Preventive care covered. 100%

Know what to pay. That's it.

No fine print. True story.

THE SIMPLICITY PLAN

The health plan with **no surprises**

Seriously, not even one.

For budget-conscious employees in good general health, this is the simple, easy-to-use health plan.

PREVENTIVE CARE

100% covered in-network.

- Annual physicals
- Well-child visits
- Lab/blood work
- Flu and allergy shots
- X-rays, mammograms

ADDITIONAL CARE

Members only pay a simple, straightforward copay in-network. Here are some examples:

Sick visits	$40
Specialist visits	$80
Urgent care	$100
Emergency room	$400
Advanced imaging MRI, CAT scan, PET scan, etc.	$400
Inpatient hospital First 3 days, then covered in full	$1,250/day
Outpatient surgery	$1,250

NEED MORE DETAIL? HERE YOU GO:

NO DEDUCTIBLES IN-NETWORK

Yep, as long as members use in-network doctors and facilities, there's no deductible. Zero. Zilch.

PAY NOTHING AFTER THE OUT-OF-POCKET MAX

How's that possible? Easy. During the plan year, once in-network copays add up to the maximum out-of-pocket dollar amount, members pay nothing for in-network healthcare services for the rest of the plan year.

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Still skeptical? Need to see more?
Check out the plan in action on the back.

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The plan in action

HOW DOES IT COMPARE?

Service	Simplicity Plan	Humana PPO 80/50
Deductible (Individual in-network)	$0	$2,000
Coinsurance	100/50	80/50
Out of pocket maximum (Individual in-network)	$6,000	$6,500
Preventive care	$0 copay	$0 copay
Doctor's office visit (Primary office visit for services like: cough, sore throat, earache, etc.)	$45	$40
Advanced imaging (MRI claim with negotiated charge of $2,500)	$400 copay	Deductible Coinsurance
Outpatient surgery facility (Negotiated charge of $4,500)	$1,250 copay	Deductible Coinsurance
Diagnostic X-ray	$0 copay	Deductible Coinsurance

*Varies by plan selection. Please refer to your Benefit Plan Document (Certificate of Coverage or Summary Plan Description) for more information on the company providing your benefits. Our health benefit plans have limitations and exclusions. This is not a complete disclosure of plan qualifications and limitations. Premiums and benefits vary based on the plan selected.

These examples are for illustrative purposes only. Services based on average costs and copays (what you pay) if you use in-network providers. You can find a complete list of services and what you'll pay by signing in to MyHumana at **Humana.com** and viewing your Summary of Benefits and Coverage. Humana group medical plans are offered by Humana Medical Plan, Inc., Humana Employers Health Plan of Georgia, Inc., Humana Health Plan, Inc., Humana Health Benefit Plan of Louisiana, Inc., Humana Health Plan of Ohio, Inc., Humana Health Plans of Puerto Rico, Inc. License #00235-0008, Humana Wisconsin Health Organization Insurance Corporation, or Humana Health Plan of Texas, Inc., or insured by Humana Health Insurance Company of Florida, Inc., Humana Health Plan, Inc., Humana Health Benefit Plan of Louisiana, Inc., Humana Insurance Company, Humana Insurance Company of Kentucky, Humana Insurance of Puerto Rico, Inc. License #00187-0009, or administered by Humana Insurance Company or Humana Health Plan, Inc. For Arizona residents: Offered by Humana Health Plan, Inc. or insured by Humana Insurance Company. Administered by Humana Insurance Company. Please refer to your Benefit Plan Document (Certificate of Coverage/Insurance or Summary Plan Description) for more information about your benefits.

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THE SIMPLICITY PLAN

ARIZONA
MEDICAL LIMITATIONS AND **EXCLUSIONS**
For employers with 50 or fewer employees

These limitations and exclusions apply even if a healthcare practitioner has performed or prescribed a medically appropriate procedure, treatment or supply. This does not prevent your healthcare practitioner from providing or performing the procedure, treatment or supply. However, the procedure, treatment or supply will not be a covered expense.

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

- Treatments, services, supplies or surgeries that are not medically necessary, except for the preventive services required by the U.S. Department of Health and Human Services (HHS). For a list of these recommended services, refer to www.healthcare.gov.
- A sickness or bodily injury arising out of, or in the course of, any employment for wage, gain or profit if the person is insured, or is required to be insured by Workers' Compensation.
- Care and treatment given in a hospital owned, or run, by any government entity, unless you are legally required to pay for such care and treatment. However, care and treatment provided by military hospitals to covered persons who are armed services retirees and their dependents are not excluded.
- Any service furnished while you are confined in a hospital or institution owned or operated by the United States government or any of its agencies for any military service-connected sickness or bodily injury.
- Any service you would not be legally required to pay for in the absence of this coverage.
- Sickness or bodily injury for which you are in any way paid or entitled to payment or care and treatment by or through a government program, other than Medicaid or Medicare.
- Any service not ordered by a healthcare practitioner.
- Services provided to you, if you do not comply with the HMO/POS Contract's requirements. These include services:
  - Not provided by a network provider, unless required for emergency care {this applies to HMO plans and some POS plans};
  - Received in an emergency room, unless required because of emergency care;
  - Which require preauthorization if preauthorization was not obtained;
  - Which require a primary care physician referral if a referral was not obtained {this applies only to some HMO and POS plans}.
- Services rendered by a standby physician, surgical assistant, assistant surgeon, physician assistant, registered nurse or certified operating room technician unless medically necessary.
- Any service that is not rendered by the billing provider.
- Any service not substantiated in the medical records of the billing provider.

