Important

At Humana, it is important you are treated fairly.

Humana Inc. and its subsidiaries do not discriminate or exclude people because of their race, color, national origin, age, disability, sex, sexual orientation, gender, gender identity, ancestry, ethnicity, marital status, religion, or language. Discrimination is against the law. Humana and its subsidiaries comply with applicable Federal Civil Rights laws.

If you believe that you have been discriminated against by Humana or its subsidiaries, there are ways to get help.

- You may file a complaint, also known as a grievance:
  Discrimination Grievances, P.O. Box 14618, Lexington, KY 40512-4618
  If you need help filing a grievance, call **866-427-7478** or if you use a **TTY**, call **711**.
- You can also file a civil rights complaint with the **U.S. Department of Health and Human Services**, Office for Civil Rights electronically through their Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or at **U.S. Department of Health and Human Services**, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, DC 20201, **800-368-1019**, **800-537-7697 (TDD)**. Complaint forms are available at **https://www.hhs.gov/ocr/office/file/index.html**.
- **California residents**: You may also call California Department of Insurance toll-free hotline number: **800-927-HELP (4357)**, to file a grievance.

Auxiliary aids and services, free of charge, are available to you. 866-427-7478 (TTY: 711)

Humana provides free auxiliary aids and services, such as qualified sign language interpreters, video remote interpretation, and written information in other formats to people with disabilities when such auxiliary aids and services are necessary to ensure an equal opportunity to participate.

Language assistance services, free of charge, are available to you. 866-427-7478 (TTY: 711)

Español (Spanish): Llame al número arriba indicado para recibir servicios gratuitos de asistencia lingüística.
繁體中文 (Chinese): 撥打上面的電話號碼即可獲得免費語言援助服務。
Tiếng Việt (Vietnamese): Xin gọi số điện thoại trên đây để nhận được các dịch vụ hỗ trợ ngôn ngữ miễn phí.
한국어 (Korean): 무료 언어 지원 서비스를 받으려면 위의 번호로 전화하십시오 .
Tagalog (Tagalog – Filipino): Tawagan ang numero sa itaas upang makatanggap ng mga serbisyo ng tulong sa wika nang walang bayad.
Русский (Russian): Позвоните по номеру, указанному выше, чтобы получить бесплатные услуги перевода.
Kreyòl Ayisyen (French Creole): Rele nimewo ki pi wo la a, pou resevwa sèvis èd pou lang ki gratis.
Français (French): Appelez le numéro ci-dessus pour recevoir gratuitement des services d'aide linguistique.
Polski (Polish): Aby skorzystać z bezpłatnej pomocy językowej, proszę zadzwonić pod wyżej podany numer.
Português (Portuguese): Ligue para o número acima indicado para receber serviços linguísticos, grátis.
Italiano (Italian): Chiamare il numero sopra per ricevere servizi di assistenza linguistica gratuiti.
Deutsch (German): Wählen Sie die oben angegebene Nummer, um kostenlose sprachliche Hilfsdienstleistungen zu erhalten.
日本語 (Japanese): 無料の言語支援サービスをご要望の場合は、上記の番号までお電話ください。

فارسی (Farsi)
برای دریافت تسهیلات زبانی بصورت رایگان با شماره فوق تماس بگیرید.

Diné Bizaad (Navajo): Wódahí béésh bee hani'í bee wolta'ígíí bich'į' hódíílnih éí bee t'áá jiik'eh saad bee áká'ánída'áwo'dę́ę́ niká'adoowoł.

العر بية (Arabic)
الرجاء الاتصال بالرقم المبين أعلاه للحصول على خدمات مجانية للمساعدة بلغتك

GCHJV5REN 0122

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Colorado Regulatory Pre-enrollment Disclosure Guide for Group Health Products

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INTRODUCTION

This document identifies certain plan provisions which may exclude, limit, reduce, modify or terminate plan coverage. This information is provided to you prior to enrollment to help you make an informed health care coverage decision, and to help meet state pre-enrollment disclosure requirements.

