INDIVIDUAL HMO MEDICAL POLICY
HUMANA MEDICAL PLAN, INC.

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

For All Other Inquiries
PO Box 14642
Lexington, KY 40512-4642
Toll-Free 1-800-833-6917

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

PLEASE READ THIS POLICY CAREFULLY

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

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

This *policy* is issued in consideration of the *policyholder's* application, a copy of which is attached and made a part of this *policy*, and the *policyholder's* payment of premium as provided under this *policy*. **Intentional omissions, fraud or misstatements of a material fact in the application may cause *your policy* to be voided, terminated or cancelled and claims to be denied.** Please check *your* application for errors and write to *us* if any information is not correct or is incomplete. If *you* purchased *your* coverage through the *marketplace*, please contact the *marketplace* for any information that is not correct or complete. The website is www.healthcare.gov.

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

Renewability

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

Right to return policy

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

THIS *POLICY* CONTAINS A *DEDUCTIBLE* PROVISION

Bruce Broussard
President

Multi-Language Interpreter Services

English: ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call 1-877-320-1235 (TTY: 711).

Español (Spanish): ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-320-1235 (TTY: 711).

繁體中文 (Chinese): 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-877-320-1235 (TTY: 711)。

Tiếng Việt (Vietnamese): CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-877-320-1235 (TTY: 711).

한국어 (Korean): 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-877-320-1235 (TTY: 711)번으로 전화해 주십시오.

Tagalog (Tagalog – Filipino): PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-877-320-1235 (TTY: 711).

Русский (Russian): ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-877-320-1235 (телетайп: 711).

Kreyòl Ayisyen (French Creole): ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-877-320-1235 (TTY: 711).

Français (French): ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-877-320-1235 (ATS : 711).

Polski (Polish): UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-877-320-1235 (TTY: 711).

Português (Portuguese): ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-877-320-1235 (TTY: 711).

Italiano (Italian): ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-877-320-1235 (TTY: 711).

Deutsch (German): ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-877-320-1235 (TTY: 711).

العربية (Arabic):
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-877-320-1235 (رقم هاتف الصم والبكم: 711).

日本語 (Japanese): 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-877-320-1235 (TTY：711) まで、お電話にてご連絡ください。

فارسی (Farsi):
توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-877-320-1235 (TTY: 711) تماس بگیرید.

Diné Bizaad (Navajo): Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, koji' hódíílnih 1-877-320-1235 (TTY: 711).

Discrimination is Against the Law

Humana Inc. and its subsidiaries comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Humana Inc. and its subsidiaries do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Humana:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats

- Provides free language services to people whose primary language is not English when those services are necessary to provide meaningful access, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Dr. Michelle Griffin, PhD.

If you believe that Humana has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Dr. Michelle M. Griffin, PhD (FACHE)
Civil Rights/LEP/ADA/Section 1557
Compliance Officer: 500 W. Main Street -10th floor Louisville, Kentucky 40202
Phone: **1-877-320-1235** Fax: **1-877-320-1269**
Email: **Mgriffin5@humana.com** or **Accessibility@humana.com**

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Dr. Michelle Griffin PHD, Civil Rights/LEP/ADA/Section 1557 Compliance Officer is available to help you at the contact information listed above.

You can also file a civil rights complaint with the **U.S. Department of Health and Human Services**, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800–368–1019, 800-537-7697 (TDD)
Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**

GUIDE TO YOUR POLICY

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GUIDE TO YOUR POLICY

INTRODUCTION

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

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

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

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

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

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

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

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

SCHEDULE OF BENEFITS

This Schedule of Benefits outlines benefit information and the date these benefits take effect. As *your* needs change over time, *you* may change some of these benefits. See the "Changes to the Policy" section.

In most cases, if a *covered person* receives *services* from an *in-network provider*, *we* will pay a higher percentage of benefits and the *covered person* will incur lower out-of-pocket costs.

There is no cost sharing for services furnished by the Indian Health Service, An Indian Tribe, Tribal Organization, or Urban Indian Organization (each as defined in 25 U.S.C. 1603) that qualify as an essential health benefit in the Health Insurance Marketplace for a Native American Indian, as defined by Section 4 of the Indian Health Care Improvement Act.

Please read *your* entire *policy* to fully understand all terms, conditions, exclusions, and limitations that apply.

Coverage Information

Date benefits take effect:

Policy Holder	99/99/99
Dependent Name 1	99/99/99
Dependent Name 2	99/99/99
Dependent Name 3	99/99/99
Dependent Name 4	99/99/99
Dependent Name 5	99/99/99
Dependent Name 6	99/99/99
Dependent Name 7	99/99/99
Dependent Name 8	99/99/99
Dependent Name 9	99/99/99
Dependent Name 10	99/99/99

Policyholder: Policy Holder

Covered Person(s):

Policy Holder
Dependent Name 1
Dependent Name 2
Dependent Name 3
Dependent Name 4
Dependent Name 5
Dependent Name 6
Dependent Name 7
Dependent Name 8
Dependent Name 9
Dependent Name 10

SCHEDULE OF BENEFITS

Deductible - Each *deductible* is separate and does not apply toward satisfying any other *deductible.* *Copays* do not apply to the *deductible.* See the "Definitions" section for the definition of the *deductible.*

Medical Deductible

Individual deductible (per covered person per calendar year)

Services from in-network providers:	$3,550
Services from out-of-network providers:	not covered

Family deductible (per family per calendar year)

Services from in-network providers:	$7,100
Services from out-of-network providers:	not covered

Prescription Drug Deductible

Individual deductible (per covered person per calendar year)

Services from in-network providers:	$500
Services from out-of-network providers:	not covered

Family deductible (per family per calendar year)

Services from in-network providers:	$1,000
Services from out-of-network providers:	not covered

Out-of-Pocket Limit - Some *services* do not apply to the *out-of-pocket limit.* See the "Definitions" section for the definition of the *out-of-pocket limit*.

Individual maximum (per covered person per calendar year)

Services from in-network providers:	$7,150
Services from out-of-network providers:	not covered

Family maximum (per family per calendar year)

Services from in-network providers:	$14,300
Services from out-of-network providers:	not covered

Coinsurance Levels and Benefit Maximums for Covered Expenses

If *you* have family coverage, the individual *deductible* and *out-of-pocket limit* accumulates to the medical and *prescription* drug individual and family maximum. An individual covered family member will receive *coinsurance* benefits once they have met their individual *deductible.* The rest of the covered family members will receive *coinsurance* benefits once they have satisfied the earlier of their individual *deductible* or when the entire family *deductible* has been satisfied.

After the *out-of-pocket limit* is met, then this *policy* pays 100% of all *covered expenses* for the balance of that *calendar year.* See the "Definitions" section for the definitions of *coinsurance* and *benefit maximum.*

All covered expenses except as noted below

Covered person pays for services from in-network providers:	20% after deductible
Covered person pays for services from out-of-network providers:	not covered

SCHEDULE OF BENEFITS

Medical Covered Expenses

Ambulance

Services from in-network providers:	20% after deductible
Services from out-of-network providers:	20% after deductible

Habilitative Services

Services from in-network providers:	20% after deductible
Services from out-of-network providers:	not covered

- **Benefit Maximum:** 35 combined visit limit for physical therapy, massage therapy, occupational therapy, and speech therapy per person per calendar year

  Speech therapy related to cleft lip/cleft palate is not subject to the visit limit.

Emergency Room Facility Services

Services from in-network providers:	$600 copay per visit and deductible
Services from out-of-network providers:	$600 copay per visit and deductible

Healthcare Practitioner Services

Office visits for mental health

Services from in-network providers:	$20 copay per visit
Services from out-of-network providers:	not covered

Office visits for bodily injury and all other sickness

Services from in-network providers:

PCP	$20 copay per visit
Specialist	$40 copay per visit
Retail Clinic	$30 copay per visit
Urgent Care	$40 copay per visit

Services from out-of-network providers:	not covered

Emergency room healthcare practitioner services

Services from in-network providers:	20% after deductible
Services from out-of-network providers:	20% after deductible

Therapeutic injections (includes allergy injections and administration fee; excludes routine injections)

Services from in-network providers:	$5 copay
Services from out-of-network providers:	not covered

SCHEDULE OF BENEFITS

Home Healthcare

Services from in-network providers:	0% for the first 10 visits, then subject to applicable coinsurance per person per calendar year
Services from out-of-network providers:	not covered

- **Benefit Maximum:** 20 days per person per calendar year

Outpatient Therapies and Rehabilitative Services

Services from in-network providers:	20% after deductible
Services from out-of-network providers:	not covered

- **Benefit Maximum:**
  - 35 combined visit limit for spinal manipulations, adjustments, and modalities, physical therapy, massage therapy, occupational therapy, speech therapy, and cardiac rehabilitation per person per calendar year

  Respiratory therapy, pulmonary rehabilitation, and speech therapy related to cleft lip/cleft palate is not subject to the visit limit.

Preventive Medical Services – Does not include drugs, medicines or medications and supplies on the Preventive Medication Coverage drug list. Refer to the "Prescription drugs" provision in the "Your Policy Benefits" section.

Services from in-network providers:	0%
Services from out-of-network providers:	not covered

Skilled Nursing and Rehabilitation Facility

Services from in-network providers:	20% after deductible
Services from out-of-network providers:	not covered

- **Benefit Maximum:**
  - 60 days per person per calendar year for skilled nursing
  - 21 days per person per calendar year for rehabilitation facility

Transplants

Transplant services

Services from in-network providers:	20% after deductible
Services from out-of-network providers:	not covered

Transportation and lodging direct non-medical costs

Services from in-network providers:	0% after deductible up to a maximum of $10,000 for each covered transplant
Services from out-of-network providers:	not covered

SCHEDULE OF BENEFITS

Prescription Drug Covered Expenses

Your cost share for covered orally administered anticancer medications for the treatment of cancer will not exceed any applicable copayment, coinsurance or deductible amount you are responsible to pay for intravenously administered or injected anticancer medications.

Retail Pharmacy – Coverage for up to a 30-day supply

Level one drugs – Preferred, lowest cost generics

Services from in-network pharmacy:	$10 copay per prescription fill or refill
Services from out-of-network pharmacy:	not covered

Level two drugs – Low cost generic drugs

Services from in-network pharmacy:	$20 copay per prescription fill or refill
Services from out-of-network pharmacy:	not covered

Level three drugs – Preferred brand drugs and some higher cost generic drugs

Services from in-network pharmacy:	$50 copay after prescription drug deductible per prescription fill or refill
Services from out-of-network pharmacy:	not covered

Level four drugs – Non-preferred brand drugs and some non-preferred highest cost generic drugs

Services from in-network pharmacy:	50% coinsurance after prescription drug deductible per prescription fill or refill
Services from out-of-network pharmacy:	not covered

Preventive Medication Coverage

Drugs, medicines or medications and supplies on the Preventive Medication Coverage *drug list* are covered with no *cost share* when obtained from an *in-network pharmacy*.

Specialty Pharmacy and Retail Pharmacy – Coverage for up to a 30-day supply from an in-network Specialty or Retail Pharmacy

Level five drugs – Specialty drugs

Specialty drugs and services from an in-network pharmacy designated by us as a preferred provider
40% coinsurance after prescription drug deductible per prescription fill or refill

Specialty drugs and services from all other in-network pharmacy providers of specialty drugs
50% coinsurance after prescription drug deductible per prescription fill or refill

Specialty drugs and services from an out-of-network pharmacy
not covered

Mail Order Pharmacy - Coverage for up to a 90-day supply from an in-network Mail Order Pharmacy

Prescription drugs (excludes specialty drugs)

Services from in-network pharmacy:	Applicable coinsurance outlined above or 2.5 times the applicable level copay, if any, outlined above after prescription drug deductible per prescription fill or refill
Services from out-of-network pharmacy:	not covered

SCHEDULE OF BENEFITS

Pediatric Vision Covered Expenses

Comprehensive eye exam
Services from in-network providers: 50% after deductible
Services from out-of-network providers: not covered

- **Benefit Maximum:** one exam in any 12-month period

Prescription lenses (Single vision, bifocal, trifocal, and lenticular lenses)
Services from in-network providers: 50% after deductible
Services from out-of-network providers: not covered

- **Benefit Maximum:** one pair of covered prescription lenses in any 12-month period

Frames
Services from in-network providers: 50% after deductible
Services from out-of-network providers: not covered

- **Benefit Maximum:** one covered new frame per person in any 12-month period

Elective contact lenses (in lieu of all other benefits for frames and/or lenses)
Services from in-network providers: 50% after deductible
Services from out-of-network providers: not covered

- **Benefit Maximum:** a single purchase of up to a 3-month supply of daily disposables, or a 6-month supply of non-daily disposables, once per person in any 12-month period. Replacements are limited to once in any 12-month period.

Medically necessary contact lenses (in lieu of all other benefits for frames and/or lenses)
Services from in-network providers: 50% after deductible
Services from out-of-network providers: not covered

- **Benefit Maximum:** replacement is limited to once in any 12-month period

Contact lens fitting and follow up exam
Services from in-network providers: 50% after deductible
Services from out-of-network providers: not covered

Low vision services
Services from in-network providers: 50% after deductible
Services from out-of-network providers: not covered

- **Benefit Maximum:**
  - one comprehensive eye exam in any 5 year period
  - four follow-up exams in any 5 year period
  - one low vision aid per person in any 36-month period except for video magnification which is limited to one in any 5 calendar years for aids

ACCESS TO CARE

How to find an in-network provider

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

Use of in-network providers

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

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

Selecting a primary care physician

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

Role of the primary care physician

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

When a primary care physician is not available

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

ACCESS TO CARE

Seeing a specialist

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

Open access to specialists

We allow open access to certain in-network *specialty care physicians* without a referral from a *primary care physician* or authorization from *us*. These include chiropractor, dermatologist (for the first five visits in a *calendar year*; thereafter a referral from a *primary care physician* is required), podiatrist, obstetrical and gynecological *services* from an in-network *healthcare practitioner*. However, *you* must have a referral from *your primary care physician* and an *authorization* from *us* to see any other *in-network provider* or any *out-of-network provider.* In addition, *services* from an *out-of-network provider* must be *authorized* by *us* before receiving any *services* from the *out-of-network provider.* Refer to the 'Use of out-of-network providers' provision in this section for information on *out-of-network provider services*.

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

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

Seeking emergency care services

If *you* need *emergency care*:

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

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

If *you* seek *emergency care* at an out-of-network *hospital*, arrangements will be made to transfer *you* to an in-network *hospital* after *your* condition is *medically stable. Medically stable* with respect to an emergency medical condition means that no material deterioration of the *covered person's* condition is likely to result from or occur during the transfer of the *covered person* from a facility.

