

**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.**

SAMPLE

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## INDIVIDUAL HMO MEDICAL POLICY HUMANA MEDICAL PLAN, INC.

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

For All Other Inquiries  
PO Box 14647  
Lexington, KY 40512-4647  
Toll-Free 1-800-833-6917

*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 Medical Plan, Inc. agrees to pay benefits for *services* rendered to *covered persons* who are named in the "Schedule of Benefits", subject to all the terms of this *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 12:01 a.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 after the day *we* mailed this *policy* to *you*. If *you* choose to return this *policy* to *us* within the 10 day period, *we* will refund any premium that *you* have paid. If *you* return this *policy* within the 10 day period, it will be void and *we* will have no liability under any of the terms or provisions of this *policy*. There will be no coverage for any claims incurred.

**THIS *POLICY* CONTAINS A *DEDUCTIBLE* PROVISION**



Bruce Broussard  
President

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# GUIDE TO YOUR POLICY

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## INTRODUCTION

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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*.

**Please read *your policy* carefully. The requirement for referrals is subject to certain limitations and not mandatory for all *services*.**

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## ACCESS TO CARE

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### How to find an in-network provider

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

### Use of in-network providers

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

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

### Open access to specialists

We allow open access to certain *specialty care physicians* without a referral or authorization from us. These include chiropractor, dermatologist (for the first five visits in a *calendar year*; thereafter a referral from a *primary care physician* is required), podiatrist, obstetrical and gynecological *services* from an *in-network healthcare practitioner*.

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

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

### Seeking emergency care services

If you need *emergency care*:

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

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

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## ACCESS TO CARE

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

If we deem a transfer is appropriate and the transfer does not take place, benefits will be denied for your continued *hospital confinement* at the out-of-network *hospital*. If you refuse to be transferred, benefits will 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". These *services* are subject to any applicable *copayment*, *deductible*, and *coinsurance*. Follow up care from an *out-of-network provider* will not be covered.

### Seeking urgent care services

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

1. You may go to an *urgent care center* that is an *in-network provider* under this *policy*. You can obtain the names of *in-network provider urgent care centers* by accessing an online directory of *in-network providers* on our Website at [www.humana.com](http://www.humana.com) or calling us.
2. You must receive any follow-up *services* from an *in-network provider*.
3. You must pay any applicable *deductible*, *copayment*, and/or *coinsurance* required for urgent care.

### Use of out-of-network providers

No benefits are available for *services* from an *out-of-network provider* that are not authorized in advance by us. If seeing an *out-of-network provider* is determined to be necessary, an authorization must be obtained from us. This authorization must be obtained prior to seeking *services*, unless such authorization cannot be reasonably obtained. Only those *services* authorized by us to be provided by an *out-of-network provider* will be covered *expenses*.

Not all *healthcare practitioners* who provide *services* at in-network *hospitals* are in-network *healthcare practitioners*. If *services* are provided by out-of-network pathologists, anesthesiologists, radiologists, and emergency room *healthcare practitioners* at an in-network *hospital*, we will pay for those *services* at the *in-network provider* benefit level. Out-of-network *healthcare practitioners* may require payment from you for any amount not paid by us. If possible, you may want to verify whether *services* are available from in-network *healthcare practitioners*.

It is your responsibility to verify the network participation status of all providers prior to receiving all non-emergency *services*. You should verify network participation status, only from us, by either accessing your network information on our Website at [www.humana.com](http://www.humana.com) or calling the telephone number on your *ID card*. We are not responsible for the accuracy or inaccuracy of network participation representations made by any provider whether contracted with us or not. This means that even if your *healthcare practitioner* or other provider or entity recommends that *services* be received from another entity, it is your responsibility to verify the network participation status of that entity before receiving such *services*. If you do not, and the entity is not an *in-network provider* (regardless of what the referring provider may have told you), you will be responsible for all costs incurred.



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## ACCESS TO CARE

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### Continuity of care

A *covered person* may be eligible for continuation of *services* from a terminated provider through continuity of care. In the event that a network contract between a *healthcare practitioner* and *us* is terminated at the time the *covered person* was receiving *medically necessary* care, a *covered person* has the right to continuity of care as follows:

1. The *covered person* will be allowed to continue receiving covered *services*, subject to the consent of the treating *healthcare practitioner*, until the course of treatment is completed, not to exceed six months from the *effective date* of termination of the contract.
2. The *covered person* has initiated a course of prenatal care, regardless of the trimester in which care was initiated, to continue receiving covered *services* subject to the consent of the treating *healthcare practitioner*, through delivery and postpartum care.

Continuity of care will not apply when:

1. The reason for termination is due to suspension, revocation, or applicable restrictions of the *healthcare practitioner's* license to practice; or for another documented reason related to quality of care;
2. The *covered person* chooses to change *healthcare practitioners*; or
3. The *healthcare practitioner* refuses to continue to provide care to the *covered person*.

*Our* liability to the *healthcare practitioner* will be under the agreement that was in effect prior to the termination of the contract.

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## UTILIZATION MANAGEMENT

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### 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](http://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;
  - b. *Prescription* drugs, medicines, and medications, including *specialty drugs* as identified on the drug list on our Website at [www.humana.com](http://www.humana.com) that require *prior authorization*; or
  - c. *Services* provided by an *out-of-network provider* except as expressly provided in this *policy*.

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## UTILIZATION MANAGEMENT

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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](http://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*.

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## YOUR POLICY BENEFITS

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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*.

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## YOUR POLICY BENEFITS

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**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*; and
2. When required by *us* to transfer a *covered person* to the nearest appropriate medical facility equipped to provide the *medically necessary services*.

### Cleft lip and cleft palate

*Covered expenses* are *expenses incurred* for treatment of cleft lip and cleft palate for a *dependent* under the age of 18. This coverage includes medical, dental, speech therapy, audiology, and nutrition *services* when prescribed by a *healthcare practitioner*. The *healthcare practitioner* must certify that such *services* are *medically necessary* and consequent to treatment of the cleft lip and cleft palate.

