Humana.

Administrative Office:
500 West Main Street
Louisville, Kentucky 40202

Certificate of Insurance
Humana Health Plan, Inc.

Policyholder: KYDB0025

Policy Number: 455051

Effective Date: 01/01/2014

Product Name: KYDB0025 CPYH

End Date:

In accordance with the terms of the *policy* issued to the *policyholder*, Humana Health Plan, Inc. certifies that a *covered person* is insured for the benefits described in this *certificate*. This *certificate* becomes the Certificate of Insurance and replaces any and all certificates and certificate riders previously issued.

Bruce Broussard
President

The insurance *policy* under which this *certificate* is issued is not a policy of Workers' Compensation insurance. *You* should consult *your employer* to determine whether *your employer* is a subscriber to the Workers' Compensation system.

This is not a policy of Long Term Care insurance.

This booklet, referred to as a Benefit Plan Document, is provided to describe *Your* Humana coverage

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UNDERSTANDING YOUR COVERAGE

As *you* read through the *certificate*, *you* will see some words are printed in italics. Italicized words may have different meanings in the *certificate* than in general. Refer to the "Glossary" section for the meaning of the italicized words, as they apply to *your* plan.

The *certificate* gives *you* information about *your* plan. It tells *you* what is covered and what is not covered. It also tells *you* what *you* must do and how much *you* must pay for services. *Your* plan covers many services, but it is important to remember it has limits. Be sure to read *your certificate* carefully before using *your* benefits.

Covered and non-covered expenses

We will provide coverage for services, equipment and supplies that are *covered expenses*. All requirements of the *policy* apply to *covered expenses*.

The date used on the bill *we* receive for *covered expenses* or the date confirmed in *your* medical records is the date that will be used when *your* claim is processed to determine the benefit period.

If *you* incur *non-covered expenses*, whether from a *network provider* or *non-network provider*, *you* are responsible for making the full payment to the health care provider. Not all services and supplies are a *covered expense*, even when they are ordered by a *health care practitioner*.

Refer to the "Schedule of Benefits", the "Covered Expenses" and the "Limitations and Exclusions" sections and any rider or amendment attached to the *certificate* to see when services or supplies are covered expenses or are not covered.

How your policy works

You may have to pay a *deductible* before *we* pay for certain *covered expenses*. If a *deductible* applies, and it is met, *we* will pay *covered expenses* at the *coinsurance* amount. Refer to the "Schedule of Benefits" to see when the *deductible* applies and the *coinsurance* amount *we* pay. *You* will be responsible for the *coinsurance* amount *we* do not pay.

If an *out-of-pocket limit* applies, and it is met, *we* will pay *covered expenses* at 100% the rest of the *year*, subject to the *maximum allowable fee*.

Our payment for *covered expenses* is calculated by applying any *deductible* and *coinsurance* to the net charges. "Net charges" means the total amount billed by the provider, less any amounts such as:

- Those negotiated by contract, directly or indirectly, between *us* and the provider;
- Those in excess of the *maximum allowable fee*; or
- Adjustments related to *our* claims processing edits.

The service and diagnostic information submitted on the provider's bill will be used to determine which provision of the "Schedule of Benefits" applies.

Your choice of providers affects your benefits

We will pay a higher percentage most of the time if *you* see a *network provider*. The amount *you* pay will be lower. *You* must pay any *copayment*, *deductible* or *coinsurance* to the *network provider*. Be sure to check if *your* provider is a *network provider* before seeing them.

We may appoint certain *network providers* for certain kinds of services. If *you* do not see the appointed *network provider* for these services, *we* may pay less.

We will pay a lower percentage if *you* see a *non-network provider.* The amount *you* pay will be higher. *Non-network providers* have not signed an agreement with *us* for lower costs for services and they may bill *you* for any amount over the *maximum allowable fee*. *You* will have to pay this amount and any *copayment*, *deductible* and *coinsurance* to the *non-network provider*. Any amount *you* pay over the *maximum allowable fee* will not apply to *your deductible* or any *out-of-pocket limit*.

Some *non-network providers* work with *network hospitals. We* will pay *non-network* pathologists, anesthesiologists, radiologists, and emergency room physicians working with a *network hospital,* at the *network provider* benefit level. However, *you* may still have to pay these *non-network providers* any amount over the *maximum allowable fee*. If possible, *you* may want to check if all health care providers working with *network hospitals* are *network providers*.

Refer to the "Schedule of Benefits" sections to see what *your network provider* and *non-network provider* benefits are.

Claims processing edits

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

The intensity and complexity of a service;

- Whether a service is one of multiple services performed at the same service session such that the cost of the service to the provider is less than if the service had been provided in a separate service session. For example:

    - Two or more *surgeries* occurring at the same service session that do not require two preparation times; or
    - Two or more radiologic imaging views performed on the same body part;

- Whether an assistant surgeon, physician assistant, registered nurse, certified operating room technician or any other health care professional who is billing independently is involved;
- When a charge includes more than one claim line, whether any service is part of or incidental to the primary service that was provided, or if these services cannot be performed together;
- If the service is reasonably expected to be provided for the diagnosis reported;
- Whether a service was performed specifically for *you*; and/or
- Whether services can be billed as a complete set of services under one billing code.

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

- *Medicare* laws, regulations, manuals and other related guidance;
- Appropriate billing practices;
- National Uniform Billing Committee (NUBC);
- American Medical Association (AMA)/Current Procedural Technology (CPT);
- UB-04 Data Specifications Manual;
- International Classification of Diseases of the U.S. Department of Health and Human Services and the Diagnostic and Statistical Manual of Mental Disorders;
- Medical and surgical specialty certification boards;
- *Our* medical coverage policies; and/or
- Generally accepted standards of medical, behavioral health and dental practice based on credible scientific evidence recognized in published peer reviewed medical or dental literature.

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

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

Your provider may access *our* claims processing edits and *our* medical coverage policies at the provider link on *our* website at www.humana.com. *You* or *your* provider may also call *our* toll-free customer service number listed on *your* ID card to obtain a copy of a policy. *You* should discuss these policies and their availability with any *non-network provider* that *you* choose to use prior to receiving any services from them.

How to find a network provider

You may find a list of *network providers* at www.humana.com. This list is subject to change. Please check this list before receiving services from a provider. *You* may also call *our* customer service department at the number listed on *your* ID card to determine if a provider is a *network provider*, or we can send the list to *you*. A *network provider* can only be confirmed by *us*.

How to use your preferred provider organization (PPO) plan

You may receive services from a *network provider* or a *non-network provider* without a referral. Refer to the "Schedule of Benefits" for any *preauthorization* requirements.

Seeking emergency care

If *you* need *emergency care*:

- Go to the nearest *network hospital* emergency room; or
- Find the nearest *hospital* emergency room if *your* condition does not allow *you* to go to a *network hospital*.

You, or someone on *your* behalf, must call *us* within 48 hours after *your admission* to a *non-network hospital* for *emergency care*. If *your* condition does not allow *you* to call *us* within 48 hours after *your admission*, contact *us* as soon as *your* condition allows. *We* may transfer *you* to a *network hospital* in the *service area* when *your* condition is stable. *You* must receive services from a *network provider* for any follow-up care to receive the *network provider* benefit level.

Seeking urgent care

If *you* need *urgent care*, go to the nearest network *urgent care center* to receive the *network provider* benefit limit. *You* must receive services from a *network provider* for any follow-up care to receive the *network provider* benefit level.

Our relationship with providers

Network providers and *non-network providers* are not *our* agents, employees or partners. All providers are independent contractors. Providers make their own clinical judgments or give their own treatment advice without coverage decisions made by us.

The *policy* will not change what is decided between *you* and health care providers regarding *your* medical condition or treatment options. Providers act on *your* behalf when they order services. *You* and *your health care practitioner* make all decisions about your health care, no matter what we cover. *We* are not responsible for anything said or written by a provider about *covered expenses* and/or what is not covered under this *certificate*. Call *our* customer service department at the telephone number listed on *your* ID card if *you* have any questions.

Our financial arrangements with providers

We have agreements with network providers that may have different payment arrangements

- Many *network providers* are paid on a discounted fee-for-services basis. This means they have agreed to be paid a set amount for each *covered expense*;
- Some health care providers may have capitation agreements. This means the provider is paid a set dollar amount each month to care for each *covered person* no matter how many services a *covered person* may receive, from the primary care physician or a specialist.
- *Hospitals* may be paid on a Diagnosis Related Group (DRG) basis or a flat fee per day basis for *inpatient* services. *Outpatient* services are usually paid on a flat fee per service or procedure or a discount from their normal charges.

Continuity of care

If the *covered person* is receiving treatment from a participating provider and that provider's agreement to provide *medically necessary* services terminates for reasons other than medical competence or professional behavior, the *covered person* may be entitled to continue treatment by the terminating provider if at the time of the provider's termination the *covered person* is: (1) disabled; (2) being treated for a congenital condition; (3) being treated for a life threatening illness; or (4) past the twenty-fourth week of pregnancy. The treating provider must contact *us* requesting continuity of treatment. If *we* agree to the continued treatment, *medically necessary* services provided to the *covered person* by the terminating provider will continue to be payable at the participating provider level of benefit. The maximum duration of continued treatment under this provision may not exceed (1) 90 days from the date of termination of the provider's agreement; (2) nine months in the case of the *covered person* being diagnosed with a terminal illness; or (3) through the delivery of a child, including immediate post-partum care and the follow-up visit within the first six weeks of delivery in the case of you past the twenty-fourth week of pregnancy.

