INDIVIDUAL MAJOR MEDICAL POLICY
HUMANA INSURANCE COMPANY

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 Insurance Company agrees to pay benefits for *services* rendered to *covered persons* who are named in the "Schedule of Benefits", subject to all the terms of this *policy*. *We* reserve the 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.

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.

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**

NOTICE CONCERNING COVERAGE LIMITATIONS AND EXCLUSIONS UNDER THE LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

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

The state law that provides for this safety-net coverage is called the Tennessee Life and Health Insurance Guaranty Association Act. The following is a brief summary of this law's coverages, exclusions and limits. **This summary does not cover all provisions of the law or describe all of the conditions and limitations relating to coverage. This summary does not in any way change anyone's rights or obligations under the act or the rights or obligations of the Guaranty Association.**

COVERAGE

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

EXCLUSIONS FROM COVERAGE

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

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

The Guaranty Association also does not provide coverage for:

1. Any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
2. Any policy of reinsurance (unless an assumption certificate was issued);
3. Interest rate yields that exceed an average rate;
4. Dividends;
5. Credits given in connection with the administration of a policy by a group contractholder;
6. Employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
7. Unallocated annuity contracts (which give rights to group contractholder, not individuals).

LIMITS ON AMOUNT OF COVERAGE

The act also limits the amount the Guaranty Association is obligated to pay out. The Guaranty Association cannot pay more than what the insurance company would owe under a policy or contract. For any one insured life, the Guaranty Association guarantees payments up to a stated maximum no matter how many policies and contracts there were with the same company, even if they provided different types of coverage. These aggregate limits per life are as follows:

1. $300,000 for policies and contracts of all types, except as described in the next point
2. $500,000 for basic hospital, medical and surgical insurance and major medical insurance issued by companies that become insolvent after January 1, 2010

Within these overall limits, the Guaranty Association cannot guarantee payment of benefit greater than the following:

1. Life insurance death benefits - $300,000
2. Life insurance cash surrender value - $100,000
3. Present value of annuity benefits for companies insolvent before July 1, 2009 - $100,000
4. Present value of annuity benefits for companies insolvent after June 30, 2009 - $250,000
5. Health insurance benefits for companies declared insolvent before January 1, 2010 - $100,000
6. Health insurance benefits for companies declared insolvent on or after January 1, 2010
7. $100,000 for limited benefits and supplemental health coverages
8. $300,000 for disability and long term care insurance
9. $500,000 for basic hospital, medical and surgical insurance or major medical insurance

The Tennessee Life and Health Insurance Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in Tennessee. You should not rely on coverage by the Tennessee Life and Health Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy.

Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer for which you have assumed the risk, such as a variable contract sold by prospectus.

Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Guaranty Association to induce you to purchase any kind of insurance policy.

Tennessee Life and Health Guaranty Association
1200 One Nashville Place
150 4th Avenue North
Nashville, TN 37219

Tennessee Department of Commerce and Insurance
500 James Robertson Parkway
Nashville, TN 37243

NOTICE

Residents of this state who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Tennessee Life and Health Insurance Guaranty Association. The purpose of this association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the Guaranty Association is not unlimited, however, and is not available at all for some policies.

COVERAGE IS NOT PROVIDED FOR YOUR POLICY OR ANY PORTION OF IT THAT IS NOT GUARANTEED BY THE INSURER OR FOR WHICH YOU HAVE ASSUMED THE RISK, SUCH AS A VARIABLE CONTRACT SOLD BY PROSPECTUS.

Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Guaranty Association to induce you to purchase any kind of insurance policy.

Tennessee Life and Health Guaranty Association
1200 One Nashville Place
150 4th Avenue North
Nashville, TN 37219

Tennessee Department of Commerce and Insurance
500 James Robertson Parkway
Nashville, TN 37243

GUIDE TO YOUR POLICY

Contents **Page number**

GUIDE TO YOUR POLICY

INTRODUCTION

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

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

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

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

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

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

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.

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:	$7,150
Services from out-of-network providers:	$14,300
Family deductible (per family per calendar year)	
Services from in-network providers:	$14,300
Services from out-of-network providers:	$28,600

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:	does not apply
Family maximum (per family per calendar year)	
Services from in-network providers:	$14,300
Services from out-of-network providers:	does not apply

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:	0% after deductible
Covered person pays for services from out-of-network providers:	50% after deductible

SCHEDULE OF BENEFITS

Medical Covered Expenses

Ambulance

Services from in-network providers:	0% after deductible
Services from out-of-network providers:	0% after deductible

Emergency Room Facility Services

Services from in-network providers:	0% after deductible
Services from out-of-network providers:	0% after deductible

Emergency Room Healthcare Practitioner Services

Services from in-network providers:	0% after deductible
Services from out-of-network providers:	0% after deductible

Habilitative Services

Services from in-network providers:	0% after deductible
Services from out-of-network providers:	50% after deductible

- **Benefit Maximum:** 20 visit limit per person per calendar year per therapy for physical, occupational and speech therapy

Healthcare Practitioner Services

Office visits for bodily injury and sickness

Services from in-network providers:

PCP	$15 copay per visit
Services from out-of-network providers:	50% after deductible

- **Benefit Maximum:** 3 visit limit for all PCP visits per person per calendar year; thereafter subject to the medical deductible and coinsurance per person per calendar year

Home Healthcare

Services from in-network providers:	0% after deductible
Services from out-of-network providers:	50% after deductible

- **Benefit Maximum:** 60 visits per person per calendar year

Nutritional Counseling

Services from in-network providers:	0% after deductible
Services from out-of-network providers:	50% after deductible

- **Benefit Maximum:** 6 visits per person per calendar year combined for hyperlipidemia, hypertension, coronary artery disease and congestive heart failure.

  Nutritional counseling for diabetes does not apply to the visit limit.