### 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.

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## YOUR POLICY BENEFITS

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### Dental services

1. Treatment for a *dental injury* to a *sound natural tooth*. Treatment must begin within 90 days from the date of the *dental injury* and be completed within 12 months from the first date of *service* for treatment of the *dental injury*. We limit *covered expenses* to the least expensive *service* that we determine will produce professionally adequate results.
2. Certain oral surgical operations:
  - a. Excisions of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth and related biopsy of bone, tooth or related tissues when such conditions require pathological examinations;
  - b. *Services* required to correct accidental injuries of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
  - c. Reduction of fractures and dislocation of the jaw;
  - d. External incision and drainage of abscess;
  - e. External incision of cellulites;
  - f. Incision and closure of accessory sinuses, salivary glands or ducts; and
  - g. Cutting of the tissue in the midline of the tongue (Frenectomy).

### Diabetes services

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

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

*Prescription* drugs for the treatment of diabetes are explained under the "Prescription drug" provision.

### Durable medical equipment and medical supplies

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

1. Non-motorized wheelchair;
2. Hospital bed;
3. Ventilator;
4. Hospital type equipment;
5. Oxygen and rental of equipment for its administration;
6. Initial permanent prosthetic devices or supplies, including, but not limited to, limbs and eyes. The prosthetic devices for a lost limb or absent limb must be necessary to provide or to restore their minimal basic function. Replacement of prosthetic devices is a *covered expense* when the replacement is due to pathological changes or growth;
7. Orthotics used to support, align, prevent or correct deformities. *Covered expense* does not include replacement orthotics, dental braces or oral and dental splints and appliances unless custom made for the treatment of documented obstructive sleep apnea;
8. Initial contact lenses or eyeglasses following cataract *surgery*;
9. Casts, splints (other than dental), trusses, braces (other than orthodontic), and crutches;
10. Wigs following cancer treatment (not to exceed one per lifetime);

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## YOUR POLICY BENEFITS

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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](http://www.humana.com) or call the telephone number on your *ID card* to obtain a list of *durable medical equipment*.

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

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

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

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

1. Repair or maintenance of the *durable medical equipment* or prosthetic; or
2. Duplicate or similar rentals of *durable medical equipment*, as determined by *us*.

### Emergency services

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

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

If you need *emergency services*:

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

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

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## YOUR POLICY BENEFITS

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

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

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

### Eye care

*Covered expenses* are *expenses incurred* for the following:

1. *Healthcare practitioner services*, soft lenses or sclera shells, for the treatment of aphakic patients; and
2. *Healthcare practitioner services* to treat an injury to or disease of the eyes.

*Covered expense* for initial glasses or contact lenses following cataract surgery is explained under the "Durable medical equipment and medical supplies" provision.

### Habilitative services

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

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

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

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

### Healthcare treatment facility services

1. Daily room and board 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*;



## YOUR POLICY BENEFITS

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*.

### Healthcare practitioner services

1. *Healthcare practitioner* visits;
2. Diagnostic laboratory and radiology tests;
3. Second surgical opinions;
4. *Surgery*. If several *surgeries* are performed during one operation, *covered services* will be subject to the *maximum allowable fee* for the most complex procedure. For each additional procedure *we* will allow:
  - a. 50% of *maximum allowable fee* for the secondary procedure; and
  - b. 25% of *maximum allowable fee* for the third and subsequent procedures.
 If two surgeons work together as primary surgeons performing distinct parts of a single reportable procedure, *we* will allow each surgeon 62.5% of the *maximum allowable fee* for the procedure;
5. *Surgical services* rendered by a surgical assistant and/or assistant surgeon when *medically necessary*. Surgical assistants and/or assistant surgeon will be allowed at 20% of the *covered expense* for *surgery*;
6. *Surgical services rendered* by a physician assistant (P.A.), registered nurse (R.N.), or a certified operating room technician when *medically necessary*. Physician assistants (P.A.), registered nurses (R.N.), and certified operating room technicians will be allowed at 10% of the *covered expense* for the *surgery*;
7. Anesthesia administered by a *healthcare practitioner* or certified registered anesthetist attendant to a *surgery*;
8. *Services* of a pathologist;
9. *Services* of a radiologist;
10. Allergy injections, therapy, testing, and serum. Therapy and testing for treatment of allergies must be approved by the American Academy of Allergy and Immunology or the Department of Health and Human Services or any of its offices or agencies; and
11. Injections other than allergy.

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

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

*Covered expense* during a *healthcare practitioner's* office visit for charges incurred for *advanced imaging*, pulmonary function studies, cardiac catheterization, electrocardiogram (EKG), electroencephalogram (EEG) are not subject to the office visit *copayment*. Benefits will be provided at the medical payment level as shown on the "Schedule of Benefits" subject to any applicable *deductible* and *coinsurance*.

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

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## YOUR POLICY BENEFITS

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### Home healthcare

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

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

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

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

### 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*.

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;

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## YOUR POLICY BENEFITS

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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.

### 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 for the mother provided by a *healthcare practitioner* including physical assessment and *medically necessary* clinical tests provided at a *hospital*, *healthcare practitioner's* office, *outpatient* maternity center, or at the mother's home.

### 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*.

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## YOUR POLICY BENEFITS

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### 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* or licensed birth center charges for *routine nursery care*;
  - b. *Healthcare practitioner's*, certified nurse midwife's, or licensed midwife's charges for circumcision of the newborn child; and
  - c. *Healthcare practitioner's*, certified nurse midwife's or licensed midwife's charges for routine examination of the newborn before release from the *hospital*;
2. *Bodily injury* or *sickness*;
3. Care and treatment for premature birth;
4. Medically diagnosed birth defects and abnormalities; and
5. Postpartum care for the *dependent* newborn provided by a *healthcare practitioner* including physical assessment, *medically necessary* clinical tests and immunizations provided at a *hospital*, *healthcare practitioner's* office, *outpatient* maternity center, or at the mother's home.

*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.

### 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.

### Osteoporosis

*Covered expenses* are *expenses incurred* for the *medically necessary* diagnosis and treatment of osteoporosis for high-risk individuals, including, but not limited to:

1. Estrogen-deficient individuals who are at clinical risk for osteoporosis;
2. Individuals who have vertebral abnormalities;
3. Individuals who are receiving long-term glucocorticoid (steroid) therapy;
4. Individuals who have primary hyperparathyroidism; and
5. Individuals who have a family history of osteoporosis.

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## YOUR POLICY BENEFITS

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### 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. Massage therapy;
4. Occupational therapy *services*;
5. Spinal manipulations, adjustments, and modalities;
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*.

