabilitation *services*;
8. Audiology therapy *services*;
9. Radiation therapy *services*;
10. Pulmonary rehabilitation *services*;
11. Chemotherapy; and
12. Cardiac rehabilitation *services*.

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

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

Therapy *services* rendered during a *home healthcare visit* are explained under the "Home healthcare" provision.

YOUR POLICY BENEFITS

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. Insulin and *diabetic supplies*;
4. Hypodermic needles or syringes or other methods of delivery when prescribed by a *healthcare practitioner* for use with insulin or *self-administered injectable drugs*. (Hypodermic needles, syringes, and other methods of delivery used in conjunction with covered drugs may be available at no cost to the *covered person*);
5. *Self administered injectable drugs* approved by *us*;
6. Drugs, medicines or medications on the Preventive Medication Coverage *drug list* with a *prescription* from a *healthcare practitioner*;
7. Enteral formulas and nutritional supplements for the treatment of phenylketonuria (PKU) or other inherited metabolic diseases, or as otherwise determined by *us*;
8. Spacers and/or peak flow meters for the treatment of asthma; and
9. Immunosuppressive drugs when prescribed for covered transplants.

Regardless of any other provisions of this *policy*, *we* may decline coverage or if applicable, exclude from the *drug list* any and all *prescriptions*, except drugs used for the treatment of cancer, 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. The *covered person* is responsible for the payment of local taxes on the sale of *prescription* drugs and pharmacist *services*.

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

When an *out-of-network pharmacy* is used, the *covered person* will be responsible to pay for the *prescription* fill or refill at the time it is dispensed and then file a claim for reimbursement with *us.* In addition to any applicable *cost share* shown in the "Schedule of Benefits", the *covered person* will be responsible for 30% of the *default rate*. Any amount over the *default rate* does not apply to the *out-of-pocket limit.* The *covered person* is also responsible for 100% of the difference between the *default rate* and the *out-of-network pharmacy's* charge. The charge received from an *out-of-network pharmacy* for a *prescription* fill or refill may be higher than the *default rate.*

YOUR POLICY BENEFITS

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

Preventive medical services

Services for well child and adult care preventive medical *services*. Preventive medical *services* under this *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 medical *services* are subject to change. A *covered person* may obtain the current list of preventive *services* at www.healthcare.gov or by calling the telephone number on *your ID card* prior to receiving a preventive medical *service.*

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

1. Evidence-based items or *services* that have in effect a rating of A or B in the current recommendations of the U.S. Preventive Services Task Force (USPSTF);
2. Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control (CDC) that are listed on the Immunization Schedules of the CDC;
3. Evidence-informed preventive care and screenings provided for in the Health Resources and Services Administration (HRSA) guidelines for infants, children, adolescents, and women;
4. Current recommendations of the USPSTF regarding breast cancer screening, mammography, and prevention (does not include recommendations issued in or around November 2009);
5. Breast cancer screening mammograms for a female *covered person* including the following:
   a. One baseline mammogram for ages 35-39;
   b. One mammogram every 1-2 years for ages 40-49; and
   c. One mammogram every 12 months for age 50 or older;
6. Prostate cancer detection including digital rectal examinations and Prostate Specific Antigen (PSA) testing for a male *covered person* who is:
   a. 50 years of age or older; or
   b. Over age 40 as *medically necessary* and appropriate;
7. Colorectal cancer screening in accordance with the American College of Gastroenterology (ACOG) guidelines for a *covered person* as follows:
   a. Colonoscopy every 10 years beginning at age 50 (45 for African Americans);
   b. Flexible sigmoidoscopy every 5-10 years; and
   c. Annual Fecal Immunochemical Test for blood (FIT); and
8. Pap test for cervical cancer when rendered or prescribed by *healthcare practitioner.*

YOUR POLICY BENEFITS

Private duty nursing services

Services rendered on an outpatient basis by an actively practicing Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.) who is unrelated to the *covered person* by blood, marriage or adoption. *Services* must be ordered by the attending *healthcare practitioner* and require the technical skills of a (R.N.) or (L.P.N.). No benefits are will be provided for, or on account of private duty nursing *services* provided on an inpatient basis.

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

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; and
4. Because of a congenital *sickness* or anomaly of a *dependent* child that resulted in a functional defect.

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

Cosmetic *services* and *services* for complications from cosmetic *services* are not covered regardless of whether the initial *surgery* occurred while the *covered person* was covered under this *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*. The *covered person* must enter the *sub-acute rehabilitation facility* or *skilled nursing facility* within 14 days after discharge from the *hospital*.

YOUR POLICY BENEFITS

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

Rehabilitation services include but are not limited to:

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

Sleep studies

Medically necessary sleep studies and associated professional claims are eligible for coverage when a sleep study is obtained in a facility that is accredited by the Joint Commission or the American Academy of Sleep Medicine (AASM).

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:

3. For the purpose of diagnosis, consultation or treatment; and
4. 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.

YOUR POLICY BENEFITS

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.

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. Autologous parathyroid transplants;
11. Any combination of the above listed transplants; and
12. 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.

YOUR POLICY BENEFITS

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".

Transplant provider selection

The *covered person* may select any provider he/she wishes to perform the transplant *services*. However, if the *covered person* selects an *in-network provider,* he/she will avoid having the benefit payment reduced for receiving *services* from an *out-of-network provider.*

YOUR POLICY BENEFITS

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 urgent care is obtained through an out-of-network *urgent care center*, *we* will pay benefits at the out-of-network level.

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

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* for care and treatment of non-covered procedures;
2. *Services* incurred before the *effective date* or after the termination date of this *policy*;
3. *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*;
4. *Services* performed in association with a *service* that is not covered under this *policy*;
5. 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;
6. *Services* which *are experimental, investigational or for research purposes* except as expressly provided in this *policy,* 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*;
7. 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* except as expressly provided in this *policy,* 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*;
8. Expenses in excess of the *maximum allowable fee* for the *service*;
9. *Services* exceeding the amount of benefits available for a particular *service*;
10. *Services* for any condition excluded by amendment under this *policy*;
11. *Services* provided when this *policy* is past the premium due date and the required premium is not received within 31 days (90 days if *you* are receiving an Advanced Premium Tax Credit (APTC)) after the premium is due and the *policy* is terminated;
12. *Services* for treatment of complications of non-covered procedures or *services*;
13. *Services* relating to a *sickness* or *bodily injury* incurred as a result of the *covered person* operating a motorized vehicle while intoxicated, as defined by applicable law in the state in which the loss occurred;
14. *Services* where *sickness* or *bodily injury* was contributed to by the *covered person* being under the influence of illegal narcotics or a controlled substance unless administered by or used as prescribed by a *healthcare* practitioner;
15. *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;

GENERAL EXCLUSIONS

16. *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, except for medical facilities owned and operated by the state of Louisiana or any of its political subdivisions;
    d. Furnished while a *covered person* is *confined* in a *hospital* or institution owned or operated by the United States government or any of its agencies for any service-connected *sickness* or *bodily injury*;
    e. For expenses received from a *healthcare practitioner* over the *maximum allowable fee we* would pay for the least costly provider;
    f. Which are not rendered by the billing provider;
    g. Which are not substantiated in the medical records by the billing provider;
    h. Provided by a *family member* or person who resides with the *covered person*; or
    i. Rendered by a standby *health*care *practitioner*, surgical assistant, assistant surgeon, physician's assistant, *nurse* or certified operating room technician unless *medically necessary*;
17. 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;
18. *Hospital inpatient services* when the *covered person* is in *observation status*;
19. Cosmetic *services*, or any complication therefrom except for preventive medical *services* in accordance with USPSTF recommendations;
20. *Custodial care* and *maintenance care*, except as expressly stated in this *policy*;
21. 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*;
22. Medical or surgical procedures that are not *medically necessary* except elective tubal ligation and vasectomy;
23. Elective medical or surgical abortion unless:
    a. Required to save the life or preserve the health of an unborn child or mother;
    b. To remove a dead unborn child caused by spontaneous abortion, missed abortion or inevitable abortion; or
    c. To remove an ectopic pregnancy;
24. Reversal of sterilization;
25. *Infertility services*, unless for diagnosis and treatment of a correctable medical condition that results in infertility if that condition is otherwise covered under this *policy*;
26. Sexual dysfunction;
27. Sex change *services*, regardless of any diagnosis of gender role or psychosexual orientation problems;
28. 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*;

