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.

VAHJGXQEN

INDIVIDUAL MAJOR MEDICAL PPO POLICY HUMANA INSURANCE COMPANY

Policyholder:	[John Doe]
Policy number:	[12345]
Effective date:	[January 1, 2016] as of 12:01 a.m.
Premium amount:	$[xxxx] 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. This *policy* is not a Medicare Supplement policy. If *you* are eligible for Medicare, review the "Guide to Health Insurance for People with Medicare" available from the company.

Humana Insurance Company 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.

This *policy* and the insurance it provides become effective 12:01a.m. (*your* time) on the *effective date* stated above. This *policy* and the insurance it provides terminate at 12:00 midnight (*your* time) on the date of termination. The provisions stated above and on the following pages are part of this *policy*. Humana Insurance Company is regulated by both the State Corporation Commission Bureau of Insurance and the Virginia Department of Health.

Guaranteed renewability

This *policy* remains in effect at the option of the *policyholder* except for the conditions stated below. We will terminate *your policy* on the occurrence of the following events:

1. The required premium was due to *us* and not received by *us*. Termination will be effective on the last day for which the premium was paid;
2. *You* or a *covered person* commit fraud or make an intentional misrepresentation of a material fact, as determined by *us*. Termination will be effective at 12:01 a.m. local time at the *policyholder's* state of residence on the date the misrepresentation occurred. A 30 day advance written notice of the termination will be provided;
3. *You* cease to live, work or 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* request termination of the *policy*. Termination will be effective on the last day of the billing period in which the requested termination date occurs;
5. *We* cease to offer a type of policy. A 90 day advance notice will be provided prior to the discontinuance of coverage; or
6. *We* cease to business in the individual medical insurance market, as allowed or required by state or Federal law. A 180 day advance notice will be provided prior to discontinuance of coverage.

Right to return policy

You have the right to return this *policy* within 10 calendar days from the date *you* received the *policy*. If *you* choose to return this *policy* to *us* within the 10 day period, *we* will promptly 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*.

THIS POLICY MAY NOT APPLY WHEN YOU HAVE A CLAIM! PLEASE READ!

This *policy* was issued based on the information entered on *your* application, a copy of which is attached to the *policy*. Please check *your* application carefully. If *you* know of any misstatement in *your* application, *you* should advise *us* immediately regarding the incorrect or omitted information, otherwise, *your* policy may not be a valid contract.

[Signature of Officer]

Bruce Broussard
President

NOTICE

In the event y*ou* need to contact someone about this insurance for any reason, please contact *your* agent. If no agent was involved in the sale of this insurance, or if *you* have additional questions, *you* may contact *us* at 1-800-558-4444 or submit a written complaint to the following:

Humana Insurance Company
P.O. Box 14618
Lexington, KY 40512-4618

We recommend that you familiarize yourself with our grievance procedure and make use of it before taking any other action.

If *you* have been unable to contact or obtain satisfaction from *us* or *your* agent, *you* may contact the Virginia State Corporation Commission's Bureau of Insurance at:

P.O. Box 1157
Richmond, VA 23218
Toll-Free Telephone: 1-800-552-7945
Telephone for out-of-state calls: 1-804-371-9741
E-Mail: bureauofinsurance@scc.virginia.gov

If *you* have any questions regarding an appeal or grievance concerning the health care services that *you* have been provided which have not been satisfactorily addressed by *your* plan, *you* may contact the Office of the Managed Care Ombudsman for assistance at:

Office of the Managed Care Ombudsman
Bureau of Insurance
P.O. Box 1157
Richmond, VA 23218
Toll-Free Telephone: 1-877-310-6560
Richmond Metropolitan Area Telephone: 1-804-371-9032
E-Mail: ombudsman@scc.virginia.gov
Web Page: http://www.state.va.us/scc

Written correspondence is preferable so that a record of *your* inquiry is maintained. When contacting *your* agent, *us*, or the Bureau of Insurance, please have *your* policy number and insured identification number available.

For assistance with quality of care complaints, *you* may contact the Office of Licensure and Certification at:

Office of Licensure and Certification
Virginia Department of Health
9960 Mayland Drive, Suite 401
Richmond, VA 23233-1463
Toll-Free Telephone: 1-800-955-1819
Richmond Metropolitan Area Telephone: 1-804-367-2104
Fax: 1-804-527-4503
E-Mail: www.mchip@vdh.virginia.gov
Website: www.vdh.virginia.gov/olc

Humana Insurance Company is regulated by the Commonwealth by both the State Corporation Commission Bureau of Insurance pursuant to Title 38.2 and the Virginia Department of Health pursuant to Title 32.1.

NOTICE OF PROTECTION PROVIDED BY VIRGINIA LIFE, ACCIDENT AND SICKNESS INSURANCE GUARANTY ASSOCIATION

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

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

The basic protections provided by the Association are:

- Life Insurance
  - $300,000 in death benefits
  - $100,000 in cash surrender or withdrawal values

- Health Insurance
  - $500,000 in hospital, medical and surgical insurance benefits
  - $300,000 in disability [income insurance benefits
  - $300,000 in long-term care insurance benefits
  - $100,000 in other types of health insurance benefits

- Annuities
  - $250,000 in withdrawal and cash values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $350,000, except for hospital, medical and surgical insurance benefits, for which the limit is increased to $500,000.

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

NOTICE OF PROTECTION PROVIDED BY VIRGINIA LIFE, ACCIDENT AND SICKNESS INSURANCE GUARANTY ASSOCIATION

To learn more about the above protections, please visit the Association's website at www.valifega.org or contact:

VIRGINA LIFE, ACCIDENT AND SICKNESS
INSURANCE GUARANTY ASSOCIATION
c/o APM Management Services, Inc.
1503 Santa Rosa Road, Suite 101
Henrico, VA 23229-5105
804-282-2240

STATE CORPORATION COMMISSION
Bureau of Insurance
P. O. Box 1157
Richmond, VA 23218-1157
804-371-9741
Toll Free Virginia only: 1-800-552-7945
http://scc.virginia.gov/boi/index.aspx

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

GUIDE TO YOUR POLICY

Contents **Page number**

INTRODUCTION

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

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

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

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

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

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

UTILIZATION MANAGEMENT

Preauthorization for medical services and prior authorization for prescription drugs

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

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

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

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

Reduction of payment

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

1. No benefits will be paid for:
   a. Any transplant *services* that are not authorized by *us* prior to the transplant evaluation, testing, preparative treatment or donor search; or
   b. *Prescription* drugs, medicines, and medications, including *specialty drugs* as identified on the *drug list* on *our* Website at www.humana.com that require *prior authorization*.

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

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

YOUR POLICY BENEFITS

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

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

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

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

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

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

YOUR POLICY BENEFITS

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. To transfer a *covered person* to the nearest appropriate medical facility equipped to provide the *medically necessary services*.

Bleeding disorders

Treatment of routine bleeding episodes associated with hemophilia and congenital bleeding disorders. Including coverage for the purchase of blood products and blood *infusion* equipment required for home treatment when the home treatment program is under the supervision of Virginia's state approved hemophilia treatment center.

Clinical trial

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

Routine costs include items and *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. Investigational item, device or *service* itself;
2. *Services* provided only for data collection and analysis that is not directly related to the clinical management of the *covered person*; or
3. *Services* that are 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 conducted in relation to prevention, detection or for the treatment of cancer or a life-threatening condition which the likelihood of death is probable unless the course of disease or condition is interrupted and is:

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

Dental services

1. Treatment for a *dental injury* to a *sound natural tooth*. Treatment must begin within 60 days from the date of the *dental injury*;
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; and
   f. Incision and closure of accessory sinuses, salivary glands or ducts.

   We will limit *covered expenses* to the least expensive *service* that *we* determine will produce professionally adequate results;
3. Dental *services* and dental appliances only when required to diagnose or treat a *dental injury*;
4. Repair of dental appliances damaged as a result of an accidental injury to the jaw, mouth, or face;
5. Inpatient and outpatient dental *services* and dental appliances furnished to a newborn when required to treat medically diagnosed cleft lip, cleft palate, or ectodermal dysplasia;
6. Dental *services* to prepare the mouth for radiation therapy to treat head and neck cancer; and
7. General anesthesia, and *hospital* or *healthcare treatment facility* expenses where anesthesia is required in order to safely and effectively perform a dental procedure for a *covered person*:
   a. Under the age of five;
   b. Who is severely disabled; or
   c. Who has a medical condition which requires admission to a *hospital* or *healthcare treatment facility* or general anesthesia for dental care treatment.