The document is for informational purposes only. Information relating to employer-funded, customized or state-mandated plans may differ. While every effort has been made to provide the most accurate and up-to-date information, it is not intended to be a full description of coverage, does not constitute a contract, and will be updated periodically without notice. Benefit, coverage, and eligibility determinations will be based on the terms and conditions of the Contract.

The following terms have the meaning indicated below when used within this document:

"Covered Person" means an employee or dependent covered by the Contract.

"Contract" means the legal agreement between us and the Contractholder. The Contract may also be known as a policy or master group contract.

"Contractholder" means the legal entity identified as the policyholder or group plan sponsor on the face page of the Contract who establishes, sponsors and endorses an employee benefit plan for insurance or health care coverage.

Please contact your Sales Agent if you need further assistance regarding the information presented here or are interested in specific plan information. Note information is also available regarding any standardized health plans which your state may require us to offer.

The agent does not have the authority to waive a complete answer to any question, determine coverage or insurability, alter any Contract, bind the insuring or offering entity by making any promise or representation, or waive any other rights or requirements of the insuring or offering entity.

ENROLLMENT

Each employee must complete the enrollment process to enroll for coverage under the Contract for themselves and their eligible dependents, if any.

We reserve the right to require an eligible employee and/or eligible dependent to submit evidence of health status. No eligible employee or eligible dependent will be refused enrollment or charged a different premium than other group members based on health status-related factors. Health status will not be used to determine the premium rates for products offered through a small employer group health plan. We will not use health status-related factors to decline medical coverage to an eligible employee or eligible dependent. We will administer this provision in a non-discriminatory manner.

Late applicant means an employee or dependent who requests enrollment for coverage under the Contract more than 31 days after his/her eligibility date, later than the time period specified in the "Special enrollment" provision, or after the open enrollment period.

Open enrollment period means no less than a 31-day period of time, occurring annually for the group, during which employees have an opportunity to enroll themselves and their eligible dependents for coverage under Contract.

Special enrollment

Special enrollment is available if the following apply:

- You have a change in family status due to:
  - Marriage;
  - Partner in a civil union;
  - Divorce;
  - A Qualified Medical Child Support Order (QMCSO);
  - A National Medical Support Notice (NMSN);
  - The birth of a natural born child; or
  - The adoption of a child or placement of a child for the purpose of adoption or placement in foster care;
  - Entering into a designated beneficiary agreement, or a court order requiring coverage for the individual to be covered; and
  - You enroll within 31 days after the special enrollment date; or
- You are an employee or dependent eligible for coverage under the Contract, and:
  - You previously declined enrollment stating you were covered under another group health plan or other health insurance coverage; and
  - Loss of eligibility of such other coverage occurs, regardless of whether you are eligible for, or elect COBRA; and
  - You enroll within 31 days after the special enrollment date.
- Loss of eligibility of other coverage includes, but is not limited to:
  - Termination of employment or eligibility;
  - Reduction in number of hours of employment;
  - Divorce, legal separation or death of a spouse or partner in a civil union;
  - Loss of dependent eligibility, such as attainment of the limiting age;
  - Termination of your employer's contribution for the coverage;

- Loss of individual HMO coverage because you no longer reside, live or work in the service area;
- Loss of group HMO coverage because you no longer reside, live or work in the service area, and no other benefit package is available;
- The plan no longer offers benefits to a class of similarly situated individuals; or

- You had COBRA continuation coverage under another plan at the time of eligibility, and:

  - Such coverage has since been exhausted; and
  - You stated at the time of the initial enrollment that coverage under COBRA was your reason for declining enrollment; and
  - You enroll within 31 days after the special enrollment date; or

- You were covered under an alternate plan provided by the employer that terminates, and:

  - You are replacing coverage with the Contract; and
  - You enroll within 31 days after the special enrollment date; or

- You are an employee or dependent eligible for coverage under the Contract, and:

  - Your Medicaid coverage or your Children's Health Insurance Program (CHIP) coverage terminated as a result of loss of eligibility; and
  - You enroll within 60 days after the special enrollment date; or

- You are an employee or dependent eligible for coverage under the Contract, and

  - You become eligible for a premium assistance subsidy under Medicaid or CHIP; and
  - You enroll within 60 days after the special enrollment date; or

- You were covered under the "Colorado Medical Assistance Act" and you enroll within 60 days of the special enrollment date; or

- You are an employee or dependent eligible for coverage under the Contract, and:

  - Your children's basic health plan coverage terminated as a result of loss of eligibility or disenrollment; and
  - You enroll within 60 days after the special enrollment date.