GENERAL EXCLUSIONS

29. 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*;
30. *Pre-surgical/procedural testing* duplicated during a *hospital confinement*;
31. Any treatment for obesity except for preventive medical *services* in accordance with USPSTF recommendations, which includes *morbid obesity*, regardless of any potential benefits for co-morbid conditions, including but not limited to:
    a. Surgical procedures for *morbid obesity*;
    b. *Services* or procedures for the purpose of treating a *sickness* or *bodily injury* caused by, complicated by or exacerbated by the obesity; or
    c. *Services* for complications related to any *services* rendered for weight reduction;
32. Surgical procedures for the removal of excess skin and/or fat in conjunction with or resulting from weight loss or a weight loss *surgery*;
33. Treatment of nicotine habit or addiction, including but not limited to, nicotine patches, hypnosis, smoking cessation classes, tapes or *electronic* media, except for preventive medical *services* in accordance with USPSTF recommendations;
34. Educational or vocational training or therapy, *services*, and schools including but not limited to videos and books; nutritional therapy except for treatment of diabetes, except for preventive medical *services* in accordance with USPSTF recommendations;
35. 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 *services* related to the treatment of diabetes; and
    f. Arch supports, heel wedges, lifts, shoe inserts, the fitting or provision of foot orthotics or orthopedic shoes, unless *medically necessary* because of diabetes or hammertoe;
36. Hair prosthesis except as expressly provided in this *policy*, hair transplants or implants;
37. Hearing care that is routine, including but not limited to exams and tests except for routine hearing screenings that are covered under preventive medical *services*, any artificial hearing device (except for hearing aids for covered *dependent* children under the age of 18), cochlear implant, auditory prostheses or other electrical, digital, mechanical or surgical means of enhancing, creating or restoring auditory comprehension;
38. *Services* rendered in a premenstrual syndrome clinic or holistic medicine clinic;
39. Transplant *services* except as expressly provided in this *policy*;
40. Charges for growth hormones;
41. Over-the-counter medical items or supplies that can be provided or prescribed by a *healthcare practitioner* but are also available without a written order or *prescription* except for drugs prescribed for use for a covered preventive medical *service*;
42. Immunizations including those required for foreign travel for *covered persons* of any age except as expressly provided in this *policy*;
43. Treatment for any jaw joint problem, including but not limited to, temporomandibular joint disorder, 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;

GENERAL EXCLUSIONS

44. Genetic testing, counseling or *services* except for BRCA screening, counseling, and appropriate testing as recommended by the Health Resources and Services Association (HRSA) or for:
    a. Assessment of cleft lip and palate; or
    b. Specifically required for a medical treatment decision of a *covered person* in accordance with *our* medical guidelines;
45. *Sickness* or *bodily injury* for which medical payments/personal injury protection (PIP) coverage exists under any automobile, homeowner, marine, aviation, premise or any other similar coverage whether such coverage is in effect on a primary, secondary or excess basis, except expenses incurred as a results of the treatment of an injury or *sickness* caused by the fault of a third party. 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;
46. *Covered expense* to the extent of any amount received from others for the *bodily injuries* or losses which necessitated such benefits, except expenses incurred as a result of the treatment of an injury or *sickness* caused by the fault of a third party. Amounts received from others specifically includes, without limitation, liability insurance, Workers' Compensation, uninsured motorists, underinsured motorists, "no-fault" and automobile medical payments;
47. Expense for employment, school, sports or camp physical examinations or for the purpose of obtaining insurance, or premarital tests or examinations;
48. *Services* received in an emergency room unless required because of *emergency care*;
49. Any expense including related complications incurred for *services* received outside of the United States except as required by law for *emergency care services*;
50. *Services* received during an inpatient stay when the stay is primarily related to behavioral, social maladjustment, lack of discipline or other antisocial actions which are not specifically the result of *mental health*;
51. *Services* and supplies which are:
    a. Rendered in connection with *mental illnesses* not classified in the International Classification of Diseases of the U.S. Department of Health and Human Services;
    b. Extended beyond the period necessary for evaluation and diagnosis of learning and behavioral disabilities or for intellectual or physical disability; and
    c. Marriage counseling;
52. *Services* rendered for:
    a. Immunotherapy for recurrent abortion;
    b. Chemonucleolysis (non-surgical treatment for a bulging disc that involves the injection of an enzyme in an intervertebral disc with the goal of dissolving the inner part of the disc);
    c. Biliary lithotripsy (procedure using high energy shock waves to fragment gall stones);
    d. Home uterine activity monitoring;
    e. Sleep therapy;
    f. Light treatment for Seasonal Affective Disorder (S.A.D.);
    g. Immunotherapy for food allergy;
    h. Prolotherapy (injection of an irritant solution);
    i. Hyperhidrosis (excessive sweating); and
    j. Sensory integration therapy;
53. *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;
54. *Court-ordered mental health services* unless *medically necessary*;

GENERAL EXCLUSIONS

55. Expenses for alternative medicine, including medical diagnosis, treatment, and therapy. Alternative medicine *services* includes, but is not limited to:
    a. Acupressure;
    b. Acupuncture;
    c. Aromatherapy;
    d. Ayurveda;
    e. Biofeedback;
    f. Faith healing;
    g. Guided mental imagery;
    h. Herbal medicine;
    i. Holistic medicine;
    j. Homeopathy;
    k. Hypnosis;
    l. Macrobiotic;
    m. Massage therapy, except as expressly provided in this *policy*;
    n. Naturopathy;
    o. Ozone therapy;
    p. Reflexotherapy;
    q. Relaxation response;
    r. Rolfing;
    s. Shiatsu;
    t. Yoga;
    u. Herbs, nutritional supplements, and alternative medicines; and
    v. Chelation therapy;
56. Private-duty nursing, except as expressly provided in this *policy*;
57. Living expenses, travel, transportation, except as expressly provided in the "Ambulance services" provision or "Transplant services" provision in the "Your Policy Benefits" section of this *policy*; and
58. Expenses for *services* (whether or not prescribed by a *healthcare practitioner*) that are primarily and customarily used for a non-medical purpose or used for environmental control or enhancement including but not limited to:
    a. Common household items such as air conditioners, air purifiers, water purifiers, vacuum cleaners, waterbeds, hypoallergenic mattresses or pillows or exercise equipment;
    b. Scooters or motorized transportation equipment, escalators, elevators, ramps, modifications or additions to living/working quarters or transportation vehicles;
    c. Personal hygiene equipment including bath/shower chairs, transfer equipment or supplies or bed side commodes;
    d. Personal comfort items including cervical pillows, gravity lumbar reduction chairs, swimming pools, whirlpools or spas or saunas;
    e. Medical equipment including blood pressure monitoring devices, PUVA lights and stethoscopes;
    f. Expenses for any membership fees or program fees paid by a *covered person*, including but not limited to:
        i. Health clubs;
        ii. Health spas;
        iii. Aerobic and strength conditioning;
        iv. Work-hardening programs and weight loss or similar programs; and
        v. Any related material or products related to these programs;
    g. Communication system, telephone, television or computer systems and related equipment or similar items or equipment; and
    h. Communication devices except after surgical removal of the larynx or a diagnosis of permanent lack of function of the larynx.

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;
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*, except for preventive medical *services* in accordance with USPSTF recommendations;
4. Dietary supplements except enteral formulas and nutritional supplements for the treatment of phenylketonuria (PKU) or other inherited metabolic disease, except for preventive medical *services* in accordance with USPSTF recommendations;
5. Nutritional products, except for preventive medical *services* in accordance with USPSTF recommendations;
6. Drugs and/or ingredients not approved by the FDA, including bulk compounding ingredients;
7. Minerals, except for preventive medical *services* in accordance with USPSTF recommendations;
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, unless *medically necessary* for the treatment of lymphedema;
    c. Test reagents;
    d. Mechanical pumps for delivery of medication; and
    e. Other non-medical substances;
18. Anorectic or any drug used for the purpose of weight control;
19. Abortifacients (drugs used to induce abortions);
20. Any drug used for cosmetic purposes, including but not limited to:
    a. Dermatologicals or hair growth stimulants; or
    b. Pigmenting or de-pigmenting agents;

PRESCRIPTION DRUG EXCLUSIONS

21. Any drug or medicine that is:
    a. Lawfully obtainable without a *prescription* (over-the-counter drugs), except insulin and drugs or medicines on the Preventive Medication Coverage *drug list*; or
    b. Available in *prescription* strength without a *prescription*;
22. Compounded drugs in any dosage form except when prescribed for pediatric use for children through 19 years of age or as otherwise determined by *us*;
23. *Infertility services* including medications, unless for diagnosis and treatment of a correctable medical condition that results in *infertility* if that condition is otherwise covered under this *policy*;
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, except as expressly provided in this *policy*, 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*;

PRESCRIPTION DRUG EXCLUSIONS

38. Any *prescription* fill or refill for drugs, medicines or medications that are lost, stolen, spilled, spoiled or damaged;
39. Any amount the *covered person* paid for a *prescription* that has been filled, regardless of whether the *prescription* is revoked or changed due to adverse reaction or change in dosage or *prescription*; and
40. Sales tax where applicable, if not included in the *covered person's cost share.*

PEDIATRIC DENTAL CARE BENEFIT

This section describes the *services* that will be considered *covered expenses* for pediatric dental care *services* under this *policy.* Benefits *we* pay for pediatric dental care *services* will be based on the *reimbursement limit* and as shown in the "Schedule of Benefits – Pediatric Dental Covered Expenses" 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*.