ACCESS TO CARE

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

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

Seeking urgent care services

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

1. Go to an *urgent care center* that is an *in-network provider*. *You* can obtain the names of *in-network provider urgent care centers* by accessing our online directory of *in-network providers* on *our* Website at www.humana.com or by calling *us*.
2. *You* must receive any follow-up *services* from the *primary care physician* or an *in-network provider.*
3. *You* must pay any applicable *deductible, copayment,* and *coinsurance* required for urgent care.

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

Use of out-of-network providers

No benefits are available for *services* from an *out-of-network provider* that are not *authorized* in advance by *us* except as expressly provided in the "General Exclusions" section. This *authorization* must be obtained prior to seeking *services*. Only those *services authorized* by *us* to be provided by an *out-of-network provider* will be *covered expenses*.

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

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

ACCESS TO CARE

Continuity of care

If a *covered person's* provider ceases being an *in-network provider* without cause while the *covered person* is undergoing an active course of treatment, the *covered person* may continue the active course of treatment with the same provider until treatment is complete or for 90 days, whichever is shorter. If the provider agrees to continue providing the *covered person's* active course of treatment, *we* will pay *in-network provider* benefits based on the amount established by the provider's terminated *in-network provider* agreement with *us.* In addition to any applicable *in-network provider deductibles, copayments* and *coinsurance,* the *covered person* is responsible to pay the difference between the amount *we* pay to the provider and the amount the provider bills the *covered person* for the *services.* Any amount other than the *deductible, copayment* or *coinsurance* the *covered person* pays to the provider will not apply to the *out-of-pocket limit*.

For the purposes of this 'Continuity of care' provision, active course of treatment means:

1. An ongoing course of treatment for a life-threatening condition, defined as a disease or condition for which likelihood of death is probable unless the course of the disease or condition is interrupted;

2. An ongoing course of treatment for a serious acute condition, defined as a disease or condition requiring complex ongoing care which the *covered person* is currently receiving, such as chemotherapy, radiation therapy, or post-operative visits;

3. The second or third trimester of pregnancy, through the postpartum period; or

4. An ongoing course of treatment for a health condition for which the treating *healthcare practitioner* or healthcare provider attests that discontinuing care by that provider would worsen the condition or interfere with anticipated outcomes.

Continuity of care is not available if:

1. The provider's participation in *our* network is terminated for cause;
2. The *covered person* transitions to another provider; or
3. The *covered person's* coverage under this *policy* terminates.

All terms and provisions of this *policy* are applicable to *covered expenses.*

UTILIZATION MANAGEMENT

Preauthorization for medical services and prior authorization for prescription drugs

***Preauthorization* for medical *services* is a determination of *medical necessity* only and is NOT a guarantee of coverage for or the payment of the medical *service* reviewed.**

***Prior authorization* for *prescription* drugs is a confirmation of the dosage, quantity, and duration as *medically necessary* for the *covered person* for the *prescription* drug reviewed.**

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

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

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

Reduction of payment

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

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

UTILIZATION MANAGEMENT

2. Benefits will be reduced for otherwise *covered expenses* by $500.00 if authorization is not obtained from *us* prior to *services* being rendered for:
   a. *Durable medical equipment*; or
   b. *Services* from:
      i. A *home healthcare provider*;
      ii. *Skilled nursing facility*;
      iii. *Hospice facility*; or
      iv. Other medical *services* 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, ground and water)

Licensed ambulance service as follows:

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

Bones or joints of the jaw and facial region

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

Benefits include one splint every six months and/or appliances.

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

1. Treatment of the teeth or gums for intraoral prosthetic devices; or
2. Treatment for *cosmetic* purposes.

Cleft lip and cleft palate

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

Clinical trial

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

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

Routine costs do not include *services* that are:

1. *Experimental, investigational or for research purposes*;
2. Provided only for data collection and analysis that is not directly related to the clinical management of the *covered person*; or
3. Inconsistent with widely accepted and established standards of care for a diagnosis.

The *covered person* must be eligible to participate in a clinical trial, according to the trial protocol and:

1. Referred by a *healthcare practitioner*; or
2. Provide medical and scientific information supporting their participation in the clinical trial is appropriate.

YOUR POLICY BENEFITS

For the routine costs to be considered a *covered expense*, the approved clinical trial must be a Phase I, II, III or IV clinical trial for the prevention, detection or treatment of cancer or other life-threatening disease or condition and is:

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

Dental services

1. Treatment for a *dental injury* to a *sound natural tooth.* Treatment must begin within 62 days from the date of the *dental injury* and be completed within 12 months from the first date of *service* for treatment of the *dental injury. We* limit *covered expenses* to the least expensive *service* that *we* determine will produce professionally adequate results.
2. Orthodontic *services* for cleft lip/cleft palate for a *dependent* child through age 19.
3. Certain oral surgical operations:
   a. Excisions of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth and related biopsy of bone, tooth or related tissues when such conditions require pathological examinations;
   b. *Services* required to correct accidental injuries of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
   c. Reduction of fractures and dislocation of the jaw;
   d. External incision and drainage of abscess;
   e. External incision of cellulites;
   f. Incision and closure of accessory sinuses, salivary glands or ducts; and
   g. Cutting of the tissue in the midline of the tongue (Frenectomy).
4. Extraction of teeth required prior to radiation therapy when there is a diagnosis of cancer of the head and/or neck.
5. Anesthesia and *healthcare treatment facility covered expenses* where anesthesia and hospitalization are required in order to safely and effectively perform a dental procedure for the following *covered persons*:
   a. A *dependent* child under the age of eight with a complex dental condition or developmental disability; or
   b. A *covered person* with one or more medical conditions that would create a medical risk for dental treatment in a place other than a *healthcare treatment facility*.

Diabetes services

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

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

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

YOUR POLICY BENEFITS

Durable medical equipment and medical supplies

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

1. Non-motorized wheelchair;
2. Hospital bed;
3. Ventilator;
4. Hospital type equipment;
5. Oxygen and rental of equipment for its administration;
6. Initial permanent prosthetic devices or supplies, including limbs and eyes. The prosthetic devices for a lost limb or absent limb must be necessary to provide or to restore their minimal basic function. Replacement of prosthetic devices is a *covered expense* when the replacement is due to pathological changes or growth;
7. Orthotics used to support, align, prevent or correct deformities. *Covered expense* does not include replacement orthotics, dental braces or oral and dental splints and appliances unless custom made for the treatment of documented obstructive sleep apnea;
8. Initial contact lenses or eyeglasses following cataract *surgery*;
9. Casts, splints (other than dental), trusses, braces (other than orthodontic), and crutches;
10. Repair or maintenance of the *durable medical equipment* (other than prosthetic)*;*
11. The following special supplies up to a 30-day supply for the initial order or a subsequent refill, when prescribed by the *healthcare practitioner*:
    a. Surgical dressings;
    b. Catheters;
    c. Colostomy bags, rings, and belts;
    d. Flotation pads;
    e. Equipment prescribed by a *healthcare practitioner* for the treatment of diabetes; and
12. Other *durable medical equipment.* Visit *our* Website at www.humana.com or call the telephone number on *your ID card* to obtain a list of *durable medical equipment.*

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

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

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

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

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

YOUR POLICY BENEFITS

Emergency services

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

If *emergency care* is 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*. In addition, the *covered person* is responsible for the difference between the *maximum allowable fee* and the amount the *out-of-network provider* bills the *covered person* for the *services.* Any amount the *covered person* pays to the *out-of-network provider* in excess of the *maximum allowable fee* will not apply to the *covered person's out-of-pocket limit* or any applicable *deductible.*

If *you* need *emergency care*:

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

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

If *you* seek *emergency care* at an out-of-network *hospital*, arrangements will be made to transfer *you* to an in-network *hospital* after *your* condition is *medically stable. Medically stable* with respect to an emergency medical condition means that no material deterioration of the *covered person's* condition is likely to result from or occur during the transfer of the *covered person* from a facility.

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

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

Eye care

Covered expenses are *expenses incurred* for the following:

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

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

YOUR POLICY BENEFITS

Habilitative services

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

1. Physical therapy *services*;
2. Massage therapy;
3. Occupational therapy *services*; and
4. Speech therapy or speech pathology *services*.

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

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

Healthcare treatment facility services

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

Healthcare practitioner services

1. *Healthcare practitioner* visits;
2. Diagnostic laboratory and radiology tests;
3. Second surgical opinions;
4. *Surgery*. If several *surgeries* are performed during one operation, covered *services* will be subject to the *maximum allowable fee* for the most complex procedure. Subsequent procedures received from *in-network providers* will be paid according to the *provider contract.* For *out-of-network providers,* 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, each surgeon will be paid according to the *provider contract* if they are *in-network providers.* For *out-of-network providers, 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.* The surgical assistants and/or assistant surgeon will be paid according to the *provider contract* if they are an *in-network provider.* For *out-of-network providers, we* will allow 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 paid according to the *provider contract* if they are an *in-network provider.* For *out-of-network providers, we* will allow 10% of the *covered expense* for the *surgery*;
7. Anesthesia administered by a *healthcare practitioner* or certified registered anesthetist attendant to a *surgery*;
8. *Services* of a pathologist;
9. *Services* of a radiologist;
10. Allergy injections, therapy, testing, and serum. Therapy and testing for treatment of allergies must be approved by the American Academy of Allergy and Immunology or the Department of Health and Human Services or any of its offices or agencies; and
11. Injections other than allergy.

For the purposes of this "Healthcare practitioner services" provision, *provider contract* means a written contract with an *in-network provider* that specifies reimbursement for a *covered expense.*

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

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

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

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

Home healthcare

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

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

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

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

YOUR POLICY BENEFITS

Hospice care

Covered expenses for *services* provided under a *hospice care program* furnished in a *hospice facility* or in the *covered person's* home by a *hospice care agency*. A *healthcare practitioner* must certify that the *covered person* is terminally ill with a life expectancy of 12 months or less:

1. Room and board in a *hospice facility*, when it is for management of acute pain or for an acute phase of chronic symptom management;
2. Other *services*;
3. Part-time nursing care provided by or supervised by a *nurse* for up to eight hours per day;
4. Psychological and dietary counseling;
5. Physical therapy;
6. Part-time home health aide *services* for up to eight hours in any one day; and
7. Medical supplies, drugs, and medicines prescribed by a *healthcare practitioner* for *palliative care*.

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

1. Private-duty nursing when *confined* in a *hospice facility*;
2. *Services* relating to a *confinement* that is not for management of acute pain control or other treatment for an acute phase of chronic symptom management;
3. Counseling for the *hospice patient* and his/her immediate *family members* by a licensed clinical social worker or pastoral counselor;
4. Medical social *services* for the *hospice patient* or his/her immediate *family members* under the direction of a *healthcare practitioner* including:
   a. Assessment of social, emotional, and medical needs and the home and family situation; and
   b. Identification of the community resources available;
5. Funeral arrangements;
6. *Services* by volunteers or persons who do not regularly charge for their *services*;
7. Financial or legal counseling, including estate planning or drafting of a will;
8. Homemaker or caretaker *services*, including:
   a. Sitter or companion *services*;
   b. Housecleaning;
   c. Household maintenance;
9. *Services* of a social worker other than a licensed clinical social worker; and
10. *Services* by a licensed pastoral counselor to a member of his/her congregation.

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

Maternity services

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

YOUR POLICY BENEFITS

No benefits will be provided for, or on account of, maternity *services* rendered to a *covered person* who becomes pregnant as a *surrogate* under the terms of, and in accordance with, a *surrogacy contract or arrangement.* This exclusion applies to all expenses for prenatal, intra-partial (care provided during delivery and childbirth), and post-partial (care for the mother following childbirth) maternity/obstetrical care, and healthcare *services* rendered to the *covered person* acting as a *surrogate.* This *policy* does not cover the newborn child(ren) of a *surrogate* because the newborn child(ren) do not qualify as a *dependent* child pursuant to this *policy.*

The *covered person* must provide *us* with a copy of the *surrogacy contract or arrangement* within 30 days of entering into the agreement to provide *surrogate services.* Notice must be given to *us* in writing or by *electronic* mail and sent to *us* at *our* mailing address shown on *your ID card* or on *our* Website at www.humana.com.

Mental health

Covered expenses are charges made by a:

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

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

Inpatient care for mental health

Covered expenses are *expenses incurred* for:

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

Outpatient care and office services for mental health

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

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

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

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

YOUR POLICY BENEFITS

Newborn services

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

1. Routine well newborn care for the first 48 hours or 96 hours following birth for:
   a. *Hospital* or licensed birth center charges for *routine nursery care*;
   b. *Healthcare practitioner's*, certified nurse midwife's, or licensed midwife's charges for circumcision of the newborn child; and
   c. *Healthcare practitioner's*, certified nurse midwife's or licensed midwife's charges for routine examination of the newborn before release from the *hospital*;
2. *Bodily injury* or *sickness*;
3. Care and treatment for premature birth;
4. Medically diagnosed birth defects and abnormalities; and
5. Postpartum care for the *dependent* newborn provided by a *healthcare practitioner* including physical assessment, *medically necessary* clinical tests and immunizations provided at a *hospital*, *healthcare practitioner's* office, *outpatient* maternity center, or at the mother's home.

Services provided by an *in-network provider* for routine well newborn care for the first 48 hours or 96 hours following birth that are the recommended preventive *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 the first 48 hours 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.

Osteoporosis

Covered expenses are *expenses incurred* for the *medically necessary* diagnosis and treatment of osteoporosis for high-risk individuals, including:

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

YOUR POLICY BENEFITS

Outpatient therapies and rehabilitative services

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

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

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

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

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

Prescription drugs

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

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

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

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.

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

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

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

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

Preventive medical services

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

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

1. Evidence-based items or *services* that have in effect a rating of A or B in the current recommendations of the U.S. Preventive Services Task Force (USPSTF);
2. Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control (CDC) and prevention that are listed on the Immunization Schedules of the CDC;
3. Evidence-informed preventive care and screenings provided for in the Health Resources and Services Administration (HRSA) guidelines for infants, children, adolescents, and women;
4. Current recommendations of the USPSTF regarding breast cancer screening, mammography, and prevention (does not include recommendations issued in or around November 2009); and
5. Breast cancer screening mammograms for a female *covered person* including the following:
   a. One baseline breast cancer screening mammogram performed at least 35 years of age but prior to 40 years of age;
   b. One breast cancer screening mammogram performed every two years for a woman at least 40 years of age but prior to 50 years of age, or more frequently based on the *healthcare practitioner's* recommendations;

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c. One breast cancer screening mammogram performed annually for a woman who is 50 years of age or older; or
d. One or more mammograms a year, based upon a *healthcare practitioner's* recommendation for any woman who is at risk for breast cancer because of a personal or family history of breast cancer, because of having a history of biopsy-proven benign breast disease, because of having a mother, sister, or daughter who has had breast cancer, or because a woman has not given birth before the age of 30.