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

### Prescription drugs

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

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*; and
8. Spacers and/or peak flow meters for the treatment of asthma.

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## YOUR POLICY BENEFITS

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

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

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

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

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

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

### 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](http://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](http://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); and

## YOUR POLICY BENEFITS

5. Breast cancer screening mammograms for a female *covered person* including the following:
  - a. One baseline breast cancer screening mammogram performed at least 35 years of age but prior to 40 years of age;
  - b. One breast cancer screening mammogram performed every two years for a woman at least 40 years of age but prior to 50 years of age, or more frequently based on the *healthcare practitioner's* recommendations;
  - c. One breast cancer screening mammogram performed annually for a woman who is 50 years of age or older; or
  - d. One or more mammograms a year, based upon a *healthcare practitioner's* recommendation for any woman who is at risk for breast cancer because of a personal or family history of breast cancer, because of having a history of biopsy-proven benign breast disease, because of having a mother, sister, or daughter who has had breast cancer, or because a woman has not given birth before the age of 30.

### 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*.

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## YOUR POLICY BENEFITS

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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, massage therapy, speech therapy, pulmonary rehabilitation, cardiac rehabilitation; and
3. The evaluation of the need for the *services* listed above.

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

### Specialty drug medical benefit

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

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

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

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

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

### Telehealth and telemedicine services

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

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

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

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



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## YOUR POLICY BENEFITS

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

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

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

### Temporomandibular joint disorder

*Covered expenses* are *expenses incurred* for diagnostic or surgical procedure involving bones or joints of the jaw and facial region, if *medically necessary* to treat conditions caused by congenital or developmental deformity, disease or *bodily injury*.

No benefits will be provided for, or on account of splints or appliances.

### Transplant services

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

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

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

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

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

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## YOUR POLICY BENEFITS

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

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

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

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

1. Transplants which are *experimental, investigational or for research purposes*;
2. Expenses related to the donation or acquisition of an organ for a recipient who is not covered by *us*;
3. Expenses that are eligible to be paid under any private or public research fund, government program except Medicaid, or another funding program, whether or not such funding was applied for or received;
4. Expenses related to a transplant for which *we* do not approve coverage based on *our* established criteria;
5. Expenses related to the transplantation of any non-human organ or tissue except as expressly provided in this *policy*;
6. Expenses related to donor costs that are payable in whole or in part by any other medical plan, insurance company, organization or person other than the donor's family or estate;
7. Expenses related to the storage of cord blood and stem cells unless it is an integral part of a transplant approved by *us*; or
8. Expenses related to a transplant performed outside of the United States and any care resulting from that transplant.

### **Transplant transportation and lodging**

Direct non-medical costs for:

1. The *covered person* receiving the transplant if he/she lives more than 100 miles from the transplant facility; and
2. One designated caregiver or support person (two, if the *covered person* receiving the transplant is under 18 years of age), if they live more than 100 miles from the transplant facility.

Direct non-medical costs include:

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

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

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## YOUR POLICY BENEFITS

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### **Urgent care services**

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

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

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

SAMPLE

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## GENERAL EXCLUSIONS

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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](http://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* provided by an *out-of-network provider* except for the following when *medically necessary* to render emergency care:
  - a. Licensed ambulance service;
  - b. *Services* in a *hospital* emergency room; or
  - c. *Services* in an *urgent care center*;
2. *Services* for care and treatment of non-covered procedures;
3. *Services* incurred before the *effective date* or after the termination date of this *policy*;
4. *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*;
5. *Services* performed in association with a *service* that is not covered under this *policy*;
6. 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;
7. *Services* which are *experimental, investigational or for research purposes*;
8. Complications of a *service* that is not a *covered expense* under this *policy* including the diagnosis or treatment of any condition which is a complication of a non-covered *service*;
9. Expenses in excess of the *maximum allowable fee* for the *service*;
10. *Services* exceeding the amount of benefits available for a particular *service*;
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;

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## GENERAL EXCLUSIONS

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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;
  - 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 *healthcare practitioner*, surgical assistant, assistant surgeon, physician's assistant, *nurse* or certified operating room technician unless *medically necessary*;
17. Weekend non-emergency *hospital* admissions, specifically admissions to a *hospital* on a Friday or Saturday at the convenience of the *covered person* or his or her *healthcare practitioner* when there is no cause for an emergency admission and the *covered person* receives no surgery or therapeutic treatment until the following Monday;
18. Cosmetic *services*, or any complication therefrom;
19. *Custodial care* and *maintenance care*;
20. Ambulance *services* for routine transportation to, from or between medical facilities and/or a *healthcare practitioner's* office except as expressly provided in this *policy*;
21. Medical or surgical procedures that are not *medically necessary* except elective tubal ligation and vasectomy;
22. Elective medical or surgical abortion unless:
  - a. The pregnancy is as a result of an act of rape or incest; or
  - b. The woman suffers from a physical disorder, physical injury or physical illness, including a life endangering physical condition caused by or arising from the pregnancy itself and a *healthcare practitioner* certifies that it endangers her life, if not performed;
23. Reversal of sterilization;
24. *Infertility services*;
25. Sexual dysfunction;
26. Sex change *services*, regardless of any diagnosis of gender role or psychosexual orientation problems;
27. 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*;