SCHEDULE OF BENEFITS

Outpatient Therapies and Rehabilitative Services

Services from in-network providers:	0% after deductible
Services from out-of-network providers:	50% after deductible

- **Benefit Maximum:**
  - 20 visit limit per person per calendar year for spinal manipulations, adjustments, and modalities
  - 20 visit limit per person per calendar year per therapy for physical, occupational, speech and audiology therapy
  - 36 visit limit per person per calendar year per rehabilitative service for cardiac and pulmonary rehabilitation

  All other therapies are 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:	50% after deductible

Skilled Nursing and Rehabilitation Facility

Services from in-network providers:	0% after deductible
Services from out-of-network providers:	50% after deductible

- **Benefit Maximum:** 60 days per person per calendar year

Transplants

Transplant services

Services from in-network providers:	0% after deductible
Services from out-of-network providers:	50% after deductible up to a maximum of $35,000 for each covered transplant

Transportation, meals 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

- **Benefit Maximum:** Meals and lodging expenses are limited to $150 per day

SCHEDULE OF BENEFITS

Prescription Drug Covered Expenses

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

Services from in-network pharmacy:	0% after deductible per prescription fill or refill
Services from out-of-network pharmacy:	50% after deductible per prescription fill or refill

Specialty Pharmacy - Coverage for up to a 30-day supply

Services from in-network pharmacy:	0% 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 or out-of-network Mail Order Pharmacy

Prescription drugs (excludes specialty drugs)

Services from in-network pharmacy:	0% after deductible per prescription fill or refill
Services from out-of-network pharmacy:	50% after deductible per prescription fill or refill

SCHEDULE OF BENEFITS

Pediatric Vision Covered Expenses

Comprehensive eye exam
Services from in-network providers: 0% after deductible
Services from out-of-network providers: 50% after deductible

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

Prescription lenses (Single vision, bifocal, trifocal, and lenticular lenses)
Services from in-network providers: 0% after deductible
Services from out-of-network providers: 50% after deductible

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

Frames
Services from in-network providers: 0% after deductible
Services from out-of-network providers: 50% after deductible

- **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: 0% after deductible
Services from out-of-network providers: 50% after deductible

- **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: 0% after deductible
Services from out-of-network providers: 50% after deductible

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

Contact lens fitting and follow up exam
Services from in-network providers: 0% after deductible
Services from out-of-network providers: 50% after deductible

Low vision services
Services from in-network providers: 0% after deductible
Services from out-of-network providers: 50% after deductible

- **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

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. Benefits will be reduced by 40% to a maximum of $2,500 for:
   a. Any transplant *services* that are not authorized by *us* prior to the transplant evaluation, testing, preparative treatment or donor search; or
   b. *Prescription* drugs, medicines, and medications, including *specialty drugs* as identified on the *drug list* on *our* Website at www.humana.com that require *prior authorization.*

UTILIZATION MANAGEMENT

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

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

YOUR POLICY BENEFITS

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

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

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

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

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

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

YOUR POLICY BENEFITS

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

Ambulance (licensed air and ground)

Licensed ambulance service as follows:

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

Autism Spectrum disorder

Covered expenses are *expenses incurred* for *services* related to *Autism Spectrum disorder*.

Chlamydia screening

Chlamydia screen for one annual *Chlamydia screening test* in conjunction with an annual Pap smear for covered females to age 29, if the test if determined to be *medically necessary* by a *healthcare practitioner*.

Clinical trial

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

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

Routine costs do not include *services* that are:

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

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

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

For the routine costs to be considered a *covered expense,* the approved clinical trial must be a Phase I, II, III or IV clinical trial for the 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.

YOUR POLICY BENEFITS

Dental services

1. Treatment for a *dental injury* to a *sound natural tooth*. Treatment must begin within 90 days from the date of the *dental injury* and be completed within 12 months from the date the *dental injury* occurred. *We* limit *covered expenses* to the least expensive *service* that *we* determine will produce professionally adequate results.
2. Anesthesia, *healthcare practitioner*, and *hospital* expenses associated with procedures performed on a *covered person* for any of the following reasons:
   a. Dental treatment or *surgery* performed for *covered persons* age eight years or younger which cannot be safely performed in an office setting;
   b. Use of general anesthesia and the *covered person*'s medical condition requires that *services* be performed in a *hospital*;
   c. *Mental illness* or behavioral condition that precludes oral *surgery* in the office;
   d. Concomitant systemic disease for which the *covered person* is under current medical management and that significantly increases the probability of complications; and
   e. Complex oral surgical procedures that have a high probability of complications due to the nature of the *surgery*;
3. Certain oral surgical operations:
   a. Excisions of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth and related biopsy of bone, tooth or related tissues when such conditions require pathological examinations;
   b. *Services* required to correct accidental injuries of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
   c. Reduction of fractures and dislocation of the jaw;
   d. External incision and drainage of abscess;
   e. External incision of cellulites;
   f. Incision and closure of accessory sinuses, salivary glands or ducts; and
   g. Cutting of the tissue in the midline of the tongue (Frenectomy).

Diabetes services

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

1. Routine eye exams;
2. Routine foot care; and
3. 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. Insulin pumps. Replacement is covered for pumps older than 48 months or if the pump cannot be repaired;
5. Hospital type equipment;
6. Oxygen and rental of equipment for its administration;
7. Initial permanent prosthetic devices or supplies, including, but not limited to, limbs and eyes. The prosthetic devices for a lost limb or absent limb must be necessary to provide or to restore their minimal basic function. Replacement of prosthetic devices is a *covered expense* when the replacement is due to pathological changes or growth;
8. 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;
9. Initial contact lenses or eyeglasses following cataract *surgery*;
10. Casts, splints (other than dental), trusses, braces (other than orthodontic), and crutches;
11. Wigs following cancer treatment (not to exceed one per lifetime);
12. 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
13. 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*.

Coverage herein also includes the cost for repair, adjustment or replacement to components and accessories necessary for the effective functioning of covered *durable medical equipment* and medical supplies.

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.