The certificate

The *certificate* is part of the insurance *policy* and tells *you* what is covered and not covered and the requirements of the *policy*. Nothing in the *certificate* takes the place of or changes any of the terms of the *policy*. The final interpretation of any provision in the *certificate* is governed by the *policy*. If the *certificate* is different than the *policy*, the provisions of the *policy* will apply. The benefits in the *certificate* apply if *you* are a *covered person*.
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SCHEDULE OF BENEFITS

Reading this "Schedule of Benefits" section will help *you* understand:

- The level of benefits generally paid for *covered expenses*;
- The amounts of *copayments* and/or *coinsurance you* are required to pay;
- The services that require *you* to meet a *deductible*, if any, before benefits are paid; and
- *Preauthorization* requirements.

The benefits outlined in this "Schedule of Benefits" are a summary of coverage and limitations provided under the *policy*. A more detailed explanation of *your* coverage and its limitations and exclusions for these benefits is provided in the "Covered Expenses" and "Limitations and Exclusions" sections of this *certificate*. Please refer to any applicable riders for additional coverage and/or limitations.

All services are subject to all of the terms, provisions, limitations and exclusions of the *policy*.

The benefits outlined under the "Schedule of Benefits – Behavioral Health", "Schedule of Benefits – Transplant Services", "Specialty Drug Benefit", "Prescription Drug Benefit", "Schedule of Benefits – Pediatric Dental", and "Schedule of Benefits – Pediatric Vision Care" sections are not payable under any other Schedule of Benefits of the *policy*. However, all other terms and provisions of the *policy*, including the *individual lifetime maximum benefit*, *preauthorization* requirements, annual *deductible(s)* and maximum *out-of-pocket limit(s)*, unless otherwise stated, are applicable.

Network provider verification

This *certificate* contains multiple *network provider* benefit levels. The benefits are identified as "*Level 1*" and "*Level 2*" or "*Concentra*" in the Schedules of Benefits.

To know which benefit level is assigned to a *network provider*, please refer to the Online Physician Directory on *our* Website at www.humana.com. *You* may also contact *our* customer service department at the telephone number shown on *your* identification card. This list is subject to change.

Individual lifetime maximum benefit

The total amount of benefits payable for all *covered expenses* incurred by *you* will not exceed the *individual lifetime maximum benefit* as follows.

Individual lifetime maximum benefit	Maximum benefit amount
Individual lifetime maximum benefit	Unlimited

Preauthorization requirements and penalty

Preauthorization by *us* is required for certain services and supplies. Visit *our* Website at www.humana.com or call the customer service telephone number on *your* identification card to obtain a list of services and supplies that require *preauthorization*. The list of services and supplies that require *preauthorization* is subject to change. Coverage provided in the past for services or supplies that did not receive or require *preauthorization*, is not a guarantee of future coverage of the same services or supplies.

You are responsible for informing *your health care practitioner* of the *preauthorization* requirements. *You* or *your health care practitioner* must contact *us* by telephone, *electronic mail*, or in writing to request the appropriate authorization. *Your* identification card will show the *health care practitioner* the telephone number to call to request authorization. Benefits are not paid at all for services or supplies that are not *covered expenses*.

If any required *preauthorization* of services or supplies is not obtained, the benefit payable for any *covered expenses* incurred for the services, will be reduced to 50% after any applicable *deductibles* or *copayments*. If the rendered services are not *covered expenses*, no benefits are payable. The out-of-pocket amounts incurred by *you* due to these benefit reductions may not be used to satisfy any *out-of-pocket limits*. This *preauthorization* penalty will apply if *you* received the services from either a *network provider* or a *non-network provider* when *preauthorization* is required and not obtained.

Annual deductible

An annual *deductible* is a specified dollar amount that *you* must pay for *covered expenses* per *year* before most benefits will be paid under the *policy*. The *deductible* does not include any *deductible* met for *prescriptions* or *specialty drugs* from a *pharmacy* or *specialty pharmacy*, if applicable to *your* plan. There are individual and family *network provider* and *non-network provider deductibles*. The *deductible* amount(s) for each *covered person* and each covered family are as follows, and must be satisfied each *year*, either individually or combined as a covered family. Once the family *deductible* is met, any remaining *deductible* for a *covered person* in the family will be waived for that *year*. *Copayments* do not apply toward the annual *deductible*.

Any expense incurred by *you* for *covered expenses* provided by a *network provider* will be applied to the *network provider deductible*. Any expense incurred by *you* for *covered expenses* provided by a *non-network provider* will be applied to the *non-network provider deductible*.

The *deductible* is based on the maximum deductible amount allowed by the Department of Health and Human Services (HHS). The *deductible* of the *policy* will be revised without notice at *your group 's* next renewal, based on HHS adjustments.

SCHEDULE OF BENEFITS (continued)

Deductible	**Deductible amount**
Individual *network provider deductible*	$1,000
Family *network provider deductible*	$2,000
Individual *non-network provider deductible*	$3,000
Family *non- network provider deductible*	$6,000

Maximum out-of-pocket limit

The *out-of-pocket limit* is the maximum amount of any *copayments*, *deductibles* and/or *coinsurance* for *covered expenses*, which must be paid by *you*, either individually or combined as a covered family, per *year* before a benefit percentage for *covered expenses* will be increased. There are individual and family *network provider* and *non-network provider out-of-pocket limits*.

After the individual *network provider out-of-pocket limit* has been satisfied in a *year*, the *network provider* benefit percentage for *covered expenses* for that *covered person* will be payable at the rate of 100% for the rest of the *year,* subject to any maximum benefit and all other terms, provisions, limitations and exclusions of the *policy*. After the family *network provider out-of-pocket limit* has been satisfied in a *year*, the *network provider* benefit percentage for *covered expenses* will be payable at the rate of 100% for the rest of the *year,* subject to any maximum benefit and all other terms, provisions, limitations and exclusions of the *policy*.

SCHEDULE OF BENEFITS (continued)

After the individual *non-network provider out-of-pocket limit* has been satisfied in a *year*, the *non-network provider* benefit percentage for *covered expenses* for that *covered person* will be payable at the rate of 100% for the rest of the *year,* subject to any maximum benefit and all other terms, provisions, limitations and exclusions of the *policy*. After the family *non-network provider out-of-pocket limit* has been satisfied in a *year*, the *non-network provider* benefit percentages for *covered expenses* will be payable at the rate of 100% for the rest of the *year*, subject to any maximum benefit and all other terms, provisions, limitations and exclusions of the *policy*.

Any expense incurred by *you* for *covered expenses* provided by a *network provider* will be applied to the *network provider out-of-pocket limit*. Any expense incurred by *you* for *covered expenses* provided by a *non-network provider* will be applied to the *non-network provider out-of-pocket limit*.

The *out-of-pocket limit* is based on the maximum out-of-pocket expense amount allowed by the IRS. The *out-of-pocket limit* of the *policy* will be revised without notice at *your group's* next renewal, based on IRS adjustments.

If any *copayment*, *deductible* or *coinsurance* amount applied to *your* claim is waived by *your* health care provider, *you* are required to inform *us*. Any amount, thus waived and not paid by *you*, would not apply to any *out-of-pocket limit*.

Out-of-pocket expenses for covered *organ transplants* provided by a *non-network provider* and *prescriptions* and *specialty drugs* obtained from a *non-network pharmacy* or non-network *specialty pharmacy*, and *specialty drugs* provided by or obtained from a *non-network provider* do not apply towards any *out-of-pocket limit*.

Out-of-pocket limit	**Out-of-pocket limit amount**
Individual *network provider out-of-pocket limit*	$4,000
Family *network provider out-of-pocket limit*	$8,000
Individual *non-network provider out-of-pocket limit*	$12,000
Family *non-network provider out-of-pocket limit*	$24,000

SCHEDULE OF BENEFITS (continued)

Preventive services

Preventive services and prostate specific antigen (PSA) test

Network provider	100% benefit payable
Non-network provider	50% benefit payable after *non-network provider deductible*

Health care practitioner office visit services

Health care practitioner office visit

Excludes diagnostic laboratory and radiology services, *advanced imaging* and *outpatient surgery*.

Level 1 network health care practitioner	100% benefit payable after $25 *copayment* per visit
Level 2 network health care practitioner	100% benefit payable after $40 *copayment* per visit
Non-network health care practitioner	50% benefit payable after *non-network provider deductible*

Diagnostic laboratory and radiology services when performed in the office and billed by the health care practitioner

Excludes *advanced imaging*.

Level 1 network health care practitioner	100% benefit payable
Level 2 network health care practitioner	100% benefit payable
Non-network health care practitioner	50% benefit payable after *non-network provider deductible*

SCHEDULE OF BENEFITS (continued)

Advanced imaging when performed in a health care practitioner's office

Level 1 network health care practitioner	80% benefit payable after *network provider deductible*
Level 2 network health care practitioner	80% benefit payable after *network provider deductible*
Non-network health care practitioner	50% benefit payable after *non-network provider deductible*

Allergy serum when received in the health care practitioner's office

Level 1 network health care practitioner	100% benefit payable
Level 2 network health care practitioner	100% benefit payable
Non-network health care practitioner	50% benefit payable after *non-network provider deductible*

Allergy injections when received in a health care practitioner's office

Level 1 network health care practitioner	100% benefit payable after $5 *copayment* per visit
Level 2 network health care practitioner	100% benefit payable after $5 *copayment* per visit
Non-network health care practitioner	50% benefit payable after *non-network provider deductible*

SCHEDULE OF BENEFITS (continued)

Injections other than allergy when received in a health care practitioner's office

Level 1 network health care practitioner	100% benefit payable after $5 *copayment* per visit
Level 2 network health care practitioner	100% benefit payable after $5 *copayment* per visit
Non-network health care practitioner	50% benefit payable after *non-network provider deductible*

Surgery performed in the office and billed by the health care practitioner

Level 1 network health care practitioner	80% benefit payable after *network provider deductible*
Level 2 network health care practitioner	80% benefit payable after *network provider deductible*
Non-network health care practitioner	50% benefit payable after *non-network provider deductible*

Telehealth consultations by the health care practitioner

Level 1 network health care practitioner	Same as any other *sickness* based upon location of services and the type of provider.
Level 2 network health care practitioner	Same as any other *sickness* based upon location of services and the type of provider.
Non-network health care practitioner	Same as any other *sickness* based upon location of services and the type of provider.