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continued –

- (For PPO/Indemnity plans) Expenses for services, prescriptions, equipment or supplies received outside the United States or from a foreign provider unless:
  - For emergency care; or
  - The employee is traveling outside the United States due to employment with the employer sponsoring this policy and the services are not covered under any Workers' Compensation or similar law; or
  - The employee and dependents live outside the United States and the employee is in active status with the employer sponsoring this policy.
- Education or training, except for habilitative services and therapeutic self-management training for a diagnosed chronic disease specified in the certificate, including diabetes self-management training.
- Educational or vocational therapy, testing, services or schools, including therapeutic boarding schools and other therapeutic environments. Educational or vocational videos, tapes, books and similar materials are also excluded.
- Ambulance services for routine transportation to, from or between medical facilities and/or a healthcare practitioner's office.
- Any drug, biological product, device, medical treatment or procedure which is experimental, investigational or for research purposes, except for clinical trials as described in the "Covered Expenses" section of the certificate.
- Vitamins, except for preventive services with a prescription from a healthcare practitioner, dietary supplements and dietary formulas, except enteral formulas, nutritional supplements or low protein modified food products for the treatment of an inherited metabolic disorder, e.g. phenylketonuria (PKU).
- Over-the-counter, non-prescription medications, unless for drugs, medicines or medications, or supplies on the Preventive Medication Coverage Drug List, with a prescription from a healthcare practitioner.
- 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 preventive services as recommended by the U.S. Department of Health and Human Services (HHS). For a list of these recommended services, refer to the www.healthcare.gov website.
- Growth hormones, except as otherwise specified in the "Pharmacy Services" sections of the certificate.
- Services received in an emergency room, unless required because of emergency care.
- Weekend non-emergency hospital admissions, specifically admissions to a hospital on a Friday or Saturday at the convenience of the covered person, or his or her healthcare practitioner, when there is no cause for an emergency admission and the covered person receives no surgery or therapeutic treatment until the following Monday
- Hospital inpatient services when you are in observation status.
- Infertility services, after evaluation and diagnosis is completed, or reversal of elective sterilization.
- In vitro fertilization regardless of the reason for treatment.
- Services for, or in connection with, a transplant if:
  - The expense relates to storage of cord blood and stem cells, unless it is an integral part of a transplant approved by us
  - We do not approve coverage for the transplant, based on our established criteria
  - Expenses 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
  - The expense relates to the transplantation of any non-human organ or tissue, unless otherwise stated in the contract
  - The expense relates to the donation or acquisition of an organ for a recipient who is not covered by us
  - The expense relates to donor costs that are payable in whole or in part by any other group plan, insurance company, organization or person other than the donor's family or estate
  - The expense relates to a transplant performed outside of the United States and any care resulting from that transplant

continued –

- Services provided for:
  - Immunotherapy for recurrent abortion;
  - Chemonucleolysis;
  - Biliary lithotripsy;
  - Sleep therapy;
  - Light treatments for Seasonal Affective Disorder (S.A.D.);
  - Immunotherapy for food allergy;
  - Prolotherapy; or
  - Sensory integration therapy.
- Cosmetic surgery and cosmetic services or devices, unless for reconstructive surgery:
  - Resulting from a bodily injury, infection or other disease of the involved part, when a functional impairment is present;
  - Resulting from congenital anomaly of a covered dependent child; or
  - In connection with a mastectomy as specified in the "Covered Expenses" section of the certificate.
- Hair prosthesis, hair transplants or implants, and wigs, except as provided as a covered expense in the certificate.
- Dental services, appliances or supplies for treatment of the teeth, gums, jaws or alveolar processes, including but not limited to, any oral surgery, endodontic services or periodontics, implants and related procedures, orthodontic procedures, and any dental services related to a bodily injury or sickness unless otherwise stated in the certificate.
- The following types of care of the feet:
  - Shock wave therapy of the feet;
  - The treatment of weak, strained, flat, unstable or unbalanced feet;
  - Hygienic care, and the treatment of superficial lesions of the feet, such as corns, calluses or hyperkeratosis;
  - The treatment of tarsalgia, metatarsalgia, or bunion, except surgically;
  - The cutting of toenails, except the removal of the nail matrix; and
  - Heel wedges, lifts or shoe inserts.
- Custodial care and maintenance care.
- Any loss contributed to, or caused by:
  - War or any act of war, whether declared or not;
  - Insurrection; or
  - Any conflict involving armed forces of any authority.
- Expenses for any membership fees or program fees paid by you, including but not limited to, health clubs, health spas, aerobic and strength conditioning, work-hardening programs and weight loss or surgical programs, and any materials or products related to these programs.
- Surgical procedures for the removal of excess skin and/or fat in conjunction with or resulting from weight loss or a weight loss surgery.
- Expenses for services that are primarily and customarily used for environmental control or enhancement (whether or not prescribed by a healthcare practitioner) and certain medical devices including, but not limited to:
  - Common household items including air conditioners, air purifiers, water purifiers, vacuum cleaners, waterbeds, hypoallergenic mattresses or pillows, or exercise equipment;
  - Motorized transportation equipment (e.g. scooters), escalators, elevators, ramps or modifications or additions to living/working quarters or transportation vehicles;
  - Personal hygiene equipment including bath/shower chairs, transfer equipment or supplies, or bedside commodes;