YOUR POLICY BENEFITS

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

1. Unnecessary repair, adjustment or maintenance of the *durable medical equipment* or prosthetic as determined by *us*;
2. Items to replace those that were lost, damaged, stolen or prescribed as a result of new technology; or
3. Duplicate or similar rentals of *durable medical equipment*, as determined by *us.*

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

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

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

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. Occupational therapy *services*; and
3. 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*;

YOUR POLICY BENEFITS

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.

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

Hearing Aids

Coverage will be provided for *hearing aids* which are prescribed by a licensed audiologist or *healthcare practitioner*. If hearing loss becomes significantly worse during the three-year period, coverage will be provided for a new *hearing aid.*

Coverage will not be provided for maintenance or repairs.

YOUR POLICY BENEFITS

Home healthcare

Services provided by a *home healthcare agency* at the *covered person's* home. All home healthcare *services* must be provided on a part-time or intermittent basis in conjunction with a *home healthcare plan*.
No benefits will be provided for, or on account of:

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

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

Hospice care

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

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

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

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

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

YOUR POLICY BENEFITS

Infertility evaluation

Covered expenses for *medically necessary* and appropriate *services* for the evaluation of infertility including genetic testing.

No benefits will be provided for or on account of *services* that are designed to create a pregnancy, enhance fertility or improve conception quality, including but not limited to:

1. *Infertility services;*
2. Fallopian tube reconstruction;
3. Uterine reconstruction;
4. Fertility injections;
5. Fertility drugs; or
6. *Services* for follow up care related to infertility treatments.

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.

No benefits will be provided for, or on account of, maternity *services* rendered to a *covered person* who becomes pregnant as a *surrogate* when expenses for maternity *services* are reimbursed 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.

YOUR POLICY BENEFITS

Inpatient care for mental health

Covered expenses are *expenses incurred* for:

1. *Inpatient services* including room and board;
2. *Healthcare practitioner* visits; and
3. A *residential treatment center* for *chemical dependency*.

We may substitute other levels of care for inpatient days as follows:

1. Two residential treatment days for one inpatient day;
2. Two partial hospital days for one inpatient day; and
3. Three intensive outpatient program days for one inpatient day.

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, including electro-convulsive therapy.

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

1. A halfway house;
2. Vagus nerve stimulation for the treatment of depression;
3. Pain management; or
4. *Court-ordered mental health services* unless *medically necessary.*

Newborn services

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

1. Routine well newborn care for the first 48 hours or 96 hours following birth for:
   a. *Hospital* charges for *routine nursery care*;
   b. *Healthcare practitioner's* charges for circumcision of the newborn child; and
   c. *Healthcare practitioner's* charges for routine examination of the newborn and hearing screening in accordance with current hearing screening standards established by a nationally recognized organization such as the Joint Committee on Infant Hearing Screening of the American Academy of Pediatrics before release from the *hospital*;
2. *Bodily injury* or *sickness*;
3. Care and treatment for premature birth; and
4. Medically diagnosed birth defects and abnormalities.

Services 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.

YOUR POLICY BENEFITS

Occupational coverage

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

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

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

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

Outpatient therapies and rehabilitative services

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

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

Other than for *habilitative 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".

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

Perinatal Group B Streptococcal testing

Covered expenses incurred for the testing of Perinatal Group B Streptococcal disease for a covered newborn or pregnant female in accordance with the American College of Obstetricians and Gynecologist and the Centers for Disease Control.

YOUR POLICY BENEFITS

Prescription drugs

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

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

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

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

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

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

YOUR POLICY BENEFITS

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

Preventive medical services

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

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

1. Evidence-based items or *services* that have in effect a rating of A or B in the current recommendations of the U.S. Preventive Services Task Force (USPSTF);
2. Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control (CDC) 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. Prostate cancer screening for males 50 years of age or older.

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;

YOUR POLICY BENEFITS

3. Following a *medically necessary* mastectomy or partial mastectomy (other than lumpectomy). *Reconstructive surgery* includes all stages and revisions of reconstruction of the breast on which the mastectomy has been performed, reconstruction of the other breast to establish symmetry, and physical complications in all stages of mastectomy, including lymphedemas; and
4. Because of a congenital *sickness* or anomaly of a *dependent* child that resulted in a functional defect.

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

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

Skilled nursing facility and rehabilitation services

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

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

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

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

Rehabilitation services include but are not limited to:

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

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.

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

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

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

Temporomandibular joint disorder (TMJ) and Craniomandibular joint disorder (CMJ)

Covered expenses are *expenses incurred* for surgical and non-surgical *services* for treatment of TMJ and CMJ. Coverage for non-surgical treatment is limited to the following:

1. History and diagnostic examinations;
2. Diagnostic x-rays;
3. Injection of muscle relaxants;
4. Therapeutic drug injections;
5. Thermal agents; and
6. Splint therapy with necessary adjustments.

YOUR POLICY BENEFITS

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

1. Cosmetic or elective orthodontic care;
2. Periodontic care;
3. General dental care; or
4. Removable appliances for orthodontic purposes.

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 including but not limited to the following procedures:

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

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

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

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

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

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

YOUR POLICY BENEFITS

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 and meals at a prearranged location when requested by the *hospital* and approved by *us.*