SCHEDULE OF BENEFITS (continued)

Hospital services

Hospital inpatient services

Network hospital	80% benefit payable after *network provider deductible*
Non-network hospital	50% benefit payable after *non-network provider deductible*

Health care practitioner inpatient services when provided in a hospital

Level 1 network health care practitioner	80% benefit payable after *network provider deductible*
Level 2 network health care practitioner	80% benefit payable after *network provider deductible*
Non-network health care practitioner	50% benefit payable after *non-network provider deductible*

Hospital outpatient surgical services

Must be performed in a *hospital's outpatient* department.

Network hospital	80% benefit payable after *network provider deductible*
Non-network hospital	50% benefit payable after *non-network provider deductible*

SCHEDULE OF BENEFITS (continued)

Health care practitioner outpatient services when provided in a hospital

Includes *outpatient surgery*.

Level 1 network health care practitioner	80% benefit payable after *network provider deductible*
Level 2 network health care practitioner	80% benefit payable after *network provider deductible*
Non-network health care practitioner	50% benefit payable after *non-network provider deductible*

Hospital outpatient non-surgical services

Must be performed in a *hospital's outpatient* department. Excludes *advanced imaging*.

Network hospital	80% benefit payable after *network provider deductible*
Non-network hospital	50% benefit payable after *non-network provider deductible*

Hospital outpatient advanced imaging

Must be performed in a *hospital's outpatient* department.

Network hospital	80% benefit payable after *network provider deductible*
Non-network hospital	50% benefit payable after *non-network provider deductible*

Pregnancy and newborn benefit

Same as any other *sickness* based upon location of services and the type of provider.

Emergency services

Hospital emergency room services

Excludes *advanced imaging*.

Network hospital	100% benefit payable after $250 *copayment* per visit. *Copayment* waived if admitted.
Non-network hospital	100% benefit payable after $250 *copayment* per visit. *Copayment* waived if admitted.

Hospital emergency room advanced imaging

Network hospital	80% benefit payable after *network provider deductible*
Non-network hospital	80% benefit payable after *network provider deductible*

Hospital emergency room health care practitioner services

Network health care practitioner	100% benefit payable
Non-network health care practitioner	100% benefit payable

Ambulance

Network provider	80% benefit payable after *network provider deductible*
Non-network provider	80% benefit payable after *network provider deductible*

Ambulatory surgical center services

Ambulatory surgical center for outpatient surgery

Network provider	80% benefit payable after *network provider deductible*
Non-network provider	50% benefit payable after *non-network provider deductible*

Health care practitioner outpatient services provided in an ambulatory surgical center

Includes *outpatient surgery*.

Level 1 network health care practitioner	80% benefit payable after *network provider deductible*
Level 2 network health care practitioner	80% benefit payable after *network provider deductible*
Non-network health care practitioner	50% benefit payable after *non-network provider deductible*

SCHEDULE OF BENEFITS (continued)

Durable medical equipment

Network provider	80% benefit payable after *network provider deductible*
Non-network provider	50% benefit payable after *non-network provider deductible*

Diabetes equipment

Network provider	80% benefit payable after *network provider deductible*
Non-network provider	50% benefit payable after *non-network provider deductible*

Diabetes self management training

Level 1 network health care practitioner	Same as any other *sickness* based upon location of services and the type of provider.
Level 2 network health care practitioner	Same as any other *sickness* based upon location of services and the type of provider.
Non-network health care practitioner	Same as any other *sickness* based upon location of services and the type of provider.

Hearing aids and related services

Limited to children through age 17. One hearing aid, per hearing impaired ear, every 36 months.

Network provider	Same as any other *sickness* based upon location of services and the type of provider.
Non-network provider	Same as any other *sickness* based upon location of services and the type of provider.

SCHEDULE OF BENEFITS (continued)

Free-standing facility services

Free-standing facility non-surgical services

Excludes *advanced imaging*.

Network provider	100% benefit payable
Non-network provider	50% benefit payable after *non-network provider deductible*

Health care practitioner non-surgical services provided in a free-standing facility

Level 1 network health care practitioner	80% benefit payable after *network provider deductible*
Level 2 network health care practitioner	80% benefit payable after *network provider deductible*
Non-network health care practitioner	50% benefit payable after *non-network provider deductible*

Free-standing facility advanced imaging

Network provider	80% benefit payable after *network provider deductible*
Non-network provider	50% benefit payable after *non-network provider deductible*

Cochlear implants

Network provider	Same as any other *sickness* based upon location of services and the type of provider.
Non-network provider	Same as any other *sickness* based upon location of services and the type of provider.

Home health care

Limited to a maximum of 100 visits per *year*.

Network provider	80% benefit payable after *network provider deductible*
Non-network provider	50% benefit payable after *non-network provider deductible*

Hospice

Inpatient and *outpatient* hospice services are at least equal to the same as *Medicare* per *year*.

Network provider	100% benefit payable
Non-network provider	100% benefit payable

Jaw joint benefit

Network provider	Same as any other *sickness* based upon location of services and the type of provider.
Non-network provider	Same as any other *sickness* based upon location of services and the type of provider.

Physical medicine and rehabilitative services

Speech therapy

Limited to a maximum of 20 visits per year. After 10 visits are incurred, no coverage is available for services received from a *non-network provider* for the remainder of the *year*.

Network provider	100% benefit payable after $40 *copayment* per visit
Non-network provider	50% benefit payable after *non-network provider deductible*

Audiology therapy

Limited to a maximum of 20 visits per year. After 10 visits are incurred, no coverage is available for services received from a *non-network provider* for the remainder of the *year*.

Network provider	100% benefit payable after $40 *copayment* per visit
Non-network provider	50% benefit payable after *non-network provider deductible*

Cognitive rehabilitation services

Limited to a maximum of 20 visits per year. After 10 visits are incurred, no coverage is available for services received from a *non-network provider* for the remainder of the *year*.

Network provider	100% benefit payable after $40 *copayment* per visit
Non-network provider	50% benefit payable after *non-network provider deductible*

Physical therapy

Limited to a maximum of 20 visits per year. After 10 visits are incurred, no coverage is available for services received from a *non-network provider* for the remainder of the *year*.

Network provider	100% benefit payable after $25 *copayment* per visit
Non-network provider	50% benefit payable after *non-network provider deductible*

Occupational therapy

Limited to a maximum of 20 visits per year. After 10 visits are incurred, no coverage is available for services received from a *non-network provider* for the remainder of the *year*.

Network provider	100% benefit payable after $25 *copayment* per visit
Non-network provider	50% benefit payable after *non-network provider deductible*

Spinal manipulations/adjustments.

Limited to a maximum of 12 visits per year.

Network provider	100% benefit payable after $25 *copayment* per visit
Non-network provider	50% benefit payable after *non-network provider deductible*

Orthoptic training (eye exercises)

Orthoptic training (eye exercises) is limited to a person up to age 21 who is eligible and enrolled for benefits provided under the *policy*.

Network provider	80% benefit payable after *network provider deductible*
Non-network provider	50% benefit payable after *non-network provider deductible*

Other therapy

Network provider	80% benefit payable after *network provider deductible*
Non-network provider	50% benefit payable after *non-network provider deductible*

Autism spectrum disorders

Network provider	Same as any other *sickness* based upon location of services and the type of provider.
Non-network provider	Same as any other *sickness* based upon location of services and the type of provider.

Skilled nursing facility

Limited to a maximum of 100 days per *year*.

Network provider	80% benefit payable after *network provider deductible*
Non-network provider	50% benefit payable after *non-network provider deductible*

Urgent care services

Concentra *network provider*	100% benefit payable after $40 *copayment* per visit
Network provider	100% benefit payable after $100 *copayment* per visit
Non-network provider	50% benefit payable after *non-network provider deductible*

Private duty nursing

Limited to a maximum of 250 visits per *year*.

Network provider	80% benefit payable after *network provider deductible*
Non-network provider	50% benefit payable after *non-network provider deductible*

Additional covered expenses

Same as any other *sickness* based upon location of services and the type of provider.

SCHEDULE OF BENEFITS – PEDIATRIC DENTAL

Reading this "Schedule of Benefits – Pediatric Dental" section will help *you* understand:

- The level of benefits generally paid for the *pediatric dental services* under the *policy*;
- The amounts of *copayments* and/or *coinsurance you* are required to pay; and
- The services that require *you* to meet a *deductible* before benefits are paid.

The benefits outlined in this "Schedule of Benefits – Pediatric Dental" are a summary of coverage and limitations provided under the *policy*. A more detailed explanation of *your* coverage and its limitations and exclusions for these benefits is provided in the "Covered Expenses – Pediatric Dental" and "Limitations and Exclusions" sections of this *certificate*. Please refer to this *certificate* and any applicable riders for additional coverage and/or limitations.