continued –

  - Personal comfort items including cervical pillows, gravity lumbar reduction chairs, swimming pools, whirlpools, spas or saunas;
  - Medical equipment including:
    1. Blood pressure monitoring devices, unless prescribed by a healthcare practitioner for preventive services and ambulatory blood pressure monitoring is not available to confirm diagnosis of hypertension;
    2. PUVA lights; and
    3. Stethoscopes.
  - Communication systems, telephone, television or computer systems and related equipment or similar items or equipment;
  - Communication devices, except after surgical removal of the larynx or a diagnosis of permanent lack of function of the larynx.
- Duplicate or similar rentals or purchases of durable medical equipment or diabetes equipment.
- Therapy and testing for treatment of allergies including, but not limited to, services related to clinical ecology, environmental allergy and allergic immune system dysregulation and sublingual antigen(s), extracts, neutralization tests and/or treatment. Allergy therapy or testing approved by the following is a covered expense:
  - The American Academy of Allergy and Immunology; or
  - The Department of Health and Human Services or any of its offices or agencies.
- Lodging accommodations or transportation, except as indicated under transplant services within the certificate and coverage of travel expenses to receive approved services from a non-network provider.
- Communications, except as it relates to telemedicine benefits as described within the certificate, or travel time.
- Sickness or bodily injury for which no-fault medical payment or expense coverage benefits are paid or payable under any homeowners, premises or any other similar coverage.
- Elective medical or surgical abortion unless:
  - The pregnancy would endanger the life of the mother; or
  - The pregnancy is a result of rape or incest.
- Alternative medicine.
- Acupuncture, unless:
  - The treatment is medically necessary, appropriate and is provided within the scope of the acupuncturist's license; and
  - You are directed to the acupuncturist for treatment by a licensed physician.
- Services rendered in a premenstrual syndrome clinic or holistic medicine clinic.
- Services of a midwife, unless the midwife is licensed.
- Vision examinations or testing for the purposes of prescribing corrective lenses, except annual, routine eye exams for adults as provided as a covered expense in the certificate and comprehensive eye exams provided under the "Covered Expenses – Pediatric Vision Care" section in the certificate.
- Orthoptic/vision training (eye exercises).
- Radial keratotomy, refractive keratoplasty or any other surgery or procedure to correct myopia, hyperopia or stigmatic error.
- The purchase or fitting of eyeglasses or contact lenses, except as:
  - The result of an accident or following cataract surgery as stated in the certificate
  - Otherwise specified in the "Covered Expenses – Pediatric Vision Care" section if included in the certificate.

continued –

- Services and supplies, which are:
  - Rendered in connection with mental illnesses not classified in the International Classification of Diseases of the U.S. Department of Health and Human Services; or
  - Extended beyond the period necessary for evaluation and diagnosis of learning and behavioral disabilities or for mental retardation.
- Marriage counseling.
- Expenses for employment, school, sport or camp physical examinations or for the purposes of obtaining insurance.
- Expenses for care and treatment of non-covered procedures or services.
- Expenses for treatment of complications of non-covered procedures or services.
- Expenses incurred for services prior to the effective date or after the termination date of your coverage under the contract. Coverage will be extended as described in the "Extension of Benefits" section of the certificate, as required by state law.
- For HMO plans, any care, treatment, services, equipment or supplies received outside of the service area:
  - If you could have reasonably foreseen or anticipated their need prior to departure from the service area; and
  - Which are not authorized by us.
- For PPO, Classic/Indemnity and POS plans, any expense for services received outside of the United States except for emergency care, as required by law and specified in the "Covered Expenses" section of the certificate, or services authorized by us to be provided by a non-network provider.
- Pre-surgical/procedural testing duplicated during a hospital confinement.
- Home healthcare for:
  - Charges for mileage or travel time to and from the covered person's home;
  - Wage or shift differentials for any representative of a home healthcare agency;
  - Charges for supervision of home healthcare agencies;
  - Charges for services of a home health aide;
  - Custodial care; or
  - The provision or administration of self-administered injectable drugs.
- Hospice care for:
  - A confinement not required for acute pain control or other treatment for an acute phase of chronic symptom management;
  - Services by volunteers or persons who do not regularly charge for their services;
  - Bereavement counseling services for family members not covered under the contract.
- Orthotics if:
  - Replacement orthotics, except replacement due to normal wear and tear or if a change in the covered person's size causes the orthotic to become non-functional;
  - Dental braces;
  - Oral or dental splints and appliances, except for the treatment of temporomandibular joint (TMJ) disorder as a result of accident, trauma, a congenital defect, a developmental defect or a pathology or custom made for the treatment of documented obstructive sleep apnea.
- Repair or replacement of a prosthetic device when covered by the manufacturer.
- Repair or maintenance of durable medical equipment or diabetes equipment, unless the:
  - Manufacturer's warranty is expired;
  - Repair or maintenance is not a result of misuse or abuse;
  - Repair cost is less than replacement cost.