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## GENERAL EXCLUSIONS

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28. Dental *services*, appliances or supplies for treatment of the teeth, gums, jaws or alveolar processes including 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*;
29. *Pre-surgical/procedural testing* duplicated during a *hospital confinement* unless *medically necessary*;
30. Any treatment for obesity, which includes *morbid obesity*, regardless of any potential benefits for co-morbid conditions, including:
  - a. Surgical procedures for *morbid obesity*; or
  - b. *Services* or procedures for the purpose of treatment a *sickness* or *bodily injury* caused by, complicated by or exacerbated by the obesity other than screening for obesity and behavioral interventions for weight management as recommended by the USPSTF:
    - Group and individual sessions of high intensity (12 to 26 sessions in a year)
    - Behavioral management activities, such as weight loss goals
    - Improving diet or nutrition and increasing physical activity
    - Addressing barriers to change
    - Self-monitoring, and
    - Strategizing how to maintain lifestyle changes;
31. Surgical procedures for the removal of excess skin and/or fat in conjunction with or resulting from weight loss or a weight loss *surgery*;
32. Treatment of nicotine habit or addiction including nicotine patches, hypnosis, smoking cessation classes, tapes or *electronic* media unless prescribed by a *healthcare practitioner*. This exclusion does not apply to smoking and tobacco cessation counseling as recommended by the USPSTF;
33. Educational or vocational training or therapy, *services*, and schools including videos and books; nutritional therapy except for treatment of diabetes;
34. Except as expressly provided in this *policy*, foot care *services* including:
  - a. Shock wave therapy of the feet;
  - b. Treatment of weak, strained, flat, unstable or unbalanced feet;
  - c. Hygienic care, and the treatment of superficial lesions of the feet, such as corns, calluses or hyperkeratosis;
  - d. Tarsalgia, metatarsalgia or bunion treatment, except *surgery* which involves exposure of bones, tendons or ligaments;
  - e. Cutting of toenails, except removal of nail matrix; and
  - f. Arch supports, heel wedges, lifts, shoe inserts, the fitting or provision of foot orthotics or orthopedic shoes, unless *medically necessary*;
35. Hair prosthesis except as expressly provided in this *policy*, hair transplants or implants;
36. Hearing care that is routine, including exams and tests except for routine hearing screenings that are covered under preventive medical *services*, any artificial hearing device, cochlear implant, auditory prostheses or other electrical, digital, mechanical or surgical means of enhancing, creating or restoring auditory comprehension;
37. *Services* rendered in a premenstrual syndrome clinic or holistic medicine clinic;
38. Transplant *services* except as expressly provided in this *policy*;
39. Charges for growth hormones;
40. 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*;

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## GENERAL EXCLUSIONS

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41. Immunizations including those required for foreign travel for *covered persons* of any age except as expressly provided in this *policy*;
42. Treatment for any jaw joint problem, including temporomandibular joint disorder, craniomaxillary disorder, craniomandibular disorder, head and neck neuromuscular disorder or other conditions of the joint linking the jaw bone and skull or any orthognathic *surgery* to correct any of the above, except as expressly provided in this *policy*;
43. Genetic testing, counseling or *services* except for BRCA screening, counseling, and appropriate testing as recommended by the Health Resources and Services Association (HRSA);
44. *Sickness* or *bodily injury* for which medical payments/personal injury protection (PIP) coverage exists under any automobile, homeowner, marine, aviation, premise or any other similar coverage whether such coverage is in effect on a primary, secondary or excess basis. This exclusion applies up to the available limit under the other coverage regardless of whether a claim is filed with the medical payments/PIP carrier. Whether medical payment or expense coverage is payable under another coverage is to be determined as if the coverage under this *policy* did not exist;
45. *Covered expense* to the extent of any amount received from others for the *bodily injuries* or losses which necessitated such benefits. Amounts received from others specifically includes, without limitation, liability insurance, Workers' Compensation, uninsured motorists, underinsured motorists, "no-fault" and automobile medical payments;
46. Expense for employment, school, sports or camp physical examinations or for the purpose of obtaining insurance, or premarital tests or examinations;
47. *Services* received in an emergency room unless required because of *emergency care*;
48. Any expense including related complications incurred for *services* received outside of the United States except as required by law for *emergency care services*;
49. *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*, as classified in the Diagnostic and Statistical Manual of Mental Disorders;
50. *Services* and supplies which are:
  - a. Rendered in connection with *mental illnesses* not classified in the International Classification of Diseases of the U.S. Department of Health and Human Services;
  - b. Extended beyond the period necessary for evaluation and diagnosis of learning and behavioral disabilities or for mental retardation; and
  - c. Marriage counseling;
51. *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;

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## GENERAL EXCLUSIONS

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52. *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, if benefits are available under Workers' Compensation except as expressly provided in this *policy*;
53. *Court-ordered mental health services* unless *medically necessary*, as classified in the Diagnostic and Statistical Manual of Mental Disorders;
54. Expenses for alternative medicine, including medical diagnosis, treatment, and therapy, unless deemed as an essential health benefit (EHB). Alternative medicine *services* includes, but is not limited to:
  - a. Acupressure;
  - b. Acupuncture;
  - c. Aromatherapy;
  - d. Ayurveda;
  - e. Biofeedback;
  - f. Faith healing;
  - g. Guided mental imagery;
  - h. Herbal medicine;
  - i. Holistic medicine;
  - j. Homeopathy;
  - k. Hypnosis;
  - l. Macrobiotic;
  - m. Massage therapy;
  - n. Naturopathy;
  - o. Ozone therapy;
  - p. Reflexotherapy;
  - q. Relaxation response;
  - r. Rolfing;
  - s. Shiatsu;
  - t. Yoga;
  - u. Herbs, nutritional supplements, and alternative medicines; and
  - v. Chelation therapy;
55. Private-duty nursing;
56. Living expenses, travel, transportation, except as expressly provided in the "Ambulance services" provision or "Transplants" provision in the "Your Policy Benefits" section of this *policy*; and
57. 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:
  - 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;



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## GENERAL EXCLUSIONS

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- f. Expenses for any membership fees or program fees paid by a *covered person*, including:
  - 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.

SAMPLE

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## PRESCRIPTION DRUG EXCLUSIONS