All services are subject to all the terms and provisions, limitations and exclusions of the *policy*.

Pediatric dental services apply toward the *deductible* and *out-of-pocket limit* of the *policy*.

Pediatric dental benefit

Class I services

Network provider	100% benefit payable
Non-network provider	50% benefit payable after the *non-network provider deductible*

Class II services

Network provider	50% benefit payable after the *network provider deductible*
Non-network provider	50% benefit payable after the *non-network provider deductible*

SCHEDULE OF BENEFITS – PEDIATRIC DENTAL (continued)

Class III services

Network provider	50% benefit payable after the *network provider deductible*
Non-network provider	50% benefit payable after the *non-network provider deductible*

SCHEDULE OF BENEFITS – PEDIATRIC VISION CARE

Reading this "Schedule of Benefits – Pediatric Vision Care" section will help *you* understand:

- The level of benefits generally paid for *pediatric vision care* covered under the *policy*;
- The amounts of *copayments* and/or *coinsurance you* are required to pay; and
- The services that require *you* to meet a *deductible* before benefits are paid.

The benefits outlined in this "Schedule of Benefits – Pediatric Vision Care" are a summary of coverage and limitations provided under the *policy*. A more detailed explanation of *your* coverage and its limitations and exclusions for these benefits is provided in the "Covered Expenses – Pediatric Vision Care" and "Limitations and Exclusions" sections of this *certificate*. Please refer to this *certificate* and any applicable riders for additional coverage and/or limitations.

All services are subject to all of the terms, provisions, limitations and exclusions of the *policy.*

Expenses covered for *pediatric vision care* apply toward the *deductible* and any *out-of-pocket limit* of the *policy*.

Comprehensive eye exam

Limited to one exam in any 12 month period.

Network provider	50% benefit payable after the *network provider deductible*
Non-network provider	50% benefit payable after the *non-network provider deductible*

SCHEDULE OF BENEFITS – PEDIATRIC VISION CARE (continued)

Prescription lenses

Limited to one pair of covered prescription lenses in any 12 month period.

Single vision lenses

Network provider	50% benefit payable after the *network provider deductible*
Non-network provider	50% benefit payable after the *non-network provider deductible*

Bifocal lenses

Network provider	50% benefit payable after the *network provider deductible*
Non-network provider	50% benefit payable after the *non-network provider deductible*

Trifocal lenses

Network provider	50% benefit payable after the *network provider deductible*
Non-network provider	50% benefit payable after the *non-network provider deductible*

SCHEDULE OF BENEFITS – PEDIATRIC VISION CARE (continued)

Lenticular lenses

Network provider	50% benefit payable after the *network provider deductible*
Non-network provider	50% benefit payable after the *non-network provider deductible*

Lens options

Must be selected at the same time covered prescription lenses are selected.

Standard polycarbonate

Network provider	50% benefit payable after the *network provider deductible*
Non-network provider	50% benefit payable after the *non-network provider deductible*

Standard scratch coating

Network provider	50% benefit payable after the *network provider deductible*
Non-network provider	50% benefit payable after the *non-network provider deductible*

SCHEDULE OF BENEFITS – PEDIATRIC VISION CARE (continued)

Frames

Limited to one covered new frame in any 12 month period.

Network provider	50% benefit payable after the *network provider deductible*
Non-network provider	50% benefit payable after the *non-network provider deductible*

Medically necessary eyeglasses

Limited to one covered replacement frame, pair of prescription lenses, and/or lens options in any 12 month period.

Network provider	50% benefit payable after the *network provider deductible*
Non-network provider	50% benefit payable after the *non-network provider deductible*

Medically necessary contact lenses

Network provider	50% benefit payable after the *network provider deductible*
Non-network provider	50% benefit payable after the *non-network provider deductible*

SCHEDULE OF BENEFITS – PEDIATRIC VISION CARE (continued)

Medically necessary contact lens fitting and follow-up exam

Network provider	50% benefit payable after the *network provider deductible*
Non-network provider	50% benefit payable after the *non-network provider deductible*

SCHEDULE OF BENEFITS - BEHAVIORAL HEALTH

Reading this "Schedule of Benefits – Behavioral Health" section will help *you* understand:

- The level of benefits generally paid for the *mental health services* and *chemical dependency* services under the *policy*;
- The amounts of *copayments* and/or *coinsurance you* are required to pay; and
- The services that require *you* to meet a *deductible* before benefits are paid.

The benefits outlined in this "Schedule of Benefits – Behavioral Health" are a summary of coverage and limitations provided under the *policy*. A more detailed explanation of *your* coverage and its limitations and exclusions for these benefits is provided in the "Covered Expenses – Behavioral Health" and "Limitations and Exclusions" sections of this *certificate*. Please refer to this *certificate* and any applicable riders for additional coverage and/or limitations.

All services are subject to all the terms and provisions, limitations and exclusions of the *policy*.

Acute inpatient services

Network provider	80% benefit payable after *network provider deductible*
Non-network provider	50% benefit payable after *non-network provider deductible*

Health care practitioner inpatient visits

Network health care practitioner	80% benefit payable after *network provider deductible*
Non-network health care practitioner	50% benefit payable after *non-network provider deductible*

Residential treatment facility services

Same as any other *sickness* based upon location of services and the type of provider.

SCHEDULE OF BENEFITS - BEHAVIORAL HEALTH (continued)

Outpatient therapy and office therapy

Network provider	100% benefit payable after $25 *copayment* per visit
Non-network provider	50% benefit payable after *non-network provider deductible*

SCHEDULE OF BENEFITS - TRANSPLANT SERVICES

Reading this "Schedule of Benefits – Transplant Services" section will help *you* understand:

- The level of benefits generally paid for the transplant services covered under the *policy*;
- The amounts of *copayments* and/or *coinsurance you* are required to pay; and
- The services that require *you* to meet a *deductible* before benefits are paid.

The benefits outlined in this "Schedule of Benefits – Transplant Services" are a summary of coverage and limitations provided under the *policy*. A more detailed explanation of *your* coverage and its limitations and exclusions for these benefits is provided in the "Covered Expenses – Transplant Services" and "Limitations and Exclusions" sections of this *certificate*. Please refer to this *certificate* and any applicable riders for additional coverage and/or limitations.

All services are subject to all of the terms, provisions, limitations and exclusions of the *policy*.

Organ transplant benefit

Medical services

- *Hospital* services

  Hospital benefits as shown in the "Schedule of Benefits" section under the "Hospital Services" provision of the *certificate* will be payable as follows:

Network hospital designated by *us* as an approved transplant facility	Same as any other *sickness* based on location of services and type of provider
Non-network hospital	Same as any other *sickness* based on location of services and type of provider to the transplant *non-network provider* benefit limit. *You* are also responsible for all expenses exceeding the *non-network provider* benefit limit.

SCHEDULE OF BENEFITS - TRANSPLANT SERVICES (continued)

- *Health care practitioner* services

  Health care practitioner benefits as shown in the "Schedule of Benefits" section under the "Health Care Practitioner Services" provision of the *certificate* will be payable as follows:

Network health care practitioner designated by us as an approved transplant *health care practitioner*	Same as any other *sickness* based upon location of services and type of provider
Non-network health care practitioner	Same as any other *sickness* based on location of services and type of provider to the transplant *non-network provider* benefit limit. *You* are also responsible for all expenses exceeding the *non-network provider* benefit limit.

Direct, non-medical costs

- Transportation

Network hospital designated by *us* as an approved transplant facility	100% benefit payable

- Temporary lodging

Network hospital designated by *us* as an approved transplant facility	100% benefit payable

COVERED EXPENSES

The "Covered Expenses" section describes the services that will be considered *covered expenses* under the *policy*. Benefits will be paid for such covered medical services for a *bodily injury* or *sickness*, or for specified *preventive services*, on a *maximum allowable fee* basis and as shown on the "Schedules of Benefits" subject to any applicable:

- *Deductible*;
- *Copayment*;
- *Coinsurance* percentage; and
- Maximum benefit.

Refer to the "Limitations and Exclusions" section listed in this *certificate*. All terms and provisions of the *policy*, including the *preauthorization* requirements specified in this *certificate*, are applicable to *covered expenses*.

Preventive services

Covered expenses include the *preventive services* recommended by the U.S. Department of Health and Human Services (HHS) for *your* plan *year*.

For the recommended *preventive services* that apply to *your* plan *year*, refer to the HHS website at www.healthcare.gov or call the customer service telephone number on *your* identification card.

Health care practitioner office services

We will pay the following benefits for *covered expenses* incurred by *you* for *health care practitioner* office visit charges. *You* must incur the *health care practitioner's* charges as the result of a *sickness* or *bodily injury*.

Health care practitioner office visit

Covered expenses include:

- Office visits for the diagnosis and treatment of a *sickness* or *bodily injury*.
- Office visits for prenatal care.
- Office visits for *diabetes self-management training*.
- Diagnostic laboratory and radiology.
- Allergy testing.
- Allergy serum.
- Allergy injections.
- Injections other than allergy.
- *Surgery*, including anesthesia.
- Second surgical opinions.

Hospital services

We will pay benefits for *covered expenses* incurred by *you* while *hospital confined* or for *outpatient* services. A *hospital confinement* must be ordered by a *health care practitioner*.

For *emergency medical condition* benefits provided in a *hospital*, refer to the "Emergency services" provisions of the "Covered Expenses" section.