Diabetes services

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

1. Routine eye exams;
2. Routine foot care including treatment of corns, calluses, and toenails;
3. Insulin pumps;
4. Home glucose monitors;
5. *Diabetic supplies*; and
6. In person 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. Walkers;
3. Hospital bed;
4. Ventilator;
5. Hospital type equipment, including traction equipment;
6. Nebulizers;
7. Oxygen and rental of equipment for its administration;
8. Prosthetic devices, components 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;
9. Orthotics (other than foot orthotics, unless *medically necessary* because of diabetes or hammertoe) 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. Fitting, adjustment and repair of orthotics (other than foot orthotics, unless *medically necessary* because of diabetes or hammertoe) are *covered expenses* when prescribed by the *healthcare practitioner* for *activities of daily living*;
10. Cochlear implants and bone anchored health aids (osseointegrated auditory implants);
11. The first pair of contact lenses or eyeglasses only when required as a result of *surgery*, or for the treatment of accidental injury. The purchase and fitting of eyeglasses or contact lenses are covered if:
    a. Prescribed to replace the human lens;
    b. "Pinhole" glasses are prescribed for use after *surgery* for detached retina; or
    c. Lenses are prescribed instead of *surgery* in the following situations:
        i. Contact lenses are used for the treatment of infantile glaucoma;
        ii. Corneal or scleral lenses are prescribed to retain moisture when normal tearing is not possible or not adequate;
        iii. Corneal or scleral lenses are prescribed in connection with keratoconus; or
        iv. Corneal or scleral lenses are required to reduce a corneal irregularity other than astigmatism;
12. Casts, splints (other than dental), trusses, braces (other than orthodontic), and crutches;
13. Orthopedic braces;
14. Leg braces, including attached or built-up shoes attached to a leg brace;
15. Molded, therapeutic shoes for diabetics with peripheral vascular disease;
16. Arm braces, back braces, and neck braces;
17. Head halters;
18. Catheters and related supplies;
19. Wigs and hair prosthesis following cancer treatment (not to exceed one per lifetime);
20. 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; and
    e. Equipment and supplies for home *dialysis*;
21. Other *durable medical equipment*. Visit *our* Website at www.humana.com or call the telephone number on *your ID card* to obtain a list of *durable medical equipment*.

If the equipment and device include comfort or convenience items or features that exceed what is *medically necessary* in the situation or needed to treat the condition, the allowable amount 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 allowable amount for a motorized wheelchair will be limited to the coverage for expenses 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. 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 if due to neglect; or
2. Duplicate or similar rentals of *durable medical equipment.*

Early intervention services

Medically necessary speech and language therapy, occupational therapy, physical therapy and assistive technology *services* and devices for a *covered person* from birth to age three who are certified by the Virginia Department of Behavioral Health and Development Services as eligible for *services,* to attain or retain the capability to function age-appropriately within the *covered person's* environment and includes *services* that enhance function age-appropriately within the *covered person's* environment and includes *services* that enhance functional ability without effecting a cure. These outpatient therapy *services* for early intervention are not subject to the Habilitative/Rehabilitative Services limit shown in the "Schedule of Benefits".

Emergency services

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

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

If *you* need *emergency services*:

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

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

If *you* seek *emergency services* at an out-of-network *hospital*, arrangements will be made to transfer *you* to an in-network *hospital* after *your* condition is *medically stable*. *Medically stable* means that *you* can be transported by ambulance with no expected increase in morbidity or mortality, as determined by *your* attending *healthcare practitioner* or, with respect to a pregnant *covered person* that she has delivered, including the placenta.

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

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

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

Habilitative services

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

1. Physical therapy *services* to relieve pain, teach, keep, improve or restore function, and prevent disability after illness, injury, or loss of limb, including treatment of lymphedema;
2. Occupational therapy *services* to teach, keep, improve or restore activities such as walking, eating, drinking, dressing, toileting, transferring from wheelchair to bed, and bathing;
3. Spinal manipulations, adjustments, and modalities;
4. Speech therapy or speech pathology *services* for correction of a speech impairment, or *services* necessary to improve or teach speech;
5. Cardiac rehabilitation *services* for the process of restoring, maintaining, teaching, or improving the physiological, psychological, social and vocational capabilities of patients with heart disease; and
6. Audiology *services.*

No benefits will be provided for, or on account of group physical, occupational or speech therapy *services*. A *healthcare practitioner* will include *services* of a licensed therapist.

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

Healthcare treatment facility services

1. Inpatient *hospital* stay for injury, illness, or pregnancy, to include injectable drugs and nuclear medicine;
2. Daily room and board up to the semi-private room rate for each day of *confinement* which includes a bed, meals, and special diets and coverage for a private room if *medically necessary*;
3. *Confinement* in a critical care or intensive care unit;
4. Operating room;
5. Inpatient *healthcare practitioner* and surgical *services*;
6. Inpatient stay of not less than 23 hours for laparoscopy-assisted vaginal hysterectomy;
7. Inpatient stay of not less than 48 hours for vaginal hysterectomy;

8. Diagnostic *services* including *advanced imaging*, pulmonary function studies, cardiac catheterization, electrocardiogram (EKG), electroencephalogram (EEG) and colonoscopies;
9. *Healthcare practitioner services*;
10. Ancillary *services* and supplies (such as surgical dressings, supplies, casts, hypodermic needles, syringes, and splints);
11. Oxygen and its administration;
12. Blood and blood products which is not replaced by donation;
13. Biological sera;
14. Administration of blood and blood products including blood extracts or derivatives;
15. Inpatient and outpatient *infusion services*;
16. Other *healthcare treatment facility* charges and fees;
17. Drugs and medicines that are provided or administered to the *covered person* while *confined* in a *hospital* or *skilled nursing facility*;
18. Regularly scheduled treatment such as dialysis, including hemodialysis and peritoneal dialysis, chemotherapy, inhalation therapy or radiation therapy in a *healthcare treatment facility* as ordered by the *covered person's healthcare practitioner*; and
19. *Outpatient services* in a *hospital* or *surgical facility*, office of a *healthcare practitioner*, or *retail clinic*. 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, including visits to the *covered person's* home;
2. Diagnostic laboratory and radiology, including x-rays, mammograms, ultrasounds, or nuclear medicine tests, interpretation, and reading;
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*, including an anesthesiologist or certified registered anesthetist attendant to a *surgery*;
8. *Services* of a pathologist;
9. *Services* of a radiologist;
10. Regularly scheduled treatment such as dialysis, including hemodialysis and peritoneal dialysis in a *healthcare practitioner's* office;
11. Contraceptive management visits;
12. FDA approved contraceptive drugs and devices;
13. Injectable contraceptive drugs;
14. Sleep testing and treatment;

15. Dialysis treatments;
16. Allergy injections, therapy, testing, and serum; and
17. Injections other than allergy.

The office visit *copay*, if applicable, for 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.

Other *services* provided in the course of a visit to the *healthcare practitioner's* office are subject to any applicable *deductible* and *coinsurance*.

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

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

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

Home healthcare

Services provided by a *home healthcare agency* at the *covered person's* home. These *services* include medically skilled *services* of a currently licensed Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.), therapist or home health aide in the *covered person's* home when the *nurse* is not a family member of the *covered person* and the *healthcare practitioner* certifies that the private duty nursing *services* are *medically necessary* for the *covered person's* condition, and not merely custodial in nature. Coverage also includes *medically necessary infusion services* and dialysis. 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. *Custodial care*; and
5. Provision or administration of *self-administered injectable drugs*. For coverage of self-administered drugs, please see the "Prescription drug" provision.

These *services* are subject to an annual visit limit as shown on the "Schedule of Benefits". Occupational, physical and speech therapies provided during *home healthcare visits* are subject to the *home healthcare visit* limit.

Hospice care

Covered expenses for *hospice services* provided under a *hospice care program* furnished in a *hospice facility* or in the *covered person's* home by a *hospice care agency* for *covered persons* diagnosed with a terminal illness with a life expectancy of six months or less:

1. Room and board in a *hospice facility*, when it is for management of pain or for an acute phase of chronic symptom management;
2. Respite care *services* include non-acute inpatient care for the *covered person* to provide the *covered person's* primary caregiver a temporary break from caregiving responsibilities on an intermittent, non-routine basis for up to five days every 90 days;
3. Other *hospice services*;
4. Part-time nursing care including IV therapy *services* provided by or supervised by a *nurse* for up to eight hours per day;
5. Counseling *services* for the *hospice patient* and the *hospice patient's family*;
6. Medical social services for the *hospice patient* or the *hospice patient's family* 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;
7. Psychological, dietary, and nutritional counseling;
8. Physical, speech or occupational therapy;
9. Part-time home health aide services; and
10. Medical supplies, drugs, and medicines prescribed by a *healthcare practitioner* for *palliative care* and pain management.

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 pain control or other treatment for an acute phase of chronic symptom management or respite care;
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. Housekeeping *services* and *services* provided by volunteers; and
7. Services by a licensed pastoral counselor to a member of his/her congregation.