Reconstructive surgery

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

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

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

No benefits are available for *surgery* or treatment to change the texture or appearance of the skin or to change the size, shape or appearance of facial or body features (including a *covered person's* nose, eyes, ears, cheeks, chin, chest or breasts).

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

Skilled nursing facility and rehabilitation services

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

Services in a *sub-acute rehabilitation facility* or *skilled nursing facility* must be:

1. Provided in lieu of care in a *hospital*; or
2. For the same condition that required *confinement* in a *hospital*. The *covered person* must enter the *sub-acute rehabilitation facility* or *skilled nursing facility* within 14 days after discharge from the *hospital*.

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

YOUR POLICY BENEFITS

Rehabilitation services include but are not limited to:

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

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

Specialty drug medical benefit

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

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

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

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

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

Telehealth and telemedicine services

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

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

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

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

YOUR POLICY BENEFITS

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

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

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

Transplant services

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

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

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

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

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

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

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

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

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

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

Transplant transportation and lodging

Direct non-medical costs for:

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

Direct non-medical costs include:

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

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

Urgent care services

Services in an *urgent care center* or *retail clinic* 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* or in-network *retail clinic* to receive the *in-network provider* benefit level. If *services* are received at an *out-of-network provider*, no benefits will be provided except as expressly stated in this *policy*.

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

To find the nearest in-network *urgent care center* or in-network *retail clinic,* visit *our* Website at www.humana.com or call the telephone number on *your ID card*.

GENERAL EXCLUSIONS

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

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

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

1. *Services* which require a *primary care physician* referral if the referral was not approved by *us* prior to the *service* being rendered or a referral was not obtained;
2. *Services* provided by an *out-of-network provider,* except when:
   a. *Authorized* by *us*;
   b. A referral is obtained from a *primary care physician* and *we* have approved the referral prior to the *service* being rendered; or
   c. The following *services* are *medically necessary* to render *emergency care*;
      i. Licensed ambulance *service*; or
      ii. *Services* in a *hospital* emergency room;
3. *Services* for care and treatment of non-covered procedures or *services*;
4. *Services* incurred before the *effective date* or after the termination date of this *policy*;
5. *Services* not *medically necessary* for diagnosis and treatment of a *bodily injury* or *sickness* or do not meet *our* medical and *pharmacy* coverage policies, claim payment policies or benefit *policy* guidelines, except for the specified routine preventive medical *services*;
6. *Services* performed in association with a *service* that is not covered under this *policy*;
7. Expenses for prophylactic *services* performed to prevent a disease process from becoming evident in the organ tissue at a later date;
8. *Services* which are *experimental, investigational or for research purposes*;
9. Complications of a *service* that is not a *covered expense* under this *policy* including the diagnosis or treatment of any condition which is a complication of a non-covered *service*;
10. Expenses in excess of the *maximum allowable fee* for the *service*;
11. *Services* exceeding the amount of benefits available for a particular *service*;
12. *Services* provided when this *policy* is past the premium due date and the required premium is not received within 31 days (90 days if *you* are receiving an Advanced Premium Tax Credit (APTC)) after the premium is due and the *policy* is terminated;
13. *Services* for treatment of complications of non-covered procedures or *services*;
14. *Services* relating to a *sickness* or *bodily injury* incurred as a result of the *covered person* operating a motorized vehicle while intoxicated, as defined by applicable law in the state in which the loss occurred;
15. *Services* where *sickness* or *bodily injury* was contributed to by the *covered person* being under the influence of illegal narcotics or a controlled substance unless administered by or used as prescribed by a *healthcare practitioner*;
16. *Services* relating to a *sickness* or *bodily injury* as a result of:
    a. War or an act of war, whether declared or not;
    b. Taking part in a riot;
    c. Engaging in an illegal profession or occupation;
    d. Any act of armed conflict, or any conflict involving armed forces or any authority; or
    e. Commission of or an attempt to commit a criminal act.

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17. *Services*:
    a. For expenses which are not authorized, furnished or prescribed by a *healthcare practitioner* or *healthcare treatment facility*;
    b. For which no charge is made, or for which the *covered person* would not be required to pay if he/she did not have this insurance, unless expenses are received from and reimbursable to the United States government or any of its agencies as required by law;
    c. Furnished by or payable under any plan or law through a government or any political subdivision, unless prohibited by law;
    d. Furnished while a *covered person* is *confined* in a *hospital* or institution owned or operated by the United States government or any of its agencies for any service-connected *sickness* or *bodily injury*;
    e. For expenses received from a *healthcare practitioner* over the *maximum allowable fee we* would pay for the least costly provider;
    f. Which are not rendered by the billing provider;
    g. Which are not substantiated in the medical records by the billing provider;
    h. Provided by a *family member* or person who resides with the *covered person*; or
    i. Rendered by a standby *healthcare practitioner*, surgical assistant, assistant surgeon, physician's assistant, *nurse* or certified operating room technician unless *medically necessary*;
18. Weekend non-emergency *hospital* admissions, specifically admissions to a *hospital* on a Friday or Saturday at the convenience of the *covered person* or his or her *healthcare practitioner* when there is no cause for an emergency admission and the *covered person* receives no surgery or therapeutic treatment until the following Monday;
19. *Hospital services* which could have been provided without admission to the *hospital*:
    a. Room and board provided during the admission;
    b. *Healthcare practitioner services* provided while *you* are an inpatient;
    c. Occupational therapy; speech therapy, physical therapy, and cardiac therapy; and
    d. Other *services* provided while *you* are an inpatient;
20. *Cosmetic services*, or any complication therefrom;
21. *Custodial care* and *maintenance care*;
22. Ambulance *services* for routine transportation to, from or between medical facilities and/or a *healthcare practitioner's* office except as expressly provided in this *policy*;
23. Medical or surgical procedures that are not *medically necessary* except elective tubal ligation and vasectomy;
24. Elective medical or surgical abortion unless:
    a. The pregnancy is as a result of an act of rape or incest; or
    b. The woman suffers from a physical disorder, physical injury or physical illness, including a life endangering physical condition caused by or arising from the pregnancy itself and a *healthcare practitioner* certifies that it endangers her life, if not performed;
25. Reversal of sterilization;
26. *Infertility services*;
27. Sexual dysfunction;
28. Vision examinations or testing for the purposes of prescribing corrective lenses except for routine eye screenings that are covered under preventive medical *services*; radial keratotomy; refractive keratoplasty; or any other *surgery* or procedure to correct myopia, hyperopia or stigmatic error; orthoptic treatment (eye exercises); or the purchase or fitting of eyeglasses or contact lenses, unless specified in this *policy*;

GENERAL EXCLUSIONS

29. Dental *services*, appliances or supplies for treatment of the teeth, gums, jaws or alveolar processes including excision of partially or completely unerupted impacted teeth, surgical preparation of soft tissue and excision of bone or bone tissue performed with or without extraction or excision of erupted, partially erupted, or completely un-erupted impacted teeth, surgical procedures related to repositioning of teeth, tooth transplantation or re-implantation, any oral *surgery*, *endodontic services* or *periodontics*, preoperative and post operative care, implants and related procedures, orthodontic procedures, orthognathic *surgery*, and any dental *services* related to a *bodily injury* or *sickness* except as expressly provided in this *policy*;
30. *Pre-surgical/procedural testing* duplicated during a *hospital confinement* unless *medically necessary*;
31. Any treatment for obesity, which includes *morbid obesity*, regardless of any potential benefits for co-morbid conditions, including:
    a. Surgical procedures for *morbid obesity*; or
    b. *Services* or procedures for the purpose of treating a *sickness* or *bodily injury* caused by, complicated by or exacerbated by the obesity other than screening for obesity and behavioral interventions for weight management as recommended by the USPSTF:
        - Group and individual sessions of high intensity (12 to 26 sessions in a year)
        - Behavioral management activities, such as weight loss goals
        - Improving diet or nutrition and increasing physical activity
        - Addressing barriers to change
        - Self-monitoring, and
        - Strategizing how to maintain lifestyle changes;
32. Surgical procedures for the removal of excess skin and/or fat in conjunction with or resulting from weight loss or a weight loss *surgery*;
33. Treatment of nicotine habit or addiction, including nicotine patches, hypnosis, smoking cessation classes, tapes or *electronic* media unless prescribed by a *healthcare practitioner*. This exclusion does not apply to smoking and tobacco cessation counseling as recommended by the USPSTF;
34. Educational or vocational training or therapy, *services*, and schools including videos and books;
35. Nutritional therapy except for treatment of diabetes;
36. Except as expressly provided in this *policy*, foot care *services* including:
    a. Shock wave therapy of the feet;
    b. Treatment of weak, strained, flat, unstable or unbalanced feet;
    c. Hygienic care, and the treatment of superficial lesions of the feet, such as corns, calluses or hyperkeratosis;
    d. Tarsalgia, metatarsalgia or bunion treatment, except *surgery* which involves exposure of bones, tendons or ligaments;
    e. Cutting of toenails, except removal of nail matrix; and
    f. Arch supports, heel wedges, lifts, shoe inserts, the fitting or provision of foot orthotics or orthopedic shoes, except for therapeutic shoes (including inserts and/or modifications) for the treatment of severe diabetic foot disease;
37. Wigs and/or hair prosthesis, hair transplants or implants;
38. Hearing care that is routine, including exams and tests except for routine hearing screenings that are covered under preventive medical *services*, any artificial hearing device, cochlear implant, auditory prostheses or other electrical, digital, mechanical or surgical means of enhancing, creating or restoring auditory comprehension;
39. *Services* rendered in a premenstrual syndrome clinic or holistic medicine clinic;
40. Transplant *services* except as expressly provided in this *policy*;

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41. Charges for growth hormones except as expressly provided in this *policy*;
42. 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*;
43. Immunizations including those required for foreign travel for *covered persons* of any age except as expressly provided in this *policy*;
44. Treatment for any jaw joint problem, including temporomandibular joint disorder, craniomaxillary disorder, craniomandibular disorder, head and neck neuromuscular disorder or other conditions of the joint linking the jaw bone and skull or any orthognathic *surgery* to correct any of the above, except as expressly provided in this *policy;*
45. Genetic testing, counseling or *services* except for BRCA screening, counseling, appropriate testing as recommended by the Health Resources and Services Association (HRSA) and for the purpose of explaining current signs and symptoms of a possible hereditary disease;
46. *Sickness* or *bodily injury* for which medical payments/personal injury protection (PIP) coverage exists under any automobile, homeowner, marine, aviation, premise or any other similar coverage whether such coverage is in effect on a primary, secondary or excess basis. This exclusion applies up to the available limit under the other coverage regardless of whether a claim is filed with the medical payments/PIP carrier. Whether medical payment or expense coverage is payable under another coverage is to be determined as if the coverage under this *policy* did not exist;
47. *Covered expense* to the extent of any amount received from others for the *bodily injuries* or losses which necessitated such benefits. Amounts received from others specifically includes, without limitation, liability insurance, Workers' Compensation, uninsured motorists, underinsured motorists, "no-fault" and automobile medical payments;
48. Expense for employment, school, sports or camp physical examinations or for the purpose of obtaining insurance, or premarital tests or examinations;
49. *Services* received in an emergency room unless required because of *emergency care*;
50. Any expense including related complications incurred for *services* received outside of the United States or from a foreign provider except as required by law for *emergency care services*;
51. *Services* received during an inpatient stay when the stay is primarily related to behavioral, social maladjustment, lack of discipline or other antisocial actions which are not specifically the result of *mental health*, as classified in the Diagnostic and Statistical Manual of Mental Disorders;
52. *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. Rendered in connection with marriage counseling;
53. *Services* rendered for:
    a. Immunotherapy for recurrent abortion;
    b. Chemonucleolysis (non-surgical treatment for a bulging disc that involves the injection of an enzyme in an intervertebral disc with the goal of dissolving the inner part of the disc);
    c. Biliary lithotripsy (procedure using high energy shock waves to fragment gall stones);
    d. Home uterine activity monitoring;

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e. Sleep therapy;
f. Light treatment for Seasonal Affective Disorder (S.A.D.);
g. Immunotherapy for food allergy;
h. Prolotherapy (injection of an irritant solution);
i. Hyperhidrosis (excessive sweating); and
j. Sensory integration therapy;

54. *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*;
55. *Court-ordered mental health services* unless *medically necessary*, as classified in the Diagnostic and Statistical Manual of Mental Disorders;
56. *Services* of a midwife, unless the midwife is licensed;
57. Expenses for alternative medicine, including medical diagnosis, treatment, and therapy, unless deemed as an essential health benefit (EHB). Alternative medicine *services* includes, but is not limited to:
    a. Acupressure;
    b. Acupuncture;
    c. Aromatherapy;
    d. Ayurveda;
    e. Biofeedback;
    f. Faith healing;
    g. Guided mental imagery;
    h. Herbal medicine and supplements;
    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;
58. Private-duty nursing;
59. Living expenses, travel, transportation, except as expressly provided in the "Ambulance services" provision or "Transplants" provision in the "Your Policy Benefits" section of this *policy*;
60. Costs related to telephone consultations, failure to keep a scheduled appointment, or completion and preparation of any form and/or medical information; and
61. 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 and certain medical devices including:
    a. Common household items such as air conditioners, air purifiers, water purifiers, vacuum cleaners, waterbeds, hypoallergenic mattresses or pillows or exercise equipment;
    b. Scooters or motorized transportation equipment, escalators, elevators, ramps, modifications or additions to living/working quarters or transportation vehicles;

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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 PUVA lights and stethoscopes;
f. Expenses for any membership fees or program fees paid by a *covered person*, including:
    i. Health clubs;
    ii. Health spas;
    iii. Aerobic and strength conditioning;
    iv. Work-hardening programs and weight loss or similar programs; and
    v. Any related material or products related to these programs;
g. Communication system, telephone, television or computer systems and related equipment or similar items or equipment; and
h. Communication devices except after surgical removal of the larynx or a diagnosis of permanent lack of function of the larynx.