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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](http://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*;
4. Dietary supplements except enteral formulas and nutritional supplements for the treatment of phenylketonuria (PKU) or other inherited metabolic disease;
5. Nutritional products;
6. Drugs and/or ingredients not approved by the FDA, including bulk compounding ingredients;
7. Minerals;
8. Herbs and vitamins except prenatal (including greater than one milligram of folic acid), pediatric multi-vitamins with fluoride, and vitamins on the Preventive Medication Coverage *drug list*;
9. *Legend drugs* which are not deemed *medically necessary* by *us*;
10. Any drug prescribed for a *sickness* or *bodily injury* not covered under this *policy*;
11. Any drug prescribed for intended use other than for:
  - a. Indications approved by the FDA;
  - b. Off-label indications recognized through peer-reviewed medical literature;
12. Any amount exceeding the *default rate*;
13. Any drug, medicine or medication that is either:
  - a. Labeled "Caution-limited by Federal law to investigational use"; or
  - b. *Experimental, investigational or for research purposes*, even though a charge is made to the *covered person*;
14. Allergen extracts;
15. The administration of covered medication(s);
16. *Specialty drugs* for which coverage is not approved by *us*;
17. Therapeutic devices or appliances, including but not limited to:
  - a. Hypodermic needles and syringes except when prescribed by a *healthcare practitioner* for use with insulin, and *self-administered injectable drugs* whose coverage is approved by *us*;
  - b. Support garments;
  - c. Test reagents;
  - d. Mechanical pumps for delivery of medication; 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;
24. Any drug prescribed for impotence and/or sexual dysfunction;
25. Any drug, medicine or medication that is consumed or injected at the place where the *prescription* is given or dispensed by the *healthcare practitioner* (these drugs are covered under the "Healthcare practitioner services" provision);
26. *Prescriptions* that are to be taken by or administered to the *covered person*, in whole or in part, while he/she is a patient in a facility where drugs are ordinarily provided by the facility on an inpatient basis by the facility. Inpatient facilities include, but are not limited to:
  - a. *Hospital*;
  - b. *Skilled nursing facility*; or
  - c. *Hospice facility*;
27. Injectable drugs, including but not limited to:
  - a. Immunizing agents unless otherwise determined by *us*;
  - b. Biological sera;
  - c. Blood;
  - d. Blood plasma; or
  - e. *Self-administered injectable drugs* or *specialty drugs* for which *prior authorization* has not been obtained from *us*;
28. *Prescription* fills or refills:
  - a. In excess of the number specified by the *healthcare practitioner*; or
  - b. Dispensed more than one year from the date of the original order;
29. Any portion of a *prescription* fill or refill that exceeds a 90-day supply when received from a *mail-order pharmacy* or a retail *pharmacy* that participates in *our* program which allows a *covered person* to receive a 90-day supply of a *prescription* fill or refill;
30. Any portion of a *prescription* fill or refill that exceeds a 30-day supply when received from a retail *pharmacy* that does not participate in *our* program which allows a *covered person* to receive a 30-day supply of a *prescription* fill or refill;
31. Any portion of a *specialty drug prescription* fill or refill that exceeds a 30-day supply, unless otherwise determined by *us*;
32. Any drug for which *we* require *prior authorization* or *step therapy* and it is not obtained;
33. Any drug for which a charge is customarily not made;
34. Any portion of a *prescription* fill or refill that:
  - a. Exceeds *our* drug specific *dispensing limit*;
  - b. Is dispensed to a *covered person* whose age is outside the drug specific age limits defined by *us*;
  - c. Is refilled early, as defined by *us*; or
  - d. Exceeds the duration-specific *dispensing limit*;
35. Any drug, medicine or medication received by the *covered person*:
  - a. Before becoming covered under this *policy*; or
  - b. After the date the *covered person's* coverage under this *policy* has ended;
36. Any costs related to the mailing, sending or delivery of *prescription* drugs;
37. Any intentional misuse of this benefit, including *prescriptions* purchased for consumption by someone other than the *covered person*;

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## PRESCRIPTION DRUG EXCLUSIONS

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- 38. Any *prescription* fill or refill for drugs, medicines or medications that are lost, stolen, spilled, spoiled or damaged;
- 39. Any amount the *covered person* paid for a *prescription* that has been filled, regardless of whether the *prescription* is revoked or changed due to adverse reaction or change in dosage or *prescription*; and
- 40. *Prescription drugs* filled or refilled at an *out-of-network pharmacy*.

SAMPLE

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## PEDIATRIC DENTAL CARE BENEFIT

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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*.

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 three years. Benefit is not available when a periodontal evaluation is performed.
3. Limited, problem focused evaluations. Limited to a maximum of one per year.
4. Periodontal evaluations. Limited to a maximum of one every three years. 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. Limited to a maximum of two per year.
10. Topical fluoride varnish treatment for *covered persons* five years of age or younger.

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## PEDIATRIC DENTAL CARE BENEFIT

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

### Class II services

1. Restorative *services* as follows:
  - a. Fillings. Limited to a maximum of two per year. 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.

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## PEDIATRIC DENTAL CARE BENEFIT

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### 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. Periodontal maintenance, (at least 30 days following periodontal therapy), unless a cleaning (prophylaxis) is performed on the same day visit. Limited to two per year.
- c. Periodontal and osseous surgical procedures, including bone replacement, tissue regeneration and/or graft procedures. Limited to a maximum of one quadrant every three years. If more than one surgical procedure is performed on the same day, only the most inclusive procedure will be considered a *pediatric dental service*.
- d. 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. Limited to a maximum of one per tooth in a two-year period. 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. Limited to a maximum of one time per tooth per lifetime. 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. Limited to a maximum of one time per tooth per lifetime.
- d. Partial pulpotomy for apexogenesis for permanent teeth. Limited to a maximum of one time per tooth per lifetime.
- e. Vital pulpotomy for permanent and primary teeth. Limited to a maximum of one time per tooth per lifetime.
- f. Pulp debridement, pupal therapy (resorbable) for permanent and primary teeth. Limited to a maximum of one time per tooth per lifetime.
- g. Apexification/recalcification for permanent and primary teeth. Limited to a maximum of one time per tooth per lifetime.

### 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. Limited to a maximum of two every year.
- 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. Limited to one per tooth every five years.
- 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.

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## PEDIATRIC DENTAL CARE BENEFIT

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- 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 limited to one per tooth per lifetime.
  - b. Extraction of an erupted tooth or exposed root for permanent and primary teeth limited to one per tooth per lifetime.
  - 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 limited to one per tooth per lifetime:
- 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. 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.

### 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.



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## PEDIATRIC DENTAL CARE BENEFIT

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### 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*;
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;

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## PEDIATRIC DENTAL CARE BENEFIT

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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 anesthesiologist;
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;
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*;
24. Any caries susceptibility testing, laboratory tests, saliva samples, anaerobic cultures, sensitivity testing or charges for oral pathology procedures; or
25. *Services* provided by an *out-of-network provider*.

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## PEDIATRIC DENTAL CARE BENEFIT

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### 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; 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 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*.

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## PEDIATRIC DENTAL CARE BENEFIT

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**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.

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

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## PEDIATRIC VISION CARE BENEFIT

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### 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 the limits shown in the "Schedule of Benefits–Pediatric Vision Covered Expenses" section of this *policy*.
2. *Materials* covered by this *policy* that are lost, or stolen. Broken or damaged *materials* will only be replaced at normal intervals as specified in the "Schedule of Benefits–Pediatric Vision Covered Expenses" section of this *policy*.
3. Basic cost for lenses and frames covered by the *policy*.