Counseling services and medical social services are subject to annual *benefit maximums* as shown on the "Schedule of Benefits".

Benefit maximums for therapy *services* as shown on the "Schedule of Benefits" do not apply to therapy *services* provided under the "Hospice care" benefit.

Infertility

Covered expenses include the diagnosis and treatment of the conditions resulting in infertility. Coverage does not include *services* or prescription *drugs* for infertility.

Lymphedema

Treatment for lymphedema including equipment, supplies, complex decongestive therapy, and outpatient self-management training and education for the treatment of lymphedema, if prescribed by a *healthcare practitioner*.

Maternity services

1. Obstetrical care and complications of pregnancy *services* including *services* rendered by a *healthcare practitioner* at an inpatient or outpatient *healthcare treatment facility*;
2. Prenatal care, including pregnancy testing;
3. Fetal screenings, which are tests for the genetic and/or chromosomal status of the fetus. The term also means anatomical, biochemical, or biophysical tests to better define the likelihood of genetic and/or chromosomal anomalies;
4. Diagnostic BRCA testing and counseling;
5. *Confinement* and use of the delivery room in a *healthcare treatment facility* for a minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated caesarean section delivery. An earlier discharge is permitted if the attending *healthcare practitioner*, in consultation with the patient, determines that a shorter *hospital* stay is appropriate consistent with the most current protocols and guidelines of the American College of Obstetricians and Gynecologists or the American Academy of Pediatrics;
6. A post-discharge office visit to the *healthcare practitioner* or a *home visit* or visits consistent with the most current protocols and guidelines of the American College of Obstetricians and Gynecologists or the American Academy of Pediatrics;
7. Anesthesia *services* provided by a *healthcare treatment facility* and *healthcare practitioner*;
8. Delivery *services* provided by:
   a. A *healthcare practitioner*; or
   b. A midwife working within the scope of his or her license in a home setting; and
9. Postpartum care.

Mental health and substance use disorder services

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 and substance use disorder

Covered expenses are *expenses incurred* for:

1. *Inpatient services* including room and board;
2. Individual and group psychotherapy;
3. Psychological testing;
4. Counseling with family members;
5. Convulsive therapy;
6. A *partial hospitalization* program when *medically necessary*;
7. *Residential treatment center* for *substance use disorder*; and
8. *Healthcare practitioner* visits.

Up to 10 days of inpatient benefits may be converted to *partial hospitalization*. An exchange of days shall equal 1.5 days of *partial hospitalization* for each one day of *inpatient* day of coverage.

Outpatient care and office services for mental health and substance use disorder

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;
2. Individual and group psychotherapy;
3. Psychological testing; and
4. *Medication management visits*.

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

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

Newborn services

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

1. Routine well newborn care for a minimum of the first 48 hours or 96 hours following birth for:
   a. *Hospital* charges for *routine nursery care*;
   b. *Healthcare practitioner's* charges for circumcision of the newborn child; and
   c. *Healthcare practitioner's* charges for routine examination of the newborn before release from the *hospital*;
2. *Bodily injury* or *sickness*;
3. Care and treatment for premature birth; and
4. Medically diagnosed birth defects and abnormalities.

Services for routine well newborn care that are recommended preventive medical *services* identified on the Department of Health and Human Services (HHS) Website at www.healthcare.gov are explained under the "Preventive medical services" provision. All other well newborn care during a minimum of the first 48 or 96 hours following birth is explained under this "Newborn 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.

Orthodontia services

Orthodontic treatment when *medically necessary* for a *covered person* through the end of the month in which they attain age 19.

Covered expenses do not include:

1. Repair of damaged orthodontic appliances;
2. Replacement of lost or missing appliances; and
3. *Services* to alter vertical dimension and/or restore or maintain the occlusion. Such procedures include but are not limited to equilibration, periodontal splinting, full mouth rehabilitation and restoration or misaligned teeth.

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* to relieve pain, teach, keep, improve or restore function, and prevent disability after illness, injury or loss of limb, including treatment of lymphedema;
3. Occupational therapy *services* to teach, keep, improve or restore activities such as walking, eating, drinking, dressing, toileting, transferring from wheelchair to bed, and bathing;
4. Spinal manipulations, adjustments, and modalities;
5. Speech therapy or speech pathology *services* for correction of a speech impairment, or *services* necessary to improve or teach speech;
6. Cognitive rehabilitation *services*;
7. Audiology therapy *services*;
8. Radiation therapy *services*, which includes radiation administration and treatment of disease by x-ray, radium, cobalt, or high energy particle sources and the cost of rental of or cost of radioactive materials;
9. Pulmonary rehabilitation *services*;
10. *Infusion services*;
11. Chemotherapy drugs administered orally and intravenously or by injection; and
12. Cardiac rehabilitation *services* for the process of restoring, maintaining, teaching, or improving the physiological, psychological, social and vocational capabilities of patients with heart disease.

The expectation must exist that the therapy is not considered *maintenance care* other than for "Rehabilitative/Habilitative 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".

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

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*, both *brand-name drugs* and *generic drugs*, that under Federal or state law may be dispensed only by *prescription* from a *healthcare practitioner*;
2. Drugs, medicines, medications, both *brand-name drugs* and *generic drugs*, 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*;
6. Drugs, medicines or medications, including FDA approved emergency contraceptive *drugs* on *our drug list* entitled "Preventive Medication Coverage" with a *prescription* from a *healthcare practitioner*;
7. A 30-day supply, upon *prescription*, if *your* medication was lost or stolen;
8. Enteral formulas and nutritional supplements for the treatment of phenylketonuria (PKU), inborn errors of amino acid or organic acid metabolism, metabolic abnormality or severe protein or soy allergies or other inherited metabolic diseases, or as otherwise determined by *us*;
9. *Drugs* for the treatment of cancer:
    a. The drug does not have to be FDA approved for the treatment of a specific cancer if the drug has been recognized as safe and effective for treatment of specific types of cancer by one or more standard medical reference compendia or medical literature; and
    b. *Drugs* approved by the FDA to treat intractable cancer pain will be covered in excess of the recommended dosage; and
10. Spacers and/or peak flow meters for the treatment of asthma.

Covered expenses include administration of a preventive immunization that is given at a *pharmacy*.

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.

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

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

Preventive medical services

Services for well child and adult care preventive medical *services*. Preventive medical *services* under this *policy* are the recommended preventive *services* identified on the Department of Health and Human Services (HHS) Website at www.healthcare.gov on the date a *covered person* receives *services*. The recommended preventive medical *services* are subject to change and such *services* when rendered by an *in-network provider* do not have a *cost share*. A *covered person* may obtain the current list of preventive *services* at www.healthcare.gov or by calling the telephone number on *your ID card* prior to receiving a preventive medical *service*.

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

1. Evidence-based items or *services* that have in effect a rating of A or B in the current recommendations of the U.S. Preventive Services Task Force (USPSTF);
2. Immunization for children from birth to 36 months of age against diphtheria, pertussis, tetanus, polio, hepatitis B, measles, mumps and rubella. 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. Hearing screening tests and all necessary audiological examinations, using technology approved by the U.S.F.D.A., and as recommended by the National Joint Committee on Infant Hearing Coverage, which includes benefits for any follow-up audiological examinations as recommended by a *healthcare practitioner* or audiologist, and performed by a licensed audiologist, to confirm the existence or absence of hearing loss of a covered *dependent* infant;
4. Screening for hemoglobinopathies, hypothyroidism, phenylketonuria (PKU), and gonorrhea prophylactic medication;
5. Evidence-informed preventive care and screenings provided for in the Health Resources and Services Administration (HRSA) guidelines for infants, children, adolescents, and women;
6. Current recommendations of the USPSTF regarding breast cancer screening, mammography, and prevention (does not include recommendations issued in or around November 2009) including one screening mammogram for a female *covered person* age 35 through 39;

7. Prostate Specific Antigen test (PSA) for a male *covered person* as follows:
   a. One PSA test in a 12 month period, age 40 and over, who are at high risk for prostate cancer;
   b. One PSA test in a 12 month period, age 50 and over; and
   c. Digital rectal examination;
8. Colorectal cancer screening to include annual fecal occult blood test, flexible sigmoidoscopy or colonoscopy, or in appropriate circumstances radiologic imaging, in accordance with the most recently published recommendations established by the American College of Gastroenterology, in consultation with the American Cancer Society, for the ages, family histories, and frequencies referenced in such recommendations;
9. Annual Pap smear for a female *covered person*;
10. Breastfeeding *services* provided in conjunction with each birth including:
    a. Comprehensive lactation support and counseling; and
    b. Rental or purchase of breastfeeding equipment; and
11. Smoking and tobacco cessation counseling and domestic violence screening and counseling as recommended by the United States Preventive Services Task Force (USPSTF).