Coverage and benefits will be provided for all eligible children as required by law.

For a complete listing of the required *pediatric dental services* please visit the FEDVIP website at: http://www.opm.gov/insure/health/planinfo/2012/brochures/MetLife.pdf.

Refer to the "Pediatric dental care exclusions" provision below, the "General Exclusions" section and the "Prescription Drug Exclusions" section in this *policy.* All terms and provisions of this *policy*, including *preauthorization* requirements specified in this *policy,* are applicable to the pediatric dental 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.

Pediatric dental care covered expenses

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

Class I services

1. Periodic evaluations. Limited to a maximum of two per year. Benefit is not available when a comprehensive oral evaluation is performed.
2. Comprehensive oral evaluation. Limited to a maximum of one every two years. Benefit is not available when a periodontal evaluation is performed.
3. Limited, problem focused evaluations. Limited to a maximum of two per year.
4. Periodontal evaluations. Limited to a maximum of one every six months. Benefit allowed only for a *covered person* showing signs or symptoms of periodontal disease and for patients with risk factors such as smoking, diabetes or related health issues. No benefit is payable when performed with a cleaning (prophylaxis). Benefit is not available when a comprehensive oral evaluation is performed.
5. Cleaning (prophylaxis), including all scaling and polishing procedures. Limited to a maximum of two per year. Benefit is not available if periodontal maintenance has been previously provided.
6. Intra-oral complete series x-rays (at least 14 films, including bitewings) or panoramic x-ray for *covered persons.* Limited to a maximum of one per every five years. If the total cost of periapical and bitewing x-rays exceeds the cost of a complete series of x-rays, *we* will consider these as a complete series.
7. Bitewing x-rays for *covered persons.* Limited to a maximum of one set of up to four films per year.
8. Other x-rays, including intra-oral periapical and occlusal and extra-oral x-rays. Limited to x-rays necessary to diagnose a specific treatment.
9. Topical fluoride treatment for *covered persons.* Limited to a maximum of two per year.

PEDIATRIC DENTAL CARE BENEFIT

10. Application of sealants to the occlusal surface of permanent molars that are free of decay and restorations for *covered persons.* Limited to a maximum of one per tooth every three years.
11. Installation of initial space maintainers for retaining space when a primary tooth is prematurely lost for *covered persons. Pediatric dental services* do not include separate adjustment expenses.
12. Re-cementation of space maintainers for *covered persons.*
13. Removal of fixed space maintainers for *covered persons.*
14. Occlusal guard for *covered persons* 13 to 19 years of age.

Class II services

1. Restorative *services* as follows:
   a. Fillings. Multiple restorations on the same tooth that have an overlapping surface are considered one restoration. Composite restorations are allowed on anterior teeth only. Alternate benefit of amalgam for composite allowed on pre-molar and molar teeth. The *covered person* will be responsible for the cost difference between the amalgam and composite filing for composite restorations on posterior teeth.
   b. Pin retention per tooth in addition to restoration that is not in conjunction with core build-up.
   c. Re-cementing of inlays, onlays, crowns, and bridges.
   d. Non-cast pre-fabricated stainless steel, esthetic stainless steel, and resin crowns on primary teeth that cannot be adequately restored with amalgam or composite restorations. Limited to a maximum of one per tooth every five years. Esthetic stainless steel and resin crowns are considered an alternate *service* and will be payable as a comparable non-case pre-fabricated stainless steel crown. The *covered person* will be responsible for the remaining *expense incurred.*

2. Miscellaneous *services* as follows:
   a. *Dental emergency* care for the treatment for initial *palliative dental care* of pain or an *accidental dental injury* to the teeth and supporting structures. *We* will consider the *service* a separate benefit only if no other *service,* except for x-rays and/or problem focused oral evaluation is provided during the same visit.
   b. Diagnostic consultations provided by a *dentist* or *healthcare practitioner* not providing the treatment subject to clinical review.

Class III services

1. Restorative *services* as follows:
   a. Initial placement of laboratory-fabricated restorations, for a permanent or primary tooth, when the tooth, as a result of extensive decay or a traumatic injury, cannot be restored with a direct placement filling material. *Pediatric dental services* include inlays, onlays, crowns, veneers, core build-ups and posts, and implant supported crowns and abutments. Limited to a maximum of one per tooth every five years.
   b. Replacement of inlays, onlays, crowns or other laboratory-fabricated restorations for primary and permanent teeth. *Pediatric dental services* include the replacement of the existing major restoration if:
      i. It has been five years since the prior insertion and is not, and cannot be made serviceable;
      ii. It is damaged beyond repair as a result of an *accidental dental injury* (non-chewing injury) while in the oral cavity; or
      iii. Extraction of functioning teeth, excluding third molars or teeth not fully in occlusion with an opposing tooth or prostheses requires the replacement of the prosthesis.

PEDIATRIC DENTAL CARE BENEFIT

2. Periodontic *services* as follows:
   a. Periodontal scaling and root planning. Limited to one every three years limited to four quadrants per visit. Additional quadrants are considered *pediatric dental services* seven days following the completion of the initial quadrant(s).
   b. Full mouth debridement to enable comprehensive evaluation and diagnosis. Limited to one per lifetime.
   c. Periodontal maintenance, (at least 30 days following periodontal therapy), unless a cleaning (prophylaxis) is performed on the same day visit. Limited to four per year.
   d. Periodontal and osseous surgical procedures, including bone replacement, tissue regeneration and/or graft procedures. If more than one surgical procedure is performed on the same day, only the most inclusive procedure will be considered a *pediatric dental service*.
   e. Occlusal adjustments when performed in conjunction with a periodontal surgical procedure. Limited to a maximum of one per quadrant every three years.

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

3. Endodontic procedures as follows:
   a. Root canal therapy, including root canal treatments and root canal fillings – procedure available to permanent teeth only. Any test x-ray, laboratory, exam or any other follow-up care is considered integral to root canal therapy.
   b. Root canal retreatment, including root canal treatments and root canal fillings for permanent and primary teeth. Any test, intraoperative, x-rays, exam, laboratory or any other follow-up care is considered integral to root canal therapy.
   c. Periradicular surgical procedures for permanent teeth, including apicoectomy, root amputation, tooth reimplementation and/or surgical isolation.
   d. Partial pulpotomy for apexogenesis for permanent teeth.
   e. Vital pulpotomy for permanent and primary teeth.
   f. Pulp debridement, pupal therapy (resorbable) for permanent and primary teeth.
   g. Apexification/recalcification for permanent and primary teeth.

4. Prosthodontics *services* as follows:
   a. Repairs of bridges, complete dentures, immediate dentures, partial dentures, and crowns.
   b. Denture adjustments when done by a *dentist* other than the one providing the denture, or adjustments performed more than six months after initial installation.
   c. Initial placement of bridges, complete dentures, immediate dentures, and partial dentures. Limited to one every five years. *Pediatric dental services* include pontics, inlays, onlays and crowns.
   d. Replacement of bridges, complete dentures, immediate dentures, and partial dentures. *Pediatric dental services* include the replacement of the existing prosthesis if:
      i. It has been five years since the prior insertion and is not, and cannot be made serviceable;
      ii. It is damaged beyond repair as a result of an *accidental dental injury* while in the oral cavity; or
      iii. Extraction of functioning teeth, excluding third molars or teeth not fully in occlusion with an opposing tooth or prostheses requires the replacement of the prosthesis.

PEDIATRIC DENTAL CARE BENEFIT

e. Tissue conditioning for permanent teeth. Limited to a maximum of one every three years.
f. Denture relines or rebases. Limited to a maximum of one every three years after six months of installation.
g. Post and core build-up on permanent teeth in addition to partial denture retainers with or without core build up. Limited to a maximum of one per tooth every five years.

5. The following oral surgical *services* as follows:
   a. Extractions of coronal remnants of a deciduous tooth.
   b. Extraction of an erupted tooth or exposed root for permanent and primary teeth.
   c. Excision of partially or completely impacted teeth.
   d. Surgical preparation of soft tissues and excision of bone or bone tissue performed with or without extraction of excision of erupted, partially erupted or completely un-erupted teeth.
   e. Surgical procedures related to repositioning of teeth, tooth transplantation or re-implantation.

6. The following complex oral surgery *services* as follows:
   a. Surgical extractions.
   b. Bone smoothing.
   c. Trim or remove over growth or non-vital tissue or bone.
   d. Removal of tooth or root from sinus and closing opening between mouth and sinus.
   e. Surgical access of an unerupted tooth.
   f. Mobilization of erupted or malpositioned tooth to aid eruption or surgical reposition of teeth.
   g. Excision or removal of malignant oral cysts or tumors.
   h. Bone, cartilage or synthetic grafts.
   i. Reduction of dislocation for temporomandibular joint dysfunction.