When you are notified or become aware of a special enrollment event that will occur in the future, you may apply for coverage during the 30 days prior to the special enrollment date. Coverage will begin no earlier than the special enrollment date. You must be able to provide written documentation to support the special enrollment.

Dependent special enrollment

The dependent special enrollment is the time period specified in the "Special enrollment" provision.

If dependent coverage is available under the employer's Contract or added to the Contract, an employee who is a Covered Person can enroll eligible dependents during the applicable special enrollment. An employee, who is otherwise eligible for coverage and had waived coverage under the Contract when eligible, can enroll himself/herself and eligible dependents during the special enrollment.

The employee or dependent are a late applicant if enrolled later than the time period specified in the "Special enrollment" provision after the special enrollment date. A late applicant must wait to enroll for coverage during the open enrollment period.

MEDICAL LIMITATIONS AND EXCLUSIONS

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 the HHS website at www.healthcare.gov.

- A sickness or bodily injury arising out of, or in the course of, any employment for wage, gain or profit. This exclusion applies whether or not you have Workers' Compensation coverage. This exclusion does not apply to employees of entities that are not legally required to obtain and have not obtained workers' compensation coverage and does not apply to an employee that is sole proprietor, partner, or corporate officer if the sole proprietor, partner or corporate officer is not eligible to receive Workers' Compensation benefits.

- 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.

- Services, or any portion of a service, for which no charge is made.

- Services, or any portion of a service, you would not be required to pay for, or would not have been charged for, in the absence of this coverage.

- Any portion of the amount we determine you owe for a service that the provider waives, rebates or discounts, including your copayment, deductible or coinsurance.

- 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.

- Any service not ordered by a health care 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 or as otherwise specified in the certificate {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; and
  - Which require a primary care physician referral if a referral was not obtained {this applies only to some HMO and POS plans}.

- Private duty nursing.

- Services rendered by a standby physician, surgical assistant or assistant surgeon, unless medically necessary.

- Any service not rendered by the billing provider.

- Any service not substantiated in the medical records of the billing provider.

- Any amount billed for a professional component of an automated:

  - Laboratory service; or
  - Pathology service.

- For PPO, Indemnity and POS plans, expenses for services, prescriptions, equipment, or supplies received outside the United States or from a foreign provider unless:

  - For emergency care;
  - The employee is traveling outside the United States due to employment with the employer sponsoring this Contract 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 the Contract.

- 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.

- Services provided by a Covered Person's family member, unless the covered expense is performed by a family member who is a licensed provider.

- Ambulance services for routine transportation to, from or between medical facilities and/or a health care practitioner's office.

- Any drug, biological product, device, medical treatment, or procedure which is experimental, investigational or for research purposes.

- Vitamins, except for preventive services with a prescription from a health care practitioner, dietary supplements and dietary formulas, except metabolic formulas and their modular counterparts, amino acid based elemental formulas, nutritional supplements or low protein modified food products for the treatment of inherited enzymatic disorders and severe protein allergic conditions.

- 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 health care practitioner.

- Over-the-counter medical items or supplies that can be provided or prescribed by a health care practitioner but are also available without a written order or prescription, except for preventive services.

- Immunizations required for foreign travel for a Covered Person of any age.

- Growth hormones, except as otherwise specified in the pharmacy services sections of the certificate.