continued –

- Replacement of purchased durable medical equipment and diabetes equipment, unless the:
  - Manufacturer's warranty is expired;
  - Replacement cost is less than repair cost; and
  - Replacement is not due to lost equipment, or misuse or abuse of the equipment; or
  - Replacement is required due to a change in your condition that makes the current equipment non-functional.
- For a plan that includes benefits for pediatric dental:
  - Any expense arising from the completion of forms
  - Any expense due to your failure to keep an appointment
  - Any expense for a service we consider cosmetic, unless it is due to an accidental dental injury
  - Expenses incurred for:
    1. Precision or semi-precision attachments
    2. Overdentures and any endodontic treatment associated with overdentures
    3. Other customized attachments
    4. Any services for 3D imaging (cone beam images)
    5. Temporary and interim dental services
    6. Additional charges related to materials or equipment used in the delivery of dental care
  - Charges for services rendered:
    1. In a dental facility or healthcare treatment facility sponsored or maintained by the employer under this plan or an employer of any covered person covered by the contract; or
    2. By an employee of any covered person covered by the contract
- For the purposes of this exclusion, Covered Person means the employee and/or the employee's dependents enrolled for benefits under the contract and as defined in the "Glossary" section of the certificate.
  - Any service related to:
    1. Altering vertical dimension of teeth or changing the spacing and/or shape of the teeth
    2. Restoration or maintenance of occlusion
    3. Splinting teeth, including multiple abutments, or any service to stabilize periodontally weakened teeth
    4. Replacing tooth structures lost as a result of abrasion, attrition, erosion or abfraction
    5. Bite registration or bite analysis
  - Infection control, including but not limited to, sterilization techniques.
  - Expenses incurred for services performed by someone other than a dentist, except for scaling and teeth cleaning and the topical application of fluoride, which can be performed by a licensed dental hygienist. The treatment must be rendered under the supervision and guidance of the dentist in accordance with generally accepted dental standards.
  - Any hospital, surgical or treatment facility or for services of an anesthesiologist or anesthetist.
  - Prescription drugs or pre-medications, whether dispensed or prescribed.
  - Any service that:
    1. Is not eligible for benefits based on the clinical review
    2. Does not offer a favorable prognosis
    3. Does not have uniform professional acceptance
    4. Is deemed to be experimental or investigational in nature
  - Repair and replacement of orthodontic appliances.
  - Preventive control programs including, but not limited to, oral hygiene instructions, plaque control, take-home items, prescriptions and dietary planning.
  - Replacement of any lost or misplaced prosthesis or appliance.

continued –

- Any caries susceptibility testing, laboratory tests, saliva samples, anaerobic cultures, sensitivity testing or charges for oral pathology procedures.
- The following services when performed at the same time as a root canal:
  1. Partial pulpotomy for apexogenesis
  2. Vital pulpotomy
  3. Pulp debridement or pulpal therapy

- For a plan that includes benefits for pediatric vision care, benefits are limited as follows:
  - In no event will benefits exceed the lesser of the limits of the contract, shown in the "Schedule of Benefits – Pediatric Vision Care" or in the "Schedule of Benefits" of the certificate.
  - Materials covered by the contract that are lost, stolen, broken or damaged will only be replaced at normal intervals as specified in the "Schedule of Benefits – Pediatric Vision Care" of the certificate.
- For a plan that includes benefits for pediatric vision care, unless specifically stated otherwise, no benefits will be provided for, or on account of, the following items:
  - Orthoptic or vision training and any associated supplemental testing
  - Two or more pair of glasses, in lieu of bifocals or trifocals
  - Medical or surgical treatment of the eye, eyes or supporting structures
  - Any services and materials required by an employer as a condition of employment
  - Safety lenses and frames
  - Contact lenses, when benefits for frames and lenses are received
  - Cosmetic items
  - Any services or materials not listed in this benefit section as a covered benefit or in the "Schedule of Benefits – Pediatric Vision Care" of the certificate
  - Expenses for missed appointments
  - Any charge from a providers' office to complete and submit Claim Forms
  - Treatment relating to or caused by disease
  - Non-prescription materials or vision devices
  - Costs associated with securing materials
  - Pre- and post-operative services
  - Orthokeratology
  - Maintenance of materials
  - Refitting or change in lens design after initial fitting
  - Artistically painted lenses

continued –

THE SIMPLICITY PLAN

ARIZONA **PRESCRIPTION DRUG LIMITATIONS** AND **EXCLUSIONS**

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

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

- Legend drugs, which are not deemed medically necessary by us.
- Prescription drugs not included on the Drug List.
- Any amount exceeding the default rate.
- Specialty drugs for which coverage is not approved by us.
- Drugs not approved by the FDA, except drugs, medicines or medications prescribed by a healthcare practitioner and recognized as safe and effective by one or more of the following medical reference compendia for the treatment of a specific type of cancer:
  - The American Hospital Formulary Service Drug Information, a publication of the American Society of Health System Pharmacists
  - The National Comprehensive Cancer Network Drugs and Biologics Compendium
  - Thompson Micromedex Compendium Drugdex
  - Elsevier Gold Standard's Clinical Pharmacology Compendium
  - Other authoritative compendia as identified by the Secretary of the United States Department of Health and Human Services
- Covered expense will also include drugs, medicines or medications recognized as safe and effective for a type of cancer in medical literature, if all of the following apply:
  - At least two articles from major peer reviewed professional medical journals have recognized, based on scientific or medical criteria, the drug's safety and effectiveness for treatment of the indication for which the drug has been prescribed
  - No article from a major peer reviewed professional medical journal has concluded, based on scientific or medical criteria, that the drug is unsafe or ineffective or that the drug's safety and effectiveness cannot be determined for the treatment of the indication for which the drug has been prescribed
  - The literature meets the uniform requirements for manuscripts submitted to biomedical journals established by the international committee of medical journal editors or is published in a journal specified by the United States Department of Health and Human Services as acceptable peer reviewed medical literature
- Any drug prescribed for intended use other than for:
  - Indications approved by the FDA; or
  - Off-label indications recognized through peer-reviewed medical literature.
- Any drug prescribed for a sickness or bodily injury not covered under the Contract.
- Any drug, medicine or medication that is either:
  - Labeled "Caution-limited by federal law to investigational use"; or
  - Experimental, investigational or for research purposes, even though a charge is made to you.