7. Implant *services*, subject to *clinical review*. Dental implants and related *services* including implant supported crowns, abutments, bridges, complete dentures, and/or partial dentures. *Pediatric dental services* do not include an implant if it is determined a standard prosthesis or restoration will satisfy the dental need.

8. General anesthesia or conscious sedation subject to *clinical review* and administered by a *dentist* in conjunction with covered oral surgical procedures, and/or periodontal and osseous surgical procedures, and/or periradicular surgical procedures, and/or dental *services*. General anesthesia is not considered a *pediatric dental service* if administered for, including but not limited to, the following:
   a. Pain control, unless the *covered person* has a documented allergy to local anesthetic;
   b. Anxiety;
   c. Fear of pain;
   d. Pain management; or
   e. Emotional inability to undergo a surgical procedure.

PEDIATRIC DENTAL CARE BENEFIT

Integral service

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

1. Local anesthetics;
2. Bases;
3. Pulp testing;
4. Study models/diagnostic casts;
5. *Treatment plans*;
6. Occlusal (chewing or grinding surfaces of molar and bicuspid teeth) adjustments;
7. Nitrous oxide;
8. Irrigation; and
9. Tissue preparation associated with impression or placement of a restoration.

Pretreatment plan

We suggest that if dental treatment is expected to exceed $300, a *covered person* or their *dentist* should submit a *treatment plan* to *us* for review before treatment begins.

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

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

Pretreatment plan process and timing

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

Alternate services

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

Pediatric Dental Care Limitations and Exclusions

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

1. Any expense arising from the completion of forms;
2. Any expense due to a *covered person's* failure to keep an appointment;
3. Any expense for a *service we* consider *cosmetic,* unless it is due to an *accidental dental injury*;

PEDIATRIC DENTAL CARE BENEFIT

4. Expenses incurred for:
   a. Precision or semi-precision attachments;
   b. Overdentures and any endodontic treatment associated with overdentures;
   c. Other customized attachments;
   d. Any *services* for 3D imaging (cone beam images);
   e. Temporary and interim dental *services*; or
   f. Additional charges related to materials or equipment used in the delivery of dental care;
5. Charges for *services* rendered by a *family member* or person who resides with the *covered person*;
6. Any *service* related to:
   a. Altering vertical dimension of teeth or changing the spacing and/or shape of the teeth;
   b. Restoration or maintenance of occlusion;
   c. Splinting teeth, including multiple abutments, or any *service* to stabilize periodontally weakened teeth;
   d. Replacing tooth structures lost as a result of abrasion, attrition, erosion, or abfraction; or
   e. Bite registration or bite analysis;
7. Infection control, including but not limited to, sterilization techniques;
8. Local anesthetics, irrigation, nitrous oxide, pulp caps, study models, treatment plans, occlusal adjustments or tissue preparation associated with the impression or placement of a restoration when charged as a separate *service.* These *services* are considered an integral part of the entire dental *service*;
9. Any non-emergent dental *expenses incurred* for *services* rendered outside of the United States;
10. Elective removal of non-pathologic impacted teeth;
11. Replacement of restorations (fillings) placed less than two years ago;
12. Expenses incurred for *services* performed by someone other than a *dentist,* except for scaling and teeth cleaning and the topical application of fluoride, which can be performed by a licensed dental hygienist. The treatment must be rendered under the supervision and guidance of the *dentist* in accordance with generally accepted dental standards;
13. Any *hospital*, surgical or treatment facility, or for *services* of an anesthesiologist or anesthetist;
14. Any *services* for:
   a. Orthognathic surgery;
   b. Destruction of lesions by any method;
   c. Tooth transplantation;
   d. Removal of a foreign body from the oral tissue or bone; or
   e. Reconstruction of surgical, traumatic or congenital defects of the facial bones;
15. *Prescription drugs* or pre-medications, whether dispensed or prescribed except for oral fluoride supplements for *covered persons* age 6 months or older whose water supply is deficient in fluoride;
16. Any *service* that:
   a. Is not eligible for benefits based on the *clinical review*;
   b. Does not offer a favorable prognosis;
   c. Does not have uniform professional acceptance; or
   d. Is deemed to be experimental or investigational in nature;
17. Orthodontic *services*, unless specified in this *policy*;
18. Repair or replacement of orthodontic appliances;
19. Any separate fees for pre and post-operative *services*;
20. *Services* generally considered to be medical *services*;
21. Preventive control programs including, but not limited to, oral hygiene instructions, plaque control, take-home items, *prescriptions* and dietary planning;

PEDIATRIC DENTAL CARE BENEFIT

22. Replacement of any lost, stolen, damaged, misplaced or duplicate major restoration, prosthesis or appliance;
23. Expenses incurred for any type of implant and all related *services*, including crowns or the prosthetic device attached to it including the removal of implants unless specified in this *policy*; or
24. Any caries susceptibility testing, laboratory tests, saliva samples, anaerobic cultures, sensitivity testing or charges for oral pathology procedures.

Definitions

Accidental dental injury means damage to the mouth, teeth and supporting tissue due directly to an accident. It does not include damage to the teeth, appliances or prosthetic devices that results from chewing or biting food or other substances.

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

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

1. Facings on crowns or pontics (the portion of a fixed bridge between the abutments) posterior to the second bicuspid;
2. Any *service* to correct congenital malformation, except for cleft lip or cleft palate; or
3. Characterizations and personalization of prosthetic devices.

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.

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

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

Expense incurred date means the date on which:

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

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

1. Toothache;
2. Localized infection;
3. Muscular pain; or
4. Sensitivity and irritations of the soft tissue.

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

PEDIATRIC DENTAL CARE BENEFIT

Pediatric dental services mean the following:

1. *Services* that are ordered by a *dentist*;
2. Described in the "Pediatric dental care covered expenses" provision in this *policy*; and
3. Incurred when a *covered person* is insured for that benefit under this *policy* on the *expense incurred date*.

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

1. The actual cost for covered *services*;
2. The fee most often charged in the geographical area where the *service* was performed;
3. The fee most often charged by the provider;
4. The fee determined by comparing charges for similar *services* to a national database adjusted to the geographical area where the *services* or procedures were performed;
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;
6. In the case of *services* rendered by 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* in the geographic area for the same or similar *services*;
8. The fee based on the provider's costs for providing the same or similar *services* as reported by the provider in the most recent, publicly available Medicare cost report submitted annually to the Centers for Medicare and Medicaid Services; or
9. The fee based on a percentage of the fee Medicare allows for the same or similar *services* provided in the same geographic area.

The bill a *covered person* receives for *services* provided by *out-of-network providers* may be significantly higher than the *reimbursement limit.* In addition to any applicable *medical deductible* and *coinsurance,* a *covered person* is responsible for the difference between the *reimbursement limit* and the amount the provider bills *you* or the *covered person* for the *services.* Any amount paid to the provider in excess of the *reimbursement limit* will not apply to any applicable medical *deductible,* or medical *out-of-pocket limit.*

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

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

PEDIATRIC VISION CARE BENEFIT

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–Pediatric Vision Covered Expenses" 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 "Pediatric vision care exclusions" provision below, the "General Exclusions", and the "Prescription Drug 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.

Pediatric vision care covered expenses

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

1. *Comprehensive eye exam*;
2. Prescription glasses or contacts as follows: single vision conventional (lined) bifocal or trifocal lenticular;
3. Optional lenses and treatments as follows: polycarbonate lenses, blended segment lenses, intermediate vision lenses, standard progressives, premium progressives (Verilux, etc.), photochromic glass lenses, plastic photosensitive lenses (Transitions), polarized lenses, standard anti-reflective (AR) coating, premium AR coating, ultra AR coating, Hi-Index lenses, UV coating. Lenses may be glass or plastic, all lens power (single, bifocal, trifocal, lenticular), fashion and gradient tinting, oversized and glass-grey #3 prescription sunglass lenses, polycarbonate lenses. Polycarbonate lenses are covered in full for children. All lenses include scratch resistant coating with no additional *copayment*;
4. 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. If frames are provided by an *out-of-network provider,* benefits are limited to the amount shown above in the "Schedule of Benefits";
5. Elective contact lenses available from a selection of covered contact lenses, *contact lens fitting and follow-up.* The *in-network provider* will inform the *covered person* of the contact lens selection covered by this *policy.* If a *covered person* selects a contact lens that is not part of the contact lens selection this *policy* covers, the *covered person* is responsible for the difference in cost between the lowest cost contact lens available from the contact lens selection covered by this *policy* and the cost of the contact lens selected. If contact lenses are provided by an *out-of-network provider,* benefits are limited to the amount shown above in the "Schedule of Benefits";

PEDIATRIC VISION CARE BENEFIT

6. *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, those for treatment of patients affected by certain conditions – keratoconus, pathological myopia, aphakia, anisometropia, aniseikonia, aniridia, corneal disorders, post-traumatic disorders, irregular astigmatism. Contact lenses are *medically necessary* when the use of contact lenses in lieu of eyeglasses, will result in significantly better visual and/or improved binocular function, including avoidance of diplopia or suppression; or
7. *Low vision services* includes the following when *preauthorization* is obtained:
   a. Low vision supplementary testing; or
   b. Low vision aids include but are not limited to:
      i. Spectacle-mounted magnifiers;
      ii. Hand-held and stand magnifiers;
      iii. Hand held or spectacle-mounted telescopes; or
      iv. Video magnification.