Hospital inpatient services

Covered expenses include:

- Daily semi-private, ward, intensive care or coronary care *room and board* charges for each day of *confinement*. Benefits for a private or single-bed room are limited to the *maximum allowable fee* charged for a semi-private room in the *hospital* while a registered bed patient.

- Services and supplies, other than *room and board*, provided by a *hospital* to a registered bed patient.

Health care practitioner inpatient services when provided in a hospital

Services which are payable as a *hospital* charge are not payable as a *health care practitioner* charge. If *you* receive services from a *non-network provider*, *you* may be responsible for any charges in excess of the *maximum allowable fee* and charges in excess of any percentages listed in this provision.

Covered expenses include:

- Medical services furnished by an attending *health care practitioner* to *you* while *you* are *hospital confined*.

- *Surgery* performed on an *inpatient* basis. If several *surgeries* are performed during one operation, *we* will pay the *maximum allowable fee* for the most complex procedure. For each additional procedure *we* will pay:

  - 50% of *maximum allowable fee* for the secondary procedure; and
  - 25% of *maximum allowable fee* for the third and subsequent procedures.

  If two surgeons work together as primary surgeons performing distinct parts of a single reportable procedure, *we* will pay each surgeon 62.5% of the *maximum allowable fee* for the procedure.

- Services of a surgical assistant and/or assistant surgeon when *medically necessary*. Surgical assistants and/or assistant surgeon will be paid at 20% of the *covered expense* for *surgery*.

- Services of a physician assistant (P.A.), registered nurse (R.N.), *registered nurse first assistant* or a certified operating room technician when *medically necessary*. Physician assistants, registered nurses, *registered nurse first assistants* and certified operating room technicians will be paid at 10% of the *covered expense* for the *surgery*.

- Anesthesia administered by a *health care practitioner* or certified registered anesthetist attendant to a *surgery*.

- Consultation charges requested by the attending *health care practitioner* during a *hospital confinement*. The benefit is limited to one consultation by any one consultant per specialty during a *hospital confinement*.

- Services of a pathologist.

- Services of a radiologist.

- Services performed on an emergency basis in a *hospital* if the *sickness* or *bodily injury* being treated results in a *hospital confinement*.

Hospital outpatient services

Covered expenses include *outpatient* services and supplies, as outlined in the following provisions, provided in:

- A *hospital's outpatient* department;
- An *ambulatory surgical center;* or
- A *free-standing facility*.

Covered expenses provided in a *hospital's outpatient* department will not exceed the average semi-private room rate when *you* are in *observation status*.

Hospital outpatient surgical services

Covered expenses include:

- Services provided in a *hospital's outpatient* department in connection with *outpatient surgery*.
- Services provided in an *ambulatory surgical center* in connection with *outpatient surgery*.

Health care practitioner outpatient services when provided in a hospital or ambulatory surgical center

Services which are payable as a *hospital* or *ambulatory surgical center* charge are not payable as a *health care practitioner* charge. If *you* receive services from a *non-network provider*, *you* may be responsible for any charges in excess of the *maximum allowable fee* and charges in excess of any percentages listed in this provision.

Covered expenses include:

- *Surgery* performed on an *outpatient* basis. If several *surgeries* are performed during one operation, *we* will pay the *maximum allowable fee* for the most complex procedure. For each additional procedure *we* will pay:

  - 50% of *maximum allowable fee* for the secondary procedure; and
  - 25% of *maximum allowable fee* for the third and subsequent procedures.

  If two surgeons work together as primary surgeons performing distinct parts of a single reportable procedure, *we* will pay each surgeon 62.5% of the *maximum allowable fee* for the procedure.

- Services of a surgical assistant and/or assistant surgeon when *medically necessary*. Surgical assistants and/or assistant surgeon will be paid at 20% of the *covered expense* for *surgery*.

- Services of a physician assistant (P.A.), registered nurse (R.N.), *registered nurse first assistant* or a certified operating room technician when *medically necessary*. Physician assistants, registered nurses, *registered nurse first assistant* and certified operating room technicians will be paid at 10% of the *covered expense* for the *surgery*.

- Anesthesia administered by a *health care practitioner* or certified registered anesthetist attendant for a *surgery*.

- Services of a pathologist.

- Services of a radiologist.

Hospital outpatient non-surgical services

Covered expenses include:

- Services provided in a *hospital's outpatient* department in connection with non-surgical services.
- Services provided in a *free-standing facility* in connection with non-surgical services.

Covered expenses for *hospital* non-surgical services do not include *advanced imaging*.

Hospital outpatient advanced imaging

We will pay benefits for *covered expenses* incurred by *you* for *outpatient advanced imaging* in a *hospital's outpatient* department.

Pregnancy and newborn benefit

We will pay benefits for *covered expenses* incurred by a *covered person* for a pregnancy.

Covered expenses include:

- A minimum stay of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated cesarean section. If an earlier discharge is consistent with the most current protocols and guidelines of the American College of Obstetricians and Gynecologists or the American Academy of Pediatrics and is consented to by the mother and the attending *health care practitioner*, a post-discharge office visit to the *health care practitioner* or a home health care visit within the first 48 hours after discharge is also covered, subject to the terms of this *certificate*.

- For a newborn, *hospital confinement* during the first 48 hours or 96 hours following birth, as applicable and listed above for:

  - *Hospital* charges for *routine nursery care*;
  - The *health care practitioner's* charges for circumcision of the newborn child; and
  - The *health care practitioner's* charges for routine examination of the newborn before release from the *hospital*.

- If the covered newborn must remain in the *hospital* past the mother's *confinement*, services and supplies received for:

  - A *bodily injury* or *sickness*;
  - Care and treatment for premature birth; and
  - Medically diagnosed birth defects and abnormalities.

Covered expenses also include *cosmetic surgery* specifically and solely for:

- Reconstruction due to *bodily injury*, infection or other disease of the involved part; or
- *Congenital anomaly* of a covered *dependent* child which resulted in a *functional impairment*.

The covered newborn will not be required to satisfy a separate *deductible* and/or *copayment* for *hospital* facility charges for the *confinement* period for the first 31 days following the newborn's date of birth. A *deductible* and/or *copayment*, if applicable, will be required for any subsequent *hospital admission*. Please see the "Eligibility and Effective Dates" section of this *certificate* for an explanation of the enrollment requirements and the *effective date* for a newborn *dependent* child.

Emergency services

We will pay benefits for *covered expenses* incurred by *you* for an *emergency medical condition,* including the treatment and stabilization of an *emergency medical condition*.

An *emergency medical condition* provided by a *non-network hospital* or a *non-network health care practitioner* will be covered at the *network provider* benefit percentage, subject to the *maximum allowable fee*. *Non-network providers* have not agreed to accept discounted or negotiated fees, and may bill *you* for charges in excess of the *maximum allowable fee*. *You* may be required to pay any amount not paid by *us*.

Covered expenses also include *health care practitioner* services for an *emergency medical condition*, including the treatment and stabilization of an *emergency medical condition*, provided in a *hospital* emergency facility. These services are subject to the terms, conditions, limitations, and exclusions of the *policy*.

Ambulance

We will pay benefits for *covered expenses* incurred by *you* for professional *ambulance* service to, from or between medical facilities for *emergency medical conditions*.

Ambulance service for *emergency medical conditions* provided by a *non-network provider* will be covered at the *network provider* benefit percentage, subject to the *maximum allowable fee*. *Non-network providers* have not agreed to accept discounted or negotiated fees, and may bill *you* for charges in excess of the *maximum allowable fee*. *You* may be required to pay any amount not paid by *us*.

Ambulatory surgical center

We will pay benefits for *covered expenses* incurred by *you* for services provided in an *ambulatory surgical center* for the utilization of the facility and ancillary services in connection with *outpatient surgery*.

Health care practitioner outpatient services when provided in an ambulatory surgical center

Services which are payable as an *ambulatory surgical center* charge are not payable as a *health care practitioner* charge. If *you* receive services from a *non-network provider*, *you* may be responsible for any charges in excess of the *maximum allowable fee* and charges in excess of any percentages listed in this provision.

Covered expenses include:

- *Surgery* performed on an *outpatient* basis. If several *surgeries* are performed during one operation, *we* will pay the *maximum allowable fee* for the most complex procedure. For each additional procedure *we* will pay:

  - 50% of *maximum allowable fee* for the secondary procedure; and
  - 25% of *maximum allowable fee* for the third and subsequent procedures.

  If two surgeons work together as primary surgeons performing distinct parts of a single reportable procedure, *we* will pay each surgeon 62.5% of the *maximum allowable fee* for the procedure.

- Services of a surgical assistant and/or assistant surgeon when *medically necessary*. Surgical assistants and/or assistant surgeon will be paid at 20% of the *covered expense* for *surgery*.

- Services of a physician assistant (P.A.), registered nurse (R.N.), *registered nurse first assistant* or a certified operating room technician when *medically necessary*. Physician assistants, registered nurses, *registered nurse first assistants* and certified operating room technicians will be paid at 10% of the *covered expense* for the *surgery*.

- Anesthesia administered by a *health care practitioner* or certified registered anesthetist attendant to a *surgery*.

- Services of a pathologist.

- Services of a radiologist.

Durable medical equipment and diabetes equipment

We will pay benefits for *covered expenses* incurred by *you* for *durable medical equipment* and *diabetes equipment*.