continued –

- Allergen extracts.
- Therapeutic devices or appliances, including, but not limited to:
  - 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);
  - Support garments;
  - Test reagents;
  - Mechanical pumps for delivery of medications; and
  - Other non-medical substances.
- Dietary supplements and nutritional products, except enteral formulas and nutritional supplements for the treatment of phenylketonuria (PKU) or other inherited metabolic disease or eosinophilic gastrointestinal disorders. Refer to the "Covered Expenses" section of the certificate for coverage of low protein modified foods.
- Non-prescription, over-the-counter minerals, except as specified on the Preventive Medication Coverage drug list when obtained from a network pharmacy with a prescription from a healthcare practitioner.
- 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.
- For PPO/HMO/NPOS plans – 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 a network pharmacy with a prescription from a healthcare practitioner.
- Any drug used for the purpose of weight loss.
- Any drug used for cosmetic purposes, including but not limited to:
  - Dermatologicals or hair growth stimulants; or
  - Pigmenting or de-pigmenting agents.
- Any drug or medicine that is lawfully obtainable without a prescription (over-the-counter drugs), except:
  - Insulin; and
  - Drugs, medicines or medications, and supplies on the Preventive Medication Coverage Drug List when obtained from a network pharmacy with a prescription from a healthcare practitioner.
- Compounded drugs that:
  - Are prescribed for a use or route of administration that is not FDA approved or compendia supported;
  - Are prescribed without a documented medical need for specialized dosing or administration;
  - Only contain ingredients that are available over-the-counter;
  - Only contain non-commercially available ingredients; or
  - Contain ingredients that are not FDA approved, including bulk compounding powders.
- Abortifacients (drugs used to induce abortions).
- Any prescription related to infertility services after evaluation and diagnosis is completed.
- Any drug prescribed for impotence and/or sexual dysfunction.
- Any drug, medicine or medication that is consumed or injected at the place where the prescription is given, or dispensed by the healthcare practitioner.
- The administration of covered medication(s).
- Prescriptions that are to be taken by or administered to you, in whole or in part, while you are a patient in a facility where drugs are ordinarily provided by the facility on an inpatient basis. Inpatient facilities include, but are not limited to:
  - Hospital;
  - Skilled nursing facility; or
  - Hospice facility.

continued –

- Injectable drugs, including, but not limited to:
  - Immunizing agents, unless for preventive services determined by us to be dispensed by or administered in a pharmacy;
  - Biological sera;
  - Blood;
  - Blood plasma; or
  - Self-administered injectable drugs or specialty drugs for which prior authorization or step therapy is not obtained from us.
- Prescription fills or refills:
  - In excess of the number specified by the healthcare practitioner; or
  - Dispensed more than one year from the date of the original order.
- Any portion of a prescription fill or refill that exceeds a 90-day supply when received from a mail-delivery pharmacy or a retail pharmacy that participates in our program, which allows you to receive a 90-day supply of a prescription fill or refill.
- 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 you to receive a 90-day supply of a prescription fill or refill.
- Any portion of a specialty drug prescription fill or refill that exceeds a 30-day supply, unless otherwise determined by us.
- Any portion of a prescription fill or refill that:
  - Exceeds our drug specific dispensing limit;
  - Is dispensed to a covered person, whose age is outside the drug specific age limits defined by us;
  - Is refilled early, as defined by us; or
  - Exceeds the duration-specific dispensing limit.
- Any drug for which we require prior authorization or step therapy and it is not obtained.
- Any drug for which a charge is customarily not made.
- Any drug, medicine or medication received by you:
  - Before becoming covered; or
  - After the date your coverage has ended.
- Any costs related to the mailing, sending or delivery of prescription drugs.
- Any intentional misuse of the prescription drug benefit, including prescriptions purchased for consumption by someone other than you.
- Any prescription fill or refill for drugs, medicines or medications that are lost, stolen, spilled, spoiled or damaged.
- Drug delivery implants and other implant systems or devices, except insulin pumps and implantable contraceptive products.
- Any amount you 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.
- For HMO plans and some POS plans, prescriptions filled at a non-network pharmacy, except for prescriptions required during an emergency.

continued –

THE SIMPLICITY PLAN

ARIZONA
MEDICAL LIMITATIONS AND **EXCLUSIONS**
For employers with 51 or more employees

These limitations and exclusions apply even if a healthcare practitioner has performed or prescribed a medically appropriate procedure, treatment or supply. This does not prevent your healthcare practitioner from providing or performing the procedure, treatment or supply. However, the procedure, treatment or supply will not be a covered expense.

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

- Treatments, services, supplies or surgeries that are not medically necessary, except for the preventive services required by the U.S. Department of Health and Human Services (HHS). For a list of these recommended services refer to www.healthcare.gov.
- A sickness or bodily injury arising out of, or in the course of, any employment for wage, gain or profit if the person is insured, or is required to be insured by Workers' Compensation.
- Care and treatment given in a hospital owned, or run, by any government entity, unless you are legally required to pay for such care and treatment. However, care and treatment provided by military hospitals to covered persons who are armed services retirees and their dependents are not excluded.
- Any service furnished while you are confined in a hospital or institution owned or operated by the United States government or any of its agencies for any military service-connected sickness or bodily injury.
- Any service you would not be legally required to pay for in the absence of this coverage.
- Sickness or bodily injury for which you are in any way paid or entitled to payment or care and treatment by or through a government program, other than Medicaid.
- Any service not ordered by a healthcare practitioner.
- Services provided to you, if you do not comply with the HMO/POS Contract's requirements. These include services:
  - Not provided by a network provider, unless required for emergency care {this applies to HMO plans and some POS plans};
  - Received in an emergency room, unless required because of emergency care;
  - Which require preauthorization if preauthorization was not obtained;
  - Which require a primary care physician referral if a referral was not obtained {this applies only to some HMO and POS plans}.
- Services rendered by a standby physician, surgical assistant, assistant surgeon, physician assistant, registered nurse or certified operating room technician unless medically necessary
- Any service that is not rendered by the billing provider.
- Any service not substantiated in the medical records of the billing provider.