Pediatric vision care exclusions

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

1. In no event will benefits exceed the lesser of:
   a. The limits shown in the "Schedule of Benefits–Pediatric Vision Covered Expenses" section of this *policy*; or
   b. The *reimbursement limit,* as shown in the "Schedule of Benefits–Pediatric Vision Covered Expenses" section when *services* are rendered by an *out-of-network provider*.
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*.

Refer to the "General Exclusions" section and "Prescription Drug Exclusions" section 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;

PEDIATRIC VISION CARE BENEFIT

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; or
20. Premium lens options, except as expressly provided in this *policy*.

Definitions

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

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

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

Covered person under this section means a person who is eligible and enrolled for benefits provided under this *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;

PEDIATRIC VISION CARE BENEFIT

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.

The bill a *covered person* receives for *services* provided by, or *materials* obtained from *out-of-network providers* may be significantly higher than the *reimbursement limit.* In addition to any applicable *deductibles* and *coinsurance*, the *covered person* is responsible for the difference between the *reimbursement limit* and the amount the provider bills *you* or the *covered person* for the *services* or *materials.* Any amount paid to the provider in excess of the *reimbursement limit* will not apply to any applicable *deductible, coinsurance,* or *out-of-pocket limit.*

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.

COORDINATION OF BENEFITS

This "Coordination of Benefits" *policy* section applies when a *covered person* has healthcare coverage under more than one plan. Plan is defined below.

If the *covered person* is covered by more than one health benefit *plan*, all claims should be filed with each plan.

Definitions

Plan means, for the purpose of coordination of benefits, one which covers *hospital* or medical expenses and provides benefits or *services* through:

1. Group or blanket insurance coverage;
2. Hospital service prepayment plan on a group basis, medical service prepayment plan on a group basis, group practice or other prepayment coverage on a group basis;
3. Any coverage under labor-management plans, employer plans, trustee plans, union welfare plans, employee benefit organization plans;
4. Any coverage under governmental programs or any coverage mandated by state statute or sponsored or provided by an educational institution, if such coverage is not otherwise excluded from the calculation of benefits under this *policy*; or
5. Individual insurance.

Employers' plans under the same trust policy are considered separate *plans*.

The term *plan* is construed separately with respect to each policy, contract, or other arrangement for benefits or *services* and separately with respect to that portion of any such policy, contract or other arrangement which reserves the right to take the benefits or *services* of other *plans* into consideration in determining its benefits and that portion which does not.

This "Coordination of Benefit" *policy* section does not apply to Blanket Student Accident Insurance provided by or through an educational institution. The term *plan* does not apply to medical coverage in a group, group-type, or individual motor vehicle "no-fault" and traditional "fault" type coverage.

Allowable expense means a *healthcare service* or expense, including *deductible*, *coinsurance* or a *copayment* that is covered in full or in part by any of the *plans* covering the person.

When a *plan* provides benefits in the form of *services* rather than cash payments the reasonable cash value of each *service* rendered will be considered as both an *allowable expense* and a benefit paid.

Claim determination period means a *calendar year*, except that if in any *calendar year* the person is not covered under this *policy* for the full *calendar year*, the claim determination period for that year will be that portion during which he/she was covered under this *policy*.

Benefit reserve means the savings recorded by a *plan* for claims paid for a *covered person* as a secondary *plan* rather than as a primary *plan*.

COORDINATION OF BENEFITS

Effect on benefits

We will apply this *policy* section when the *covered person* incurs an *allowable expense* during a *claim determination period* for which benefits are payable under any other *plan*(*s*). This *policy* section will apply only when the sum of the *covered expense* under this *policy* and any other *plan*(*s*) would, in the absence of the "Coordination of Benefits" *policy* section or any similar provisions in the other plan(s), exceed the *allowable expense*.

Benefits provided under this *policy* during a *claim determination period* for *allowable expenses* incurred by the *covered person* will be determined as follows:

1. If benefits under this *policy* are to be paid before benefits are paid under any other *plan*, benefits under this *policy* will be reduced so that the sum of the benefits so reduced plus the benefits payable under all other *plans* will not exceed the total of the *allowable expense*.
2. If the benefits under this *policy* are to be paid before benefits are paid under any other *plan,* benefits under this *policy* will be paid without regard to other *plan*(*s*).

Covered expense under any other *plan* includes the benefits that would have been payable had the claim been made.

Reimbursement will not exceed 100% of the total *allowable expense* incurred under this *policy* and any other *plans* included under this *policy* section.

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

1. Determine its obligation to pay or provide benefits under this *policy*;
2. Determine whether a *benefit reserve* has been recorded for the *covered person*; and
3. Determine whether there are any unpaid *allowable expenses* during the *claim determination period*.

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

A *plan* not containing a coordination of benefits policy section that is consistent with state regulations is always primary except for supplementary coverage, which will be secondary.

COORDINATION OF BENEFITS

Order of benefits determination

For the purpose of the "Effect on benefits" provision above, the rules establishing the order of benefit determination are:

1. The benefits of a *plan* which covers the person on whose expenses the claim is based other than as a *dependent* are determined before the benefits of a *plan* which covers such person as a *dependent.*
2. The benefits of a *plan* which covers the person on whose expenses the claim is based as a *dependent* are determined according to which parent's birth date occurs first in a *calendar year*, excluding year of birth. If the birthdates of both parents are the same, the *plan* which has covered the parent for the longer period of time will be determined first, except if a claim is made for a *dependent* child:
   a. When parents are separated or divorced and the parent with custody of the child has not remarried, the benefits of a *plan* which covers the child as a *dependent* of a parent with custody of the child are determined before the benefits of a *plan* which covers the child as a *dependent* of the parent without custody;
   b. When parents are divorced and the parent with custody of the child has remarried, the benefits of a *plan* which covers the child as a *dependent* of the parent with custody are determined before the benefits of a *plan* which covers that child as a *dependent* of the step-parent, and the benefits of a *plan* which covers that child as a *dependent* of the step-parent are determined before the benefits of a *plan* which covers that child as a dependent of the parent without custody;
   c. Regardless of the two preceding rules, if there is a court decree which would otherwise establish financial responsibility for the medical or other healthcare expenses with respect to a child, and that parent has actual knowledge of those terms, the benefits of a *plan* which covers the child as a *dependent* of the parent with such financial responsibility are determined before the benefits of any other *plan* which covers the child as a *dependent* child. If the parent with financial responsibility has no coverage for the child's healthcare expenses, but the parent's spouse does, the spouse's *plan* will be primary;
   d. If the specific term of the court decree state that parents shall share joint custody without stating that one parent is responsible for *healthcare* expenses of the *dependent* child, the order of benefits will be determined according to which parent's birth date occurs first in a *calendar year,* as described above.
3. When the first two rules do not establish an order of benefit determination, the benefits of a *plan* which covers the person on whose expense claim is based as a laid-off or retired employee or as the *dependent* of such person are determined after the benefits of a *plan* which covers such person through present employment.
4. When the above stated rules do not establish an order of benefit determination, the benefits of a *plan* which has covered the person on whose expense claim is based for the longer period of time are determined before the benefits of a *plan* which has covered such person the shorter period of time.
5. If *plans* cannot agree on the order of benefits within 30 calendar days after the *plans* have received all of the information needed to process the claim, the *plans* shall immediately pay the claim in equal shares and determine their relative liabilities following payment, except that no *plan* shall be required to pay more than it would have paid had it been primary.

When this *policy* section reduces the total amount of benefits otherwise payable under this *policy* during any *claim determination period,* each benefit that would be payable in the absence of this *policy* section is reduced proportionately and such reduced amounts are charged against any applicable benefit limit of this *policy.*

COORDINATION OF BENEFITS

Right to necessary information

We may require certain information in order to apply and coordinate this *policy* section with other *plans*. To obtain the needed information, *we*, without the *covered person's* consent, will release or obtain from any insurance company, organization or person information needed to implement this *policy* section. The *covered person* agrees to furnish any information *we* need to apply this *policy* section.