At *our* option, *covered expense* includes the purchase or rental of *durable medical equipment* or *diabetes equipment*. If the cost of renting the equipment is more than *you* would pay to buy it, only the cost of the purchase is considered to be a *covered expense*. In either case, total *covered expenses* for *durable medical equipment* or *diabetes equipment* shall not exceed its purchase price. In the event *we* determine to purchase the *durable medical equipment* or *diabetes equipment*, any amount paid as rent for such equipment will be credited toward the purchase price.

Repair and maintenance of purchased *durable medical equipment* and *diabetes equipment* is a *covered expense* if:

- 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* is a *covered expense* if:

- Manufacturer's warranty is expired;
- Replacement cost is less than repair cost; and
- Replacement is not due to lost or stolen 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.

Hearing aids and related services

Hearing aid and related services, any wearable, non-disposable instrument or device designed to aid or compensate for impaired hearing, including any parts, attachments, or accessories (excluding batteries and cords). Services to access, select, and adjust/fit the hearing aid to ensure optimal performance, as prescribed by a licensed audiologist and dispensed by a licensed audiologist or hearing instrument specialist. Limited to children through age 17. One hearing aid, per hearing impaired ear, every 36 months.

Free-standing facility services

Free-standing non-surgical services

We will pay benefits for *covered expenses* for services provided in a *free-standing facility* for the utilization of the facility and ancillary services.

Covered expenses for *outpatient* non-surgical services do not include *advanced imaging*.

Health care practitioner services provided in a free-standing facility

We will pay benefits for *outpatient* non-surgical services provided by a *health care provider* in a *free-standing facility*.

Free-standing advanced imaging

We will pay benefits for *covered expenses* incurred by *you* for *outpatient advanced imaging* in a *free-standing facility*.

Home health care

We will pay benefits for *covered expenses* incurred by *you* in connection with a *home health care plan*. All home health care services and supplies must be provided on a part-time or intermittent basis to *you* in conjunction with the approved *home health care plan*.

The "Schedule of Benefits" shows the maximum number of visits allowed by a representative of a *home health care agency*, if any. A visit by any representative of a *home health care agency* will be considered one visit, except that at least four hours of home health aide service will be counted as one visit.

Home health care *covered expenses* include:

- Care provided by a *nurse*;
- Physical, occupational, respiratory or speech therapy, medical social work and nutrition services; and
- Medical appliances, equipment and laboratory services.
- Private duty nursing.

Home health care *covered expenses* do not include:

- 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*; or
- The provision or administration of *self-administered injectable drugs,* unless otherwise determined by *us*.

Hospice

We will pay benefits for *covered expenses* incurred by *you* for a *hospice care program*. A *hospice care program* must include hospice services at least equal to *Medicare* benefits. A *health care practitioner* must certify that the *covered person* is terminally ill with a life expectancy of 18 months or less.

If the above criteria is not met, no benefits will be payable under the *policy*.

Covered expenses for hospice services are payable as shown on the "Schedule of Benefits", subject to the *individual lifetime maximum* and any other maximum(s), and include:

- *Room and board* at a hospice*,* when it is for management of acute pain or for an acute phase of chronic symptom management;
- Part-time nursing care provided by or supervised by a registered nurse (R.N.) for the hours approved in the *hospice care program*;
- Counseling for the terminally ill *covered person* and his/her immediate covered family members by a licensed:
  - Clinical social worker; or
  - Pastoral counselor.
- Medical social services provided to the terminally ill *covered person* or his/her immediate covered family members under the direction of a *health care practitioner*, including:
  - Assessment of social, emotional and medical needs, and the home and family situation; and
  - Identification of the community resources available.
- Psychological and dietary counseling;

- Physical therapy;
- Home health care;
- Part-time home health aide services for the hours approved in the *hospice care program*; and
- Medical supplies, drugs, and medicines prescribed by a *health care practitioner* for *palliative care*.

Hospice care *covered expenses* do not include:

- 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; and
- 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.

Jaw joint benefit

We will pay benefits for *covered expenses* incurred by *you* during a plan of treatment for any jaw joint problem, including temporomandibular joint disorder, craniomaxillary disorder, craniomandibular disorder, head and neck neuromuscular disorder or other conditions of the joint linking the jaw bone and the skull, subject to the maximum benefit shown on the "Schedule of Benefits", if any.

The following are *covered expenses*:

- A single examination including a history, physical examination, muscle testing, range of motion measurements, and psychological evaluation, as necessary;

- Diagnostic x-rays;

- Physical therapy of necessary frequency and duration, limited to a multiple modality benefit when more than one therapeutic treatment is rendered on the same date of service;

- Therapeutic injections;

- Appliance therapy utilizing an appliance which does not permanently alter tooth position, jaw position or bite. Benefits for reversible appliance therapy will be based on the *maximum allowable fee* for use of a single appliance, regardless of the number of appliances used in treatment. The benefit for the appliance therapy will include an allowance for all jaw relation and position diagnostic services, office visits, adjustments, training, repair, and replacement of the appliance; and

- Surgical procedures.

Covered expenses do not include charges for:

- Computed Tomography (CT) scans or magnetic resonance imaging except in conjunction with surgical management;
- Electronic diagnostic modalities;
- Occlusal analysis; or
- Any irreversible procedure, including: orthodontics, occlusal adjustment, crowns, onlays, fixed or removable partial dentures, full dentures.

Physical medicine and rehabilitative services benefit

We will pay benefits for *covered expenses* incurred by *you* for the following physical medicine and/or rehabilitative services for a documented *functional impairment*, pain, or developmental defect as ordered by a *health care practitioner* and performed by a *health care practitioner*:

- Physical therapy services;
- Occupational therapy services;
- Spinal manipulations/adjustments;
- Speech therapy or speech pathology services;
- Audiology services;
- Cognitive rehabilitation services;
- Respiratory or pulmonary therapy services; and
- Cardiac rehabilitation services.
- Orthoptic training (eye exercises) up to the age of 21.

The "Schedule of Benefits" shows the maximum number of visits for physical medicine and/or rehabilitative services, if any.

Autism spectrum disorders

We will pay benefits for *covered expenses* incurred by for *autism* services provided by a *health care practitioner.*

Covered expenses include:

- Medical care;
- Habilitative or rehabilitative care;
- Pharmacy care, if covered by plan;
- Psychiatric care;
- Psychological care;
- Therapeutic care;
- Applied behavior analysis prescribed or ordered by a licensed health or allied health professional

Refer to the "Schedule of Benefits" section for benefits payable for *autism*.

Skilled nursing facility

We will pay benefits for *covered expenses* incurred by *you* for charges made by a *skilled nursing facility* for *room and board*, and services and supplies. *Your confinement* to a *skilled nursing facility* must be based upon a written recommendation of a *health care practitioner*.

The "Schedule of Benefits" shows the maximum length of time for which *we* will pay benefits for charges made by a *skilled nursing facility*, if any.

Urgent care services

We will pay benefits for *covered expenses* incurred by *you* for charges made by an *urgent care center* for *urgent care* services. *Covered expense* also includes *health care practitioner* services for *urgent care* provided at and billed by an *urgent care center*.

Additional covered expenses

We will pay benefits for *covered expenses* incurred by *you* based upon the location of the services and the type of provider for:

- Blood and blood plasma which is not replaced by donation; administration of the blood and blood products including blood extracts or derivatives.

- Oxygen and rental of equipment for its administration.

- Prosthetic devices and supplies, including limbs and eyes. Coverage will be provided for prosthetic devices to:

  - Restore the previous level of function lost as a result of a *bodily injury* or *sickness*; or
  - Improve function caused by a *congenital anomaly*.

  Covered expense for prosthetic devices includes repair or replacement, if not covered by the manufacturer and if due to:

  - A change in the *covered person's* physical condition causing the device to become non-functional; or
  - Normal wear and tear.

- Cochlear implants, when provided to a *covered person* diagnosed with profound hearing impairment.

Replacement or upgrade of a cochlear implant and its external components may be a *covered expense* if:

- The existing device malfunctions and cannot be repaired;
- Replacement is due to a change in the *covered person's* condition that makes the present device non-functional; or
- The replacement or upgrade is not for cosmetic purposes.

- Hearing examinations.

- Orthotics used to support, align, prevent, or correct deformities.

  Covered expense does not include:

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

- The following special supplies, dispensed up to a 30-day supply, when prescribed by *your* attending *health care practitioner*:

  - Surgical dressings;
  - Catheters;
  - Colostomy bags, rings and belts;
  - Flotation pads.

- The initial pair of eyeglasses or contacts needed due to cataract *surgery* or an *accident* if the eyeglasses or contacts were not needed prior to the *accident*.

- Dental treatment only if:

  - The charges are incurred for treatment of a *dental injury* to a *sound natural tooth*; and
  - The treatment begins within 90 days after the date of the *dental injury*; and
  - The treatment is completed within 12 months after the date of the *dental injury*.

  However, benefits will be paid only for the least expensive service that will, in *our* opinion, produce a professionally adequate result.

- Certain oral surgical operations as follows:

  - Excision of partially or completely impacted teeth;

  - Surgical preparation of soft tissues and excision of bone or bone tissue performed with or without extraction or excision of erupted, partially erupted or completely un-erupted teeth;

  - Excisions of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth and related biopsy of bone, tooth, or related tissues when such conditions require pathological examinations;

  - Surgical procedures related to repositioning of teeth, tooth transplantation or re-implantation;

  - Services required to correct accidental injuries of the jaws, cheeks, lips, tongue, roof and floor of the mouth;

  - Reduction of fractures and dislocation of the jaw;

  - External incision and drainage of cellulitis and abscess;

  - Incision and closure of accessory sinuses, salivary glands or ducts;

  - Frenectomy (the cutting of the tissue in the midline of the tongue); and

  - Orthognathic *surgery* for a *congenital anomaly*, *bodily injury* or *sickness* causing a *functional impairment*.