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continued –

- Education or training, except for diabetes self-management training and habilitative services.
- Educational or vocational therapy, testing, services or schools, including therapeutic boarding schools and other therapeutic environments. Educational or vocational videos, tapes, books and similar materials are also excluded.
- Ambulance services for routine transportation to, from or between medical facilities and/or a healthcare practitioner‘s office.
- Any drug, biological product, device, medical treatment or procedure which is experimental, investigational or for research purposes, except for clinical trials as described in the “Covered Expenses” section of the certificate.
- Vitamins, except for preventive services with a prescription from a healthcare practitioner, dietary supplements, and dietary formulas, except enteral formulas, nutritional supplements or low protein modified food products for the treatment of an inherited metabolic disorder, e.g. phenylketonuria (PKU).
- Over-the-counter, non-prescription medications, unless for drugs, medicines or medications or supplies on the Preventive Medication Coverage Drug List, with a prescription from a healthcare practitioner.
- 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 preventive services as recommended by the U.S. Department of Health and Human Services (HHS). For a list of these recommended services refer to the www.healthcare.gov website
- Growth hormones, except as otherwise specified in the “Pharmacy Services” sections of the certificate.
- Services received in an emergency room, unless required because of emergency care.
- Weekend non-emergency hospital admissions, specifically admissions to a hospital on a Friday or Saturday at the convenience of the covered person, or his or her healthcare practitioner, when there is no cause for an emergency admission and the covered person receives no surgery or therapeutic treatment until the following Monday.
- Hospital inpatient services when you are in observation status.
- Infertility services, after evaluation and diagnosis is completed, or reversal of elective sterilization.
- No benefit is payable for, or in connection with, a transplant if:
  - The expense relates to storage of cord blood and stem cells, unless it is an integral part of a transplant approved by us
  - We do not approve coverage for the transplant, based on our established criteria
  - Expenses 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
  - The expense relates to the transplantation of any non-human organ or tissue, unless otherwise stated in the contract
  - The expense relates to the donation or acquisition of an organ for a recipient who is not covered by us
  - The expense relates to donor costs that are payable in whole or in part by any other group plan, insurance company, organization, or person other than the donor‘s family or estatee
  - The expense relates to a transplant performed outside of the United States and any care resulting from that transplant
- No benefits will be provided for:
  - Immunotherapy for recurrent abortion;
  - Chemonucleolysis;
  - Biliary lithotripsy;
  - Sleep therapy;
  - Light treatments for Seasonal Affective Disorder (S.A.D.);
  - Immunotherapy for food allergy;
  - Prolotherapy; or
  - Sensory integration therapy.

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- Cosmetic surgery and cosmetic services or devices, unless reconstructive surgery is necessary due to a covered mastectomy.
- Hair prosthesis, hair transplants or implants, and wigs.
- Dental services, appliances or supplies for treatment of the teeth, gums, jaws or alveolar processes, including but not limited to, any oral surgery, endodontic services or periodontics, implants and related procedures, orthodontic procedures, and any dental services related to a bodily injury or sickness unless otherwise stated in the certificate.
- The following types of care of the feet:
  - Shock wave therapy of the feet;
  - The treatment of weak, strained, flat, unstable or unbalanced feet;
  - Hygienic care, and the treatment of superficial lesions of the feet, such as corns, calluses or hyperkeratosis;
  - The treatment of tarsalgia, metatarsalgia or bunion, except surgically;
  - The cutting of toenails, except the removal of the nail matrix;
  - Heel wedges, lifts or shoe inserts; and
  - Arch supports (foot orthotics) or orthopedic shoes, except for diabetes or hammertoe.
- Custodial care and maintenance care.
- Any loss contributed to, or caused by:
  - War or any act of war, whether declared or not;
  - Insurrection; or
  - Any conflict involving armed forces of any authority.
- Expenses for any membership fees or program fees paid by you, including but not limited to, health clubs, health spas, aerobic and strength conditioning, work-hardening programs and weight loss or surgical programs, and any materials or products related to these programs.
- Surgical procedures for the removal of excess skin and/or fat in conjunction with or resulting from weight loss or weight loss surgery.
- Expenses for services that are primarily and customarily used for environmental control or enhancement (whether or not prescribed by a healthcare practitioner) and certain medical devices including, but not limited to:
  - Common household items including air conditioners, air purifiers, water purifiers, vacuum cleaners, waterbeds, hypoallergenic mattresses or pillows, or exercise equipment;
  - Motorized transportation equipment (e.g. scooters), escalators, elevators, ramps or modifications, or additions to living/working quarters or transportation vehicles;
  - Personal hygiene equipment including bath/shower chairs, transfer equipment or supplies or bed side commodes;
  - Personal comfort items including cervical pillows, gravity lumbar reduction chairs, swimming pools, whirlpools, spas or saunas;
  - Medical equipment including:
    1. Blood pressure monitoring devices, unless prescribed by a health care practitioner for preventive services and ambulatory blood pressure monitoring is not available to confirm diagnosis of hypertension;
    2. PUVA lights; and
    3. Stethoscopes.
  - Communication systems, telephone, television or computer systems and related equipment or similar items or equipment;
  - Communication devices, except after surgical removal of the larynx or a diagnosis of permanent lack of function of the larynx.