Facility of payment

Payments made under any other *plan* which according to this *policy* section should have been made by *us*, will be adjusted by *us*. To do this, *we* reserve the sole right to pay the organization(s) which made such payments the amount(s) *we* determine to be warranted. Any amount(s) so paid are regarded as benefits paid under this *policy*. *We* will be fully discharged from liability under this *policy* to the extent of any payment so made.

Right of recovery

We reserve the right to recover benefit payments made for *allowable expenses* under this *policy* in the amount by which the payments exceed the maximum amount *we* are required to pay under this *policy* section. This right of recovery applied to *us* against:

1. Any person(s) to, for or with respect to whom such payments were made or
2. Any other insurance companies or organizations which according to this *policy* section owe benefits for the same *allowable expense* under any other *plan*.

We alone shall determine against which this "Right of recovery" provision will be exercised.

CLAIMS

Assignment of benefits

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

Claims processing edits

Payment of *covered expenses* for *services* rendered by a provider is also subject to *our* claims processing edits, as determined by *us.* The amount determined to be payable after *we* apply *our* claims processing edits depends on the existence and interaction of several factors. Because the mix of these factors may be different for every claim, the amount paid for a *covered expense* may vary depending on the circumstances. Accordingly, it is not feasible to provide an exhaustive description of the claims processing edits that will be used to determine the amount payable for a *covered expense*, but examples of the most commonly used factors are:

1. The intensity and complexity of a *service*;
2. Whether a *service* is one of multiple *services* performed during the same *service* session such that the cost of the *service* to the provider is less than if the *service* had been provided in a separate *service* session. For example:
   a. Two or more *surgeries* occurring during the same *service* session; or
   b. Two or more radiologic imaging views performed during the same session;
3. Whether an assistant surgeon, physician assistant, registered nurse, certified operating room technician or any other provider who is billing independently is involved;
4. When a charge includes more than one claim line, whether any *service* is part of or incidental to the primary *service* that was provided, or if these *services* cannot be performed together;
5. If the *service* is reasonably expected to be provided for the diagnosis reported;
6. Whether a *service* was performed specifically for *you*; or
7. Whether *services* can be billed as a complete set of *services* under one billing code.

We develop *our* claims processing edits in *our* sole discretion based on *our* review of one or more of the following sources, including but not limited to:

1. *Medicare* laws, regulations, manuals, and other related guidance;
2. Appropriate billing practices;
3. National Uniform Billing Committee (NUBC);
4. American Medical Association (AMA)/Current Procedural Terminology (CPT);
5. Centers for Medicare and Medicaid Services (CMS)/Healthcare Common Procedure Coding System (HCPCS);
6. UB-04 Data Specifications Manual and any successor manual;
7. International Classification of Diseases of the U.S. Department of Health and Human Services and the Diagnostic and Statistical Manual of Mental Disorders;
8. Medical and surgical specialty societies and associations;
9. *Our* medical and *pharmacy* coverage policies; or
10. Generally accepted standards of medical, *mental health* and dental practice based on credible scientific evidence recognized in published peer reviewed medical or dental literature.

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

CLAIMS

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

Your provider may access *our* claims processing edits and *our* medical and *pharmacy* coverage policies at the "For Providers" link on *our* Website at www.humana.com. *You* or *your* provider may also call *our* toll-free number on *your ID card* to obtain a copy of a policy. *You* should discuss these policies and their availability with any providers prior to receiving any *services*.

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

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.

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

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

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

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 fraudulent or misrepresented information; or
4. Made to *you* and/or any party on *your* behalf for charges that were discounted, waived or rebated.

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

CLAIMS

Right to require medical examinations

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

Time of payment of claims

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

To whom benefits are payable

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

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

This does not apply to *emergency care services* rendered by an *out-of-network provider. We* will pay *out-of-network providers* directly for *emergency care services* received by a *covered person.*

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.

APPEAL RIGHTS

If *a covered person* is dissatisfied with *our* determination of their claim, they may *appeal* the decision. *A covered person* should *appeal* in writing to the address given on the denial letter they received within 180 days after they received written or *electronic* notice of the denial (or partial denial). Such *appeal* will be handled on a timely basis and appropriate records will be kept on all appeals. The *appeal* will be reviewed by *us* and a response sent to the *covered person* no later than 60 days following receipt of the *appeal.*

An *appeal* may be submitted to:

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

Adverse determination is a denial, reduction, termination of, or failure to provide or make payment:

1. In whole or in part for a benefit (Example: Applying the plan provisions and paying less than the total amount of expense submitted for a *deductible*, *coinsurance* or *copayment*);
2. Based on eligibility to participate in the plan; and
3. Based on *rescission* of coverage.

Adverse determination means:

1. A determination that a request for a benefit under the health insurance issuer's plan does not meet the health insurance issuer's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness or is determined to be experimental or investigational and the requested benefit is denied, reduced, or terminated or payment is not provided or made, in whole or in part, for the benefit.

2. Any prospective review or retrospective review determination that denies, reduces, or terminates or fails to provide or make payment, in whole or in part, for a benefit under a health benefit plan.

Appeal means a written complaint submitted by the *covered person* or the *covered person's healthcare practitioner* regarding an *adverse determination*.

Authorized representative means a person to whom a *covered person* has given express written consent to represent the *covered person.* It may also include the *covered person's* treating *healthcare practitioner* if the *covered person* appoints the *healthcare practitioner* as his/her authorized representative and the *healthcare practitioner* waives in writing any right to payment from the *covered person* other than any applicable *copayment* or other *coinsurance* amount. In the event that the *service* is determined not to be *medically necessary*, and the *covered person* or his/her *authorized representatives*, except for the *covered person's* treating *healthcare practitioner*, thereafter requests the *services*, nothing shall prohibit the *healthcare practitioner* from charging usual and customary charges for all non-*medically necessary* services provided.

Contractual adverse determination means an *adverse determination* involving the contractual relationship between the *covered person* and *us* including claims payment, handling or reimbursement for healthcare *services.*

APPEAL RIGHTS

Contractual appeal means an *appeal* involving the contractual relationship between the *covered person* and us including claims payment, handling or reimbursement for healthcare *services.*

Final adverse determination means an *adverse determination,* including medical judgment, involving a covered benefit that has been upheld by us, or our designee utilization review organization, at the completion of our internal claims and appeals process.

Internal Appeals Process

We must receive the written request for review within 180 days from the time the *covered person's* received notice of the *adverse determination.* The *covered person* or the *covered person's health care practitioner* may also send any documentation or information which is relevant to the *adverse determination* decision.

We will review the *appeal* and provide the *covered person* or the *covered person's authorized representative* with a written decision within thirty (30) days of receipt for *medical necessity, rescissions, experimental, investigational or for research purposes,* and pre-service *adverse determinations. We* will review the *appeal* and provide the *covered person* or the *covered person's authorized representative* with a written decision within 60 days for post-service contractual *appeals*.

This notice will contain:

1. The title and qualifying credentials of the person(s) affirming the *adverse determination*; if applicable.
2. A statement of the reason for the *covered person's* request of an *appeal*;
3. An explanation of the decision in clear terms and the medical rationale in sufficient detail for the *covered person* to respond further to *our* position; and
4. A description of the process to obtain an external review of a decision, if applicable.

Expedited Appeal of an Adverse Determination

You may request an expedited external *appeal* at the same time a request is made for an expedited internal *appeal* of an *adverse determination.* An expedited *appeal* of an *adverse determination* is available when an internal *appeal* would seriously jeopardize the life or health of the *covered person* or would jeopardize the *covered person's* ability to regain maximum function and the *adverse determination* concerned an admission, availability of care, continued stay or healthcare *service* for a *covered person* who has received emergency *services* but has not been discharged from a facility. An expedited *appeal* may be initiated by a *covered person,* with the consent of the treating *healthcare practitioner* or the provider acting on behalf of the *covered person.* An expedited *appeal* is not available for retrospective *adverse determinations.*

APPEAL RIGHTS

We will provide a notice of *our* decision to the *covered person* or the *healthcare practitioner* acting on behalf of the *covered person* as expeditiously as the *covered person's* condition requires but no later than 72 hours after receiving the *appeal.* Verbal notice of *our* decision followed by a written notice or *electronic* notice will be provided within three calendar days of *our* decision. If the expedited *appeal* is a concurrent review determination, benefits will be payable for the *service,* subject to *policy* provisions, until the *health care practitioner* has been notified of *our* decision. The *covered person* will not be responsible for *expenses incurred* for *services* rendered after *we* have notified the *healthcare practitioner* until the *covered person* has received notice of *our* decision.

If the expedited *appeal* process does not resolve the difference of opinion between the *covered person,* the *healthcare practitioner* acting on behalf of the *covered person* and *us,* the *covered person* or *authorized representative* may request an external review after exhausting the internal appeal process.