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, coverage for prostheses determined as necessary in consultation with the attending *healthcare practitioner* and the *covered person*, treatment of lymphedema and physical complications in all stages of mastectomy. The length of stay from a *healthcare treatment facility* following *surgery* shall be not less than 48 hours of inpatient care following a radical or modified radical mastectomy and not less than 24 hour of inpatient care following a total mastectomy or a partial mastectomy with lymph node dissection for the treatment of breast cancer, unless an earlier discharge is consented to by the patient and attending *healthcare practitioner*; 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), except for as covered in relation to a mastectomy.

Cosmetic *services* and *services* for complications from cosmetic *services* are not covered.

Skilled nursing facility and rehabilitation services

Covered expenses include those *incurred* for daily room and board, general nursing *services*, *services* provided by a licensed therapist and other professional *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*.
Rehabilitation services include but are not limited to:

1. Physical therapy, occupational therapy, respiratory therapy (the introduction into the lungs of dry or moist gasses to treat illness or injury) and speech therapy; and
2. 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* stay;
4. *Surgical facility* visit;
5. *Urgent care center* visit;
6. *Skilled nursing facility* stay;
7. Emergency room visit; 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 *prior authorization* was not approved by *us*, except in an emergency.

Telemedicine services

Covered expenses are expenses incurred for *medically necessary services* provided via *telemedicine* 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 *services* provided via *telemedicine* when 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 *telemedicine*; and
2. The *distant site* at which the *healthcare practitioner* is providing the *service* cannot be the same site as the *originating site* where the *covered person* is located at the time the *service* is being furnished.

Services provided through *telemedicine* or that result from a *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 dysfunction

Covered services include diagnostic and surgical treatment involving any bone or joint of the head, neck, face or jaw that is deemed *medically necessary* to attain functional capacity of the affected part.

Transplant services

We will pay benefits for *covered expenses* incurred by a *covered person* for an organ or tissue transplant and transfusions for which *preauthorization* has been 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 *preauthorization* of the requested transplant is approved by *us*. Benefits are payable only if *preauthorization* of the transplant is approved by *us*.

Covered expense for a transplant includes pre-transplant *services*, storage of organs/tissue, 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 *policy* benefits and are subject to other applicable provisions of this *policy*.

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

1. *Hospital* and *healthcare practitioner services*; and
2. Acquisition for transplants and associated donor costs, including pre-transplant *services*, transportation and lodging for the donor, 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, *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;
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 for which *preauthorization* has been received; 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 and the donor 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 for which *preauthorization* has been approved by *us*.

All direct, non-medical costs for the *covered person* receiving the *transplant*, the donor and the designated caregiver(s) or support person(s) are covered for *services* from an *in-network provider* only. No benefits are payable for *services* from an *out-of-network provider*. The *in-network provider* status is determined by the provider of the medical transplant *services*.

Transplant provider selection

The *covered person* may select any provider he/she wishes to perform the transplant *services*. However, if the *covered person* selects an *in-network provider*, he/she will avoid having the benefit payment reduced for receiving *services* from an *out-of-network provider*. The amount for *out-of-network services* do not apply to the *out-of-pocket limit.*

Urgent care services

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

If a *covered person* needs urgent care, they should go to the nearest in-network *urgent care center* to receive the *in-network provider* benefit level. If urgent care is obtained through an out-of-network *urgent care center, we* will pay benefits at the out-of-network level.

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

GENERAL EXCLUSIONS

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

For the current recommended preventive *services* please see the Health and Human Services (HHS) Website at www.healthcare.gov and the "Preventive medical services" provision of this *policy*.

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

1. *Services* for care and treatment of non-covered procedures;
2. *Services* incurred before the *effective date* or after the termination date of this *policy*;
3. *Services* not *medically necessary* for diagnosis and treatment of *a bodily injury* or *sickness* except for the specified routine preventive medical *services*;
4. *Services* performed in association with a *service* that is not covered under this *policy*;
5. Expenses for preventive prophylactic *services* performed to prevent a disease process from becoming evident in the organ tissue at a later date other than a prophylactic mastectomy or preventive medical *services* provided under the "Pediatric Dental Care Benefit" section;
6. Complications directly related to a *service* that is not a *covered expense* under this *policy* because it was determined to be *experimental, investigational or for research purposes* other than *medically necessary services* received in an approved clinical trial or not *medically necessary*. Directly related means that the complication occurred as a direct result of the *service* that was *experimental, investigational or for research purposes* or not *medically necessary* and the complication would not have taken place in the absence of the *service* that was *experimental, investigational or for research purposes* or not a *medically necessary service*;
7. Expenses in excess of the *maximum allowable fee* for the *service*;
8. *Services* exceeding the amount of benefits available for a particular *service*;
9. *Services* for cosmetic *surgery* or procedures, including complications that result from such surgeries and/or procedures;
10. *Services* for procedures which are *experimental, investigational or for research purposes* as well as *services* related to or complications from such procedures except for clinical trial costs for cancer and other life threatening conditions and diseases;
11. *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;
12. 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. Payable under any plan or law through a government or any political subdivision unless prohibited by law, except Medicaid who is the payer of last resort;
    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* for which the government pays the cost;

e. For expenses received from a *healthcare practitioner* over the *maximum allowable fee we* would pay for the least costly provider. See the definition of *maximum allowable fee*;
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
i. Rendered by a standby *health*care *practitioner*, surgical assistant, assistant surgeon, physician's assistant, *nurse* or certified operating room technician unless *medically necessary*;

13. Any expenses, including *healthcare practitioner* expenses, which are incurred if a *covered person* is admitted to a *hospital* on a Friday or Saturday unless:
    a. The *hospital* admission is due to *emergency care*; and
    b. Treatment or *surgery* is performed on that same day;
14. *Hospital inpatient services* when the *covered person* is in *observation status* but not admitted as an inpatient;
15. Cosmetic *services*, or any complication therefrom except surgeries or procedures to correct congenital abnormalities, or when such *service* is incidental to or follows *surgery* resulting from trauma, infection or other diseases of the involved part;
16. *Custodial care* and *maintenance care* other than as provided under "Habilitative/rehabilitative services" provision and "Hospice care" provision;
17. Ambulance services for routine transportation to, from or between medical facilities and/or a *healthcare practitioner's* office except as expressly provided under *Ambulance (licensed air and ground)* provision;
18. Medical or surgical procedures that are not *medically necessary* except elective tubal ligation and vasectomy;
19. Elective medical or surgical abortion unless:
    a. The pregnancy would endanger the life of the mother; or
    b. The pregnancy is a result of an alleged act of rape or incest;
20. Reversal of sterilization;
21. *Infertility services* after diagnosis;
22. Sexual dysfunction;
23. Sex change *services*, regardless of any diagnosis of gender role or psychosexual orientation problems;
24. 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*;
25. Dental *services*, appliances or supplies for treatment of the teeth, gums, jaws or alveolar processes including, but not limited to, excision of partially or completely unerupted impacted teeth, 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 stated under "Dental services" provision. This exclusion does not apply to the "Pediatric Dental Care Benefits" section.;
26. *Pre-surgical/procedural testing* duplicated during a *hospital confinement*;
27. Any treatment for obesity, unless qualified as *morbid obesity*, regardless of any potential benefits for co-morbid conditions, including but not limited to:
    a. Surgical procedures for *morbid obesity*; or
    b. *Services* for complications related to any *services* rendered for weight reduction;
28. Surgical procedures for the removal of excess skin and/or fat in conjunction with or resulting from weight loss or a weight loss *surgery*;