PRESCRIPTION DRUG EXCLUSIONS

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

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

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

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

PRESCRIPTION DRUG EXCLUSIONS

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

PRESCRIPTION DRUG EXCLUSIONS

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

PEDIATRIC VISION CARE BENEFIT

This section describes the *services* that will be considered *covered expenses* for pediatric vision care *services* under this *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, including polycarbonate, scratch coating, ultraviolet-coating, blended lenses, intermediate lenses, progressive lenses, photochromatic lenses, polarized lenses, fashion and gradient tinting, oversized lenses, glass grey prescription sunglass lenses, anti-reflective coating, and hi-index lenses. If a *covered person* sees an *in-network provider*, the *in-network provider* of *materials* will show the *covered person* the selection of lens options covered by the *policy*. If a *covered person* selects a lens option that is not included in the lens option selection the *policy* covered, the *covered person* is responsible for the difference in cost between the *network provider* of *materials* reimbursement amount for covered lens options and the retail price of the lens options selected;
3. Frames available from a selection of covered frames. The *in-network provider* will show the *covered person* the selection of frames covered by this *policy*. If a *covered person* selects a frame that is not included in the frame selection this *policy* covers, the *covered person* is responsible for the difference in cost between the *in-network provider* reimbursement amount for covered frames and the retail price of the frame selected;
4. Elective contact lenses available from a selection of covered contact lenses, *contact lens fitting and follow-up*. The *in-network provider* will inform the *covered person* of the contact lens selection covered by this *policy*. If a *covered person* selects a contact lens that is not part of the contact lens selection this *policy* covers, the *covered person* is responsible for the difference in cost between the lowest cost contact lens available from the contact lens selection covered by this *policy* and the cost of the contact lens selected;
5. *Medically necessary* contact lenses under the following circumstances when *preauthorization* is obtained:
   a. Visual acuity cannot be corrected to 20/70 in the better eye except by use of contact lenses;
   b. Anisometropia greater than 3.50 diopters and aesthenopia or diplopia, with glasses;
   c. Keratoconus;
   d. Monocular aphakia or binocular aphakia where the doctor certifies contact lenses are *medically necessary* for safety and rehabilitation to a productive life;
   e. High ametropia of either +10D or -10D in any meridian;

f. Pathological myopia;
g. Aniseikonia;
h. Aniridia;
i. Corneal disorders;
j. Post-traumatic disorders; or
k. Irregular astigmatism;

6. *Low vision services* includes the following when *preauthorization* is obtained:
   a. Comprehensive low vision evaluation;
   b. Low vision follow-up care; or
   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 the limits shown in the "Schedule of Benefits–Pediatric Vision Covered Expenses" section of this *policy*.
2. *Materials* covered by this *policy* that are lost, or stolen. Broken or damaged *materials* will only be replaced at normal intervals as specified in the "Schedule of Benefits–Pediatric Vision Covered Expenses" section of this *policy*.
3. Basic cost for lenses and frames covered by the *policy*.

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

1. Orthoptic or vision training and any associated supplemental testing;
2. Two or more multiple pair of glasses, in lieu of bifocals or trifocals;
3. Medical or surgical treatment of the eye, eyes or supporting structure;
4. Any *services* and/or *materials* required by an *employer* as a condition of employment;
5. Safety lenses and frames;
6. Contact lenses, when benefits for frames and lenses are received;
7. Cosmetic items;
8. 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*;
9. Expenses for missed appointments;
10. Any charge from a providers' office to complete and submit claim forms;
11. Treatment relating to or caused by disease;
12. Non-prescription *materials* or vision devices;
13. Costs associated with securing *materials*;
14. Pre- and post-operative *services*;
15. Orthokeratology;
16. Routine maintenance of *materials*;
17. Refitting or change in lens design after initial fitting;

PEDIATRIC VISION CARE BENEFIT

18. Artistically painted lenses;
19. *Pediatric vision care* not obtained from an *in-network provider* designated by *us*; or
20. *Services* provided by an *out-of-network provider.*

Definitions

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

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

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

Covered person under this section means a person who is eligible and enrolled for benefits provided under this *policy* through the age of 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 or contact lenses and low vision aids.

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*;

PEDIATRIC VISION CARE BENEFIT

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

Severe vision problems mean the best-corrected acuity is:

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

CLAIMS

Claims processing edits

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

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

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

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

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

CLAIMS

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

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

Completing the claim form

We do not require completion of a standard claim form to process benefits. After *we* receive notice informing *us* of the claim, *we* will notify the *covered person* of any additional information *we* need to process the claim.

Cost of legal representation

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

Duplicating provisions

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

Non-duplication of Medicare benefits

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

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

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

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

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

CLAIMS

Notice of claim

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

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

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

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

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

Other insurance coverage

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

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

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

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

CLAIMS

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

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

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

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

However, *your* claims will not be reduced or denied nor will this *policy* be terminated if it was not reasonably possible to give such proof within 90 days after the date of loss. In no event, except in the absence of legal capacity, can written or *electronic* notice be given later than one year after the date written or *electronic* proof of loss is otherwise required under this *policy*.

Right to request overpayments

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

1. Made in error;
2. Made to *you* and/or any party on *your* behalf, where *we* determine that such payment made is greater than the amount payable under this *policy*;
3. Made to *you* and/or any party on *your* behalf, based on fraudulent or misrepresented information; or
4. Made to *you* and/or any party on *your* behalf for charges that were discounted, waived or rebated.

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

Right to require medical examinations

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

Time of payment of claims

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

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. However, if no request for payment has been made by the parent or legal guardian, *we* may, at *our* option, make payment to the person or institution appearing to have assumed his/her custody and support.

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

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

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

APPEAL RIGHTS

Grievance procedure

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

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

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

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

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

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

Grievance review

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

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

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

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

APPEAL RIGHTS

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

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

Exhaustion of remedies

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

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

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

RECOVERY RIGHTS

Your obligation to assist in the recovery process

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

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

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

Other insurance/non-duplication of benefits

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

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

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

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

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

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

RECOVERY RIGHTS

Right to request information

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

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

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

Our right of subrogation

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

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

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

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

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

RECOVERY RIGHTS

Right of reimbursement

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

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

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

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

Assignment of recovery rights

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

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

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

RECOVERY RIGHTS

Workers' compensation

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

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

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

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

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

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

PREMIUM PAYMENT

Your duty to pay premium

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

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

Grace period

You have 31 days from the premium due date to remit the required funds. During this grace period, coverage will remain in force. If premium is not paid *we* will terminate the insurance as of the last day of the 31-day grace period.

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

Changes to your premium

Premium may change when:

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

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

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

Return of premium

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

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

CHANGES TO THE POLICY

Your rights to make changes to the policy

You have several rights to make changes to *your policy*. *You* may be required to complete an application to request a change to *your policy*.

Changes in benefits

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

If *you* purchased *your* coverage through the *marketplace you* will need to contact the *marketplace* to request a change in benefits. The website is www.healthcare.gov.

Change in residence

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

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

We have the right to change *your* resident address in *our* records upon *our* receipt of an address change from a third party.

Changes to covered persons

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

1. **Removing dependents**

   If *you* purchased *your* coverage through the *marketplace you* will need to contact the *marketplace* and request to have *your dependent* removed from this *policy*. The website is www.healthcare.gov.

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

2. **Adding dependents**

   If *you* purchased *your* coverage through the *marketplace you* will need to contact the *marketplace* and request to have *your dependent* added to this *policy*. The website is www.healthcare.gov.

CHANGES TO THE POLICY

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

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

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

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

3. Effective date of dependent changes

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

Special enrollment

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

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

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

CHANGES TO THE POLICY

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

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

3. A *dependent* did not enroll for coverage under this *policy* when first eligible due to:
   a. Being covered under an employer sponsored health insurance plan and coverage under that plan terminates;
   b. Not a citizen of the United States, lawfully present, and subsequently gaining such lawful status;
   c. Was incarcerated and is no longer incarcerated; or
   d. Any other event as determined by the *marketplace*, for a *covered person* who purchased coverage through a *marketplace*.

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

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

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

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

Open enrollment

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

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

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

CHANGES TO THE POLICY

Our rights to make changes to the policy

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

Changes where we will notify you

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

2. If *we* determine that *you* or a *covered person* have misrepresented any material information *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). Intentional omissions, fraud or misstatements of a material fact in the application may cause *your policy* to be voided, terminated or cancelled and claims to be denied.

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

RENEWABILITY OF INSURANCE AND TERMINATION

Reasons we will terminate your policy

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

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 material misrepresentation of a material fact, as determined by *us.* Termination will be effective at 12:01 a.m. local time at the *policyholder's* state of residence on the date the misrepresentation occurred;
3. *You* cease to reside, live or work in the service area or area in which *we* are authorized to do business, as determined by *us*. Call the telephone number on *your ID card* for this *policy's* service area;
4. *You* cease to be a resident in the state in which this *policy* was issued;
5. *You* request termination of the *policy.* The request may be given verbally, *electronically,* or in writing. Termination will be effective on the last day of the billing period in which the requested termination date occurs or immediately upon the current date, if requested by *you*;
6. *We* have a right or defense to take such action by law;
7. *We* cease to offer a type of policy or cease to do business in the individual medical insurance market, as allowed or required by state or Federal law; or
8. If coverage was purchased through a *marketplace*:
   a. *You* cease to be eligible for coverage through a *marketplace*; or
   b. This *policy* ceases to be a *qualified health plan* and is decertified by a *marketplace*.

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

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

Reasons we will terminate coverage for a covered person

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

1. When the *covered person* no longer qualifies as a *dependent* or meets eligibility criteria;
2. The *covered person* commits fraud or makes an intentional material misrepresentation of a material fact, as determined by *us.* Termination will be effective at 12:01 a.m. local time at the *covered person's* state of residence on the date the misrepresentation occurred. A 30-day advance written notice of the termination will be provided;
3. When the *policyholder's* coverage under this *policy* terminates; or
4. If coverage was purchased through a *marketplace*, the *covered person* ceases to be eligible for coverage through a *marketplace*. The *marketplace* will initiate the termination and notify *us* of the event. The termination date will be assigned.

RENEWABILITY OF INSURANCE AND TERMINATION

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

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

Your duty to notify us

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

Fraud

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

Health insurance fraud is a criminal offense that can be prosecuted. Any person(s) who willingly and knowingly engages in an activity intended to defraud *us* by filing a claim or form that contains a false or deceptive statement is committing insurance fraud.

If *you* or the *covered person* commits fraud against *us,* as determined by *us, we* reserve the right to rescind coverage under this *policy* as of the date fraud is committed or as of the date otherwise determined by *us. We* will provide a 45-day advance written notice that coverage will be *rescinded. You* have the right to appeal the *rescission. We* will also provide information to the proper authorities and support any criminal charges which may be brought. Further, *we* reserve the right to seek any civil remedies which may be available to *us.*

GENERAL PROVISIONS

Assignment

This *policy* and its benefits may not be assigned by the *policyholder* or any *covered person*.

Change of beneficiary

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

Conformity with state statutes

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

Discount program

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

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

Entire contract

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

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

GENERAL PROVISIONS

Incontestability

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

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

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

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

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

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

Legal action

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

Misstatement of age or gender

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

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

Our relationship with providers

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

GENERAL PROVISIONS

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

Reinstatement

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

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

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

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

Rewards Program

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

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

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

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

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

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

GENERAL PROVISIONS

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

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

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

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

Shared savings program

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

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

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

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

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

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

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

GENERAL PROVISIONS

Third party beneficiary

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

Workers' compensation

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

DEFINITIONS

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

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

Authorize/authorization means *we* have given permission to receive *services* from an *out-of-network provider* prior to the *services* being rendered.

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

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

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

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

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

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

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

DEFINITIONS

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

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

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

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

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

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

Covered expense means a *medically necessary* expense, based on the *maximum allowable fee* for *services* incurred by a *covered person* which were ordered by a *healthcare practitioner.* To be a *covered expense*, the *service* must not be *experimental, investigational or for research purposes* or otherwise excluded or limited by this *policy* or by any amendment.

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

Creditable coverage means prior coverage under any of the following:

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

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

DEFINITIONS

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

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

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

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

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

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

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

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

Dental injury means an injury to a *sound natural tooth* caused by a sudden and external force that could not be predicted in advance and could not be avoided. It does not include biting or chewing injuries.

DEFINITIONS

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. Incapable of self-sustaining employment by reason of an intellectual or physical disability; and
3. Chiefly *dependent* upon *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*;
2. Great grandchild; or
3. Child who has not yet attained full legal age but who has been declared by a court to be emancipated.

Diabetic supplies means:

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

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

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

DEFINITIONS

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.

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

Emergency care means *services* for a *bodily injury* or *sickness* manifesting itself by acute symptoms of sufficient severity (including severe pain) to cause a prudent layperson, who possesses an average knowledge of health and medicine, to reasonably expect that not seeking immediate medical attention could result in a condition:

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

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

DEFINITIONS

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

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

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

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

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

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

1. Cannot be lawfully marketed without the final approval of the United States Food and Drug Administration (FDA) for the particular *sickness* or *bodily injury* and which lacks such final FDA approval for the use or proposed use, unless:
   a. Found to be accepted for that use in the most recently published edition of the United States Pharmacopoedia-Drug Information for Healthcare Professional (USP-DI) or in the most recently published edition of the American Hospital Formulary Service (AHFS) Drug Information;
   b. Identified as safe, widely used and generally accepted as effective for that use as reported in nationally recognized peer reviewed medical literature published in the English language as of the date of *service*; or
   c. Is mandated by Federal or state law;
2. Is a device required to receive Premarket Approval (PMA) or 510K approval by the FDA, but has not received a PMA or 510K approval;
3. Is not identified as safe, widely used, and generally accepted as effective for the proposed use as reported in nationally recognized peer reviewed medical literature published in the English language as of the date of service;
4. Is the subject of a National Cancer Institute (NCI) Phase I, II or III trial, or any trial not recognized by NCI regardless of the Phase except as expressly provided in this *policy*;
5. Is identified as not covered by the Centers for Medicare and Medicaid Services (CMS) Medicare Coverage Issues Manual, a CMS Operational Policy Letter or a CMS National Coverage Decision except as required by state or Federal law;
6. The FDA has determined the device to be contraindicated for the particular *sickness* or *bodily injury* for which the device has been prescribed; or
7. The treatment, *services* or supplies are:
   a. Not as effective in improving health outcomes and not as cost effective as established technology; or
   b. Not usable in appropriate clinical contexts in which established technology is not employable.

DEFINITIONS

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

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

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

Habilitative services means *services* and devices 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 provide preventive medical *services* or diagnose or treat a *bodily injury* or *sickness,* and who provides *services* within the scope of that license. A *healthcare practitioner's services* are not covered if the practitioner resides in the *covered person's* home or is a *family member*.

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

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

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

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

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

DEFINITIONS

A *healthcare practitioner* must:

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

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

Hospice care agency means an agency which:

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

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

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

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

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

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

Hospice patient means a terminally ill or injured person who has 12 months or less to live, as certified by a *healthcare practitioner*.