- Prescription drugs and self-administered injectable drugs, except as specified in the "Benefits/Coverage (What is Covered) – Pharmacy Services" section of the certificate or unless administered to you:

  - While an inpatient in a hospital, skilled nursing facility, health care treatment facility or residential treatment facility;
  - By the following, when deemed appropriate by us:

    - A health care practitioner:

      - During an office visit; or
      - While an outpatient; or

    - A home health care agency as part of a covered home health care plan.

- Treatment for intractable pain.

- Hearing aids, the fitting of hearing aids or advice on their care, except for covered dependent children under age 18; implantable hearing devices, except for cochlear implants as otherwise stated in the certificate.

- Services received in an emergency room, unless required because of emergency care or non-emergency care if the Covered Person was referred by his or her health care practitioner or us.

- 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 health care 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; or reversal of elective sterilization.

- In vitro fertilization regardless of the reason for treatment.

- Services for or in connection with a transplant or immune effector cell therapy if:

  - The expense relates to storage of cord blood and stem cells, unless it is an integral part of a transplant approved by us.

  - Not approved by us, 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 or tissue for a recipient who is not covered by us.

  - The expense relates to a transplant or immune effector cell therapy performed outside of the United States and any care resulting from that transplant or immune effector cell therapy. This exclusion applies even if the employee and dependents live outside the United States and the employee is in active status with the employer sponsoring the Contract.

- No benefits will be provided for:

  - Immunotherapy for recurrent abortion;
  - Chemonucleolysis;
  - 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.

- 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.

- Services relating to a sickness or bodily injury as a result of:

  - Engagement in an illegal profession or occupation; or
  - Commission of or an attempt to commit a criminal act.

  This exclusion does not apply to any sickness or bodily injury resulting from an act of domestic violence or a medical condition (including both physical and mental health conditions).

- Expenses for any membership fees or program fees, 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 health care 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:

    - 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;

    - PUVA lights; and

    - Stethoscopes;

  - Communication system, 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 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, unless provided in connection with a pre-approved transplant.

- Transportation, unless provided as part of a hospice care program or in connection with a pre-approved transplant.

- Communications 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.

- 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 comprehensive eye exams for small employer plans.

- Orthoptic/vision training (eye exercises).

- Radial keratotomy, refractive keratoplasty or any other surgery or procedure to correct myopia, hyperopia or stigmatic error.

- For a plan that does not include benefits for pediatric vision care, 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.

- For a plan that includes benefits for pediatric vision care, 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 "Benefits/Coverage (What is Covered) – Pediatric Vision Care" section in the certificate.

- 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
  - Educational services for 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 "Termination/Nonrenewal/Continuation" 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 or to the extent they exceed the maximum allowable fee.

- Pre-surgical/procedural testing duplicated during a hospital confinement.

- Home health care for:

  - Charges for services or supplies for personal comfort or convenience, including homemaker services;
  - Charges for mileage or travel time to and from the Covered Person's home;
  - Wage or shift differentials for any representative of a home health care agency;
  - Charges for supervision of home health care agencies;
  - Custodial care;
  - The provision or administration of self-administered injectable drugs, unless otherwise determined by us;
  - Charges for services related to well-baby care; or
  - Charges for food services or meals other than dietary counseling.

- Orthotics if:

  - Replacement orthotics;
  - Dental braces; or
  - Oral or dental splints and appliances, unless custom made for the treatment of documented obstructive sleep apnea.

- Repair or replacement of a prosthetic device when necessitated by misuse or loss.

- Repair or maintenance of durable medical equipment or diabetes equipment, unless the:

  - Manufacturer's warranty is expired; 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 required due to a change in your condition that makes the current equipment non-functional.

- Reconstructive surgery due to a psychological condition.

- Routine costs for an approved clinical trial do not include services or items that are:

  - Experimental, investigational or for research purposes;
  - Provided only for data collection and analysis that is not directly related to the clinical management of the Covered Person; or
  - Inconsistent with widely accepted and established standards of care for a diagnosis.

- 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:

  - Precision or semi-precision attachments;
  - Overdentures and any endodontic treatment associated with overdentures;
  - Other customized attachments;
  - Any services for 3D imaging (cone beam images);
  - Temporary and interim dental services; or
  - Additional charges related to materials or equipment used in the delivery of dental care.