- Orthodontic treatment for a *congenital anomaly* related to or developed as a result of cleft palate, with or without cleft lip.

- Reconstructive services required to correct certain deformities caused by disease, trauma, congenital anomalies, or previous therapeutic process are eligible for coverage. Reconstructive services required due to prior therapeutic process would be covered if the original procedure would have been a covered expense. Covered expenses are limited to the following:

  - Hemangiomas and port wine stains of the head and neck areas for children through age 17;
  - Limb deformities such as club hand, club foot, syndactyly (webbed digits) polydactyly (supermenary digits), macrodactylia;
  - Otoplasty when performed to improve hearing by directing sound in the ear canal, when ear or ears are absent or deformed from trauma, surgery, disease or congenital defect;
  - Tongue release for diagnosis of tongue-tied;
  - Congenital disorders that cause skull deformity such as Crouzon's disease;
  - Cleft lip; and
  - Cleft palate

- Elective vasectomy

- For a *covered person*, who is receiving benefits in connection with a mastectomy, service for:

  - Reconstructive *surgery* of the breast on which the mastectomy has been performed;
  - *Surgery* and reconstruction on the non-diseased breast to achieve symmetrical appearance; and
  - Prostheses and treatment of physical complications for all stages of mastectomy, including lymphedemas.

- For a *covered person* who has been diagnosed with breast disease, mammograms are a *covered expense* regardless of age, upon referral by a *health care practitioner*.

- Therapeutic food and low-protein modified food products for a *covered person* when prescribed or ordered by a *health care practitioner* and are for the treatment of inborn metabolic errors or genetic conditions, e.g. phenylketonuria (PKU), unless otherwise covered in the Prescription Drug Benefit, if any, attached to this *policy*.

- Human milk fortifiers or 100% human milk-based diet, when prescribed for prevention of Necrotizing Enterocolitis and administered under the direction of a physician.

- Coverage for general anesthesia in connection with dental procedures when certified by a *health care practitioner* for:

  - A *dependent* under the age of 9;
  - A *covered person* with a *serious mental condition* or a significant behavioral problem; or
  - A *covered person* with a *serious physical condition*.

- Nutritional counseling for the treatment of obesity, which includes *morbid obesity*, limited to 4 visits per *year*.

- The following habilitative services, as ordered and performed by a *health care practitioner*, for a *covered person*, with a developmental defect or *congenital anomaly*, to learn or improve skills and functioning for daily living:

  - Physical therapy services;
  - Occupational therapy services;
  - Spinal manipulations/adjustments;
  - Speech therapy or speech pathology services; and
  - Audiology services.

Habilitative services apply toward the "Physical medicine and rehabilitative services" maximum number of visits specified in the "Schedule of Benefits".

- Routine care for a *covered person* participating in an approved clinical trial.

  Routine care includes health care services that are otherwise a *covered expense* if the *covered person* were not participating in a clinical trial.

  Routine care does not include services or items that are:

  - *Experimental* or *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.

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

  - Referred by a *health care practitioner*; or
  - Provide medical and scientific information supporting their participation in the clinical trial is appropriate.

  An approved clinical trial includes a Phase I, II, III or IV clinical trial for the treatment of cancer or a life threatening condition and is:

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

- *Covered expenses* for routine patient costs associated with a clinical trial for the treatment of cancer. The clinical trial must be approved by:

  - The National Institutes of Health (NIH) or any institutional review board recognized by the NIH;
  - Federal Drug Administration (FDA);
  - Department of Defense (DOD); and
  - Department of Veterans Affairs (VA).

The clinical trial must do one of the following:

- Test how to administer a service, item, or drug for the treatment of cancer;
- Test responses to a service, item or drug for the treatment of cancer;
- Compare the effectiveness of a service, item, or drug for the treatment of cancer with that of other services, items, or drugs for the treatment of cancer; or
- Study new uses of services, items, or drugs for the treatment of cancer.

Coverage for routine patient costs does not include:

- The service, item or *experimental* or *investigational* drug that is the subject of the clinical trial;

- Any treatment modality outside the usual and customary standard of care required to administer or support the service, item or *experimental* or *investigational* drug that is the subject of the clinical trial;

- Any service, item or drug provided solely for data collection and analysis needs that are not used in the direct clinical management of the patient;

- Any drug or device that is *experimental* or *investigational* or *for research purposes*;

- Transportation, lodging, food or other expenses for the patient, *family member* or companion associated with the travel to or from the facility providing the clinical trial;

- Services, items or drugs provided for free for any new patient by the clinical trial sponsor; and

- Services, items or drugs that are eligible for reimbursement by a person other than the insurer, including the clinical trial sponsor.

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COVERED EXPENSES – PEDIATRIC DENTAL

The "Covered Expenses – Pediatric Dental" section describes expenses covered under the *policy* for *pediatric dental services*. Benefits for *pediatric dental services* will be paid on a *reimbursement limit* basis and as shown in the "Schedule of Benefits – Pediatric Dental" subject to any applicable:

- *Deductible*;
- *Copayment*;
- *Coinsurance* percentage; and
- Maximum benefit.

Notwithstanding any other provisions of the *policy*, expenses covered under this benefit section are not covered under any other provision of the *policy*. Any amount in excess of the maximum amount provided under this benefit, if any, is not covered under any other provision in the *policy*.

All terms used in this benefit have the same meaning given to them in the *certificate*, unless otherwise specifically defined in this benefit. Refer to the "Limitations and exclusions" provision in this section and the "Limitations and Exclusions" section of this *certificate* for *pediatric dental services* not covered by the *policy*. All other terms and provisions of the *policy* are applicable to expenses covered for *pediatric dental services*.

Definitions

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

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

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

- Facings on crowns or pontics (the portion of a fixed bridge between the abutments) posterior to the second bicuspid.
- Characterizations and personalization of prosthetic devices.

Covered person for the purposes of *pediatric dental services* under this "Covered Expenses – Pediatric Dental" and "Schedule of Benefits – Pediatric Dental" sections means a person under the age of 21 who is eligible and enrolled for benefits provided under the *policy*.

Dental emergency means a sudden, serious dental condition caused by an accident or dental disease that, if not treated immediately, would result in serious harm to the dental health of the *covered person*.

Dentist means an individual, who is duly licensed to practice dentistry or perform *oral surgery* and is acting within the lawful scope of his or her license.

Expense incurred date means the date on which:

- The teeth are prepared for fixed bridges, crowns, inlays or onlays;
- The final impression is made for dentures or partials;
- The pulp chamber of a tooth is opened for root canal therapy;
- A periodontal surgical procedure is performed; or
- The service is performed for services not listed above.

Palliative dental care means treatment used in a *dental emergency* to relieve, ease or alleviate the acute severity of dental pain, swelling or bleeding. *Palliative dental care* treatment usually is performed for, but is not limited to, the following acute conditions:

- Toothache;
- Localized infection;
- Muscular pain; or
- Sensitivity and irritations of the soft tissue.

Services are not considered *palliative dental care* when used in association with any other *pediatric dental services*, except x-rays and/or exams.

Pediatric dental services mean the following services:

- Ordered by a *dentist*.
- Described in the "Pediatric dental" provision in this "Covered Expenses – Pediatric Dental" section.
- Incurred when a *covered person* is insured for that benefit under the *policy* on the *expense incurred date*.

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

- The actual cost for the services.
- The fee most often charged in the geographical area where the service was performed.
- The most often charged by the provider.
- The fee determined by comparing charges for similar services to a national database adjusted to the geographical area where the services or procedures were performed.
- At *our* choice, the fee determined by using a national Relative Value Scale. Relative Value Scale means a methodology that values procedures and services relative to each other that includes, but is not limited to, a scale in terms of difficulty, work, risk, as well as the material and outside costs of providing the service, as adjusted to the geographic area where the services or procedures were performed.
- In the case of services rendered by providers with whom *we* have agreements, the fee that *we* have negotiated with that provider.

- The fee based on rates negotiated with one or more *network providers* in the geographic area for the same or similar services.

- The fee based on the provider's costs for providing the same or similar services as reported by the provider in the most recent, publicly available *Medicare* cost report submitted annually to the Centers for Medicare and Medicaid Services.

- The fee based on a percentage of the fee *Medicare* allows for the same or similar services provided in the same geographic area.

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

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

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

Pediatric dental benefit

We will pay benefits for *covered expenses* incurred by a *covered person* for *pediatric dental services*. *Pediatric dental services* include the following as categorized below. Coverage for a *dental emergency* is limited to *palliative dental care* only:

Class I services

- Periodic evaluations. Limited to a maximum of 2 per *year*. Benefit is not available when a comprehensive oral evaluation is performed.

- Comprehensive oral evaluation. Limited to a maximum of one per year. Benefit is not available when a periodontal evaluation is performed.

- Limited, problem focused periodic and comprehensive oral evaluations. Limited to a maximum of 1 per *year*.

COVERED EXPENSES – PEDIATRIC DENTAL (continued)

- Periodontal evaluations. Limited to a maximum of one per year. Benefit allowed only for a *covered person* showing signs or symptoms of periodontal disease and for patients with risk factors such as smoking, diabetes or related health issues. No benefit is payable when performed with a cleaning (prophylaxis). Benefit is not available when a comprehensive oral evaluation is performed.