29. Treatment of nicotine habit or addiction, including but not limited to, nicotine patches, hypnosis, smoking cessation classes, tapes or *electronic* media, except for smoking and tobacco cessation counseling as recommended by the USPSTF;
30. Educational or vocational training or therapy, *services*, and schools including but not limited to videos and books except when received as part of a covered wellness visit or screening;
31. Nutritional therapy except for treatment of diabetes and *hospice* care;
32. Except as expressly provided under the "Diabetes services" provision, foot care *services* (other than *medically necessary* for diabetes, vascular disease, or due to capsular or bone *surgery*) including but not limited to:
    a. Shock wave therapy of the feet;
    b. Treatment of weak, strained, flat, unstable or unbalanced feet;
    c. Hygienic care, and the treatment of superficial lesions of the feet, such as corns, calluses or hyperkeratosis;
    d. Tarsalgia, metatarsalgia or bunion treatment, except *surgery* which involves exposure of bones, tendons or ligaments;
    e. Cutting of toenails, except removal of nail matrix; and
    f. Arch supports, heel wedges, lifts, shoe inserts, the fitting or provision of foot orthotics or orthopedic shoes, unless *medically necessary* because of diabetes or hammertoe;
33. Wigs and hair prosthesis except as expressly provided under the "Durable medical equipment and medical supplies" provision, hair transplants or implants;
34. Hearing care that is routine, including but not limited to exams and tests except for routine hearing screenings that are covered under preventive medical *services*, any artificial hearing device, auditory prostheses (not including cochlear implant) or other electrical, digital, mechanical or surgical means of enhancing, creating or restoring auditory comprehension, except as expressly provided under the "Durable medical equipment and medical supplies" provision;
35. *Services* rendered in a premenstrual syndrome clinic or holistic medicine clinic;
36. Transplant *services* except as expressly provided under "Transplant services" provision;
37. Charges for growth hormones when *prior authorization* is not received from *us*;
38. 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*;
39. Immunizations including those required for foreign travel for *covered persons* of any age except as expressly provided under "Healthcare practitioner services", "Healthcare treatment facility services", "Prescription drugs" and "Preventive medical services" provisions;
40. Treatment for any jaw joint problem, including but not limited to, craniomaxillary disorder, craniomandibular disorder, head and neck neuromuscular disorder or other conditions of the joint linking the jaw bone and skull unless required due to a medical condition or injury which prevents normal function of the joint or bone and is *medically necessary* to attain functional capacity of the affected part, or any orthognathic *surgery* to correct any of the above, except as expressly provided under the "Dental services" and 'Temporomandibular joint dysfunction" provisions;
41. Genetic testing, counseling or *services* except as expressly provided in the "Maternity services" provision of this *policy* and for BRCA screening, counseling, and appropriate testing as recommended by the Health Resources and Services Association (HRSA);
42. *Covered expense* to the extent of any amount received from Workers' Compensation;
43. Expense for employment, school, sports or camp physical examinations or for the purpose of obtaining insurance, or premarital tests or examinations;
44. *Services* received in an emergency room unless required because of *emergency care*, except for an initial screening and treatment to stabilize;

45. Any expense including related complications incurred for *services* received outside of the United States except as required by law for *emergency care services*;
46. *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*;
47. *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;
48. *Services* rendered for the following which are not FDA approved:
    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. Prolotherapy (injection of an irritant solution);
    h. Hyperhidrosis (excessive sweating); and
    i. Sensory integration therapy;
49. *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*. Without limiting this exclusion, this applies when a *covered person* has Workers' Compensation coverage except as expressly provided in the "Occupational coverage" provision;
50. *Court-ordered mental health services* unless *medically necessary*;
51. Expenses for alternative medicine, including medical diagnosis, treatment, and therapy. Alternative medicine *services* includes, but is not limited to:
    a. Acupressure;
    b. Acupuncture;
    c. Aromatherapy;
    d. Ayurveda;
    e. Biofeedback;
    f. Faith healing;
    g. Guided mental imagery;
    h. Herbal medicine;
    i. Holistic medicine;
    j. Homeopathy;
    k. Hypnosis;
    l. Macrobiotic;
    m. Massage therapy;
    n. Naturopathy;
    o. Ozone therapy;
    p. Reflexotherapy;
    q. Relaxation response;
    r. Rolfing;

s. Shiatsu;
t. Yoga;
u. Herbs, nutritional supplements, and alternative medicines; and
v. Chelation therapy, except for the treatment of lead poisoning;

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

PRESCRIPTION DRUG EXCLUSIONS

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

For the current recommended preventive *services* please see the Health and Human Services (HHS) Website at www.healthcare.gov and the "Preventive medical services" provision of this *policy*.

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

1. Contraceptives, including oral and transdermal, whether medication or device, when prescribed for purpose(s) other than to prevent pregnancy;
2. Growth hormones for idiopathic short stature or any other condition unless there is a laboratory confirmed diagnosis of growth hormone deficiency;
3. Drugs which are not included on the *drug lists*;
4. Dietary supplements and nutritional products except enteral formulas and nutritional supplements for the treatment of phenylketonuria (PKU), inborn errors of amino acid or organic acid metabolism, metabolic abnormality or severe protein or soy allergies or other inherited metabolic disease;
5. Drugs and/or ingredients not approved by the FDA, including bulk compounding ingredients;
6. Minerals;
7. 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*;
8. *Legend drugs* which are not *medically necessary*;
9. Any drug prescribed for a *sickness* or *bodily injury* not covered under this *policy*;
10. 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;
11. Any amount exceeding the *default rate*;
12. 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*;
13. Allergen extracts, except as provided under the "Healthcare practitioner services" provision;
14. The administration of covered medication(s);
15. *Specialty drugs* for which *prior authorization* was not received from *us*;
16. Therapeutic devices or appliances, including but not limited to:
    a. Hypodermic needles and syringes except when prescribed in an inpatient or outpatient facility, prescribed by a *healthcare practitioner* for use with insulin, and *self-administered injectable drugs* for which *prior authorization* has been approved by *us*;
    b. Support garments;
    c. Test reagents used to detect, measure, or examine the presence of another substance;
    d. Mechanical pumps (except for insulin pumps) for delivery of medication; and
    e. Other non-medical substances;
17. Anorectic or any drug used for the purpose of weight control;
18. Abortifacients (drugs used to induce abortions);
19. 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

20. Any drug or medicine, unless recommended by the U.S. Preventive Services Task Force (USPSTF) 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*;
21. Compounded drugs in any dosage form except when prescribed for pediatric use for children through 19 years of age or as long as at least one ingredient in the compounded drug is a legend or *prescription* drug;
22. *Infertility services* including medications;
23. Any drug prescribed for impotence and/or sexual dysfunction;
24. 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);
25. *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*;
26. Injectable drugs, other than preventive immunizations, including but not limited to:
    a. Immunizing agents;
    b. Biological sera, except as expressly provided in the "Healthcare treatment facility services" provision;
    c. Blood or blood products, except as expressly provided in the "Bleeding disorders" or "Healthcare treatment facility services" provisions; or
    d. *Self-administered injectable drugs* or *specialty drugs* for which *prior authorization* has not been obtained from *us*;
27. *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;
28. 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;
29. 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;
30. Any portion of a *specialty drug prescription* fill or refill that exceeds a 30-day supply, unless *prior authorization* was received from *us*;
31. Any drug for which *we* require *prior authorization* or *step therapy* and it is not obtained;
32. Any drug for which a charge is customarily not made;
33. 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;
    c. Is refilled early; or
    d. Exceeds the duration-specific *dispensing limit*;
34. 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;
35. Any costs related to the mailing, sending or delivery of *prescription* drugs;

PRESCRIPTION DRUG EXCLUSIONS

36. Any intentional misuse of this benefit, including *prescriptions* purchased for consumption by someone other than the *covered person*;
37. Any *prescription* fill or refill for drugs, medicines or medications that are spilled, spoiled or damaged; and
38. 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*.

PEDIATRIC DENTAL CARE BENEFIT

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

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

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 routine oral 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 six months. Benefit is not available when a periodontal evaluation is performed.
3. Limited, problem focused evaluations. Limited to one per year.
4. Periodontal evaluations. Limited to a maximum of one per 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 for *covered persons*. Limited to a maximum of two per year.
10. Topical fluoride varnish treatment for *covered persons* five years of age or younger.
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. Limited to once per tooth per year.
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.
15. Diagnostic casts.

Class II services

1. Restorative *services* as follows:
   a. Fillings. Limited to a maximum of one per 12 months. 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 (including temporary) 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*.
   e. Protective restorations.

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.

2. Periodontic *services* as follows:
   a. Periodontal scaling and root planning. Limited to one every 24 months per quadrant, 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.
   e. Gingivectomy or gingivoplasty, one per two years per quadrant.
   f. Full mouth debridement, one per year.
   g. Provisional splinting.

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

3. Endodontic *services* and 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; or
      ii. It is damaged beyond repair as a result of an *accidental dental injury* while in the oral cavity;

e. 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.
f. Tissue conditioning for permanent teeth. Limited to a maximum of one every three years.
g. Denture relines or rebases. Limited to a maximum of one every three years after six months of installation.
h. 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.

8. Orthodontic treatments are limited to *medically necessary* dental treatment, subject to clinical review. *Services* include treatment of, and appliance for, tooth guidance, interception, and correction as well as x-rays, exams and follow-up care.

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;
5. *Treatment plans*;
6. Occlusal (chewing or grinding surfaces of molar and bicuspid teeth) adjustments;
7. Nitrous oxide;
8. Irrigation; and
9. Tissue preparation associated with impression or placement of a restoration.