- Charges for services rendered:

  - In a dental facility or health care treatment facility sponsored or maintained by the employer under this plan or an employer of any Covered Person covered by the Contract.
  - By an employee of any Covered Person covered by the Contract.

  For the purposes of this exclusion, Covered Person means the employee and the employee's dependents enrolled for benefits under the Contract and as defined in the "Definitions" section.

- Any service related to:

  - Altering vertical dimension of teeth or changing the spacing and/or shape of the teeth;
  - Restoration or maintenance of occlusion;
  - Splinting teeth, including multiple abutments, or any service to stabilize periodontally weakened teeth;
  - Replacing tooth structures lost as a result of abrasion, attrition, erosion, or abfraction; or
  - 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:

  - Is not eligible for benefits based on the clinical review;
  - Does not offer a favorable prognosis;
  - Does not have uniform professional acceptance; or
  - Is deemed to be experimental or investigational in nature.

- Preventive control programs including, but not limited to, oral hygiene instructions, plaque control, take-home items, prescriptions and dietary planning.

- Replacement of any lost, stolen, damaged, misplaced or duplicate major restoration, prosthesis or appliance.

- 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:

  - Partial pulpotomy for apexogenesis;
  - Vital pulpotomy; or
  - Pulp debridment 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 (Who Pays What) – Pediatric Vision Care" or in the "Schedule of Benefits (Who Pays What)" 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 (Who Pays What) – Pediatric and Adult Vision Care."

- 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 (Who Pays What) – Pediatric Vision Care."
  - 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.

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

PRESCRIPTION DRUG LIMITATIONS AND EXCLUSIONS

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.
- 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.
- 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 and nutritional products, except metabolic formulas and their modular counterparts, amino acid-based elemental formulas, and nutritional supplements for the treatment of inherited enzymatic disorders and severe protein allergic conditions. Refer to the "Benefits/Coverage (What is Covered) section of the certificate for coverage of low protein modified foods.
- For PPO, HMO and POS plans, 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 health care practitioner.
- For Indemnity plans, non-prescription, over-the-counter minerals, except as specified on the Preventive Medication Coverage drug list when obtained from a pharmacy with a prescription from a health care 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 and POS 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 health care practitioner.

- For Indemnity plan, 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 pharmacy with a prescription from a health care practitioner.

- Anabolic steroids {this does not apply to to small employer plans}.

- 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; or

  - For PPO, HMO and POS plan, drugs, medicines or medications and supplies on the Preventive Medication Coverage drug list when obtained from a network pharmacy with a prescription from a health care practitioner.

  - For Indemnity plans, drugs, medicines or medications and supplies on the Preventive Medication Coverage drug list when obtained from a pharmacy with a prescription from a health care 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).

- Infertility services including medications.

- 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 health care 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.

- 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 health care 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 order 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. This exclusion does not apply to a prescription fill or refill for up to a 12-month supply of contraceptives.

- 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. This exclusion does not apply to a prescription fill or refill for up to a 12-month supply of contraceptives.

- 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, except for prescription refills of a topical ophthalmic product when the product is written for additional fills; or
  - Exceeds the duration-specific dispensing limit.

- Any drug for which we require prior authorization or step therapy and it is not obtained by the prescribing non-network provider.

- 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 this 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.

- Treatment for onychomycosis (nail fungus) {this does not apply to small employer plans}.

- 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.

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

HIGH DEDUCTIBLE HEALTH PLAN REQUIREMENT

The IRS has certain requirements that a High Deductible Health Plan (HDHP) must meet in order for members to be eligible for a Health Savings Account (HSA). One requirement is that the deductible amount must not be lower than the "minimum annual deductible" as defined by the IRS. Each year, the IRS reviews the deductible amounts to determine if the minimum annual deductible should be increased.

If you have an HDHP and the deductible amount of your HDHP does not satisfy the IRS minimum annual deductible requirement, you will be required to move to a valid deductible amount. For most groups, this deductible change will happen on your next renewal date. However, the deductible adjustment may be applied on your initial effective date, if that is required in order to comply with IRS regulations.