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- Duplicate or similar rentals or purchases of durable medical equipment or diabetes equipment.
- Therapy and testing for treatment of allergies including, but not limited to, services related to clinical ecology, environmental allergy and allergic immune system dysregulation and sublingual antigen(s), extracts, neutralization tests and/or treatment unless such therapy or testing is approved by:
  - The American Academy of Allergy and Immunology; or
  - The Department of Health and Human Services or any of its offices or agencies.
- Lodging accommodations or transportation, except as indicated under transplant services within the certificate and coverage of travel expenses to receive approved services from a non-network provide.
- Communications, except as it relates to telemedicine benefits as described within the certificate, or travel time.
- Bariatric surgery, any services or complications related to bariatric surgery, and other weight loss products or services.
- Sickness or bodily injury for which no-fault medical payment or expense coverage benefits are paid or payable under any homeowners, premises or any other similar coverage.
- Elective medical or surgical abortion unless:
  - The pregnancy would endanger the life of the mother; or
  - The pregnancy is a result of rape or incest; or
  - The fetus has been diagnosed with a lethal abnormality.
- Alternative medicine.
- Acupuncture, unless:
  - The treatment is medically necessary, appropriate and is provided within the scope of the acupuncturist's license; and
  - You are directed to the acupuncturist for treatment by a licensed physician.
- Services rendered in a premenstrual syndrome clinic or holistic medicine clinic.
- Services of a midwife, unless the midwife is licensed.
- Vision examinations or testing for the purposes of prescribing corrective lenses.
- Orthoptic/vision training (eye exercises).
- Radial keratotomy, refractive keratoplasty or any other surgery or procedure to correct myopia, hyperopia or stigmatic error.
- The purchase or fitting of eyeglasses or contact lenses, except as the result of an accident or following cataract surgery as stated in the contract.
- Services and supplies which are:
  - Rendered in connection with mental illnesses not classified in the International Classification of Diseases of the U.S. Department of Health and Human Services; or
  - Extended beyond the period necessary for evaluation and diagnosis of learning and behavioral disabilities or for mental retardation.
- Marriage counseling.
- Court-ordered behavioral health services.
- Expenses for employment, school, sport or camp physical examinations or for the purposes of obtaining insurance.
- Expenses for care and treatment of non-covered procedures or services.
- Expenses for treatment of complications of non-covered procedures or services.
- Expenses incurred for services prior to the effective date or after the termination date of your coverage under the contract. Coverage will be extended as described in the "Extension of Benefits" section of the certificate, as required by state law.

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- Expenses incurred by you for the treatment of any jaw joint problem, including temporomandibular joint disorder, craniomaxillary disorder, craniomandibular disorder, head and neck neuromuscular disorder or other conditions of the joint linking the jaw bone and the skull.
- For HMO plans, any care, treatment, services, equipment or supplies received outside of the service area:
  - If you could have reasonably foreseen or anticipated their need prior to departure from the service area; and
  - Which are not authorized by us.
- For PPO, Classic/Indemnity and POS plans, any expense for services received outside of the United States except for emergency care, as required by law and specified in the "Covered Expenses" section of the certificate, or services authorized by us to be provided by a non-network provider.
- Pre-surgical/procedural testing duplicated during a hospital confinement.
- Home healthcare for:
  - Charges for mileage or travel time to and from the covered person's home;
  - Wage or shift differentials for any representative of a home healthcare agency;
  - Charges for supervision of home healthcare agencies;
  - Charges for services of a home health aide;
  - Custodial care; or
  - The provision or administration of self-administered injectable drugs.
- Hospice care for:
  - A confinement not required for acute pain control or other treatment for an acute phase of chronic symptom management;
  - Services by volunteers or persons who do not regularly charge for their services;
  - Services by a licensed pastoral counselor to a member of his or her congregation. These are services in the course of the duties to which he or she is called as a pastor or minister; and
  - Bereavement counseling services for family members not covered under the contract.
- Orthotics if:
  - Replacement orthotics;
  - Dental braces; or
  - Oral or dental splints and appliances, unless custom made for the treatment of documented sleep apnea.
- Repair or replacement of a prosthetic device when covered by the manufacturer.
- Repair or maintenance of durable medical equipment or diabetes equipment, unless the:
  - Manufacturer's warranty is expired;
  - Repair or maintenance is not a result of misuse or abuse;
  - Maintenance is not more frequent than every six months; and
  - Repair cost is less than replacement cost.
- Replacement of purchased durable medical equipment and diabetes equipment, unless the:
  - Manufacturer's warranty is expired;
  - Replacement cost is less than repair cost; and
  - Replacement is not due to lost equipment, or misuse or abuse of the equipment; or
  - Replacement is required due to a change in your condition that makes the current equipment non-functional.