Refer to 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;
12. Treatment relating to or caused by disease;
13. Non-prescription *materials* or vision devices;
14. Costs associated with securing *materials*;
15. Pre- and post-operative *services*;
16. Orthokeratology;
17. Routine maintenance of *materials*;
18. Refitting or change in lens design after initial fitting;
19. Artistically painted lenses;
20. Premium lens options;
21. *Pediatric vision care* not obtained from an *in-network provider* designated by *us*; or
22. *Services* provided by an *out-of-network provider*.

### Definitions

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

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

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## PEDIATRIC VISION CARE BENEFIT

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

**Covered person** under this section means a person who is eligible and enrolled for benefits provided under this *policy* through the end of the month in which he/she attains age 19.

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

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

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

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

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

**Severe vision problems** mean the best-corrected acuity is:

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

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## CLAIMS

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### 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.



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## CLAIMS

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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](http://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.

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## CLAIMS

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### 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 within 20 days after a covered loss starts, 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](http://www.humana.com). *Your* agent may notify *us* on *your* behalf.

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

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

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

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

### Other insurance coverage

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

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

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

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

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## CLAIMS

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### **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*.

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

### **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**

After receiving written or *electronic* proof of loss, *we* will pay monthly all benefits then due for *covered expenses* under this *policy*. Benefits for any other loss covered by this *policy* will be paid as soon as *we* receive proper written or *electronic* proof.

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## CLAIMS

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### To whom benefits are payable

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

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

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

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

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

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

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## APPEAL RIGHTS

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### Grievance procedure

There are situations when *you* have questions about *your* coverage or are dissatisfied with *services*. If *you* have an inquiry or complaint regarding a matter arising under *your policy*, call *us* at the telephone number on *your ID card*. Such inquiries and complaints will be handled in a timely manner.

In the event *your* problem has not been settled at the informal level and *you* are still dissatisfied, *you*, *your* authorized representative, or provider acting on *your* behalf will be advised of the process to initiate a grievance.

In the event a complaint cannot be satisfactorily resolved by contacting *us*, *you* are advised to initiate the grievance process.

Grievances must be submitted within 180 days of receiving notice of an adverse determination. A grievance unrelated to an adverse determination must be submitted within 60 days of receiving notice of our decision on a complaint that was reviewed at the informal level. Grievances may be filed by writing to:

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

Should *you* need assistance in submitting a written grievance or expedited grievance, or choose to initiate the grievance process, please call the toll-free telephone number on *your ID card*.

### Grievance review

A Grievance Specialist will review the grievance. *You* will be notified of a final decision involving an adverse determination, involving a claim denial in writing within 60 days after *our* receipt of the grievance (30 days in the case of an adverse determination involving a pre-service or concurrent review).

All expedited grievances, including adverse determination appeals are to be investigated and a decision provided to *you*, *your* authorized representative, or a provider acting on *your* behalf within three calendar days after receiving the request for review.

*You* may contact the Agency for Health Care Administration (AHCA) for assistance with the submission of a grievance or appeal at any time during the grievance process. The toll-free telephone hotline number and the address for the Agency are:

**Agency for Health Care Administration  
Bureau of Managed Health Care  
Building 1, Room 339, MS 26  
2727 Mahan Drive  
Tallahassee, FL 32308  
1-850-921-5458 or toll-free 1-888-419-3456**

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## APPEAL RIGHTS

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*You* may contact the Florida Department of Financial Services, Division of Consumer Assistance for assistance with billing problems. The toll-free telephone number and address for the Florida Department of Financial Services, Division of Consumer Assistance are:

**Florida Department of Financial Services (DFS)**  
**200 East Gaines Street**  
**Tallahassee, FL 32399-0322**  
**In-State toll free 1-877-693-5236 or Out-of-State 1-850-413-3089**

### **Exhaustion of remedies**

*You* must complete all levels of the grievance process available to *you* under state or federal law, including external review, before filing a lawsuit. This assures that both *you* and *we* have a full and fair opportunity to complete the record and resolve the dispute. Contact *us* if *you* believe *your* condition requires the use of the shorter time lines applicable to emergency health conditions.

The grievance process, however, does not preclude *you* from pursuing other appropriate remedies, including injunctive relief or equitable relief, if the requirement of exhausting the process for grievance, including the expedited grievance process, would place *your* health in serious jeopardy.

A coverage denial does not mean that *your* provider cannot provide the *service*. *Our* denial only means *we* will not pay for the *service*, unless *our* decision is reversed upon further review or in a subsequent lawsuit.

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## RECOVERY RIGHTS

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### 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 "Other insurance coverage" provision.

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

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

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.

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## RECOVERY RIGHTS

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### Right to request information

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

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

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

### Our right of subrogation

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

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

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

*We* may enforce our subrogation rights by asserting a claim to any coverage to which *you* may be entitled. *We* shall have first priority to recover amounts *we* have paid and the reasonable value of *services* and benefits provided under a managed care agreement from any funds that are paid or payable as a result of any *sickness* or *bodily injury*, regardless of whether available funds are sufficient to fully compensate the *covered person* for their *sickness* or *bodily injury*.

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



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## RECOVERY RIGHTS

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### Right of reimbursement

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

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

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

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

### Assignment of recovery rights

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

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

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

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## RECOVERY RIGHTS

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### Workers' compensation

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

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

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

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

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

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

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## PREMIUM PAYMENT

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### 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 31-day grace period.

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 provide written notice to *you* at least 30 days prior to the effective date of any premium change.

*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.

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## CHANGES TO THE POLICY

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### 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*.

## CHANGES TO THE POLICY

If *you* did not purchase *your* coverage through the *marketplace* and a child is born to a *policyholder*, or any *covered person*, a *policyholder* adopts a child, or a child is placed with the *policyholder* for the purpose of adoption or foster care *we* must be notified of the event in writing within 31 days of birth or placement. If *we* receive notice within this 31-day period, *we* will not charge premium for the child's coverage for the first 31 days of coverage. The applicable premium for the child will be charged after the initial 31 days of coverage. If notice is not given within the 31-day period outlined above, premium will be charged from the date of birth or placement. If notice is given within 60 days of the child's birth or placement, *we* will not deny coverage for that child due to failure to timely notify *us* of the birth or placement of the child. Coverage for a child born to a covered *dependent* child will terminate 18 months after the birth of the newborn..