PREAUTHORIZATION REQUIREMENTS FOR COVERAGE

Humana requires preauthorization for some services and procedures your physician or other provider may recommend for you. Humana does this solely to determine whether the service or procedure qualifies for payment under your benefit plan. You and your health care provider decide whether you should have such services or procedures. Humana's preauthorization determination relates solely to payment by Humana. To find a list of these services and supplies, please visit our Website at www.humana.com or call Customer Service. Failure to obtain necessary preauthorization when required may result in a reduction of otherwise payable benefits.

MAXIMUM ALLOWABLE FEE

We use fee schedules to pay providers for your coverage based on the criteria set forth in the following maximum allowable fee definition.

For PPO, HMO and POS plans maximum allowable fee for a covered expense, other than:

- Services provided by non-network providers at a network hospital in Colorado;

- Emergency care services provided by non-network providers in a hospital's emergency department; or
- Ambulance services,

is the lesser of:

- The fee charged by the provider for the services;

- The fee that has been negotiated with the provider whether directly or through one or more intermediaries or shared savings contracts for the services;

- 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 geographical area determined by us;

- The fee based upon rates negotiated by us or other payors with one or more network providers in a geographic area determined by us for the same or similar services;

- The fee based upon the provider's cost 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 & Medicaid Services (CMS) annually; or

- 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 provided by non-network providers at a network hospital in Colorado, other than when a Covered Person intentionally receives non-emergency services from non-network providers, or for emergency care services provided by non-network health care practitioner in a hospital's emergency department, is the greater of:

- One hundred ten percent of the median network provider rate of reimbursement for that service in the same geographic area; or
- The sixtieth percentile of the network provider rate of reimbursement for the same service in the same geographic area for the prior year based on commercial claims data from the all-payer health claims database when available.

When a Covered Person intentionally receives non-emergency services from non-network providers, maximum allowable fee for covered expenses is determined by applying the "lesser of" reimbursement method described in the paragraph above. The following paragraphs describe maximum allowable fee for covered expenses for emergency care services.

Maximum allowable fee for a covered expense for emergency care services provided by non-network providers in a hospital's emergency department, other than an emergency department of a non-network hospital in Colorado, is an amount equal to the greatest of:

- The fee negotiated with network providers;
- The fee calculated using the same method to determine maximum allowable fee for a covered expense, other than emergency care services provided by non-network providers; or
- The fee paid by Medicare for the same services.

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

- One hundred ten percent of the median network provider rate of reimbursement for that service in the same geographic area;

- The sixtieth percentile of the network provider rate of reimbursement for the same service in the same geographic area for the prior year based on commercial claims data from the all-payer health claims database when available;
- The fee calculated using the same method to determine maximum allowable fee for a covered expense, other than emergency care services provided by non-network providers; or
- The fee paid by Medicare for the same services.

Maximum allowable fee for a covered expense for emergency care services received at a hospital's emergency department, other than an emergency department of a non-network hospital in Colorado, is an amount equal to the greatest of:

- The fee negotiated with network providers;
- The fee calculated using the same method to determine maximum allowable fee for a covered expense, other than emergency care services provided by non-network providers; or
- The fee paid by Medicare for the same services.

Maximum allowable fee for a covered expense for emergency care received at an emergency department of a non-network hospital in Colorado, other than and emergency department of a non-network hospital operated by the Denver Health and Hospital Authority, is an amount equal to the greatest of:

- One hundred five percent of the our median network provider rate of reimbursement for that service provided in a similar facility or setting in the same geographic area;

- The median network provider rate of reimbursement for the same service provided in a similar facility or setting in the same geographic area for the prior year based on claims data from the Colorado all-payer health claims database when available;

- The fee calculated using the same method to determine maximum allowable fee for a covered expense, other than emergency care services provided by non-network providers; or

- The fee paid by Medicare for the same services.