Pretreatment plan

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

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

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

Pretreatment plan process and timing

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

Alternate services

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

Pediatric Dental Care Limitations and Exclusions

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

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

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*, except temporary crowns; 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*;
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, except as expressly covered under "Periodontic services" in this *policy* section; or
   d. Replacing tooth structures lost as a result of abrasion, attrition, erosion, or abfraction;
7. Bite registration or bite analysis;
8. Infection control, including but not limited to, sterilization techniques;
8. Local anesthetics, irrigation, nitrous oxide, study models, treatment plans, occlusal adjustments or tissue preparation associated with the impression or placement of a restoration when charged as a separate *service*. These *services* are considered an integral part of the entire dental *service*;
9. Any non-emergent dental *expenses incurred* for *services* rendered outside of the United States;
10. Elective removal of non-pathologic impacted teeth;
11. Replacement of restorations (fillings) placed less than two years ago;
12. Expenses incurred for *services* performed by someone other than a *dentist*, except for scaling and teeth cleaning and the topical application of fluoride, which can be performed by a licensed dental hygienist. The treatment must be rendered under the supervision and guidance of the *dentist* in accordance with generally accepted dental standards;
13. Any *hospital*, surgical or treatment facility, or for *services* of an anesthesiologist or anesthetist, except as expressly covered under the "Dental services" provision of the "Your Policy Benefits" section of this *policy*;
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, except as expressly covered under the "Reconstructive surgery" provision of the "Your Policy Benefits" section of this *policy*;
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 and as expressly provided under the "Prescription drugs" provision of this *policy*;
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*, except when *medically necessary*. *Services* are considered part of medical policy benefits and subject to other applicable provisions of 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* section; or
24. Any caries susceptibility testing, laboratory tests, saliva samples, anaerobic cultures, sensitivity testing or charges for oral pathology procedures.

Definitions

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

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

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

1. Facings on crowns or pontics (the portion of a fixed bridge between the abutments) posterior to the second bicuspid; or
2. 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*.

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

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

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

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

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

PEDIATRIC VISION CARE BENEFIT

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

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

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

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

Pediatric vision care covered expenses

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

1. *Comprehensive eye exam*;
2. Prescription 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. If frames are provided by an *out-of-network provider*, benefits are limited to the amount shown in the "Schedule of Benefits";
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. If contact lenses are provided by an *out-of-network provider*, benefits are limited to the amount shown in the "Schedule of Benefits";
5. *Medically necessary* contact lenses under the following circumstances when *preauthorization* is obtained:
   a. Visual acuity cannot be corrected to 20/70 in the better eye except by use of contact lenses;
   b. Anisometropia greater than 3.50 diopters and aesthenopia or diplopia, with glasses;
   c. Keratoconus;
   d. Pathological myopia;
   e. Anisometropia;
   f. Corneal disorders;
   g. Post-traumatic disorders;
   h. Irregular astigmatism;
   i. Aniseikonia;

   j. Aniridia;
   k. Monocular aphakia or binocular aphakia where the doctor certifies contact lenses are *medically necessary* for safety and rehabilitation to a productive life; and
   l. High ametropia of either +10D or -10D in any meridian; or
6. *Low vision services* include the following when *preauthorization* is obtained:
   a. One comprehensive low vision evaluation every five years and follow-up care of four visits in any five year period;
   b. Low vision supplementary testing, training and instruction to maximize remaining usable vision; and
   c. Low vision aids include only the following:
      i. Spectacle-mounted magnifiers;
      ii. Hand-held and stand magnifiers;
      iii. Hand held or spectacle-mounted telescopes; or
      iv. Video magnification.

Pediatric vision care exclusions

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

1. In no event will benefits exceed the lesser of:
   a. The benefit maximum amounts shown in the "Schedule of Benefits–Pediatric Vision Covered Expenses" section of this *policy*; or
   b. The *reimbursement limit*, as shown in the "Schedule of Benefits–Pediatric Vision Covered Expenses" section when *services* are rendered by an *out-of-network provider*.
2. *Materials* covered by this *policy* that are lost, or stolen. Broken or damaged *materials* will only be replaced at normal intervals as specified in the "Schedule of Benefits–Pediatric Vision Covered Expenses" section of this *policy*.
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; or
20. Premium lens options.

Definitions

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

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

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

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

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

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

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

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

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

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

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

Severe vision problems mean the best-corrected acuity is:

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

CLAIMS

Assignment of benefits

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

Claims processing edits

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

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

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

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

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

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

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

Completing the claim form

We do not require completion of a standard claim form to process benefits. After *we* receive notice informing *us* of the claim, *we* will notify the *covered person* of any additional information *we* need to process the claim within 15 days of receipt of the claim notice. If *we* fail to give notice within this time period, the proof of loss requirement will have been met by sending *us* a written statement of the nature and extent of the loss within the time limit stated in the "Proof of loss" provision.

Cost of legal representation

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

Duplicating provisions

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

Non-duplication of Medicare benefits

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

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

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

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

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

CLAIMS

Notice of claim

In-network providers will submit claims to *us* on *your* behalf. If *you* utilize an *out-of-network provider* for *covered expenses*, *you* must submit a notice of claim to *us*. Notice of claim must be given to *us* in writing or by *electronic* mail as required by this *policy*, 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.

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

1. Name of the *covered person* who incurred the *covered expenses*; and
2. *Policy* number.

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 *your* benefits are reduced due to other insurance, *we* will return part of the last premium which *you* paid prior to commencement of a loss covered under this *policy*. The proportion *we* will use to determine *your* premium refund will be the same proportion *we* use to determine the benefits payable. In no event will *our* payment be larger than the amount that would have been payable without this provision.

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.

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;
4. Any information *we* need to administer the terms of this *policy*;
5. Name and address of the provider;
6. Diagnosis;
7. Procedure or nature of the treatment;
8. Place of *service*;
9. Date of *service*; and
10. 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.

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

However, *your* claims will not be reduced or denied if it was not reasonably possible to give such proof. In any event, written or *electronic* notice must be given within one year after the date written or *electronic* proof of loss is otherwise required under this *policy*, except if *you* were legally incapacitated.

Recovery rights

Workers' compensation

Your policy excludes coverage for injuries that are covered under Workers' compensation or similar laws. 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, for which coverage was available under Workers' compensation or similar law, *we* have the right to recover payments as described under the "Right to request overpayments" provision as described below.

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 applicable *deductible* or *out-of-pocket limit*.

Right to require medical examinations

We have the right to have the *covered person* examined as often as *we* deem reasonably necessary to determine *policy* benefits while a claim is pending. *We* also have the right to have an autopsy made of the *covered person*, unless prohibited by law. These procedures will be conducted to determine *policy* benefits, at *our* expense.

Time of payment of claims

Payments due under this *policy* will be paid within 30 days after *our* receipt of complete written or *electronic* proof of loss.

CLAIMS

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.

If the *covered person* is deceased, payment will be made to *your* estate. If benefits are payable to the *covered person's* estate or a beneficiary who cannot execute a valid release, *our* payment will not exceed $2,000 and will be paid to someone related to the *covered person* by blood or by marriage or beneficiary who *we* consider to be entitled to the benefits. Any payment made by *us* in good faith will fully discharge *us* of any liability to the extent of such payment.

VIRGINIA APPEAL RIGHTS

Complaint and appeal procedures

Internal appeals

You or *your authorized representative* must appeal an adverse benefit determination within 180 days after receiving written notice of the denial (or partial denial). An appeal may be made by *you* or *your authorized representative* by means of written application to *us* by mail, postage prepaid to the address below:

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

You or *your authorized representative*, on appeal, may request an expedited internal appeal of an adverse *urgent-care claim* decision orally or in writing. In such case, all necessary information, including *our* benefit determination on review, will be transmitted between *us* and *you* or *your authorized representative* by telephone, FAX, or other available similarly expeditious method, to the extent permitted by applicable law.

You or *your authorized representative* may request an expedited external review at the same time a request is made for an expedited internal appeal of an adverse benefit determination for an *urgent-care claim* or when *you* are receiving an ongoing course of treatment.

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

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

You or *your authorized representative* on appeal may, upon request, discover the identity of medical or vocational experts whose advice was obtained on behalf of the plan in connection with the *adverse benefit determination* being appealed, as permitted under applicable law.

If the claims denial is based in whole, or in part, upon a medical judgment, including determinations as to whether a particular treatment, drug, or other service is *experimental* or *investigational* or *for research purposes*, or not *medically necessary* or appropriate, the person deciding the appeal will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The consulting health care professional will not be the same person who decided the initial appeal or a subordinate of that person.

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

VIRGINIA APPEAL RIGHTS

Time periods for decisions on appeal

Appeals of claims denials will be decided and notice of the decision provided as follows:

1. Urgent-care claims - As soon as possible but not later than 72 hours after we received the appeal request;
2. Pre-service claims - Within a reasonable period but not later than 30 days after we received the appeal request;
3. Post-service claims - Within a reasonable period but not later than 60 days after we received the appeal request;
4. Concurrent-care decisions - Within the time periods specified above depending on the type of claim involved.