DEFINITIONS

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

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

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

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

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

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

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

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

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

DEFINITIONS

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

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

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

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

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

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

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

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

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

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

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

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

DEFINITIONS

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

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

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

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

Maintenance care means *services* furnished mainly to:

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

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

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

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

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

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

DEFINITIONS

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, site, 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;
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;* and
5. Performed in the least costly site.

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

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

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

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

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

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

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

DEFINITIONS

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 *free-standing surgical facility*;
4. A licensed birthing center; or
5. An independent laboratory or clinic.

DEFINITIONS

Palliative care means care given to a *covered person* to relieve, ease or alleviate, but not to cure, a *bodily injury* or *sickness*.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Prior authorization means the required prior approval from *us* for the coverage of *prescription* drugs, medicines, or medications or *specialty drugs*, including the dosage, quantity, and duration, as *medically necessary* for a *covered person.* 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.*

DEFINITIONS

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

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

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

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

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

Residential treatment center means an institution which:

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

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

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

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

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

DEFINITIONS

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

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

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

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

Sound natural tooth means a tooth that:

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

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

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

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

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

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

DEFINITIONS

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

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

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

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

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

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

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

Surrogacy contract or arrangement means an oral or written agreement, regardless of the state or jurisdiction where executed, between the *surrogate* and the intended parent or parents.

Surrogate means a woman, regardless of age, who contracts, orally or in writing, to become pregnant by means of assisted reproductive technology for the benefit of a third party.

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

DEFINITIONS

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

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

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

You/your means the *policyholder*.

Humana.

OFFERED BY
Humana Medical Plan, Inc.

HUMANA MEDICAL PLAN, INC.
Home Office: Louisville, Kentucky
Mailing Address: N19 W24133 Riverwood Drive
Waukesha, WI 53188

INDIVIDUAL MAJOR MEDICAL EXPENSE COVERAGE
OUTLINE OF COVERAGE

Read Your Policy Carefully - This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you **READ YOUR POLICY CAREFULLY!**

INDIVIDUAL MAJOR MEDICAL EXPENSE COVERAGE: The policy is designed to provide coverage for major hospital, medical and surgical expenses incurred as the result of a covered bodily injury or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services, surgical services, anesthesia services, in-hospital medical services, and out of hospital care. Coverage is subject to any applicable copayments, deductibles, coinsurance, maximum allowable fee, and all conditions, limitations and maximums of the policy.

PRIMARY CARE PHYSICIAN: This policy may require each covered person to select a primary care physician who will be responsible for providing primary medical care and helping to guide any care received from other medical care providers. Please review the policy to understand if selection of a primary care physician is required.

REFERRAL REQUIREMENT: This policy may require that a referral be obtained from the primary care physician before receiving medical care from any medical care provider other than the primary care physician. Please review the policy to understand if referrals are required.

AUTHORIZATION REQUIREMENT: To be eligible to receive the maximum benefits available read the Utilization Management section in the policy carefully. Failure to follow the Utilization Management requirements could result in no payment or a reduction in benefits.

BENEFITS: The policy provides an unlimited lifetime maximum benefit for each covered person. If there is other insurance which provides benefits for covered expenses, benefits under the policy will be reduced.

COPAYMENTS: The policy may have copayment requirements. A copayment is 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 each time a covered service is received. Please review the policy to understand any applicable services that have a copayment requirement.

COVERED EXPENSES

Covered expenses are subject to the following deductible, copayment and coinsurance amounts unless noted otherwise below. Each deductible is separate and does not apply toward satisfying any other deductible. Copayments, if any, do not apply to the deductible.

Medical Deductible

Individual In-Network Deductible:	$[xx,xxx] per person per calendar year
Individual Out-of-Network Deductible:	not covered
Family In-Network Deductible:	$[xx,xxx] per family per calendar year
Family Out-of-Network Deductible:	not covered

[Prescription Drug Deductible

Individual In-Network Deductible:	$[xx,xxx] per person per calendar year
Individual Out-of-Network Deductible:	not covered
Family In-Network Deductible:	$[xx,xxx] per family per calendar year
Family Out-of-Network Deductible:	not covered]

Out-of Pocket (OOP) limit

Individual In-Network OOP:	$[xx,xxx] per person per calendar year
Individual Out-of-Network OOP:	not covered
Family In-Network OOP:	$[xx,xxx] per family per calendar year
Family Out-of-Network OOP:	not covered

The out-of-pocket limit does not include non-covered services, amounts over the maximum allowable fee, amounts over the default rate, utilization management penalties, and other policy limits.

Coinsurance a Covered Person Pays
(All Covered Expense except as otherwise noted in the policy)

In-Network Coinsurance:	[xx]% after deductible
Out-of-Network Coinsurance:	not covered

Daily Hospital Room and Board

Inpatient Healthcare Treatment Facility Services: Facility/hospital services for daily room and board (semi-private rate), critical care unit, intensive care unit, and operating room.

Miscellaneous Hospital Services

Emergency (ER) Services: Hospital emergency room, including ancillary services, and healthcare practitioner services for outpatient care for treatment and stabilization of an emergency medical condition. These services may be subject to a copayment as shown in the policy.

Outpatient Healthcare Treatment Facility Services: Outpatient services in a hospital or free standing surgical facility (limited to the semi-private room rate when in observation status).

Surgical Services

Healthcare Practitioner: Surgery and services rendered by a surgical assistant, assistant surgeon, physician assistant, and certified operating room technician.

Reconstructive Surgery: Surgical services to restore function due to an injury, or a sickness or injury when trauma, infection or other disease occurred, following a medically necessary mastectomy or due to a congenital sickness or anomaly resulting in a functional defect for a dependent child. No benefits are payable for cosmetic services, services for complications from cosmetic services or surgery to change the texture or appearance of the skin or change the size, shape or appearance of facial or body features.

Transplants: Hospital, healthcare practitioner services, acquisition and donor costs, including pre-transplant services, the acquisition procedure, and any complications resulting from the acquisition. Benefits are payable only if the transplant is approved by us.

If the in-network transplant facility performing the transplant is more than 100 miles from the patient's residence, benefits are payable for lodging and transportations costs. These are direct non-medical costs for the recipient and designated caregiver or support person when the transplant is performed in an in-network transplant facility.

Covered transplants are heart, lung(s), liver, kidney, bone marrow, pancreas, any combination of these transplants, and any transplant required by state or federal law. Corneal transplants and porcine heart valve implants are tissues and not considered transplants.

No benefits are payable for transplants which are experimental, investigational or for research purposes; non-human organ or tissue transplants; storage of cord blood and stem cells unless an integral part of a transplant approved by us; transplants not approved by us based on our established criteria; expense related to donor costs payable by any other medical plan, insurance company, organization or person other than the donor's family or estate; donation or acquisition of an organ for a recipient who is not covered by us; expenses eligible to be paid by any funding or government program (except Medicaid) whether or not such funding was applied for or received; or transplants performed outside of the United States and any care resulting from that transplant.

Anesthesia Services

Healthcare Practitioner: Services for anesthesia provided by a healthcare practitioner and certified registered anesthetist.

Diagnostic Lab and X-ray: Laboratory and radiology tests and services of a pathologist and radiologist.

In-hospital medical services

Ancillary Healthcare Treatment Facility Services: Ancillary services, blood and blood plasma (not replaced); healthcare treatment facility charges; drugs provided or administered while confined in a hospital or skilled nursing facility; dialysis, chemotherapy, inhalation therapy, and radiation therapy.

Out of hospital care

Ambulance: Licensed air and ground ambulance service from the medical emergency scene to the nearest appropriate medical facility equipped to provide the required emergency treatment, when we require to transfer the patient to the nearest appropriate medical facility equipped to provide the medically necessary services and from the medical facility to the nearest home.

Habilitative Services: 35 combined visits for physical, occupational, massage and speech therapies per covered person per calendar year. Therapy rendered during a home healthcare visit is considered a Home Healthcare service.

Healthcare Practitioner: Office visits (taking a history, performing an examination, making a diagnosis or medical decision, and administering injections), second surgical opinions, allergy therapy, testing and serum, and office visits for medication management. These services may be subject to a copayment and a visit limit as shown in the policy.

Healthcare Treatment Facility: Ancillary services; blood and blood plasma (not replaced); drugs provided while confined in a hospital or skilled nursing facility; dialysis, chemotherapy, inhalation therapy, and radiation therapy; outpatient services in a hospital or free standing surgical facility (limited to the semi-private room rate when in observation status).

Home Healthcare: In-home services on a part-time or intermittent basis by a home healthcare agency. There is a maximum of 60 visits per covered person per calendar year. No benefits are payable for mileage or travel time, wage or shift differentials, charges for supervision of home healthcare providers, charges for home health aide services, custodial care or administration of self-administered injectable drugs.

Hospice Care: Services provided under a hospice care program for room and board for management of acute pain or an acute phase of chronic symptom management; ancillary services; nursing care (limited to eight hours per day); psychological and dietary counseling; physical therapy; part-time home health aide services (limited to eight hours per day); and medical supplies, drugs and medicines. Benefits are not payable for funeral arrangements; financial or legal counseling; private duty nursing in a hospice facility; family counseling; medical social services; homemaker/caretaker services; social worker services unless a licensed clinical social worker; or services of a pastoral counselor to a congregation member.

Outpatient Therapies and Rehabilitative Services: 35 combined visits for spinal manipulations, adjustments and modalities, physical, massage, occupational, speech, and cardiac therapies per covered person per calendar year. Therapy rendered during a home healthcare visit is considered a Home Healthcare service.

Retail Clinic: Healthcare services provided by a facility located in a retail store often staffed by nurse practitioners and physician assistants who provide minor medical services on a walk in basis (no appointment required). These services may be subject to a copayment and a visit limit as shown in the policy.

Skilled Nursing Facility and Rehabilitation Services: Room and board, general nursing care and rehabilitation services for 60 days per covered person per calendar year while confined in a sub-acute rehabilitation facility or skilled nursing facility. Services must be provided in lieu of care in a hospital or for the same condition that required a hospital stay provided the covered person enters the facility within 14 days after discharge from the hospital.

Therapeutic injections (includes allergy injections and administration fee; excludes routine injections). These services may be subject to a copayment as shown in the policy.

Other services

Bones or joints of the jaw and facial region: Services for diagnostic or surgical procedure involving bones or joints of the jaw and facial region. Benefits include splints and/or appliances.

Clinical Trial: Routine costs for a covered person participating in a Phase I, II, III or IV approved clinical trial for the treatment of cancer or a life-threatening condition.

Dental Services: Oral surgical procedures and dental injury to a sound natural tooth. Treatment for dental injury must begin within 62 days of the injury date and be completed within 12 months of the first date of service for the injury.

Diabetes Services Routine eye exams, foot care, nutritional therapy and self-management training and education for the treatment of diabetes.

Durable Medical Equipment and Medical Supplies: Equipment or devices designed and intended for treatment of injury and sickness. There is a 30-day supply limit for the initial order or a subsequent refill for surgical dressings, catheters, colostomy bags, rings and belts, and flotation pads. Certain repairs, maintenance, duplicates or similar rentals may not be covered.

Eye Care: Soft lenses or sclera shells, for the treatment of aphakic patients.

Maternity: Services for prenatal and postpartum care and expense for delivery for a minimum of 48 hours of inpatient care following an uncomplicated vaginal delivery and a minimum of 96 hours of inpatient care following an uncomplicated caesarean section delivery. Benefits are not payable for, or on account of, maternity services as a surrogate under the terms of, and in accordance with, a surrogacy contract or arrangement. Newborn child(ren) of a surrogate do not qualify as a dependent child pursuant to this policy.

Mental Health: Services for treatment of mental illness and chemical and alcohol dependence. Benefits are not payable for a halfway house; court ordered mental health services (unless medically necessary), services for mental illness not classified in the International Classification of Diseases of the U.S. Department of Health and Human Services, services which extend beyond the period necessary for evaluation and diagnosis of learning and behavioral disabilities for mental retardation, or marriage counseling. Benefits for treatment of mental health are payable at parity under the policy the same as any other sickness. These services may be subject to a copayment and a visit limit as shown in the policy.

Newborn Services: For a covered dependent child for routine well newborn care for the first 48 or 96 hours following birth, and injury, sickness, premature birth and medically diagnosed birth defects and abnormalities. Routine newborn services after the 48/96 hours following birth are considered under Preventive Medical Services.

Occupational Coverage: Services for a sickness or injury arising out of or sustained in the course of any occupation, employment or activity for compensation, profit or gain for a covered person who is recognized under state law as a sole proprietor, partner or executive officer and who is not entitled to file a claim for Workers" Compensation or similar benefits.

Osteoporosis: Services for diagnosis and treatment for high-risk individuals.

Pediatric Vision Care: Services for a covered dependent child though the age of 19 for a comprehensive eye exam limited to one exam in a 12-month period, prescription eyeglasses limited to one pair in any 12-month period, contact lenses when medically necessary limited to once in any 12-month period, and low vision services when preauthorized by us. See the policy for a complete listing of exclusions.

Preventive Medical Services: Routine well child and adult care preventive medical services identified as the recommended preventive services on the Department of Health and Human Services (HHS) website at www.heathcare.gov on the date the service is received.

Specialty Drug Medical: Specialty prescription drugs received during an office visit, home healthcare visit, hospital, free-standing surgical facility visit, urgent care center visit, skilled nursing facility, emergency room or ambulance. Benefits may be subject to dispensing limits, prior authorization or step therapy requirements.

Telehealth and Telemedicine: Services delivered through the use of a two-way telephonic and/or video-enabled electronic, communication between the patient and healthcare practitioner for the purpose of diagnosis, consultation or treatment. The site at which the health practitioner is providing the service cannot be the same site as where the patient is located at the time the service is being furnished. Benefits are not payable for internet only services that lack a video component.

Urgent Care: Services in an urgent care center for a sickness or injury that develops suddenly and unexpectedly outside of a healthcare practitioner's normal business hours and requires immediate treatment but does not pose a threat to the life or limb or permanent health of a covered person. These services may be subject to a copayment and a visit limit as shown in the policy.

Prescription Drugs: Covered expenses are subject to the deductible amount noted above and the copayment and coinsurance amounts shown below. Benefits may be subject to dispensing limits, prior authorization or step therapy requirements.

Coverage for prescription drugs is provided for FDA approved drugs or devices that are included on our drug list, including insulin, diabetic supplies, self-administered injectable drugs (with our approval), specialty drugs, hypodermic needles, syringes or other methods of delivery when prescribed by a health care practitioner for use with insulin or self-administered injectable drugs, drugs on the Preventive Medication Coverage drug list with a prescription from a healthcare practitioner, enteral formulas and nutritional supplements for PKU or other inherited diseases, and spacers and/or peak flow meters required for asthma.