Maximum allowable fee for a covered expense for emergency care received at an emergency department of a non-network hospital operated by the Denver Health and Hospital Authority is an amount equal to the greatest of:

- Two hundred fifty percent of the Medicare reimbursement rate for the same services provided in a similar facility or setting in the same geographic area;

- The median network provider rate of reimbursement for the same service provided in a similar facility or setting in the same geographic area for the prior year based on claims data from the Colorado all-payer health claims database when available;

- The fee calculated using the same method to determine maximum allowable fee for a covered expense, other than emergency care services provided by non-network providers; or

- The fee paid by Medicare for the same services.

Maximum allowable fee for a covered expense for ambulance services providing emergency care, other than ground transportation on the streets and highways in Colorado, is an amount equal to the greatest of:

- The fee negotiated with network providers;
- The fee calculated using the same method to determine maximum allowable fee for a covered expense, other than emergency care services provided by non-network providers; or

- The fee paid by Medicare for the same services.

Maximum allowable fee for a covered expense for ambulance services providing ground transportation on the streets and highways in Colorado for emergency care, is an amount equal to the greatest of:

- Three hundred twenty-five percent of the Medicare reimbursement rate for the same service provided in the same geographic area, including mileage;
- The fee negotiated with network providers;
- The fee calculated using the same method to determine maximum allowable fee for a covered expense, other than emergency care services provided by non-network providers; or
- The fee paid by Medicare for the same services.

For Indemnity plans, maximum allowable fee for a covered expense, other than emergency care services provided by non-contracted providers in a hospital's emergency department, is the lesser of:

- The fee charged by the provider for the services;

- The fee that has been negotiated with the provider whether directly or through one or more intermediaries or shared savings contracts for the services;

- 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 geographical area determined by us;

- The fee based upon rates negotiated by us or other payors with one or more contracted providers in a geographic area determined by us for the same or similar services;

- The fee based upon the provider's cost 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 & Medicaid Services (CMS) annually; or

- 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 non-contracted providers in a hospital's emergency department is an amount equal to the greatest of:

- The fee negotiated with contracted providers;
- The fee calculated using the same method to determine maximum allowable fee for a covered expense, other than emergency care services provided by non-contracted providers; or
- The fee paid by Medicare for the same services.

MODIFICATION OF COVERAGE

The Contract may be modified by us, upon renewal of the Contract, as permitted by state and federal law. A large employer Contractholder will be notified in writing or electronically at least 31 days prior to the effective date of the change. A small employer Contractholder will be notified in writing or electronically at last 90 days prior to the effective date of the change.

The Contract may be modified by agreement between us and the Contractholder without the consent of any Covered Person or any beneficiary. No modification will be valid unless approved by our President, Secretary or

Vice-President. The approval must be endorsed on or attached to the Contract. No agent has authority to modify the Contract, waive any of the Contract provisions, extend the time of premium payment, or bind us by making any promise or representation.

Corrections due to clerical errors or clarifications that do not change benefits are not modifications of the Contract and may be made by us at any time without prior consent of, or notice to, the Contractholder.

CONTRACTHOLDER RESPONSIBILITIES

In addition to responsibilities outlined in the Contract, the Contractholder is responsible for:

- Collection of premium; and
- Distributing:

  - Benefit plan documents and the Summary of Benefits and Coverage (SBC);
  - Renewal notices and Contract modification information;
  - Discontinuance notices; and
  - Information regarding continuation rights.

No Contractholder has the power to change or waive any provision of the Contract.

RENEWAL OR TERMINATION OF COVERAGE

The Contractholder may terminate the Contract by giving written notice to us no later than 31 days prior to the desired termination date.

The Contractholder may terminate the coverage provided under any provision of the Contract, with our consent, by giving written notice to us as of a date mutually agreeable to the Contractholder and us.

The Contractholder may terminate an eligible class of Covered Persons, if applicable, from the group plan, with our consent, as of a date mutually agreeable to the Contractholder and us. Termination will occur only with respect to Covered Persons included in the terminated class.

We may terminate the Contract, as allowed by applicable law, by giving written notice to the Contractholder. Written notice will be mailed no later than 31 days prior to the termination date, except as otherwise outlined below.