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

Transplant provider selection

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

YOUR POLICY BENEFITS

Urgent care services

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

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

To find the nearest in-network *urgent care center* or *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* for care and treatment of non-covered procedures or *services*;
2. *Services* incurred before the *effective date* or after the termination date of this *policy*;
3. *Services* not *medically necessary* for diagnosis and treatment of *a bodily injury* or *sickness* or do not meet *our* medical and *pharmacy* coverage policies, claim payment policies or benefit policy guidelines, except for the specified routine preventive medical *services*;
4. *Services* performed in association with a *service* that is not covered under this *policy*;
5. Charges for failure to keep an appointment;
6. Expenses for prophylactic *services* performed to prevent a disease process from becoming evident in the organ tissue at a later date;
7. *Services* which *are experimental, investigational or for research purposes*, or related to such, whether incurred prior to, in connection with, or subsequent to the *service* which is *experimental, investigational or for research purposes* as determined by *us.* The fact that a *service* is the only available treatment for a condition does not make it eligible for coverage if *we* deem it to be *experimental, investigational or for research purposes*;
8. Complications directly related to a *service* that is not a *covered expense* under this *policy* because it was determined by *us* to be *experimental, investigational or for research purposes* or not *medically necessary.* Directly related means that the complication occurred as a direct result of the *service* that was *experimental, investigational or for research purposes* or not *medically necessary* and the complication would not have taken place in the absence of the *service* that was *experimental, investigational or for research purposes* or not a *medically necessary service*;
9. Expenses in excess of the *maximum allowable fee* for the *service*;
10. Medical *services* exceeding the amount of benefits available for a particular *service*;
11. *Services* provided when this *policy* is past the premium due date and the required premium is not received within 31 days (90 days if *you* are receiving an Advanced Premium Tax Credit (APTC)) after the premium is due and the *policy* is terminated;
12. *Services* for treatment of complications of non-covered procedures or *services* or that are a direct or closely related result of a *covered person*'s refusal to accept treatment, medicines, or a course of treatment that has been recommended or has been determined to be *medically necessary*;
13. *Services* relating to a *sickness* or *bodily injury* incurred as a result of the *covered person* operating a motorized vehicle while intoxicated, as defined by applicable law in the state in which the loss occurred;
14. *Services* where *sickness* or *bodily injury* was contributed to by the *covered person* being under the influence of illegal narcotics or a controlled substance unless administered by or used as prescribed by a *healthcare* practitioner;

GENERAL EXCLUSIONS

15. *Services* relating to a *sickness* or *bodily injury* as a result of:
    a. War or an act of war, whether declared or not;
    b. Taking part in a riot;
    c. Engaging in an illegal profession or occupation;
    d. Any act of armed conflict, or any conflict involving armed forces or any authority; or
    e. Commission of or attempt to commit a criminal act;
16. *Services*:
    a. For expenses which are not authorized, furnished or prescribed by a *healthcare practitioner* or *healthcare treatment facility*;
    b. For which no charge is made, or for which the *covered person* would not be required to pay if he/she did not have this insurance, unless expenses are received from and reimbursable to the United States government or any of its agencies as required by law. *We* will not deny for the reason that the *covered person* incurred no expense, charge or obligation, a claim for *expenses incurred* in connection with the patient's hospitalization for *hospital*, medical or surgical *services* rendered by a non-governmental, charitable research *hospital* that bills all patients for *services* rendered but does not enforce by judicial proceedings payment from an individual patient in the absence of insurance coverage;
    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 *health*care *practitioner*, surgical assistant, assistant surgeon, physician's assistant, *nurse* or certified operating room technician unless *medically necessary*;
17. Weekend non-emergency *hospital* admissions, specifically admissions to a *hospital* on a Friday or Saturday at the convenience of the *covered person* or his/her *healthcare practitioner* when there is no cause for an emergency admission and the *covered person* receives no *surgery* or therapeutic treatment until the following Monday;
18. *Hospital inpatient services* when the *covered person* is in *observation status*;
19. *Cosmetic services*, or any complication therefrom;
20. *Custodial care* and *maintenance care*;
21. Ambulance services for routine transportation to, from or between medical facilities and/or a *healthcare practitioner's* office except as expressly provided in this *policy*;
22. Medical or surgical procedures that are not *medically necessary* except elective tubal ligation and vasectomy;
23. Elective medical or surgical abortion;
24. Reversal of sterilization;
25. *Infertility services* except as expressly provided in this *policy*;
26. Sexual dysfunction;
27. Vision examinations or testing for the purposes of prescribing corrective lenses except for routine eye screenings that are covered under preventive medical *services*; radial keratotomy; refractive keratoplasty; or any other *surgery* or procedure to correct myopia, hyperopia or stigmatic error; orthoptic treatment (eye exercises); or the purchase or fitting of eyeglasses or contact lenses, unless specified in this *policy*;

GENERAL EXCLUSIONS

28. Dental *services*, appliances or supplies for treatment of the teeth, gums, jaws or alveolar processes including, but not limited to, excision of partially or completely unerupted impacted teeth, 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*;
29. *Pre-surgical/procedural testing* duplicated during a *hospital confinement*;
30. Any treatment for obesity, which includes *morbid obesity*, regardless of any potential benefits for co-morbid conditions, including but not limited to:
    a. Surgical procedures for *morbid obesity*; or
    b. *Services* or procedures for the purpose of treating a *sickness* or *bodily injury* caused by, complicated by or exacerbated by the obesity;
31. Surgical procedures for the removal of excess skin and/or fat in conjunction with or resulting from weight loss or a weight loss *surgery*;
32. Nicotine patches, *prescription* medications, and over-the-counter medications with a *prescription* from a *healthcare practitioner* for the treatment of nicotine habit or addiction. Coverage is available under the "Prescription drugs provision" of the "Your Policy Benefits" section;
33. Educational or vocational training or therapy, *services*, and schools including but not limited to videos and books;
34. Nutritional therapy except for treatment of diabetes;
35. Except as expressly provided in this *policy*, foot care *services* including but not limited to:
    a. Shock wave therapy of the feet;
    b. Treatment of weak, strained, flat, unstable or unbalanced feet;
    c. Hygienic care, and the treatment of superficial lesions of the feet, such as corns, calluses or hyperkeratosis;
    d. Tarsalgia, metatarsalgia or bunion treatment, except *surgery* which involves exposure of bones, tendons or ligaments;
    e. Cutting of toenails, except removal of nail matrix; and
    f. Arch supports, heel wedges, lifts, shoe inserts, the fitting or provision of foot orthotics or orthopedic shoes, unless *medically necessary* because of diabetes or hammertoe or when needed as part of a leg brace;
36. Hair prosthesis except as expressly provided in this *policy*, hair transplants or implants;
37. Hearing care that is routine, including but not limited to exams and tests except for routine hearing screenings that are covered under preventive medical *services*, any artificial hearing device, cochlear implant, auditory prostheses or other electrical, digital, mechanical or surgical means of enhancing, creating or restoring auditory comprehension except as expressly provided in this *policy*;
38. *Services* rendered in a premenstrual syndrome clinic or holistic medicine clinic;
39. Transplant *services* except as expressly provided in this *policy*;
40. Charges for growth hormones except as expressly provided in this *policy*;
41. Over-the-counter medical items or supplies that can be provided or prescribed by a *healthcare practitioner* but are also available without a written order or *prescription* except for drugs prescribed for use for a covered preventive medical *service*;
42. Immunizations including those required for foreign travel for *covered persons* of any age except as expressly provided in this *policy*;
43. Treatment for any jaw joint problem, including but not limited to, temporomandibular joint disorder, craniomaxillary disorder, craniomandibular disorder, head and neck neuromuscular disorder or other conditions of the joint linking the jaw bone and skull or any orthognathic *surgery* to correct any of the above, except as expressly provided in this *policy*;