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THE SIMPLICITY PLAN

ARIZONA **PRESCRIPTION DRUG LIMITATIONS** AND **EXCLUSIONS**

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

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

- Legend drugs, which are not deemed medically necessary by us.
- Prescription drugs not included on the Drug List.
- Any amount exceeding the default rate.
- Specialty drugs for which coverage is not approved by us.
- Drugs, ingredients not approved by the FDA, except drugs, medicines or medications prescribed by a healthcare practitioner and recognized as safe and effective by one or more of the following medical reference compendia for the treatment of a specific type of cancer:
  - The American Hospital Formulary Service Drug Information, a publication of the American Society of Health System Pharmacists
  - The National Comprehensive Cancer Network Drugs and Biologics Compendium
  - Thompson Micromedex Compendium Drugdex
  - Elsevier Gold Standard's Clinical Pharmacology Compendium
  - Other authoritative compendia as identified by the Secretary of the United States Department of Health and Human Services
- Covered expense will also include drugs, medicines or medications recognized as safe and effective for a type of cancer in medical literature, if all of the following apply:
  - At least two articles from major peer reviewed professional medical journals have recognized, based on scientific or medical criteria, the drug's safety and effectiveness for treatment of the indication for which the drug has been prescribed
  - No article from a major peer reviewed professional medical journal has concluded, based on scientific or medical criteria, that the drug is unsafe or ineffective or that the drug's safety and effectiveness cannot be determined for the treatment of the indication for which the drug has been prescribed
  - The literature meets the uniform requirements for manuscripts submitted to biomedical journals established by the international committee of medical journal editors or is published in a journal specified by the United States Department of Health and Human Services as acceptable peer reviewed medical literature
- Any drug prescribed for intended use other than for:
  - Indications approved by the FDA; or
  - Off-label indications recognized through peer-reviewed medical literature.
- Any drug prescribed for a sickness or bodily injury not covered under the contract.
- Any drug, medicine or medication that is either:
  - Labeled "Caution-limited by federal law to investigational use"; or
  - Experimental or investigational, or for research purposes, even though a charge is made to you.

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- Allergen extracts.
- Therapeutic devices or appliances, including, but not limited to:
  - Hypodermic needles and syringes (except when prescribed by a health care practitioner for use with insulin and self-administered injectable drugs, whose coverage is approved by us);
  - Support garments;
  - Test reagents;
  - Mechanical pumps for delivery of medications; and
  - Other non-medical substances.
- Dietary supplements, except enteral formulas and nutritional supplements for the treatment of phenylketonuria (PKU) or other inherited metabolic disease or eosinophilic gastrointestinal disorders. Refer to the "Covered Expenses" section of the certificate for coverage of low protein modified foods.
- Nutritional products.
- Minerals.
- 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.
- For PPO/HMO/NPOS plans – 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 a network pharmacy with a prescription from a healthcare practitioner.
- Anorectic or any drug used for the purpose of weight control.
- Any drug used for cosmetic purposes, including but not limited to:
  - Dermatologicals or hair growth stimulants; or
  - Pigmenting or de-pigmenting agents.
- Any drug or medicine that is lawfully obtainable without a prescription (over-the-counter drugs), except:
  - Insulin; and
  - Drugs, medicines or medications and supplies on the Preventive Medication Coverage Drug List when obtained from a network pharmacy with a prescription from a healthcare practitioner.
- Any drug or medicine that is available in prescription strength without a prescription.
- 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.
- Abortifacients (drugs used to induce abortions).
- Any prescription related to infertility services after evaluation and diagnosis is completed.
- Any drug prescribed for impotence and/or sexual dysfunction.
- Any drug, medicine or medication that is consumed or injected at the place where the prescription is given, or dispensed by the healthcare practitioner.
- The administration of covered medication(s).
- Prescriptions that are to be taken by or administered to you, in whole or in part, while you are a patient in a facility where drugs are ordinarily provided by the facility on an inpatient basis. Inpatient facilities include, but are not limited to:
  - Hospital;
  - Skilled nursing facility; or
  - Hospice facility.

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- Injectable drugs, including, but not limited to:
  - Immunizing agents, unless for preventive services determined by us to be dispensed by or administered in a pharmacy;
  - Biological sera;
  - Blood;
  - Blood plasma; or
  - Self-administered injectable drugs or specialty drugs for which prior authorization or step therapy is not obtained from us.
- Prescription fills or refills:
  - In excess of the number specified by the healthcare practitioner; or
  - Dispensed more than one year from the date of the original order.
- Any portion of a prescription fill or refill that exceeds a 90-day supply when received from a mail-delivery pharmacy or a retail pharmacy that participates in our program, which allows you to receive a 90-day supply of a prescription fill or refill.
- 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 you to receive a 90-day supply of a prescription fill or refill.
- Any portion of a specialty drug prescription fill or refill that exceeds a 30-day supply, unless otherwise determined by us.
- Any portion of a prescription fill or refill that:
  - Exceeds our drug specific dispensing limit;
  - Is dispensed to a covered person, whose age is outside the drug specific age limits defined by us;
  - Is refilled early, as defined by us; or
  - Exceeds the duration-specific dispensing limit.
- Any drug for which we require prior authorization or step therapy and it is not obtained.
- Any drug for which a charge is customarily not made.
- Any drug, medicine or medication received by you:
  - Before becoming covered; or
  - After the date your coverage has ended.
- Any costs related to the mailing, sending or delivery of prescription drugs.
- Any intentional misuse of the prescription drug benefit, including prescriptions purchased for consumption by someone other than you.
- Any prescription fill or refill for drugs, medicines or medications that are lost, stolen, spilled, spoiled or damaged.
- Drug delivery implants and other implant systems or devices, except insulin pumps and implantable contraceptive products.
- Any amount you 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.
- For HMO plans and some POS plans, prescriptions filled at a non-network pharmacy, except for prescriptions required during an emergency.