We may decline coverage or exclude from our 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 a brand-name drug is requested when a generic drug is available, 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 for the brand-name drug and the amount we would have paid for the generic drug. If the prescribing healthcare practitioner determines the brand-name drug is medically necessary the covered person is only responsible for the copayment or coinsurance of the brand-name drug.

Prescription Drug Covered Expenses

The cost share for covered orally administered anticancer medications for the treatment of cancer will not exceed any applicable copayment, coinsurance or deductible amount the covered person is responsible to pay for intravenously administered or injected anticancer medications. (Not applicable with Catastrophic Health Plans.)

The following is applicable to plans other than Catastrophic and High Deductible Health Plans

Retail Pharmacy – Coverage for up to a 30 day supply

Level one drugs – Preferred, lowest cost generics

Services from in-network pharmacy:	$[xx] copay per prescription fill or refill
Services from out-of-network pharmacy:	not covered

Level two drugs – Low cost generic drugs

Services from in-network pharmacy:	$[xx] copay per prescription fill or refill
Services from out-of-network pharmacy:	not covered

Level three drugs – Preferred brand drugs and some higher cost generic drugs

Services from in-network pharmacy:	$[xx] copay per prescription fill or refill
Services from out-of-network pharmacy:	not covered

Level four drugs –Brands drugs and some non-referred highest cost generic drugs

Services from in-network pharmacy:	[xx]% coinsurance per prescription fill or refill
Services from out-of-network pharmacy:	not covered

Preventive Medication Coverage

Drugs, medicines or medications and supplies on the Preventive Medication Coverage drug list are covered with no cost share when obtained from an in-network pharmacy.

Specialty Pharmacy and Retail Pharmacy – Coverage for up to a 30 day supply from an in-network Specialty or Retail Pharmacy

Level five drugs – Specialty drugs

Specialty drugs and services from an in-network pharmacy designated by us as a preferred provider

[xx]% coinsurance after prescription drug deductible per prescription fill or refill

Specialty drugs and services from all other in-network pharmacy providers of specialty drugs

[xx]% coinsurance after prescription drug deductible per prescription fill or refill

Specialty drugs and services from an out-of-network pharmacy

not covered

Mail Order Pharmacy - Coverage for up to a 90 day supply from an in-network Mail Order Pharmacy

Prescription drugs (excludes specialty drugs)

Services from in-network pharmacy:	Applicable coinsurance outlined above or 2.5 times the applicable level copay, if any, outlined above after prescription drug deductible per prescription fill or refill
Services from out-of-network pharmacy:	not covered

The following is applicable to Catastrophic and High Deductible Health Plans

Retail Pharmacy and Specialty Pharmacy – Coverage for up to a 30 day supply

Services from in-network pharmacy:	[xx]% after deductible per prescription fill or refill
Services from out-of-network pharmacy:	not covered

Preventive Medication Coverage

Drugs, medicines or medications and supplies on the Preventive Medication Coverage drug list are covered with no cost share when obtained from an in-network pharmacy.

Mail Order Pharmacy - Coverage for up to a 90 day supply from an in-network Mail Order Pharmacy

Prescription drugs (excludes specialty drugs)

Services from in-network pharmacy:	[xx]% after deductible per prescription fill or refill
Services from out-of-network pharmacy:	not covered

MEDICAL EXCLUSIONS

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 shown above under the "Out of hospital care" section.

No benefits are payable for or on account of the following:

1. Services which require a primary care physician referral if the referral was not approved by us prior to the service being rendered or a referral was not obtained.
2. Services provided by an out-of-network provider, except when:
   a. Authorized by us;
   b. A referral is obtained from a primary care physician and we have approved the referral prior to the service being rendered; or
   c. The following services are medically necessary to render emergency care:
      i. Licensed ambulance service; or
      ii. Services in a hospital emergency room.
3. Services performed before the effective date or after the termination date of the policy.
4. Services not medically necessary, or do not meet our medical and pharmacy coverage policies, claim payment policies or benefit policy guidelines, except for specified routine preventive medical services.
5. Treatment of non-covered procedures or services including services for treatment of complications of such procedures or services; services performed in association with a service that is not covered.
6. Services that are experimental, investigational or for research purposes, including complications related to such services; charges in excess of the maximum allowable fee; services for a condition excluded by amendment.

7. Complications directly related to a service that is not a covered expense because it was experimental, investigational or for research purposes or not medically necessary.
8. Services rendered after the premium due date if premium payment is not received within 31 days (90 days if receiving an Advanced Premium Tax Credit (APTC)) after the premium is due and the policy is terminated.
9. Services: (a) not authorized, furnished or prescribed by a healthcare practitioner or healthcare treatment facility; (b) the covered person is not required to pay; (c) furnished or payable by a plan or law through a government or any political subdivision unless prohibited or furnished when confined in a hospital or institution owned or operated by the United States government or any of its agencies for a service connected condition; (d) not rendered by the billing provider; (e) not substantiated in the medical records by the filling provider; (f) provided by a family member or person living with the covered person; or (g) rendered by a standby healthcare practitioner, surgical assistant, assistant surgeon, physician assistant, nurse or certified operating room technician unless medically necessary.
10. Weekend non-emergency hospital admissions, specifically admissions to a hospital on a Friday or Saturday at the convenience of the covered person or his or her healthcare practitioner when there is no cause for an emergency admission and no surgery or therapeutic treatment was received until the following Monday.
11. Hospital services which could have been provided without admission to the hospital such as room and board provided during the admission; healthcare practitioner services provided while an inpatient; occupational therapy; speech therapy; physical therapy; cardiac therapy; and other services provided while an inpatient.
12. Cosmetic services and any related complications.
13. Pre-surgical/procedural testing duplicated during a hospital confinement.
14. Prophylactic services.
15. Custodial or maintenance care.
16. Infertility services.
17. Medical or surgical procedures not medically necessary except elective tubal ligation and vasectomy; elective medical or surgical abortion except as stated in the policy; and sexual dysfunction.
18. Reversal of sterilization.
19. Routine hearing care, exams and tests except as provided under Preventive Medical Services; artificial hearing devices, cochlear implants, auditory prostheses or other electrical, digital, mechanical or surgical means of enhancing, creating or restoring auditory comprehension.
20. Eye exam or testing for prescribing corrective lenses except as provided under Preventive Medical Services; eyeglasses, contact lenses; radial keratotomy; refractive keratoplasty; surgery or procedures to correct myopia, hyperopia or stigmatic error; eye exercises.
21. Dental services (except for dental injury), appliances or supplies for the treatment of the teeth, gums, jaws or alveolar processes including but not limited to excision of partially or completely unerupted impacted teeth, oral surgery, endodontic services or periodontics, preoperative and post operative care, implants and related procedures, orthodontic procedures, orthognathic surgery.
22. Treatment for any jaw joint problem, including but not limited to, temporomandibular joint disorder, craniomaxillary disorder, craniomandibular disorder, head and neck neuromuscular disorder or other conditions of the joint linking the jaw bone and skull or any orthognathic surgery to correct any of these conditions except as stated in the policy.
23. Any treatment for obesity including services or procedures for morbid obesity; services or procedures to treat sickness or injury caused by, complicated by or exacerbated by obesity; complications related to any services rendered for weight reduction; surgical procedures for removal of excess skin and/or fat due to weight loss or weight loss surgery.
24. Wigs and/or hair prosthesis; hair transplants or implants.
25. Court ordered mental health services unless medically necessary.

26. Services rendered in connection with mental illness not classified in the International Classification of Diseases of the U.S. Department of Health and Human Services or extended beyond the period necessary for evaluation and diagnosis of learning and behavioral disabilities or for mental retardation.
27. Services received in an emergency room unless required because of emergency care.
28. Treatment of nicotine habit or addiction including but not limited to nicotine patches, smoking cessation classes, hypnosis, tapes or electronic media; educational or vocational therapy, services and schools; services rendered in a premenstrual syndrome clinic or holistic medicine clinic; alternative medicine including medical diagnosis, treatment and therapy; marital counseling; genetic testing, counseling or services except for BRCA screening, counseling and testing as recommended by the Health Resources and Services Association (HRSA) and for the purpose of explaining current signs and symptoms of a possible hereditary disease.
29. Services relating to a sickness or bodily injury resulting from operating a motorized vehicle while intoxicated as defined by applicable law in the state in which the loss occurred.
30. Services where a sickness or bodily injury was contributed to by being under the influence of illegal narcotics or a controlled substance unless administered by or used as prescribed by a healthcare practitioner.
31. Expense for which medical payments/personal injury protection coverage exists under any coverage type regardless of whether a claim is filed with the carrier; expense to the extent of any amount received from another source.
32. Foot care services, other than for diabetes or hammertoe.
33. Growth hormones, except as expressly provided under Prescription Drug Exclusions.
34. Immunotherapy for food allergy or recurrent abortion; chemonucleolysis; biliary lithotripsy; home uterine activity monitoring; sleep therapy; light treatment for seasonal affective disorder; prolotherapy; hyperhidrosis; sensory integration therapy.
35. 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 covered Preventive Medical Services.
36. Immunizations, including those required for foreign travel, except as provided under Preventive Medical Services.
37. War or act of war (declared or not); an act of armed conflict; taking part in a riot or engaging in an illegal profession or occupation; any conflict involving the armed forces or authority; commission of or an attempt to commit a criminal act.
38. Exams for employment, school, sports or camp, or for the purpose of obtaining insurance; premarital tests and exams.
39. Bodily injury or sickness arising out of, or sustained in the course of any occupation, employment or activity for compensation, profit or gain, whether or not benefits are available under Workers' Compensation except as specified under Occupational coverage.
40. Expense including any related complications incurred for services received outside of the United States or from a foreign provider except as required by law or for emergency care.
41. Private duty nursing; living expenses; travel or transportation except as specified under Ambulance and Transplant services.
42. Services of a midwife, unless the midwife is licensed.
43. Costs related to telephone consultations, failure to keep a scheduled appointment or completion and preparation of any form and/or medical information.
44. Charges for non-medical purposes or used for environment control or enhancement and certain medical devices, including but not limited to common household items, scooters or motorized transportation equipment; modifications to living or working quarters; transportation vehicles; personal hygiene equipment; personal comfort items; professional medical equipment.

45. Membership fees or program fees paid for health clubs, health spas, aerobic and strength conditioning, work hardening programs and weight loss or similar programs and any related material or products related to these programs; communication system, telephone, television or computer systems and related equipment or similar items or equipment; communication devices other than due to surgical removal of the larynx or a diagnosis of permanent lack of function of the larynx.
46. Services received when not eligible for coverage.

PRESCRIPTION DRUG EXCLUSIONS

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 shown above under the "Out of hospital care" section.

No benefits are payable for or on account of the following items obtained from a pharmacy:

1. Drugs received before the effective date or after the termination date.
2. Growth hormones for idiopathic short stature or any other condition unless there is a laboratory confirmed diagnosis of growth hormone deficiency or as otherwise determined by us.
3. Contraceptives, including oral and transdermal, whether medication or device, when prescribed for purpose(s) other than to prevent pregnancy.
4. Drugs which are not included on the drug lists.
5. Herbs and vitamins except prenatal, pediatric multi-vitamins with fluoride, and vitamins on the Preventive Medication Coverage drug list when obtained from an in-network pharmacy with a prescription from a healthcare practitioner.
6. Dietary supplements except enteral formulas and nutritional supplements for the treatment of PKU or other inherited metabolic disease.
7. Minerals and nutritional products.
8. Drugs and/or ingredients not approved by the FDA, including bulk compounding ingredients.
9. Drugs taken or administered in a hospital, skilled nursing facility, or hospice facility or any other facility where drugs are provided on an inpatient basis.
10. Legend drugs not deemed medically necessary by us; drugs prescribed for a non-covered sickness or injury.
11. Drugs prescribed for intended use other than for indications approved by the FDA or off-label indications recognized through peer-reviewed medical literature; experimental or investigational drugs; drugs labeled "Caution-limited by Federal law to investigational use".
12. Allergen extracts; anorectic or drugs used for weight control; drugs used to induce abortions, administration of medication; infertility services including medication; drugs used for cosmetic purposes; drugs prescribed for impotence and/or sexual dysfunction; and injectable drugs.
13. Therapeutic devices or appliances.
14. Specialty drugs for which coverage is not approved by us.
15. Over the counter drugs which are lawfully obtainable without a prescription except drugs, medicines or supplies on the Preventive Medication Coverage drug list.
16. Compound drugs except when prescribed for pediatric use for children up to 19 years of age.
17. Drugs consumed or injected at the place where the prescription is given or drugs dispensed by a healthcare practitioner. These drugs are considered Healthcare Practitioner services.
18. Prescription fills or refills exceeding the number specified by the healthcare practitioner or dispensed more than one year from the date of the original order.
19. Any portion of a prescription fill or refill that exceeds our drug specific dispensing limit; is dispensed to a covered person whose age exceeds our drug specific age limits; is refilled early; is dispensed to a covered person whose age is outside the drug specific age limits; or which exceeds the duration specific dispensing limit.
20. Any drug for which prior authorization or step therapy is required and not obtained.

21. Drugs that are lost, stolen, spilled, spoiled or damaged or for which a charge is customarily not made.
22. Costs related to the mailing, sending or delivery of a drug.
23. Any amount exceeding the default rate.
24. Drugs purchased for consumption by other than a covered person or any intentional misuse of the prescription drug benefit.
25. Any amount 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.
26. Prescription drugs filled or refilled at an out-of-network pharmacy.

RENEWABILITY

The policy will remain in force at the option of the policyholder, except for the following reasons:

1. Nonpayment of premium.
2. Fraud or intentional material misrepresentation.
3. Ceasing to reside, live or work in the network service area or area in which we are authorized to do business.
4. Ceasing to be a resident in the state in which the policy was issued.
5. The policyholder requests coverage to end.
6. Humana ceases to offer the plan type or do business in the individual market as allowed by state or Federal law.
7. If coverage was purchased through a marketplace, ceasing to be eligible for coverage through the marketplace or the policy ceases to be a qualified health plan and is decertified by a marketplace.