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

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

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

### 3. Effective date of dependent changes

- a. Coverage for a newborn, foster child or adopted child will be effective on the date of the birth, placement or adoption, provided *you* complete an application and remit the premium within 60 days of the child's date of birth, placement or adoption.
- b. If *we* receive the application and any required premium more than 60 days after the newborn's date of birth or the child's adoption or placement for adoption or foster care, such child will not be eligible for coverage until the next *open enrollment period*.
- c. For changes for other *dependents*, the *dependent* will not be eligible for coverage until the next *open enrollment period* or until qualifying for a special enrollment.

### Special enrollment

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

1. A *covered person* has a change in family status due to:
  - a. Marriage;
  - b. 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*; or
  - h. 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.

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## CHANGES TO THE POLICY

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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.

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.

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## CHANGES TO THE POLICY

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### 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 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.

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## RENEWABILITY OF INSURANCE AND TERMINATION

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### Reasons we will terminate your policy

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

1. The required premium was due to *us* and not received by *us*. 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;
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 have a right or defense to take such action by law;
7. We cease to offer a type of policy or cease to do business in the individual medical insurance market, as allowed or required by state or Federal law; or
8. 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.

If coverage under this *policy* is terminated for other than nonpayment of premium or termination of eligibility, a 45-day advance written notice of the termination will be provided. The written notice will state the reason(s) for the cancellation, termination, or nonrenewal.

### Reasons we will terminate coverage for a covered person

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

1. When the *covered person* no longer qualifies as a *dependent* or meets eligibility criteria;
2. The *covered person* commits fraud or makes an intentional misrepresentation of a material fact, as determined by *us*. Termination will be effective at 12:01 a.m. local time at the *covered person's* state of residence on the date the misrepresentation occurred. A 30-day advance written notice of the termination will be provided;
3. When the *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.



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## RENEWABILITY OF INSURANCE AND TERMINATION

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*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*.

If coverage under this *policy* is terminated for other than nonpayment of premium or termination of eligibility, a 45-day advance written notice of the termination will be provided. The written notice will state the reason(s) for the cancellation, termination, or nonrenewal.

### **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(s) who willingly and knowingly engages in an activity intended to defraud *us* by filing a claim or form that contains a false or deceptive statement is committing insurance fraud.

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 45-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*.

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## GENERAL PROVISIONS

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### Change of beneficiary

The *covered person* can change the beneficiary at any time by giving *us* written notice. The beneficiary's consent is not required for this or any other change in the *policy*, unless the designation of the beneficiary is irrevocable.

### 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 arrange for third-party service providers to provide *you* with discounts on goods and services or to provide *you* with information regarding monetary responsibilities *you* may have for medical *services*. Some third-party service providers may make payments to *us* when these programs are used. These payments offset the cost to *us* of making these programs available and may help reduce the costs of *your* plan administration.

Although *we* may offer or arrange for third parties to provide *you* access to these programs, they are not insured benefits under the *policy*. The third-party providers are solely responsible for providing the program. *We* are not responsible for any information provided or goods and/or services nor are *we* liable if vendors refuse to honor such programs. Further, *we* are not liable for the negligent provision of programs by third-party service providers. Programs may not be available to people who "opt out" of marketing communications, where a program is available only in specific geographic areas, or where otherwise restricted by law.

### Entire contract

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

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

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## GENERAL PROVISIONS

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### Incontestability

During the first two years from the *effective date* of this *policy*, *we* have the right to rescind or reform coverage or modify benefits under this *policy* and/or deny a claim, if there is an omission or misrepresentation in the application which *we* determine to be material.

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

The *covered person* must have completed a second claim review, and utilized any external appeals procedure available under state law before bringing legal action against *us*. No lawsuit with respect to benefits under this *policy* may be brought within 60 days after the date written proof of loss has been given, but not more than the applicable statute of limitations from the time written proof of loss is required to be given.

### 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.

If *we* determine the misstatement of age is after the *limiting age* of this *policy* and coverage would not have become effective or would have ceased prior to the acceptance of such premium, *we* will refund all premiums paid for that period not covered by this *policy*.

### 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*.

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## GENERAL PROVISIONS

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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*.

### Reinstatement

If *we* or one of *our* authorized agents accept payment of a late premium, *your policy* will be reinstated. If this *policy* is terminated due to lack of premium payment, other than *your* initial premium payment, *you* may request reinstatement. *We* will reinstate *your policy* provided all of the following are met:

1. A new application is submitted by *you*;
2. Coverage has not been terminated for more than 60 days;
3. *You* apply during an *open enrollment period*; and
4. *We* approve the reinstatement.

If *your* request for reinstatement is approved, coverage will be reinstated on the date *we* approve the reinstatement.

This reinstatement privilege is available to *you* if coverage was not purchased on the *marketplace*. If coverage was purchased on the *marketplace* *you* will need to contact the *marketplace* directly to find out what options may be available to *you*.

### 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.

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## GENERAL PROVISIONS

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

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

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

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

### Shared savings program

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

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

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

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

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

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

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

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## GENERAL PROVISIONS

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### **Third party beneficiary**

This is a contract between *you* and Humana. *You* and *your* covered *dependents* are third party beneficiaries. There are no other third party beneficiaries. Providers are not third party beneficiaries.

### **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.

SAMPLE

## 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*.

**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 1<sup>st</sup> and ending on the following December 31<sup>st</sup>. 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 31<sup>st</sup>.

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

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

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

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

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## DEFINITIONS

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**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.

**Creditable coverage** means prior coverage under any of the following:

1. A group health, including church and governmental plans;
2. Individual health insurance coverage;
3. Medicare or Medicaid;
4. Health plan for active military personnel;
5. Indian Health Services or other tribal organization program;
6. State health benefits risk pool;
7. Federal Employees Health Benefits Program;
8. Public health plan; or
9. Health benefit plan under section 5 (c) of the Peace Corps Act.

Prior coverage does not count as creditable if there was a break in coverage of 63 days or more prior to the *effective date* of coverage under this *policy*.



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## DEFINITIONS

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

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

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

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

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

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.

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## DEFINITIONS

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

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

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

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

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

*Dependent* does not mean a:

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

**Diabetic supplies** means:

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

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

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

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## DEFINITIONS

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**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](http://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.