External Review

An external review is a review, conducted by an independent review organization (IRO) approved and assigned by the Louisiana Department of Insurance, of the decision made by us for an adverse determination. This process will review our decision based on *medical necessity, experimental, investigational or for research purposes,* appropriateness, healthcare setting, level of care, effectiveness or a *rescission.*

When the *covered person* files a request for an external review, the *covered person* is required to authorize the release of any medical records of said *covered person* that may be required to be reviewed for the purpose of reaching a decision on the external review.

An external review request will not be granted until the internal *appeal* process outlined above has been exhausted. However, a request for an external review may be made before this *appeal* process is exhausted for the following:

1. Untimely *appeal* response unless the *covered person* has agreed to the delay; or
2. *We* agree to waive the internal *appeal* requirement. In this case a standard external review will be performed.

The *covered person* or the *covered person's authorized representative* may request an external review in writing within four months after notification of *our* decision. *We* will complete *our* preliminary review within five days of receiving the request for external review. Then within five days following IRO assignment, *we* will provide the documents and information used in making the *appeal* decision to the IRO.

The IRO will provide written notice of their decision to the *covered person* or the *covered person's* representative, the *covered person's healthcare practitioner* and *us* within 45 days of receiving all necessary information that is subject to external review.

APPEAL RIGHTS

Expedited External Review

A *covered person* or *authorized representative* may request an expedited external review at the time the *covered person* receives:

An *adverse determination*

1. If the *adverse determination* involves a medical condition of the *covered person* for which the timeframe for completion of an expedited internal review of a grievance involving an *adverse determination* would seriously jeopardize the life or health of the *covered person* or would jeopardize the *covered person's* ability to regain maximum function; and
2. The *covered person* or the *covered person's authorized representative* has filed a request for an expedited review of a grievance involving an *adverse determination.*

A *final adverse determination*

1. If the *covered person* has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the *covered person* or would jeopardize the *covered person's* ability to regain maximum function;
2. If the *final adverse determination* concerns an admission, availability of care, continued stay or health care *service* for which the *covered person* received emergency *services*, but has not been discharged from a facility; or
3. If the *final adverse determination* involves a denial of coverage based on a determination that the requested treatment is *experimental, investigational or for research purposes* and the *covered person's healthcare practitioner* certifies in writing that any delay in appealing the *adverse determination* may pose an imminent threat to the *covered person's* health, including but not limited to severe pain, potential loss of life, limb, or major bodily function, or the immediate deterioration of the health of the *covered person.*

Once *we* receive a request for an expedited external review, *we* will determine if the request meets reviewability requirements and notify the commissioner and the *covered person* and *authorized representative* of its eligibility determination. If *we* determine an external review request is ineligible for review, *we* will provide notice informing the *covered person* and *authorized representative* that the decision may be appealed to the commissioner. If appealed to the commissioner, the commissioner may determine that a request is eligible for external review.

After receiving notice that the request meets the reviewability requirements, the commissioner will assign an IRO to conduct the expedited external review.

APPEAL RIGHTS

If the expedited external review request involves treatment that is *experimental, investigational or for research purposes,* within one business day after the IRO receives notice of assignment to conduct the external review, the IRO will select one or more clinical peer reviewers to conduct the external review. The clinical peer reviewer will:

1. Review all of the information noted above including whether:
   a. The recommended *service* has been approved by the Federal Food and Drug Administration, if applicable, for the condition; or
   b. Medical or scientific evidence or evidence-based standards demonstrate that the expected benefits of the recommended *service* is more likely than not to be beneficial to the *covered person* than any available standard *service* and the adverse risks of the recommended *service* would not be substantially increased over those of available standard *services*.

2. Provide an opinion to the IRO as expeditiously as the *covered person's* condition or circumstances require, but in no event more than five calendar days after being selected.

The IRO's decision to either uphold or reverse the *adverse benefit determination* or *final adverse benefit determination* will be provided orally or in writing to the *covered person,* the *authorized representative,* the commissioner and us within:

1. 48 hours after receipt of each clinical peer reviewer opinion of an expedited external review for a treatment that is *experimental, investigational or for research purposes*; or
2. 72 hours after the date of receipt of the request for an expedited external review.

A *covered person* or their *authorized representative* may contact the commissioner at any time for assistance with the *appeals* process at the address and telephone number below.

Louisiana Department of Insurance
Office of Consumer Advocacy
P.O. Box 94214
Baton Rouge, LA 70804-9214
Phone: (225) 219-0619 or (800) 259-5300
www.ldi.louisiana.gov

RECOVERY RIGHTS

Your obligation to assist in the recovery process

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

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

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

Other insurance/non-duplication of benefits

We will not provide duplicate coverage for benefits under this *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 "Coordination of Benefits" section, except *expenses incurred* as a result of the treatment of an injury or *sickness* caused by the fault of a third party.

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.

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

RECOVERY RIGHTS

Right to request information

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

1. Authorizing the release of medical information including the names of all providers from whom medical attention was received;
2. Obtaining medical information/or records from any provider as requested by *us*;
3. Providing information regarding the circumstances of the *sickness*, *bodily injury* or accident;
4. Providing information about other insurance coverage benefits, including information related to any *bodily injury* or *sickness* for which another party may be liable to pay compensation or benefits;
5. Providing information *we* request to administer the *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.

To the extent that benefits are provided or paid under this *policy*, *we* shall be subrogated to all rights of recovery which any *covered person* may acquire against any other party for the recovery of the amount paid under this *policy*, however *our* right of subrogation is secondary to the right of the *covered person* to be fully compensated for his/her damages. The *covered person* agrees to deliver all necessary documents or papers, to execute and deliver all necessary instruments, to furnish information and assistance, and to take any action *we* may require to facilitate enforcement of *our* right of subrogation.

We agree to pay *our* portion of the *covered person's* attorneys' fee or other costs associated with a claim or lawsuit to the extent that *we* recover any portion of the benefits paid under this *policy* pursuant to *our* right of subrogation.

Right of reimbursement

To the extent that benefits are provided or paid under this *policy*, the *covered person* agrees that if he/she fully recovers his/her damages from a third party, then he/she will reimburse *us* the portion of the damages recovered for the *expenses incurred* by the *covered person* that were provided or paid by us. *We* agree to pay our portion of the *covered person's* attorneys' fee or other costs associated with a claim or lawsuit to the extent that *we* recover any portion of the benefits paid under this *policy* pursuant to *our* right of reimbursement.

RECOVERY RIGHTS

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 benefits *we* have paid from any funds that are paid or payable by Workers' Compensation or similar coverage *as a* result of any *sickness or bodily injury. We* are not responsible for contributing to any 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.*

PREMIUM PAYMENT

Your duty to pay premium

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

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

Grace period

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

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

Changes to your premium

Premium may change when:

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

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 coverage to end and premium has been paid past the date in which the termination is being requested.

CHANGES TO THE POLICY

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* 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. If *you* move outside of this *policy's* service area *we* will terminate this *policy*. See the "Renewability of Insurance and Termination" 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.

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 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 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, a child is placed with the *policyholder* for the purpose of adoption or foster care, a grandchild is in the *policyholder's* legal custody and residing with the *policyholder*, or a child is placed in the *policyholder's* home following execution of an act of voluntary surrender, *we* must be notified of the event in writing and receive any required premium within 60 days.

CHANGES TO THE POLICY

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

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

Upon *our* receipt of the completed application and premium, an *effective date* will be assigned. A *dependent* child is eligible to apply if they are under age 26.

3. Effective date of dependent changes

a. Coverage for a newborn, foster child, adopted child, grandchild in your legal custody or child placed in your home following execution of an act of voluntary surrender, 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, legal custody, execution 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. Divorce;
   c. Legal separation;
   d. The birth of a natural born child;
   e. The adoption of a child or placement of a child with the *policyholder* for the purpose of adoption;
   f. Placement of a foster child with the *policyholder*;
   g. Death of the *policyholder;*
   h. Loss of minimum essential coverage; or
   i. For a *covered person* who purchased coverage through a *marketplace,* any other event as determined by the *marketplace*.

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

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

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

CHANGES TO THE POLICY

3. A *dependent* 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 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*.

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

4. For a *covered person* who purchased coverage through a *marketplace*, any other event as determined by the *marketplace*. The *covered person* must enroll within 60 days of the special enrollment event date.

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

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

Open enrollment

An *open enrollment period* is the opportunity for a *dependent* who did not enroll under this *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.

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.

CHANGES TO THE POLICY

Changes where we will notify you

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

2. If *we* determine that *you* or a *covered person* have misrepresented any information 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 misrepresentation not been made; or
   b. Continue *your* present coverage and collect the difference in premium which would have been assessed had the misrepresentation not been made.