FEDERAL NOTICES

The following pages contain important information about certain federal laws. There may also be differences between this notice packet and state law.
This section includes notices about:

Federal Legislation

Women's Health and Cancer Rights Act

Statement of Rights under the Newborns' and Mothers' Health Protection Act

Patient Protection Act

Pharmacy Exception Requests

FEDERAL NOTICES

Federal Legislation

Women's health and cancer rights act of 1998
Required coverage for reconstructive surgery following mastectomies

Under federal law, health insurance issuers offering health insurance providing medical and surgical benefits with respect to mastectomy shall provide, in a case of a participant or beneficiary who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with such mastectomy, coverage for:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce symmetrical appearance; and
- Prostheses and physical complications of all stages of mastectomy, including lymphedemas;

in a manner determined in consultation with the attending physician and the patient. Such coverage may be subject to annual deductibles and coinsurance provisions as may be deemed appropriate and as are consistent with those established for other benefits under the plan.

Statement of rights under the newborns' and mothers' health protection act (NMHPA)

If your plan covers normal pregnancy benefits, the following notice applies to you.

Under federal law, health insurance issuers offering health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, health insurance issuers may not set the level of benefits or out-of-pocket costs so any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a health insurance issuer may not, under federal law, require a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain pre-authorization. For information on pre-authorization, contact your plan administrator

FEDERAL NOTICES

Patient Protection Act

Humana generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, Humana designates one for you. For children, you may designate a pediatrician or a pediatric subspecialist as the primary care provider. For information on how to select a primary care provider, and for a list of the participating primary care providers, visit our Website at www.humana.com or call the customer service telephone number on your identification card.

If you plan provides coverage for obstetric or gynecological care and requires you to designate a primary care provider, you do not need prior authorization from us or from any other person (including a primary care provider) in order to obtain access to this care from a health care professional in our network who specialize in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, visit our Website at www.humana.com or call the customer service telephone number on your identification card.

Pharmacy Exception Requests

About our drug list

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

Access to non-formulary drugs

A drug not included on our drug list is a non-formulary drug. If a healthcare practitioner prescribed a clinically appropriate non-formulary drug, a request for coverage of the non-formulary drug can be made through a standard exception request or an expedited exception request. If a covered person is dissatisfied with our decision of an exception request, they have the right to the non-formulary drug appeal procedures.

FEDERAL NOTICES

Pharmacy standard exception requests

A standard exception request for coverage of a clinically appropriate non-formulary drug may be initiated by a covered person, their appointed representative, or the prescribing healthcare practitioner by calling the telephone number on the ID card, in writing or electronically by visiting our Website at www.humana.com. We will respond to the standard exception request no later than 72 hours after the receipt date of the request.

As part of the standard exception request, the prescribing healthcare practitioner should include an oral or written statement that provides justification to support the need for the prescribed non-formulary drug to treat the covered person's condition, including a statement that all covered drugs on the drug list on any tier:

1. Will be or have been ineffective;
2. Would not be as effective as the non-formulary drug; or
3. Would have adverse effects.

If we grant a standard exception request to cover a prescribed clinically appropriate non-formulary drug, we will cover the prescribed non-formulary drug for the duration of the prescription, including refills. Any applicable cost share for the prescription will apply toward the out-of-pocket limit.

If we deny a standard exception request, a covered person has the right to appeal our decision as outlined in the "Non-formulary drug appeal procedures" provision in this section.

Pharmacy expedited exception request

An expedited exception request for coverage of a clinically appropriate non-formulary drug based on exigent circumstances may be initiated by a covered person, their appointed representative, or their prescribing healthcare practitioner by calling the telephone number on the ID card, in writing or electronically by visiting our Website at www.humana.com. We will respond to the expedited exception request within 24 hours of receipt of the request. An exigent circumstance exists when a covered person is:

1. Suffering from a health condition that may seriously jeopardize their life, health, or ability to regain maximum function; or
2. Undergoing a current course of treatment using a non-formulary drug.

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

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

FEDERAL NOTICES

If we grant an expedited exception request to cover a prescribed, clinically appropriate non-formulary drug based on exigent circumstances, we will provide access to the prescribed non-formulary drug:

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

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

If we deny an expedited exception request, a covered person has the right to appeal our decision as outlined in the "Non-formulary drug appeal procedures" provision in this section.

Non-formulary drug appeal procedures

If we deny an exception request to cover a non-formulary drug, a covered person, their appointed representative or their prescribing healthcare practitioner have the right to appeal our decision to an external independent review organization. Refer to the exception request decision letter for instructions or call the telephone number on the ID card.

Appeal and External Review Notice

The following pages contain important information about Humana's claims procedures, internal appeals and external review. There may also be differences between this notice packet and state law.

Federal standards

The Patient Protection and Affordable Care Act (PPACA) including all regulation enforcing PPACA established additional requirements for claims procedures, internal appeal and *external review* processes. Humana complies with these standards. In addition to the procedures below, you should also refer to your insurance policy.

Definitions

Adverse benefit determination means a denial, reduction, or termination of, or a failure to provide or make a payment (in whole or in part) for a benefit based on:

- A determination of your eligibility to participate in the plan or health insurance coverage;
- A determination that the benefit is not covered;
- The imposition of a source-of-injury exclusion, network exclusion, or other limitation on otherwise covered benefits; or
- A determination that a benefit is experimental, investigational, or not medically necessary or appropriate.

An *adverse benefit determination* also includes any rescission of coverage.

Claimant means a covered person (or authorized representative) who files a claim.

Clinical peer reviewer is:

- An expert in the treatment of your medical condition that is the subject of an *external review*;
- Knowledgeable about the recommended healthcare service or treatment through recent or current actual clinical experience treating patients with the same or similar to your medical condition;
- Holds a non-restricted license in a state of the United States and, for physicians, a current certification by a recognized American medical specialty board in the area or areas appropriate to the subject of the *external review*;
- Has no history of disciplinary actions or sanctions, including loss of staff privileges or participation restrictions, that have been taken or are pending by any hospital, governmental agency or unit, or regulatory body that raise a substantial question as to the *clinical peer reviewer's* physical, mental or professional competence or moral character; and

Appeal and External Review Notice

- Does not have a material professional, family or financial conflict of interest with the *claimant*, Humana and any of the following:
  - The healthcare provider, the healthcare provider's medical group or independent practice association recommending the healthcare service or treatment;
  - The facility at which the recommended healthcare service or treatment would be provided; or
  - The developer or manufacturer of the principal drug, device, procedure or other therapy being recommended.

Commissioner means the Commissioner of Insurance.

Concurrent-care decision means a decision by the plan to reduce or terminate benefits otherwise payable for a course of treatment that has been approved by the plan (other than by plan amendment or termination) or a decision with respect to a request by a *claimant* to extend a course of treatment beyond the period of time or number of treatments that has been approved by the plan.

Evidence-based standard means the conscientious, explicit and judicious use of the current best evidence based on the overall systematic review of the research in making decisions about the care of individual patients.

External review means a review of an *adverse benefit determination* including a *final adverse benefit determination* conducted by an *Independent review organization (IRO).*

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

Health insurance issuer means the offering company listed on the face page of your Policy/Certificate and referred to in this document as "Humana," "we," "us," or "our".

Independent review organization (IRO) means an entity that conducts independent *external reviews* of *adverse benefit determinations* and *final adverse benefit determinations.* All *IRO's* must be accredited by a nationally recognized private accrediting organization and have no conflicts of interest to influence its independence.

Appeal and External Review Notice

Medical or scientific evidence means evidence found in the following sources:

- Peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff;
- Peer-reviewed medical literature, including literature relating to therapies reviewed and approved by a qualified institutional review board, biomedical compendia and other medical literature that meet the criteria of the National Institutes of Health's Library of Medicine for indexing in Index Medicus (Medline) and Elsevier Science Ltd. for indexing in Excerpta Medicus (EMBASE);
- Medical journals recognized by the Secretary of Health and Human Services;
- The following standard reference compendia:
  - The American Hospital Formulary Service–Drug Information;
  - Drug Facts and Comparisons;
  - The American Dental Association Accepted Dental Therapeutics; and
  - The United States Pharmacopoeia–Drug Information;
- Findings, studies or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes, including:
  - The federal Agency for Healthcare Research and Quality;
  - The National Institutes of Health;
  - The National Cancer Institute;
  - The National Academy of Sciences;
  - The Centers for Medicare & Medicaid Services;
  - The federal Food and Drug Administration; and
  - Any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health care services; or
- Any other *medical or scientific evidence* that is comparable to the sources listed above.

Preliminary review means a review by Humana of an *external review* request to determination if:

- You are or were covered under the plan at the time a service was recommended, requested, or provided;
- The service is covered under the plan except when we determine the service is:
  - Not covered because it does not meet plan requirements for medical necessity, appropriateness, healthcare setting, level of care or effectiveness; or
  - Experimental or investigational for a particular medical condition and is not explicitly listed as an excluded benefit under the plan.
- In the case of experimental or investigational treatment:
  - Your treating physician has certified one of the following situations is applicable:
    - Standard services have not been effective in improving your condition;
    - Standard services are not medically appropriate for you; or
    - There is no available standard service covered by the plan that is more beneficial to you than the recommended or requested service.

- The treating physician certifies in writing:
  - The recommended service is likely to be more beneficial to you, in the physician's opinion, than any available standard services; or
  - Scientifically valid studies using accepted protocols demonstrate the service is likely to be more beneficial to you than any available standard services and the physician is a licensed, board certified or board eligible physician qualified to practice in the area of medicine appropriate to treat your condition.
- The internal appeals process has been exhausted as specified under the 'exhaustion of remedies' section;
- You have provided all information required to process an *external review*; including:
  - An *external review* request form provided with the *adverse benefit determination* or *final adverse benefit determination*; and
  - Release forms authorizing us to disclose protected health information that is pertinent to the *external review*.

Post-service claim means any claim for a benefit under a health plan that is not a *pre-service claim*.

Pre-service claim means a request for authorization of a benefit for which the plan conditions receipt of the benefit, in whole or in part, on advance approval.

Urgent-care claim means a claim for covered services to which the application of the time periods for making non-urgent care determinations:
- Could seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function; or
- In the opinion of a physician with knowledge of the covered person's medical condition, would subject the covered person to severe pain that cannot be adequately managed without the service that is the subject of the claim.

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

Claim procedures

Discretionary authority

With respect to paying claims for benefits or determining eligibility for coverage under a policy issued by Humana, Humana as administrator for claims determinations and as ERISA claims review fiduciary, shall have full and exclusive discretionary authority to:
- Interpret plan provisions;
- Make decisions regarding eligibility for coverage and benefits; and
- Resolve factual questions relating to coverage and benefits.

Appeal and External Review Notice

Submitting a claim

This section describes how a *claimant* files a claim for plan benefits. A claim must be filed in writing and delivered by mail, postage prepaid, by FAX or e-mail. A request for pre-authorization may be filed by telephone. The claim or request for pre-authorization must be submitted to Humana or to Humana's designee at the address indicated in the covered person's insurance policy or identification card. This is particularly important with respect to mental health coordinators and other providers to whom Humana has delegated responsibility for claims administration. Claims will be not be deemed submitted for purposes of these procedures unless and until received at the correct address.

Claims submissions must be in a format acceptable to Humana and compliant with any legal requirements Claims not submitted in accordance with the requirements of applicable federal law respecting privacy of protected health information and/or electronic claims standards will not be accepted by Humana.

Claims submissions must be timely. Claims must be filed as soon as reasonably possible after they are incurred, and in no event later than the period of time described in the insurance policy.
Claims submissions must be complete and delivered to the designated address. At a minimum they must include:

- Name of the covered person who incurred the covered expense;
- Name and address of the provider;
- Diagnosis;
- Procedure or nature of the treatment;
- Place of service;
- Date of service; and
- Billed amount.

Presentation of a prescription to a pharmacy does not constitute a claim for benefits under the plan. If a covered person is required to pay the cost of a covered prescription drug, he or she may submit a written claim for plan benefits to Humana.

A general request for an interpretation of plan provisions will not be considered a claim. Requests of this type, such as a request for an interpretation of the eligibility provisions of the plan, should be directed to the plan administrator.

Failure to provide necessary information

If a *pre-service claim* submission is not made in accordance with the plan's requirements, Humana will notify the *claimant* of the problem and how it may be remedied within five days (or as soon as possible but not more than 24 hours, in the case of an *urgent-care claim*). If a *post-service claim* is not made in accordance with the plan's requirement, it will be returned to the submitter.

Appeal and External Review Notice

Authorized representatives

A covered person may designate an authorized representative to act on his or her behalf in pursuing a benefit claim, an internal appeal or an *external review*. The authorization must be in writing and authorize disclosure of health information. If a document is not sufficient to constitute designation of an authorized representative, as determined by Humana, the plan will not consider a designation to have been made. An assignment of benefits does not constitute designation of an authorized representative.

Any document designating an authorized representative must be submitted to Humana in advance or at the time an authorized representative commences a course of action on behalf of the covered person. Humana may verify the designation with the covered person prior to recognizing authorized representative status.

In any event, a health care provider with knowledge of a covered person's medical condition acting in connection with an *urgent-care claim* will be recognized by the plan as the covered person's authorized representative.

Covered persons should carefully consider whether to designate an authorized representative. Circumstances may arise under which an authorized representative may make decisions independent of the covered person, such as whether and how to appeal a claim denial.

Claims decisions

After a determination on a claim is made, Humana will notify the *claimant* within a reasonable time, as follows:

- ***Pre-service claims*** - Humana will provide notice of a favorable or *adverse benefit determination* within a reasonable time appropriate to the medical circumstances but no later than 15 days after the plan receives the claim.

  This period may be extended by an additional 15 days, if Humana determines the extension is necessary due to matters beyond the control of the plan. Before the end of the initial 15-day period, Humana will notify the *claimant* of the circumstances requiring the extension and the date by which Humana expects to make a decision.

  If the reason for the extension is because Humana does not have enough information to decide the claim, the notice of extension will describe the required information, and the *claimant* will have at least 45 days from the date the notice is received to provide the necessary information.

Appeal and External Review Notice

- ***Urgent-care claims*** - Humana will determine whether a particular claim is an *urgent-care claim*. This determination will be based on information furnished by or on behalf of a covered person. Humana will exercise its judgment when making the determination with deference to the judgment of a physician with knowledge of the covered person's condition. Humana may require a *claimant* to clarify the medical urgency and circumstances supporting the *urgent-care claim* for expedited decision-making.

  Notice of a favorable or *adverse benefit determination* will be made by Humana as soon as possible, taking into account the medical urgency particular to the covered person's situation, but not later than 24 hours after receiving the *urgent-care claim*.

  If a claim does not provide sufficient information to determine whether, or to what extent, services are covered under the plan, Humana will notify the *claimant* as soon as possible, but not more than 24 hours after receiving the *urgent-care claim*. The notice will describe the specific information necessary to complete the claim. The *claimant* will have a reasonable amount of time, taking into account the covered person's circumstances, to provide the necessary information – but not less than 48 hours.