Appeal denial notices

Notice of a claim denial (including a partial denial) will be provided to *you* or *your authorized representative* by mail, postage prepaid, or by FAX, as appropriate, within the time periods noted above. A notice that a claim appeal has been denied will include:

1. The specific reason or reasons for the adverse benefit determination;
2. Reference to the specific *policy* provision upon which the determination is based;
3. If any internal plan rule, protocol or similar criterion was relied upon to deny the claim. A copy of the rule, protocol or similar criterion will be provided to *you* or *your authorized representative*, free of charge;
4. A statement of *you* or *your authorized representative's* right to external review, a description of the external review process, and the forms for submitting an external review request, including release forms authorizing *us* to disclose protected health information pertinent to the external review;
5. A statement about *you* or *your authorized representative's* right to bring an action under §502(a) of ERISA;
6. If an adverse benefit determination is based on medical necessity, *experimental* treatment or similar exclusion or limitation, the notice will provide an explanation of the scientific or clinical basis for the determination, free of charge. The explanation will apply the terms of the *policy* to the *covered person's* medical circumstances.

Exhaustion of remedies

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

After exhaustion of remedies, *you* or *your authorized representative* may pursue any other legal remedies available, which may include bringing civil action under ERISA section 502(a) for judicial review of the plan's determination. Additional information may be available from the local U.S. Department of Labor Office.

VIRGINIA APPEAL RIGHTS

External review

Within 120 days after *you* or *your authorized representative* receives notice of an adverse benefit determination or final adverse benefit determination involving medical necessity, appropriateness, health care setting, level of care, effectiveness, or *experimental* or *investigational* treatment, *you* or *your authorized representative* may request an external review. The request for external review must be made in writing to the commission. The commission has developed an External Review Request Form that may be used to write *your* request.

You or *your authorized representative* may contact the commissioner of insurance for assistance at any time at the address and telephone number below:

Commonwealth of Virginia State Corporation Commission
Bureau of Insurance
P.O. Box 1157
Richmond, Virginia 23218-1157
Phone: 1-877-310-6560

Website: http://www.scc.virginia.gov/boi
E-Mail: bureauofinsurance@scc.virginia.gov

You or *your authorized representative* will be required to authorize release of any medical records of the *covered person* that may be required to be reviewed for the purpose of reaching a decision on the external review. Please refer to the 'Expedited external review' provision if the adverse benefit determination involves an urgent-care claim or an ongoing course of treatment.

If the request qualifies for an external review, the commission will notify *you* or *your authorized representative* in writing of the assignment of an *IRO* and the right to submit additional information. Additional information must be submitted within the first 5 business days of receipt of the letter. *You* or *your authorized representative* will be notified of the determination within 45 days of the *IRO's* receipt of the request.

Expedited external review

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

1. At the same time *you* request an expedited internal appeal of an adverse benefit determination for an urgent-care claim or when *you* are receiving an ongoing course of treatment; or
2. When *you* receive an adverse benefit determination or final adverse benefit determination of:
3. An urgent-care claim;
4. An admission, availability of care, continued stay or health care service for which *you* received emergency services, but *you* have not been discharged from the *healthcare treatment facility*; or
5. An *experimental* or *investigational* or *for research purposes* treatment if the treating *healthcare practitioner* certifies, in writing, that the recommended service would be significantly less effective if not promptly initiated.

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

PREMIUM PAYMENT

Your duty to pay premium

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

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. Coverage will remain in force during the 31 day grace period.

Changes to your premium

Premium may change when:

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

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

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.

You may cancel this *policy* at any time by written notice delivered or mailed to *us* effective upon receipt or on such later date as may be specific in the notice. In the event of cancellation, we will promptly return the unearned portion of any premium paid. The earned premium will be computed pro rata. Cancellation will be without prejudice to any claim originating prior to the effective date of cancellation.

CHANGES TO THE POLICY

Your rights to make changes to the policy

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

Changes in benefits

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

Change in residence

We must be notified of any 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* wish to remove a *covered person* from *your policy*, simply call the telephone number on *your ID card*.

2. **Adding dependents**

   If a child is born to a *policyholder*, or any *covered person*, a *policyholder* adopts a child, or a child is placed with the *policyholder* for the purpose of adoption or foster care, coverage will be effective for 31 days from the moment of birth, placement or adoption. To continue coverage for the child beyond this 31-day period we must be notified of the event in writing and receive any required premium within 60 days of the event.

   If *we* do not receive notice and premium as outlined above and forward, the child must wait to enroll for coverage during the next *open enrollment period* unless such child becomes eligible for special enrollment as specific 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*; or
   g. Death of the *policyholder*;

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

2. Coverage under this *policy* terminates due to:
   a. A *dependent* child ceasing to be eligible due to attaining the *limiting age*; or
   b. The *policyholder* moves outside of the service area for this *policy*;

   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; or
   b. Not a citizen of the United States, lawfully present, and subsequently gaining such lawful status;
   c. Was incarcerated and is no longer incarcerated.

   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.

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*.

CHANGES TO THE POLICY

Open enrollment

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

The request to enroll must be received by *us* during the *open enrollment period*. If enrollment is requested after the *open enrollment period*, the *covered person* and/or *dependent* must wait to enroll for coverage during the next *open enrollment period*, unless they become eligible for special enrollment as specified in the "Special enrollment" provision.

The *effective date* of coverage when enrolling during an *open enrollment period* will be assigned.

Our rights to make changes to the policy

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

Changes we will make without notice to you

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

Changes where we will notify you

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

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

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

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

RENEWABILITY OF INSURANCE AND TERMINATION

Reasons we will terminate your policy

Please refer to the cover page of this *policy* for this provision.

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; or
3. When the *policyholder's* coverage under this *policy* terminates.

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

Your duty to notify us

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

Fraud

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

It is a crime to willingly and knowingly provide false, incomplete or misleading information to an insurance company for the purpose of deceiving the company.

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

GENERAL PROVISIONS

Choice of providers

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

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

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

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

Conformity with state statutes

Any provisions which are in conflict with the laws of the state in which the *policyholder* resides are amended to conform to the minimum requirements of those laws.

Continuity of care

Continuity of care means the continuation of *services* from a terminated network provider. Benefits for *services* received for health conditions for which continuity of care is available 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*.

A terminated provider is an *in-network provider* whose contract is terminated or not renewed for cause. A terminated provider is not a provider who voluntarily terminated their contract.

Continuity of care is available for a period of 90 days following the provider's termination date and is available for a *covered person* who:

1. Was in an active course of treatment prior to the provider's notice of termination; or
2. Requests to continue receiving *services* from the provider.

Continuity of care is also available for a *covered person* who:

1. Has entered the second trimester of pregnancy. Continuity of care will continue through the postpartum care directly related to the pregnancy; or
2. Has been diagnosed as terminally ill. Continuity of care will continue for the remainder of the *covered person's* life for treatment related to the terminal illness or injury.

Entire contract

The rules governing *our* agreement to provide *you* with health insurance in exchange for *your* premium payment are based upon the entire contract which consists of: this *policy*, riders, amendments, endorsements, application, and the attached papers, if any. 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.

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.

Time limit on certain defenses

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

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*.

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.

Legal action

No legal action may be brought to recover on this *policy* within 60 days after written proof of loss has been given as required by the *policy*. No legal action may be brought after three years from the time the written proof of loss is required to be given.

Misstatement of age

If *you* or the *covered person's* age has been misstated, the benefits will be those the premium paid would have purchased at the correct age.

GENERAL PROVISIONS

Our relationship with providers

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

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

Reinstatement

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 90 days; and
3. *We* approve the reinstatement.

If *your* request for reinstatement is approved, coverage will be reinstated on the date *we* approve the reinstatement. Lacking such approval, the *policy* will be reinstated on the 45th day after the date of the conditional receipt unless *we* have previously written the *policyholder* of its disapproval.

Shared savings program

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

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

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

In most cases, to maximize *your* benefit design and minimize *your* out-of-pocket expense, please access *in-network providers* associated with this *policy*.

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

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

The Shared Savings Program may be modified, amended or discontinued at any time.

State public medical assistance (Medicaid)

If a *covered person* received medical assistance from the Virginia Department of Medical Assistance Services while covered under this *policy*, *we* will reimburse the Department for the actual cost of medical expenses the Department paid through medical assistance, if such assistance was paid for a *covered expense* for which benefits are payable under this *policy*, if *we* receive notice from the Department of payment of such assistance. Any reimbursement to the Department made by *us* will discharge *us* to the extent of the reimbursement. This provision applies only to the extent *we* have not already made payment of the claim to *you* or to the provider. The Department of Medical Assistance Services shall always be the payer of last resort.

Workers' compensation

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

DEFINITIONS

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

Activities of daily living means walking, eating, drinking, dressing, toileting, transferring (e.g. wheelchair to bed), and bathing.

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

Authorized representative means someone *you* have appropriately authorized to act on *your* behalf, including *your healthcare practitioner*.

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 an injury which is accidental, the direct result of an accident, and is independent of disease, *sickness*, or other cause and occurs while this *policy* is in force.