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

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

RENEWABILITY OF INSURANCE AND TERMINATION

Reasons we will terminate your 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. Written notice will be mailed no later than 60 days prior to the termination date, except when termination is due to non-payment of premium or as otherwise outlined under this provision:

1. The required premium was due to *us* and not received by *us.* Termination will be effective on the last day for which the premium was paid;
2. *You* or a *covered person* commit fraud or make an intentional misrepresentation of a material fact, as determined by *us.* Termination will be effective at 12:01 a.m. local time at the *policyholder's* state of residence on the date the misrepresentation occurred. A 30-day advance written notice of the termination will be provided;
3. *You* cease to be a resident in the service area, as determined by *us.* Call the telephone number on *your ID card* for this *policy's* service area;
4. *You* cease to be a resident in the state in which this *policy* was issued;
5. *You* request termination of the *policy*. The request may be given verbally, *electronically,* or in writing. Termination will be effective on the last day of the billing period in which the requested termination date occurs;
6. *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.
   a. If *we* decide to discontinue offer a type of policy:
      i. *We* will notify *you* of such discontinuation at least 90 days prior to the date of discontinuation of such coverage;
      ii. *You* will be given the option to purchase any other individual medical insurance policy that is being offered by *us* at such time; and
      iii. The Commissioner of Insurance will be notified of the product being discontinued before we notify *you*;
   b. If *we* cease doing business in the individual medical insurance market, *we* will notify *you* and the Commissioner of Insurance of such discontinuation at least 180 days prior to the date of discontinuation of such coverage. The Commissioner of Insurance will be notified before *we* notify *you*; or
7. 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, as determined by *us.* Termination will be effective at 12:01 a.m. local time at the *covered person's* state of residence on the date the misrepresentation occurred. A 30-day advance written notice of the termination will be provided;

RENEWABILITY OF INSURANCE AND TERMINATION

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.

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" provisions which would result in termination of this *policy* or a *covered person.*

Fraud

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

Health insurance fraud is a criminal offense that can be prosecuted. Any person who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

If *you* or the *covered person* commits fraud against *us*, as determined by *us*, *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*.

GENERAL PROVISIONS

Choice of providers

If *you* receive *services* from an *out-of-network provider, we* will pay benefits at a lower percentage and *you* will pay a larger share of the costs. Since *out-of-network providers* have not agreed to accept discounted or negotiated fees, they may bill *you* for charges in excess of the *maximum allowable fee. You* are responsible for charges in excess of the *maximum allowable fee* in addition to any applicable *copayment, deductible,* and *coinsurance.* Any amount *you* pay to the provider in excess of any applicable *coinsurance,* or *copayment* will not apply to *your out-of-pocket limit* or *deductible.*

Not all *healthcare practitioners* who provide *services* at in-network *hospitals* are in-network *healthcare practitioners.* If *services* are provided to *you* by out-of-network pathologists, anesthesiologists, radiologists, and emergency room *healthcare practitioners* at an in-network *hospital, we* will pay for those *services* at the *in-network provider* medical payment level subject to any applicable *copayment, deductible,* and *coinsurance.* 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.*

It is *your* responsibility to verify the in-network participation status of all providers prior to receiving all non-emergency *services. You* should verify in-network participation status, only from *us b*y 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 in-network participation representations made by any provider, whether contracted with *us* or not. This means that even if *your healthcare practitioner* or other provider recommends that *services* be received from another provider or entity, it is *your* responsibility to verify the in-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 *your* referring provider may have told *you*), *your* benefits will be reduced or denied.

Please refer to the "Schedule of Benefits" section in this *policy* for a description of *in-network provider* and *out-of-network provider* benefits available to *you.*

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.

GENERAL PROVISIONS

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*, 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*.

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

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

Legal action

No lawsuit with respect to benefits under this *policy* may be brought after the expiration of one year after the later 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 determination of a timely filed appeal.

GENERAL PROVISIONS

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.*

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.

GENERAL PROVISIONS

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

As a member of a Preferred Provider Organization Plan, *you* are free to obtain *services* from providers participating in the Preferred Provider Organization network (*in-network providers*), or providers not participating in the Preferred Provider Organization network (*out-of-network providers*). If *you* choose an *in-network provider, your* out-of-pocket expenses are normally lower than if *you* choose an *out-of-network provider*.

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.

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 minimize *your* out-of-pocket expense, please access *in-network providers* associated with this *policy*.

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

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

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

Workers' compensation

This *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.

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.*

Beneficiary means a person designated by a *covered person*, or by the terms of a health insurance benefit plan, who is or may become entitled to a benefit under the plan.

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

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

Bone marrow means the transplant of human blood precursor cells. Such cells may be derived from *bone marrow,* circulating blood, or a combination of *bone marrow* and circulating blood obtained from the patient in an autologous transplant or from a matched related or unrelated donor or cord blood. The term *bone marrow* includes the harvesting, the transplantation and the integral chemotherapy components.

Brand-name drug means a drug, medicine or medication that is manufactured and distributed by only one pharmaceutical manufacturer, or any drug product that has been designated as brand-name by an industry recognized source used by *us.*

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

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

DEFINITIONS

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*.

Copayment/Copay means a specified dollar amount shown on the "Schedule of Benefits", to be paid by a *covered person* toward the cost of each separate *prescription* fill or refill dispensed by a *pharmacy* and for certain medical benefits specified in this *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"for a complete list.

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

1. The *covered person* needs *services* that include, but are not limited to, assistance with dressing, bathing, preparation and feeding of special diets, walking, supervision of medication which is ordinarily self-administered, getting in and out of bed, and maintaining continence; or
2. The *services* are required to primarily maintain and not likely to improve the *covered person's* condition.

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

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

DEFINITIONS

Deductible means the amount of *covered expense* that a *covered person,* either individually or combined as a covered family, must pay in a *calendar year* and is responsible to pay in addition to any applicable *copayments* or *coinsurance* before *we* pay medical or *prescription* drug benefits under this *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".

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

1. **Family medical deductible.** The amount of medical *covered expense* that a *covered person,* either individually or combined as a covered family, must pay each *calendar year* in addition to any applicable *copayment* and/or *coinsurance* before *we* pay medical benefits under this *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, *your* natural born child, step-child, grandchild in *your* legal custody and residing with *you,* 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, a grandchild in *your* legal custody who is residing with *you,* or a child placed in *your* home following execution of an act of voluntary surrender in *your* favor whose age is less than the *limiting age,* or *your* adult child who meets the following conditions:

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

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

In order for the covered *dependent* child to remain eligible as specified above, *we* must receive notification within 31 days prior to the covered *dependent* child attaining the *limiting age.*

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

DEFINITIONS

Dependent does not mean a:

1. Grandchild, unless such child is born to a *dependent* while covered under this *policy* or a grandchild in *your* legal custody and residing with *you*;
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.

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.

Emergency care means any *service* provided for a medical condition of recent onset and severity (including severe pain) such that a prudent layperson, acting reasonably and possessing an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

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

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.

DEFINITIONS

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

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

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

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

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

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.

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

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

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

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

A *healthcare practitioner* must:

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

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

Hospice care agency means an agency which:

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

DEFINITIONS

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

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

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

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

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

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

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

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

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

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

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

DEFINITIONS

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.

DEFINITIONS

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.

Life-threatening illness means a severe, serious or acute condition for which death is possible.

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

Low protein food products mean a food product that is especially formulated to have less than one gram of protein per serving and is intended to be used under the direction of a *healthcare practitioner* for the dietary treatment of an inherited metabolic disease. Low protein food products do not include a natural food that is naturally low in protein.

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.

DEFINITIONS

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.

Newly born means a covered *dependent* infant from the time of birth until age one month or until such time as the covered *dependent* infant is well enough to be discharged from a *hospital* or neonatal special care unit to his/her home, whichever period is longer.

DEFINITIONS

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"for the specific amounts.**

DEFINITIONS

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.*

Perioperative services means preoperative, intraoperative, and postoperative nursing care provided to surgical patients.

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

DEFINITIONS

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".

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;
3. Optometrists;
4. Pediatrics;
5. Gynecologists; and
5. Obstetricians.

DEFINITIONS

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.*

Prosthetic services means the science and practice of evaluating, measuring, designing, fabricating, assembling, fitting, aligning, adjusting, or servicing of a prosthesis through the replacement of external parts of a human body lost due to amputation or congenital deformities to restore function, cosmesis, or both. It shall also include any necessary clinical care.

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).

DEFINITIONS

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;
2. Has not become extensively decayed or involved in periodontal disease; and
3. 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.*

DEFINITIONS

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.*

DEFINITIONS

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.

Temporarily medically disabled mother means a female *covered person* who has recently given birth and whose *healthcare practitioner* has advised that normal travel would be hazardous to her health.

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

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

You/your means the *policyholder*.

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