GENERAL EXCLUSIONS

44. Genetic testing, counseling or *services* except for BRCA screening, counseling, and appropriate testing as recommended by the Health Resources and Services Association (HRSA);
45. *Sickness* or *bodily injury* for which medical payments/personal injury protection (PIP) payment is made 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 if a claim is filed with the medical payments/PIP carrier by the *covered person.* Whether medical payment or expense coverage is payable under another coverage is to be determined as if the coverage under this *policy* did not exist;
46. Expense for employment, school, sports or camp physical examinations or for the purpose of obtaining insurance, or premarital tests or examinations;
47. *Services* received in an emergency room unless required because of *emergency care*;
48. Any expense including related complications incurred for *services* received outside of the United States or from a foreign provider except as required by law for *emergency care services*;
49. *Services* received during an inpatient stay when the stay is primarily related to behavioral, social maladjustment, lack of discipline or other antisocial actions which are not specifically the result of *mental health*;
50. *Services* and supplies which are:
    a. Rendered in connection with *mental illnesses* not classified in the International Classification of Diseases of the U.S. Department of Health and Human Services;
    b. Extended beyond the period necessary for evaluation and diagnosis of learning and behavioral disabilities or for mental retardation; and
    c. Rendered in connection with marriage counseling, except when *medically necessary* due to a diagnosed *mental illness*;
51. *Services* rendered for:
    a. Immunotherapy for recurrent abortion;
    b. Chemonucleolysis (non-surgical treatment for a bulging disc that involves the injection of an enzyme in an intervertebral disc with the goal of dissolving the inner part of the disc) or intradiscal annuloplasty to treat discogenic back pain;
    c. Biliary lithotripsy (procedure using high energy shock waves to fragment gall stones);
    d. Home uterine activity monitoring;
    e. Cranial orthosis, including helmet or headband, for the treatment of non-synostotic plagiocephaly;
    f. Sleep therapy;
    g. Blepharoplasty and browplasty;
    h. Balloon sinuplasty for the treatment of chronic sinusitis;
    i. Light treatment for Seasonal Affective Disorder (S.A.D.);
    j. Immunotherapy for food allergy;
    k. Prolotherapy (injection of an irritant solution);
    l. Hyperhidrosis (excessive sweating); and
    m. Sensory integration therapy;
52. *Services* or supplies provided in connection with a *sickness* or *bodily injury* arising out of, or sustained in the course of, any occupation, employment or activity for compensation, profit or gain, whether or not benefits are available under Workers' Compensation except as expressly provided in this *policy.* This applies whether or not a *covered person* has Workers' Compensation coverage;
53. *Court-ordered mental health services* unless *medically necessary*;
54. *Services* of a midwife, unless the midwife is licensed;

GENERAL EXCLUSIONS

55. Expenses for alternative medicine, including medical diagnosis, treatment, and therapy. Alternative medicine *services* includes, but is not limited to:
    a. Acupressure;
    b. Acupuncture;
    c. Aromatherapy;
    d. Ayurveda;
    e. Biofeedback;
    f. Faith healing;
    g. Guided mental imagery;
    h. Herbal medicine 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, except when necessary for following conditions:
        i. Ventricular arrhythmias or heart block associated with digitalis toxicity;
        ii. Hypercalcemia (on an emergency basis);
        iii. Extreme metal toxicity, including thalassemia with hemosiderosis;
        iv. Wilson's disease (hepatolenticular degeneration); and
        v. Lead poisoning;
56. Private-duty nursing;
57. Living expenses, travel, transportation, except as expressly provided in the "Ambulance services" provision or "Transplant services" provision in the "Your Policy Benefits" section of this *policy*; and
58. Expenses for *services* (whether or not prescribed by a *healthcare practitioner*) that are primarily and customarily used for a non-medical purpose or used for environmental control or enhancement and certain medical devices including but not limited to:
    a. Common household items such as air conditioners, air purifiers, water purifiers, vacuum cleaners, waterbeds, hypoallergenic mattresses or pillows or exercise equipment;
    b. Scooters or motorized transportation equipment, escalators, elevators, ramps, modifications or additions to living/working quarters or transportation vehicles;
    c. Personal hygiene equipment including bath/shower chairs, transfer equipment or supplies or bed side commodes;
    d. Personal comfort items including cervical pillows, gravity lumbar reduction chairs, swimming pools, whirlpools or spas or saunas;
    e. Medical equipment including PUVA lights and stethoscopes;

GENERAL EXCLUSIONS

f. Expenses for any membership fees or program fees paid by a *covered person,* including but not limited to:
   i. Health clubs;
   ii. Health spas;
   iii. Aerobic and strength conditioning;
   iv. Work-hardening programs and weight loss or similar programs; and
   v. Any related material or products related to these programs;
g. Communication system, telephone, television or computer systems and related equipment or similar items or equipment; and
h. Communication devices except after surgical removal of the larynx or a diagnosis of permanent lack of function of the larynx.