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

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

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

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

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

DEFINITIONS

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* except for clinical trial costs required to be covered under law or otherwise excluded or limited by this *policy* or by any amendment.

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

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

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

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

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

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".

DEFINITIONS

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* which is accidental, the direct result of an accident, and is independent of disease, *sickness*, or other cause and occurs while this *policy* is in force.

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. Incapable of self-sustaining employment by reason of intellectual disability or physical handicap; and
4. Chiefly dependent on *you* for support and maintenance.

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*; or
2. Great grandchild.

DEFINITIONS

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 and hypodermic needles;
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.

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

Domestic partner means an individual of the same or opposite gender who resides with *you* in a long-term relationship of indefinite duration, and, there is an exclusive mutual commitment in which the partners agree to be jointly responsible for each other's common welfare and share financial obligations. *We* will allow coverage for only one *domestic partner* of *yours* at any one time. *You* and *your domestic partner* must each be at a minimum 18 years of age, competent to contract, and may not be related by blood to a degree of closeness which would prohibit legal marriage in the state in which *you* and *your domestic partner* both legally reside. *We* reserve the right to require an affidavit from *you* and *your domestic partner* attesting that the domestic partnership has existed for a minimum period of six months and, periodically thereafter, to require proof that the *domestic partner* relationship continues to exist.

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

Durable medical equipment means equipment which meets the following criteria:

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

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.

DEFINITIONS

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

Emergency care means emergency s*ervices* for a *bodily injury* or *sickness* manifesting itself by acute symptoms of sufficient severity, including severe pain, so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

1. Serious jeopardy to the mental or physical health of the *covered person*;
2. Danger or serious impairment to bodily functions;
3. Serious dysfunction of any bodily organ or part; or
4. In the case of a pregnant woman, serious jeopardy to the health of the fetus.

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. Pulp caps, pulpal therapy and pulpal regeneration;
5. Partial pulpotomy; or
6. Vital pulpotomy.

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

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

1. Not be a benefit for diagnosis or treatment of a *sickness* or a *bodily injury*; or
2. Not be as beneficial as any established alternative.

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

1. Cannot be lawfully marketed without the final approval of the United States Food and Drug Administration (FDA) for the particular *sickness* or *bodily injury* and which lacks such final FDA approval for the use or proposed use, unless:
   a. Found to be accepted for that use in the most recently published edition of the United States Pharmacopoedia-Drug Information for Healthcare Professional (USP-DI) or in the most recently published edition of the American Hospital Formulary Service (AHFS) Drug Information;
   b. Identified as safe, widely used and generally accepted as effective for that use as reported in nationally recognized peer reviewed medical literature published in the English language as of the date of *service*; or
   c. Is mandated by Federal or state law;
2. Is a device required to receive Premarket Approval (PMA) or 510K approval by the FDA, but has not received a PMA or 510K approval;
3. Is not identified as safe, widely used, and generally accepted as effective for the proposed use as reported in nationally recognized peer reviewed medical literature published in the English language as of the date of service;

4. Does not have adequate peer-reviewed medical and scientific literature to allow *us* to judge the safety and efficacy;
5. Does not provide scientific evidence or positive health results outside of a research setting;
6. The *service* or supply is not a safe and effective as current diagnostic or therapeutic options;
7. 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; or
8. The FDA has determined the device to be contraindicated for the particular *sickness* or *bodily injury* for which the device has been prescribed.

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.

Generic drug means a drug, medicine or medication, including a *specialty drug* 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 is an immediate *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* includes a *surgical facility*, *hospital* and outpatient *hospital* facility. *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. Not have a business interest in the *home healthcare agency* by ownership or contract.

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

Hospice means a coordinated program of home and inpatient care provided directly or through an agreement under the direction of an identifiable *hospice* administration providing palliative and supportive medical and other health *services* to terminally ill patients and their families. A *hospice* utilizes a medically directed interdisciplinary team. A *hospice* program of care provides care to meet the physical, psychological, social, spiritual and other special needs which are experienced during the final stages of illness, and during dying and bereavement. *Hospice* care shall be available 24 hours a day, seven days a week.

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 the *hospice patient's* family, 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*.

Hospice facility means an institution, place, or building owned or operated by a *hospice* provider and licensed by the Department to provide room, board, and appropriate *hospice* care on a 24-hour basis, including respite and symptom management, to individuals requiring such care pursuant to the orders of a physician. Such facilities with 16 or fewer beds are exempt from Certificate of Public Need laws and regulations. Such facilities with more than 16 beds shall be licensed as a nursing facility or *hospital* and shall be subject to Certificate of Public Need laws and regulations.

Hospice patient means a diagnosed terminally ill patient, with an anticipated life expectancy of six months or less, who alone, or in conjunction with designated family members, has voluntarily requested admission and been accepted into a licensed *hospice program*.

Hospice patient's family means the *hospice patient's* immediate kin, including a spouse, brother, sister, child or parent. Other relations and individuals with significant personal ties to the *hospice* patient may be designated as members of the *hospice patient's family* by mutual agreement among the *hospice patient*, the relation or individual, and the *hospice* team.

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

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

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

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

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

Infertility services means any 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. Therapeutic laparoscopy;
11. Hysterosalpingography;
12. Ultrasonography;
13. Endometrial biopsy; and
14. Any other assisted reproductive techniques or cloning methods.

Infusion means infusion of therapeutic agents, medication and nutrients, infusion of enteral nutrition into the gastrointestinal tract and infusion of *prescription* medications.

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

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

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

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

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

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

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

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

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 31st birthday (26th birthday if coverage was purchased through a *marketplace*).

DEFINITIONS

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.

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

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

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

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

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

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

1. In accordance with nationally recognized standards of medical practice;
2. Clinically appropriate in terms of type, frequency, extent, setting, and duration and considered effective for the patient's *sickness* or *bodily injury*;

3. Not primarily for the convenience of the patient or *healthcare practitioner* or other healthcare provider; and
4. Not more costly than an alternative *service* or sequence of *services* at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the patient's *sickness* or *bodily injury*.

For the purpose of *medically necessary*, generally accepted standards of medical practice means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations, the views of *healthcare practitioners* practicing in relevant clinical areas, and any other relevant factors.

Medication management visit means a visit no more than 20 minutes in length with a *healthcare practitioner* for the sole purpose of monitoring and adjusting medications prescribed for *mental health.*

Mental health means *mental illness* and *substance use disorder*.

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:

1. A weight that is at least 100 pounds over or twice the ideal weight for frame, age, height, and gender as specified in the 1983 Metropolitan Life Insurance tables;
2. A body mass index (BMI) equal to or greater than 35 kilograms per meter squared with co-morbidity or coexisting medical conditions such as hypertension, cardiopulmonary conditions, sleep apnea, or diabetes; or
3. A BMI of 40 kilograms per meter squared without such co-morbidity.

BMI equals weight in kilograms divided by height in meters squared.

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

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

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

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

Open enrollment period means the period during which:

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

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

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

Out-of-network pharmacy means a *pharmacy* that has not signed a direct agreement with *us* or has not been designated by *us* to provide covered *pharmacy services*, covered *specialty pharmacy services* or covered *mail-order pharmacy services* as defined by *us*, to *covered persons* including covered *prescription* fills or refills delivered to a *covered person's* home or healthcare provider.

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

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

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

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

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 *surgical facility*;
4. A licensed birthing center;
5. An independent laboratory or clinic; or
6. A sub-acute rehabilitation facility.

Palliative care means treatment directed at controlling pain, relieving other symptoms, and focusing on the special needs of the *covered person* and family.

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 six hours a day, and a minimum of three hours a day for intensive outpatient programs;
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.

DEFINITIONS

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

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

1. Family Medicine;
2. Internal Medicine;
3. Pediatrics;
4. Gynecologists; and
5. Obstetricians.

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

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.

Includes coverage for therapies to restore and in some cases, maintain capabilities lost due to disease, illness, injury or in the case of speech therapy, loss additionally due to congenital anomaly or prior medical treatment.

Rescission/rescinded/rescind 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;
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; and
4. Provides *services* for the treatment of *substance use disorder*, eating disorders and the like.

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*.

Service area means the entire state of Virginia.

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

Sickness means a disease or physical condition of a *covered person*. Sickness does not include coverage for which benefits are provided under any Workers' compensation, occupational disease, employer's liability or similar law.

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 (Specialist) 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 *sicknesses* or *bodily injuries* based on the appropriate drug indication. *Specialty drugs* may:

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

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

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

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

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

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

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

Substance use disorder 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.

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.

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*.

DEFINITIONS

Telemedicine means an audio and video real-time interactive communication between the patient and *distant site healthcare practitioner*. It does not include an audio-only telephone, *electronic* mail message, facsimile transmission or online questionnaire.

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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