**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 *services* for a *bodily injury* or *sickness* that develops suddenly and unexpectedly and if not treated immediately would:

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

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

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

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

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## DEFINITIONS

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

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

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

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

1. Cannot be lawfully marketed without the final approval of the United States Food and Drug Administration (FDA) for the particular *sickness* or *bodily injury* and which lacks such final FDA approval for the use or proposed use, unless:
  - a. Found to be accepted for that use in the most recently published edition of the United States Pharmacopoeia-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*.

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## DEFINITIONS

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

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

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

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

**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.

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## DEFINITIONS

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**Hospice care agency** means an agency which:

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

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

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

For purposes of the Hospice Care benefit only, *immediate family member* is considered to be the *covered person's* parent, spouse, *domestic partner*, 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;

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## DEFINITIONS

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5. It must be operated as a *hospital* as defined by those laws; and
6. It must not be primarily a:
  - a. Convalescent, rest or nursing home; or
  - b. Facility providing custodial or educational care.

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

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

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

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

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

**In-network pharmacy** means a *pharmacy* that has signed a direct agreement with *us* or has been designated by *us* to provide covered *pharmacy services*, covered *specialty pharmacy services* or covered *mail-order pharmacy services* as defined by *us*, to *covered persons* including covered *prescription* fills or refills delivered to a *covered person's* home or healthcare provider.

**In-network provider** means a *hospital*, *healthcare treatment facility*, *healthcare practitioner* or other provider who is designated as such or has signed an agreement with *us* as an independent contractor, or who has been designated by *us* to provide *services* to *covered persons* for this *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*".

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## DEFINITIONS

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**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](http://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 designated by *us* as level two. Visit *our* Website at [www.humana.com](http://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](http://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](http://www.humana.com) or call the telephone number on *your ID card* for a description of the drugs in this category.

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

**Lifetime maximum benefit** means the maximum dollar amount or day/visit limit for which benefits are payable for certain *covered expenses* incurred by a *covered person* while this *policy* is in effect as shown on the "Schedule of Benefits".

**Limiting age** means a covered *dependent* child's 26<sup>th</sup> birthday.

An adult *dependent* child may be eligible for coverage until the end of the *calendar year* in which they attain age 30 if they meet all of the following requirements:

1. The adult child is unmarried and does not have *dependents* of his/her own;
2. The adult child is a resident of Florida or a full-time or part-time student; and
3. The adult child does not have coverage as a *covered person* under any other health insurance coverage, individual health benefit plan or Medicare.

If a *dependent* adult child is covered under this provision at the end of the *calendar year* in which they attained age 26 and that coverage terminates, the *dependent* adult child is not eligible to again be covered under this *policy* unless the *dependent* adult child had *creditable coverage* without a gap of more than 63 days.

A *dependent* adult child will cease to be eligible for coverage on the earlier of:

1. The last day of the *calendar year* following the *dependent* adult child's attainment of the limiting age; or
2. When the *dependent* adult child ceases to meet all of the requirements listed above.

*You* must reimburse *us* for any benefits that *we* pay for a *dependent* adult child during the time in which the *dependent* adult child ceased to meet all the requirements listed above.



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## DEFINITIONS

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

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

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

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

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

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

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

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

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

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## DEFINITIONS

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

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

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

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

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

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## DEFINITIONS

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**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](http://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.

**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*.

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## DEFINITIONS

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

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

The *partial hospitalization* program must be accredited by the Joint Commission of the Accreditation of Hospitals or in compliance with an equivalent standard.

Licensed drug abuse rehabilitation programs and alcohol rehabilitation programs accredited by the Joint Commission on the Accreditation of Health Care Organizations or approved by the appropriate state agency are also considered *partial hospitalization services*.

*Partial hospitalization* does not include *services* that are for:

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

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

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

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

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

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

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

**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.

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## DEFINITIONS

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**Prescription** means a direct order written by a *healthcare practitioner* for the preparation and use of a drug, medicine, or medication. The *prescription* must be given to a *pharmacist* for a *covered person's* benefit and used for the treatment of a *bodily injury* or *sickness* which is covered under this *policy* or for drugs, medicines or medications on the *drug list*. The drug, medicine or medication must be obtainable only by *prescription* or must be obtained by *prescription* for drugs, medicines or medications on the Preventive Medication Coverage *drug list*. The *prescription* may be given to the *pharmacist* verbally, *electronically*, or in writing by the *healthcare practitioner*.

The *prescription* must include at least:

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

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

1. Laboratory tests or radiological examinations done on an outpatient basis in a *hospital* or other facility accepted by the *hospital* before *hospital confinement* or outpatient *surgery* or procedures; and
2. The tests must be for the same *bodily injury* or *sickness* causing the *covered person* to be *confined* to a *hospital* or to have the outpatient *surgery* or procedure.

**Primary care physician** means an in-network *healthcare practitioner* who provides initial and primary care *services* to *covered persons*, maintains the continuity of *covered persons* medical care and helps direct *covered persons* to *specialty care physicians* and other providers.

A *primary care physician* is a *healthcare practitioner* in one of the following specialties:

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

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

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

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

**Prior authorization** means the required prior approval from *us* for the coverage of *prescription* drugs, medicines, or medications or *specialty drugs*, including the dosage, quantity, and duration, as appropriate for a *covered person's* diagnosis, age, and gender. Certain *prescription* drugs, medicines, medications or *specialty drugs* may require *prior authorization* and/or *step therapy*. Visit *our* Website at [www.humana.com](http://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*.

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## DEFINITIONS

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**Qualified health plan** means a health plan that is certified and meets the standards issued or recognized by each *marketplace* through which the plan is offered.

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

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

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

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

**Residential treatment center** means an institution which:

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

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

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

**Routine nursery care** means the charges made by a *hospital* or licensed birthing center for the use of the nursery. It includes normal *services* and supplies given to well newborn children following birth. *Healthcare practitioner* visits are not considered *routine nursery care*. Treatment of *bodily injury*, *sickness*, birth abnormality or congenital defect following birth and care resulting from prematurity are not considered *routine nursery care*.

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

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## DEFINITIONS

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

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

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

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

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

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

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

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

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

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

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

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## DEFINITIONS

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

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

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

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

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

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

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

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

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



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## DEFINITIONS

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**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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