PRESCRIPTION DRUG EXCLUSIONS

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

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

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

1. Contraceptives, including oral and transdermal, whether medication or device, when prescribed for purpose(s) other than to prevent pregnancy;
2. Growth hormones for idiopathic short stature or any other condition unless there is a laboratory confirmed diagnosis of growth hormone deficiency, or as otherwise determined by *us*;
3. Drugs which are not included on the *drug lists*;
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; and
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*.

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* covers, the *covered person* is responsible for the difference in cost between the *in-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. If frames are provided by an *out-of-network provider*, benefits are limited to the amount shown above in the "Schedule of Benefits";
4. Elective contact lenses available from a selection of covered contact lenses, *contact lens fitting and follow-up*. The *in-network provider* will inform the *covered person* of the contact lens selection covered by this *policy*. If a *covered person* selects a contact lens that is not part of the contact lens selection this *policy* covers, the *covered person* is responsible for the difference in cost between the lowest cost contact lens available from the contact lens selection covered by this *policy* and the cost of the contact lens selected. If contact lenses are provided by an *out-of-network provider*, benefits are limited to the amount shown above in the "Schedule of Benefits";

PEDIATRIC VISION CARE BENEFIT

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:
   a. The limits shown in the "Schedule of Benefits–Pediatric Vision Covered Expenses" section of this *policy*; or
   b. The *reimbursement limit*, as shown in the "Schedule of Benefits–Pediatric Vision Covered Expenses" section when *services* are rendered by an *out-of-network provider*.
2. *Materials* covered by this *policy* that are lost, or stolen. Broken or damaged *materials* will only be replaced at normal intervals as specified in the "Schedule of Benefits–Pediatric Vision Covered Expenses" section of this *policy*.
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;

PEDIATRIC VISION CARE BENEFIT

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; or
18. Artistically painted lenses.

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;

PEDIATRIC VISION CARE BENEFIT

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

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

Severe vision problems mean the best-corrected acuity is:

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

CLAIMS

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*.

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

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

CLAIMS

Notice of claim

In-network providers will submit claims to *us* on *your* behalf. If *you* utilize an *out-of-network provider* for *covered expenses*, *you* must submit a notice of claim to *us.* Notice of claim must be given to *us* in writing or by *electronic* mail as required by this *policy,* or as soon as is reasonably possible thereafter. Notice must be sent to *us* at *our* mailing address shown on *your ID card* or on *our* Website at www.humana.com. *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 major medical 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.

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 or 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. Our* request for reimbursement from a *healthcare practitioner* or *covered person* will not be made more than 18 months after the date the claim was paid;
2. Made to *you* and/or any party on *your* behalf, based on fraudulent or misrepresented information; or
3. 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

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

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. You* may request that *we* direct a payment of selected medical benefits to the healthcare provider on whose charge the claim is based. *Your* request will be honored if the *out-of-network provider* provides written notice to the *covered person* that informs the *covered person* that:

1. The *out-of-network provider* does not have a current contract provider agreement with *us*; and
2. The *covered person* may receive a bill for medical *services* from the *out-of-network provider* for the amount unpaid by *us.*

The notice must be provided to the *covered person,* or the *covered person's* personal representative, prior to first receiving *services* from the *out-of-network provider.*

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 indemnity of this *policy* is payable to the estate of the insured, or to an insured or beneficiary who is a minor or otherwise not competent to give a valid release, *we* may pay such indemnity, up to an amount not exceeding $1,000, to any relative by blood or connection by marriage of the insured or beneficiary who is deemed by *us* to be equitably entitled thereto. Any payment made by *us* in good faith pursuant to this provision will fully discharge *us* to the extent of such payment.

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 and appeals

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:

1. The information provided, the requested *service* is not *medically necessary* or does not meet the *policy's* requirements for appropriateness, health care setting, level of care or effectiveness;
2. A determination of *your* eligibility under the *policy*;
3. A determination that the benefit is not covered.

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

Clinical peer means a healthcare provider who holds a non-restricted license in a state of the United States and in the same or similar specialty that would typically manage the medical condition, procedure or *service* under review.

Commissioner means the Commissioner of Commerce and Insurance.

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

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.

Grievance means a written appeal of an *adverse benefit determination* or *final adverse benefit determination* submitted by *you* or *your authorized representative* regarding:

1. Availability, delivery or quality of healthcare *services*;
2. Claims payment, handling or reimbursement for healthcare *services*;
3. Matters pertaining to the contractual relationship between a *covered person* and *us*; or
4. Matters pertaining to the contractual relationship between a healthcare provider and *us.*

Independent Review Organization (IRO) means an entity that conducts independent *external reviews* of *adverse benefit determinations* and *final adverse benefit determinations.*

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

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

APPEAL RIGHTS

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

1. Could seriously jeopardize the life or health of the *covered person* or the ability of the *covered person* to regain maximum function; or
2. In the opinion of a *healthcare practitioner* 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.

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

Filing a complaint

If *you* have a complaint about *us* or *our network providers*, please call *our* Customer Care Department as soon as possible. The toll-free number is identified on *your ID card.* Most problems may be resolved quickly in this manner.

You may also contact the Tennessee Department of Commerce and Insurance, the state agency that enforces Tennessee's insurance laws, for assistance at any time using the below contact information:

Tennessee Department of Commerce and Insurance
500 James Robertson Parkway
Davey Crocket Tower
Nashville, TN 37243-0565
Phone number: 1-615-741-2241
Website: http://state.tn.us/commerce/index/shtm

Filing a grievance

You may file a *grievance* with *us* at any time. *Grievances* may be sent to *us* at the following:

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

APPEAL RIGHTS

Internal appeals

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

If *you* are dissatisfied with *our* first level review decision, *you* or *your authorized representative* may request a second level review in writing to the address provided on the denial letter *you* received.