  Humana will provide notice of the plan's *urgent-care claim* determination as soon as possible but no more than 48 hours after the earlier of:
  - The plan receives the specified information; or
  - The end of the period afforded the *claimant* to provide the specified additional information.

- ***Concurrent-care decisions*** - Humana will notify a *claimant* of a *concurrent-care decision* involving a reduction or termination of pre-authorized benefits sufficiently in advance of the reduction or termination to allow the *claimant* to appeal and obtain a determination.

  Humana will decide *urgent-care claims* involving an extension of a course of treatment as soon as possible taking into account medical circumstances. Humana will notify a *claimant* of the benefit determination, whether adverse or not, within 24 hours after the plan receives the claim, provided the claim is submitted to the plan 24 hours prior to the expiration of the prescribed period of time or number of treatments.

- ***Post-service claims*** - Humana will provide notice of a favorable or *adverse benefit determination* within a reasonable time appropriate to the medical circumstances but no later than 30 days after the plan receives the claim.

  This period may be extended an additional 15 days, if Humana determines the extension is necessary due to matters beyond the plan's control. Before the end of the initial 30-day period, Humana will notify the affected *claimant* of the extension, the circumstances requiring the extension and the date by which the plan expects to make a decision.

Appeal and External Review Notice

If the reason for the extension is because Humana does not have enough information to decide the claim, the notice of extension will describe the required information, and the *claimant* will have at least 45 days from the date the notice is received to provide the specified information. Humana will make a decision on the earlier of the date on which the *claimant* responds or the expiration of the time allowed for submission of the requested information.

Initial denial notices

Notice of a claim denial (including a partial denial) will be provided to *claimants* by mail, postage prepaid, by FAX or by e-mail, as appropriate, within the time frames noted above. With respect to adverse decisions involving *urgent-care claim*s, notice may be provided to *claimants* orally within the time frames noted above. If oral notice is given, written notification must be provided no later than three days after oral notification.

A claims denial notice will convey the specific reason for the *adverse benefit determination* and the specific plan provisions upon which the determination is based. The notice will also include a description of any additional information necessary to perfect the claim and an explanation of why such information is necessary. The notice will disclose if any internal plan rule, protocol or similar criterion was relied upon to deny the claim and a copy of the rule, protocol or similar criterion will be provided to *claimants*, free of charge. In addition to the information provided in the notice, a *claimant* has the right to request the diagnosis and treatment codes and descriptions upon which the determination is based.

The notice will describe the plan's review procedures and the time limits applicable to such procedures, including a statement of the *claimant's* right to bring a civil action under ERISA Section 502(a) following an *adverse benefit determination* on review**.**

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 plan to the covered person's medical circumstances.

In the case of an adverse decision of an *urgent-care claim*, the notice will provide a description of the plan's expedited review procedures.

Appeal and External Review Notice

Contact information

For questions about your rights, this notice, or assistance, you can contact Humana, Inc. at www.humana.com or the Employee Benefits Security Administration at 1-866-444-EBSA (3272).

You may contact the *commissioner* for assistance at any time at the address and telephone number below:

Florida Office of Insurance Regulation
200 East Gaines Street
Tallahassee, FL 32399-0322
Phone: 850-413-3140 or 877-693-5236 (In State Only)
Out of State: 850-413-3089

Email: Consumer.Services@myfloridacfo.com
Website: http://www.floir.com or
http://www.myfloridacfo.com/consumers/needourhelp.htm

Appeal and External Review Notice

Internal appeals and external review of adverse benefit determinations

Internal appeals

A *claimant* 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 a *claimant* by means of written application to Humana, in person, or by mail, postage prepaid.

A *claimant*, 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 the plan's benefit determination on review, will be transmitted between the plan and the *claimant* by telephone, FAX, or other available similarly expeditious method, to the extent permitted by applicable law.

A *claimant* 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 the *claimant* relating to the claim.

On appeal, a *claimant* may review relevant documents and may submit issues and comments in writing. A *claimant* 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, investigational, 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 rational is used during the internal appeal process, Humana will provide the *claimant*, free of charge, the evidence or rational as soon as possible and in advance of the appeals decision in order to provide the *claimant* a reasonable opportunity to respond.

Appeal and External Review Notice

Time periods for decisions on appeal

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

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

Appeals denial notices

Notice of a claim denial (including a partial denial) will be provided to *claimants* by mail, postage prepaid, by FAX or by e-mail, as appropriate, within the time periods noted above.

A notice that a claim appeal has been denied will include:

- The specific reason or reasons for the *adverse benefit determination*;
- Reference to the specific plan provision upon which the determination is based;
- 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 the *claimant*, free of charge;
- A statement of the *claimant'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 Humana to disclose protected health information pertinent to the *external review*;
- A statement about the *claimant's* right to bring an action under §502(a) of ERISA; and
- 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 plan to the covered person's medical circumstances.

In addition to the information provided in the notice, a *claimant* has the right to request the diagnosis and treatment codes and descriptions upon which the determination is based.

Exhaustion of remedies

Upon completion of the internal appeals process under this section, a *claimant* will have exhausted his or her administrative remedies under the plan. If Humana fails to adhere to all requirement of the internal appeal process, except for failures that are based on a minimal error, the claim shall be deemed to have been denied and the *claimant* may request an *external review.*

After exhaustion of remedies, a *claimant* 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.

Appeal and External Review Notice

External review

Within four months after a *claimant* receives notice of an *adverse benefit determination* or *final adverse benefit determination* the *claimant* may request an *external review* if the determination concerns treatment that is *experimental, investigational* or not *medically necessary* or the determination concerns a rescission of coverage. The request for *external review* must be made in writing to the *commissioner*. The *claimant* may be assessed a $25 filing fee that will be refunded if the *adverse benefit determination* is overturned. This fee may be waived with proof of financial hardship. The annual limit on filing fees for any *claimant* within a single plan year will not exceed $75. Please refer to the section titled 'Expedited external review' if the *adverse benefit determination* involves an *urgent-care claim* or an ongoing course of treatment.

Within one business day after the receipt of a request for *external review*, the *commissioner* will send a copy of the request to Humana. Within five business days, we will complete a *preliminary review* of the request.

Within one business day after we complete the *preliminary review*, we will notify the *claimant* and the *commissioner* in writing whether:

- The request is complete and is eligible for *external review*;
- The request is not complete and the information or materials needed to make the request complete; or
- The request is not eligible for *external review*, the reasons for ineligibility and the *claimant's* right to appeal to the *commissioner.* If appealed, the *commissioner* may determine that the request is eligible for *external review*.

Within one business day after the *commissioner* receives notice that the request is eligible for *external review*, the *commissioner* will:

- Impartially assign an *IRO* from a list compiled and maintained by the *commissioner* to conduct the *external review*;
- Provide Humana with the name of the *IRO*. Within five business days after the date of receipt of this notice, we will provide the *IRO* with all documents and information we considered in making the *adverse benefit determination* or *final adverse benefit determination*;
- Notify the *claimant* in writing of the following:
  - The eligibility of the request and acceptance for *external review*; and
  - The right to submit additional information in writing to the *IRO* and the time limits to submit the information.

Any information received by the *IRO* will be forwarded to Humana within one business day of receipt. Upon receipt of additional information, we may reconsider the *adverse benefit determination* or *final adverse benefit determination.* If we reverse the *adverse benefit determination* or *final adverse benefit determination*, the *external review* will be terminated and we will provide coverage for the service. We will immediately notify the *claimant*, the *IRO*, and the *commissioner* in writing of our decision.

Appeal and External Review Notice

The *IRO* will review all of the information received including, if available and considered appropriate the following:

- Your medical records;
- The attending healthcare professional's recommendation;
- Consulting reports from appropriate healthcare professionals and other documents submitted by Humana, the *claimant*, and treating provider;
- The terms of the coverage under the plan;
- The most appropriate practice guidelines, which will include applicable *evidence-based standards* and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards and associations;
- Any applicable clinical review criteria developed and used by Humana; and
- The opinion of the *IRO's clinical peer reviewer* or reviewers after considering the information and documents listed above.

If the *external review* involves experimental or investigational treatment, within one business day after the *IRO* receives notice of assignment to conduct the *external review*, the *IRO* will select one or more *clinical peer reviewers* to conduct the *external review*. The *clinical peer reviewer* will review all of the information and within 20 days after being selected, will provide a written opinion to the *IRO* on whether the service should be covered. The written opinion will include:

- A description of the medical condition;
- A description of the indicators relevant to determining whether there is sufficient evidence to demonstrate that the service is more likely than not to be beneficial to you than any available standard services;
- The adverse risks of the service would not be substantially increased over those of available standard services;
- A description and analysis of any *medical or scientific evidence*, or *evidence-based standard* considered in reaching the opinion;
- Information on whether the reviewer's rationale for the opinion is based on either:
  - The service has been approved by the federal Food and Drug Administration, if applicable, for the condition; or
  - *Medical or scientific evidence* or *evidence-based standards* demonstrate that the expected benefits of the service is more likely than not to be beneficial to you than any available standard health care service and the adverse risks of the service would not be substantially increased over those of available standard services.

The *IRO's* decision to either uphold or reverse the *adverse benefit determination* or *final adverse benefit determination* will be provided in writing to the *claimant*, the *commissioner* and Humana within:

- 20 days after receipt of each *clinical peer reviewer* opinion for an experimental or investigational treatment; or
- 45 days after receipt of the request for an *external review*.

Appeal and External Review Notice

In the case of experimental or investigational treatment, if a majority of *clinical peer reviewers* recommend the service should be covered, the *IRO* will make a decision to reverse the *adverse benefit determination* or *final adverse benefit determination.* If a majority of *clinical peer reviewers* recommend the service should not be covered, the *IRO* will make a decision to uphold the *adverse benefit determination* or *final adverse benefit determination.* If the *clinical peer reviewers* are evenly split, the *IRO* will obtain the opinion of an additional *clinical peer reviewer* in order for the *IRO* to make a decision.

The *IRO's* written notice of the decision will include:

- A general description of the reason for the request for *external review*;
- The date the *IRO* received the assignment from the *commissioner* to conduct the *external review*;
- The date the *external review* was conducted;
- The date of the *IRO's* decision;
- The principal reason for the decision, including applicable *evidence-based standards*, if any, used as a basis for the decision;
- The rationale for the decision;
- References to the evidence or documentation, including the *evidence-based standards*, considered in reaching the decision; and
- In the case of experimental or investigational treatment, the written opinion and rational for the recommendation of each *clinical peer reviewer*.

Immediately upon our receipt of the *IRO's* decision reversing the *adverse benefit determination* or *final adverse determination,* we will approve the service.

Expedited external review

You may request an expedited *external review* from the *commissioner*:

- 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
- When you receive an *adverse benefit determination* or *final adverse benefit determination* of:
  - An *urgent-care claim*;
  - An admission, availability of care, continued stay or health care service for which you received emergency services, but you have not been discharged from the facility; or
  - An experimental or investigational treatment if the treating physician certifies, in writing, that the recommended service would be significantly less effective if not promptly initiated.

The *commissioner* will immediately send a copy of the request to Humana and upon receipt; we will immediately complete a *preliminary review* of the request. We will immediately notify the *claimant* and the *commissioner* of the *preliminary review* determination. If we determine the request is not eligible, the notice will advise you of your right to appeal to the *commissioner*. If appealed, the *commissioner* may determine that the request is eligible for *external review*.

Appeal and External Review Notice

Immediately after the commissioner receives notice that the request is eligible for *external review*, the *commissioner* will:

- Impartially assign an *IRO* to conduct the expedited *external review.*
- Provide Humana with the name of the *IRO* and we will immediately provide the *IRO* with all necessary documents and information.

The *IRO* will review all of the information received including, if available and considered appropriate, the following:

- Your medical records;
- The attending healthcare professional's recommendation;
- Consulting reports from appropriate healthcare professionals and other documents submitted by Humana, the *claimant* and treating provider;
- The terms of the coverage under the plan;
- The most appropriate practice guidelines, which will include *evidence-based standards* and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards and associations;
- Any applicable clinical review criteria developed and used by Humana; and
- The opinion of the *IRO's clinical peer reviewer* or reviewers after considering the information and documents listed above.

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

The *clinical peer reviewer* will:

- Review all of the information noted above including whether:
  - The recommended service has been approved by the federal Food and Drug Administration, if applicable, for the condition; or
  - Medical or scientific evidence or *evidence-based standards* demonstrate that the expected benefits of the recommended service is more likely than not to be beneficial to you than any available standard service and the adverse risks of the recommended service would not be substantially increased over those of available standard services.
- Provide an opinion to the *IRO* as expeditiously as your condition or circumstances require, but in no event more than five calendar days after being selected.

The *IRO's* decision to either uphold or reverse the *adverse benefit determination* or *final adverse benefit determination* will be provided orally or in writing to the *claimant*, the *commissioner* and Humana within:

- 48 hours after receipt of each *clinical peer reviewer* opinion of an expedited *external review* for an experimental or investigational treatment; or
- 72 hours after the date of receipt of the request for an expedited *external review.*

Appeal and External Review Notice

In the case of experimental or investigational treatment, if a majority of *clinical peer reviewers* recommend the service should be covered, the *IRO* will make a decision to reverse the *adverse benefit determination* or *final adverse benefit determination.* If a majority of *clinical peer reviewers* recommend the service should not be covered, the *IRO* will make a decision to uphold the *adverse benefit determination* or *final adverse benefit determination.* If the *clinical peer reviewers* are evenly split, the *IRO* will obtain the opinion of an additional *clinical peer reviewer* in order for the *IRO* to make a decision.

The *IRO* will send written confirmation within 48 hours of an oral decision and will include:

- A general description of the reason for the request for an expedited *external review*;
- The date the *IRO* received the assignment from the *commissioner* to conduct the expedited *external review*;
- The date the expedited *external review* was conducted;
- The date of the *IRO's* decision;
- The principal reason for the decision, including applicable *evidence-based standards*, if any, used as a basis for the decision;
- The rationale for the decision;
- References to the evidence or documentation, including the *evidence-based standards*, considered in reaching the decision, except in the case of experimental or investigational treatment; and
- In the case of experimental or investigational treatment, the written opinion and rational for the recommendation of each *clinical peer reviewer*.

Immediately upon receipt of the *IRO's* decision reversing the *adverse benefit determination* or *final adverse benefit determination,* we will approve the service.

Legal actions and limitations

No lawsuit may be brought with respect to plan benefits until all remedies under the plan have been exhausted.

No lawsuit with respect to plan benefits may be brought after the expiration of the applicable limitations period stated in the insurance policy. If no limitation is stated in the insurance policy, then no such suit may be brought after the expiration of the applicable limitations under applicable law.