We may refuse to renew or we may terminate the Contract if:

- The Contractholder fails to pay us any premium due, except coverage will continue during the grace period.

- The Contractholder has failed to comply with our minimum participation or contribution requirements, as specified in the Employer Group Application.

- The Contractholder is not an employer.

- For HMO and POS plans, the group has relocated outside of the service area.

- The Contractholder has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact. We may terminate the Contract after giving 30 day advance written notice to the Contractholder for instances of fraud or intentional misrepresentation of a material fact. We will also send notice of termination of coverage to each Covered Person at least 30 days prior to termination including the reason for termination.

- We decide to discontinue offering a particular group health Contract:

  - Notice of such discontinuation will be provided at least 90 days prior to the date of discontinuation. The Contractholder is responsible for distributing and providing Covered Persons access to the notice; and
  - The large employer Contractholder will be given the option to purchase any other group Contract providing medical benefits that is being offered by us at such time.
  - The small employer Contractholder will be given the option to purchase all other group Contract providing medical benefits that is being offered by us at such time.

- We cease to do business in either the small employer or the large employer group medical market, as applicable and as allowed by the state requirements. If we cease doing business in the small employer or the large employer group market, notice for the Contractholders, Covered persons will be provided at least 180 days prior to the date of discontinuation of such coverage. The Contractholder is responsible for distributing and providing Covered Persons access to the notice. The Commissioner of Insurance will be notified of such discontinuation at least 183 days prior to the date of discontinuation of such coverage.

  If the Contractholder's coverage is terminated because we cease to do business in the small employer or the large employer group market, coverage will continue to the Contractholder's next renewal, not to exceed twelve months, after the notice to the Contractholder and the employees has expired.

  If we cease to do business in the medical market completely, coverage will terminate no sooner than 180 days after the required notice is provided to the Contractholder and the employees.

Termination of a Covered Person's coverage under a group Contract will occur for the following reasons:

- The group Contract terminates;
- Premium was due to us and not received by us;
- The Covered Person no longer meets the eligibility requirements of the plan. You and the Contractholder are responsible to notify us of any change in eligibility, including the lack of eligibility of any Covered Person;
- The employee requests termination of coverage for himself/herself or covered dependents; or
- The Covered Person commits fraud or an intentional misrepresentation of a material fact, as determined by us.

We will also terminate your coverage for cause under the following circumstances:

- If you allow an unauthorized person to use your identification card or if you use the identification card of another Covered Person. Under these circumstances, the person who receives the services provided by use of the identification card will be responsible for paying us any amount we paid for those services. We will send you notice of termination of your coverage at least 30 days prior to termination including the reason for termination.

- If you or the Contractholder perpetrate fraud or intentional misrepresentation of a material fact on claims, identification cards or other identification in order to obtain services or a higher level of benefits. This includes, but is not limited to, the fabrication or alteration of a claim, identification card or other identification.

FRAUD

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, may be guilty of insurance fraud.

If you commit fraud against us or your employer commits fraud pertaining to you against us, as determined by us, we reserve the right to rescind your coverage after we provide you a 30 calendar day advance written notice that coverage will be rescinded. You have the right to appeal the rescission.

SMALL EMPLOYER CONTRACT RATING FACTORS

The following rating information applies only to small employer groups as defined by state and federal regulation.

Rate guarantee

Each small employer group's initial medical rates are guaranteed, as permitted by applicable law, for 12 months from the effective date of coverage. Thereafter, a minimum of 60 days notice of any premium rate change will be given.

If the group health plan benefits or an individual's coverage are modified other than on a premium due date, any applicable change in premium resulting from the modification will become effective on the date the change in coverage becomes effective.

Rate disclosure

Each Contractholder's group rate will be based on benefit plan, age, geographic location, and family composition.

No Contractholder's group coverage will be terminated based on the Contractholder's group claims experience or a particular medical condition. The Company reserves the right to modify its renewal rating procedures and otherwise adjust rates consistent with applicable law.