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

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

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

On appeal, *you* or *your authorized representative* may review relevant documents and may submit issues and comments in writing.

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

Time periods for decisions on appeals

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

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

APPEAL RIGHTS

Appeals denial notices

Notice of a claim denial (including a partial denial) will be provided to *you* or *your authorized representative* by mail, postage prepaid, or by FAX, as appropriate, within the time periods noted above.

A notice that a claim appeal has been denied will include:

1. The specific reason or reasons for the *adverse benefit determination*;
2. Reference to the specific *policy* provision upon which the determination is based;
3. If any internal rule, protocol or similar criterion was relied upon to deny the claim. A copy of the rule, protocol or similar criterion will be provided to *you,* free of charge, upon request;
4. A statement of *your* right to obtain a second level review of the first level review's *adverse benefit determination.* The statement will include a description of the process to obtain a second level review, the written procedures governing the second level review and the required timeframe for the review;
5. If applicable, a statement of *your* right to *external review*, a description of the *external review* process, and the forms for submitting an *external review* request, including release forms authorizing *us* to disclose protected health information pertinent to the *external review*; and
6. If an *adverse benefit determination* is based on medical necessity, experimental, investigational or for research purposes or similar exclusion or limitation, the notice will provide an explanation of the scientific or clinical basis for the determination, free of charge. The explanation will apply the terms of the *policy* to the *covered person's* medical circumstances.

Exhaustion of remedies

Upon completion of the internal appeals process under this section, *you* or *your authorized representative* will have exhausted all administrative remedies under the *policy*. If *we* fail to strictly adhere to all requirement of the internal appeal process, the claim will be deemed to have been denied and *you* or *your authorized representative* may request an *external review*. *You* or *your authorized representative* may request an *external review* before the internal appeals process remedies have been exhausted if *we* agree to waive the exhaustion requirement.

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

APPEAL RIGHTS

External review

Within six months after *you* or *your authorized representative* receives notice of an *adverse benefit determination* or *final adverse benefit determination, you* or *your authorized representative* may request an *external review*. The request for *external review* must be made in writing to *us. You* or *your authorized representative* will be required to authorize release of any medical records that may be required to be reviewed for the purpose of reaching a decision on the external review. Please refer to the provision titled 'Expedited external review' if the *adverse benefit determination* involves an *urgent-care claim* or an ongoing course of treatment.

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

Department of Commerce and Insurance
500 James Robertson Parkway
Davey Crocket Tower
Nashville, TN 37243-0565
Phone number: 1-615-741-2241
Website: http://state.tn.us/commerce/index/shtm

Consumer Affairs
500 James Robertson Parkway, 12th Floor
Nashville, TN 37243-0600
Phone number: 1-615-532-4994 or 1-800-342-8385
Fax: 1-615-532-4994
Email: consumer.affairs@tn.gov
Website: http://www.state.tn.us/consumer

Expedited external review

You or *your authorized representative* may request an expedited *external review* from *us* in writing or verbally:

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

If the request qualifies for an expedited *external review, we* will select an *IRO* and notify *you* or *your authorized representative* verbally or in writing of the resolution.

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 have a priority right to recover *our* payments from any judgment, settlement or award the *covered person* receives that may be related to the *services* for which *we* have provided payment.

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.

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 medical expenses paid for benefits covered under this *policy. We* will be subrogated to the *covered person's* rights to recover from any party, including but not limited to:

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 after the *covered person* has been made whole.

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

Right of reimbursement

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

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

RECOVERY RIGHTS

Assignment of recovery rights

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

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

If benefits are paid under this *policy* and *you* or the *covered person* recovers under any automobile, homeowners, marine, aviation, premises or similar coverage, *we* have the right to recover from *you,* the *covered person* or whomever *we* have paid an amount equal to the amount *we* paid. The amount *we* may recover shall not exceed the total amount paid under any settlement, judgment or award.

Workers' compensation

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

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

We will have first priority to recover benefits *we* have paid from any funds that are paid or payable by Workers' Compensation or similar coverage *as a* result of any *sickness or bodily injury. We* are not responsible for contributing to any attorney fees or recovery expenses under a Common Fund or similar doctrine.

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

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

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

PREMIUM PAYMENT

Your duty to pay premium

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

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

Grace period

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

If coverage was purchased through a *marketplace* and *you* are receiving an Advanced Premium Tax Credit (APTC), *you* have 90 days from the premium due date to remit the required funds. 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 material misstatement or omission is made on the application resulting in the proper amount due not being charged;
5. A new set of rates applies to this *policy*;
6. Any *covered person's* age increases; or
7. Any *covered person's* rating classification changes.

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

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

Return of premium

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

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

CHANGES TO THE POLICY

Your rights to make changes to the policy

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

Change in residence

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

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

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

Changes to covered persons

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

1. **Removing dependents**

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

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

2. **Adding dependents**

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

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

CHANGES TO THE POLICY

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

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

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

CHANGES TO THE POLICY

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

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

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

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

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

Open enrollment

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

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

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

Our rights to make changes to the policy

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

Changes we will make without notice to you

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

CHANGES TO THE POLICY

Changes where we will notify you

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

2. If *we* determine that *you* or a *covered person* have misrepresented any material information concerning eligibility, tobacco use or resident address on your application, *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. A 30-day advance written notice of the termination will be provided;
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;
6. *We* cease to offer a type of policy or cease to do business in the individual medical insurance market, as allowed or required by state or Federal law. If *we* cease to offer a type of policy, *we* will notify *you* of this decision 90 days prior to the date of discontinuation, and provide *you* with the option to purchase another individual medical policy that is offered at that time in the state of Tennessee. If *we* cease to do business in the individual medical insurance market, *we* will notify *you* 180 days prior to the expiration of *your* coverage with *us*; or
7. If coverage was purchased through a *marketplace*:
   a. *You* cease to be eligible for coverage through a *marketplace*; or
   b. This *policy* ceases to be a *qualified health plan* and is decertified by a *marketplace*.

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

Reasons we will terminate coverage for a covered person

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

1. When the *covered person* no longer qualifies as a *dependent* or meets eligibility criteria;
2. The *covered person* commits fraud or makes an intentional 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.

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.*

RENEWABILITY OF INSURANCE AND TERMINATION

Your duty to notify us

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

Fraud

You or a *covered person* 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 which are 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. *We* will provide a 30-day advance written notice that coverage will be *rescinded. You* have the right to appeal the *rescission. We* will also provide information to the proper authorities and support any criminal charges which may be brought. Further, *we* reserve the right to seek any civil remedies which may be available to *us.*

GENERAL PROVISIONS

Assignment

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

Choice of providers

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

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

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

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

Conformity with state statutes

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

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 120 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*.

GENERAL PROVISIONS

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*.

Discount program

From time to time, *we* may offer or provide access to discount programs to *you.* In addition, *we* may arrange for third party service providers such as pharmacies, optometrists, dentists and alternative medicine providers to provide discounts on goods and services to *you.* Some of these third party service providers may make payments to *us* when *covered persons* take advantage of these discount programs. These payments offset the cost to *us* of making these programs available and may help reduce the cost of *your policy* administration. Although *we* have arranged for third parties to offer discounts on these goods and services, these discounts programs are not covered *services* under this *policy*. The third party service providers are solely responsible to *you* for the provision of any such goods and/or services. *We* are not responsible for any such goods and/or services, nor are *we* liable if vendors refuse to honor such discounts. Furthermore *we* are not liable to *covered persons* for the negligent provision of such goods and/or services, by third party service providers. Discount programs may not be available to persons who "opt out" of marketing communications and where otherwise restricted by law.

Entire contract

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

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

GENERAL PROVISIONS

Incontestability

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

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

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

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

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

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

Legal action

No lawsuit with respect to benefits under this *policy* may be brought:

1. Prior to the expiration of 60 days after written proof of loss has been furnished; or
2. After the expiration of three years from the time written proof of loss is required to be furnished to *us.*

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 the claim payment based on this new information. The future premium will be adjusted based on the new information.

Our relationship with providers

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

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

GENERAL PROVISIONS

Rewards Program

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

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

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

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

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

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

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

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

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

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

Shared savings program

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

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

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

GENERAL PROVISIONS

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

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

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

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

Workers' compensation

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

DEFINITIONS

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

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

Autism spectrum disorder means neurological disorders, usually appearing in the first three years of a person's life that affect normal brain functions and are typically manifested by impairments in communication and social interaction, as well as restrictive, repetitive and stereotyped behaviors.

Benefit maximum means the visit 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.

Chlamydia screening test means any laboratory test of the urogenital tract which specifically detects infection by one or more agents of Chlamydia trachomatis, and which test is deemed appropriate for such purposes by the Federal Food and Drug Administration.

DEFINITIONS

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

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

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

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.

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.

DEFINITIONS

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.

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

1. Is beyond the *limiting age* of a child;
2. Is unmarried;
3. Is intellectually or physically disabled; and
4. Incapable of self-sustaining employment and chiefly dependent on *you* for support and maintenance.

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

DEFINITIONS

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

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

Dependent does not mean a:

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

Diabetic supplies means:

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

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

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

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

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

DEFINITIONS

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

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*.

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

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

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

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

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

DEFINITIONS

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

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

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

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

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

Habilitative services means *services* 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.

DEFINITIONS

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.

Hearing aid means any wearable, non-experimental, non-disposable instrument or device designed for the ear and used to aid or compensate for impaired human hearing, including ear molds and *services* necessary to select, fit and adjust the *hearing aid*, but excluding batteries, cords, and other assistive listening devices such as FM systems.

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

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

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

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

A *healthcare practitioner* must:

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

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

DEFINITIONS

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

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

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

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

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

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

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

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

1. It must provide, for a fee, medical care and treatment of sick or injured patients on an inpatient basis;
2. It must provide or operate, either on its premises or in facilities available to the *hospital* on a pre-arranged basis, medical, diagnostic, and surgical facilities;
3. Care and treatment must be given by and supervised by *healthcare practitioners*. Nursing *services* must be provided on a 24-hour basis and must be given by or supervised by registered nurses;

DEFINITIONS

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.

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*".

DEFINITIONS

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.

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

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*;

DEFINITIONS

4. The fee based on rates negotiated by *us* or other payers with one or more *in-network providers* in a geographic area determined by *us* for the same or similar *services*;
5. The fee based upon the provider's costs for providing the same or similar *services* as reported by such provider in its most recent publicly available Medicare cost report submitted to the Centers for Medicare and Medicaid Services (CMS) annually; or
6. The fee based on a percentage determined by *us* of the fee Medicare allows for the same or similar *services* provided in the same geographic area.

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

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

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

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

1. In accordance with nationally recognized standards of medical practice;
2. Clinically appropriate in terms of type, frequency, extent, 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*.

DEFINITIONS

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

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

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

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

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

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

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

Open enrollment period means the period during which:

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

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

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

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

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

DEFINITIONS

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

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

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

Outpatient services means *services* that are rendered to a *covered person* while they are not *confined* as a registered inpatient. *Outpatient services* include, but are not limited to, *services* provided in:

1. A *healthcare practitioner's* office;
2. A *hospital* outpatient setting;
3. A *free-standing surgical facility*;
4. A licensed birthing center; or
5. An independent laboratory or clinic.

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

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.

DEFINITIONS

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.

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.

DEFINITIONS

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

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

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

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

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.*

DEFINITIONS

Residential treatment center means an institution which:

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

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

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

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

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

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

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

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

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

DEFINITIONS

Sound natural tooth means a tooth that:

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

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

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

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

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

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

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

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

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

DEFINITIONS

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*.

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*.

INSURED BY
HUMANA INSURANCE COMPANY

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.