- Cleaning (prophylaxis), including all scaling and polishing procedures. Limited to a maximum of 2 per *year*. Benefit is not available if periodontal maintenance has been previously provided.

- Intra-oral complete series x-rays (at least 14 films, including bitewings) or panoramic x-ray for covered persons 12 to 21 years of age. Limited to a maximum of 1 per year. If the total cost of periapical and bitewing x-rays exceeds the cost of a complete series of x-rays, *we* will consider these as a complete series.

- Panoramic x-rays for *covered persons* 20 years of age or younger. Limited to one every 2 years.

- Bitewing x-rays for *covered persons* 20 years of age or younger. Limited to a maximum of 1set per *year*.

- Other x-rays, including intra-oral periapical and occlusal and extra-oral x-rays. Limited to x-rays necessary to diagnose a specific treatment.

- Topical fluoride treatment for *covered persons* 20 years of age or younger. Limited to a maximum of 2 per *year*.

- Application of sealants to the occlusal surface of permanent molars that are free of decay and restorations for *covered persons* 20 years of age or younger. Limited to 1 every 4 years.

- Installation of initial space maintainers for retaining space when a primary tooth is prematurely lost for *covered persons* 20 years of age or younger. *Pediatric dental services* do not include separate adjustment expenses.

- Recementation of space maintainers for *covered persons* 20 years or age or younger. Limited to a maximum of 2 per year.

- Removal of fixed space maintainers for covered persons 20 years of age or younger.

Class II services

- Restorative services as follows:

  - Amalgam restorations (fillings). Limited to a maximum of 1 per tooth every 2 years. Multiple restorations on one surface are considered one restoration.

  - Composite restorations (fillings) on anterior teeth. Limited to a maximum of 1 per tooth every 2 years. Composite restorations on molar and bicuspid teeth are considered an alternate service and will be payable as a comparable amalgam filling. The *covered person* will be responsible for the remaining *expense incurred*. Multiple restorations on one surface are considered one restoration.

  - Pin retention per tooth in addition to restoration that is not in conjunction with core build-up.

  - Recementing of inlays, onlays, crowns, and bridges.

  - Non-cast pre-fabricated stainless steel, esthetic stainless steel and resin crowns on primary teeth that cannot be adequately restored with amalgam or composite restorations. Esthetic stainless steel and resin crowns are considered an alternate service and will be payable as a comparable non-cast pre-fabricated stainless steel crown. The *covered person* will be responsible for the remaining *expense incurred*.

- Miscellaneous services as follows:

  - *Dental emergency* care for the treatment for initial *palliative dental care* of pain or an *accidental dental injury* to the teeth and supporting structures. *We* will consider the service a separate benefit only if no other service, except for x-rays and/or problem focused oral evaluation is provided during the same visit.

  - Diagnostic consultations provided by a *dentist* or *healthcare practitioner* not providing the treatment subject to clinical review.

Class III services

- Periodontic services as follows:

  - Periodontal scaling and root planing. Limited to 1 per quadrant, per year, limited to 2 quadrants per visit. Additional quadrants are considered *pediatric dental services* 7 days following the completion of the initial quadrant(s).

  - Periodontal maintenance (at least 30 days following periodontal therapy), unless a cleaning (prophylaxis) is performed on the same day. Limited to two per year.

  - Periodontal and osseous surgical procedures, including bone replacement, tissue regeneration and/or graft procedures. Limited to a maximum of 1 per quadrant, per year. If more than one surgical procedure is performed on the same day, only the most inclusive procedure will be considered a *pediatric dental service*.

- Occlusal adjustments when performed in conjunction with a periodontal surgical procedure. Limited to 1 per quadrant, per year.

Separate fees for pre- and post-operative care and re-evaluation within 3 months are not considered *pediatric dental services*.

- Endodontic procedures as follows:

  - Root canal therapy, including root canal treatments and root canal fillings for permanent teeth and primary teeth. Any test, intraoperative, x-rays, laboratory or any other follow-up care is considered integral to root canal therapy.

  - Root canal retreatment, including root canal treatments and root canal fillings for permanent and primary teeth. Any test, intraoperative, x-rays, exam, laboratory or any other follow-up care is considered integral to root canal therapy.

  - Periradicular surgical procedures for permanent teeth, including apicoectomy, root amputation, tooth reimplementation and/or surgical isolation.

  - Partial pulpotomy for apexogenesis for permanent teeth.

  - Vital pulpotomy for permanent and primary teeth.

  - Pulp debridement, pupal therapy (resorbable) for permanent and primary teeth.

  - Apexification/recalcification for permanent and primary teeth.

- Prosthodontics services as follows:

  - Denture adjustments when done by a *dentist* other than the one providing the denture, or adjustments performed more than six months after initial installation. Limited to a maximum of 2 every year only after 6 months after initial installation.

  - Initial placement of bridges, complete dentures, and partial dentures. Limited to 1 every year. *Pediatric dental services* include pontics, inlays, onlays and crowns.

  - Replacement of bridges, complete dentures and partial dentures. *Pediatric dental services* include the replacement of the existing prosthesis if:

    - It has been 5 years since the prior insertion and is not, and cannot be made serviceable.
    - It is damaged beyond repair as a result of an *accidental dental injury* while in the oral cavity; or
    - Extraction of functioning teeth, excluding third molars or teeth not fully in occlusion with an opposing tooth or prostheses requires the replacement of the prosthesis.

  - Tissue conditioning. Limited to one every year.

  - Denture relines or rebases. Limited to a maximum of 1 every year after 6 months of installation.

- The following simple oral surgical services as follows:

  - Extraction of coronal remnants of a deciduous tooth.
  - Extraction of an erupted tooth or exposed root for permanent and primary teeth.

- General anesthesia or conscious sedation subject to *clinical review* and administered by a *dentist* in conjunction with covered oral surgical procedures, periodontal and osseous surgical procedures, periradicular surgical procedures, and/or dental services. General anesthesia is not considered a *pediatric dental service* if administered for, including but not limited to, the following:

  - Pain control, unless the *covered person* has a documented allergy to local anesthetic.
  - Anxiety.
  - Fear of pain.
  - Pain management.
  - Emotional inability to undergo a surgical procedure.

- Orthodontic treatments are limited to Medically Necessary Dental Treatment, subject to clinical review. Services include treatment of, and appliance for, tooth guidance, interception, and correction as well as X-rays, exams, and follow-up care.

Integral service

Integral services are additional charges related to materials or equipment used in the delivery of dental care. The following services are considered integral to the dental service and will not be paid separately:

- Local anesthetics.
- Bases.
- Pulp testing.
- Pulp caps.
- Study models/diagnostic casts.
- *Treatment plans*.
- Occlusal (biting or grinding surfaces of molar and bicuspid teeth) adjustments.
- Nitrous oxide.
- Irrigation.
- Tissue preparation associated with impression or placement of a restoration.

Pretreatment plan

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

- A list of services to be performed using the American Dental Association terminology and codes.
- *Your dentist's* written description of the proposed treatment.
- Pretreatment x-rays supporting the services to be performed;
- Itemized cost of the proposed treatment; and
- Any other appropriate diagnostic materials that *we* may request.

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

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

Pretreatment plan process and timing

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

Alternate services

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

If *you* and/or the covered person and the *dentist* decide on a more costly service, payment will be limited to the *reimbursement limit* for the least costly service and will be subject to any *deductible* and/or *coinsurance*. *The* covered person will be responsible for any amount exceeding the *reimbursement limit* for the services provided.

Limitations and exclusions

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

- 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.
    - Additional charges related to materials or equipment used in the delivery of dental care.

COVERED EXPENSES – PEDIATRIC DENTAL (continued)

- Charges for services rendered by a *family member* or person who resides with the *covered person*;

- 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 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.
  - Is deemed to be experimental or investigational in nature.

- Orthodontic *services*, unless specified in this section;

- Orthodontic benefits are not available for treatment of crowded dentitions (crooked teeth), excessive spacing between teeth, and/or having horizontal/vertical (overjet/overbite) discrepancies.

- Repair and replacement of orthodontic appliances;

- Preventive control programs including, 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.

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COVERED EXPENSES – PEDIATRIC VISION CARE

The "Covered Expenses – Pediatric Vision Care" section describes expenses covered under the *policy* for *pediatric vision care*. Benefits for *pediatric vision care* will be paid on a *reimbursement limit* basis and as shown in the "Schedule of Benefits – Pediatric Vision Care" subject to any applicable:

- *Deductible*;
- *Copayment*;
- *Coinsurance* percentage; and
- Maximum benefit.

Notwithstanding any other provisions of the *policy*, expenses covered under this benefit section are not covered under any other provision of the *policy*. Any amount in excess of the maximum amount provided under this benefit, if any, is not covered under any other provision in the *policy*.

Any expenses incurred by *you* under the provisions of this benefit apply toward *your out-of-pocket limit*, if any.

All terms used in this benefit have the same meaning given to them in the *certificate*, unless otherwise specifically defined in this benefit. Refer to the "Limitations and exclusions" provision in this section and the "Limitations and Exclusions" section of this *certificate* for *pediatric vision care* expenses not covered by the *policy*. All other terms and provisions of the *policy* are applicable to expenses covered for *pediatric vision care*.

Definitions

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

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

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

Covered person under this "Covered Expenses – Pediatric Vision Care" section and the "Schedule of Benefits – Pediatric Vision Care" section means a person up to 21 who is eligible and enrolled for benefits provided under the *policy*.

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

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

Pediatric vision care means the services and *materials* specified in the "Covered expense" provision in this section for a *covered person* up to 21.

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

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

The bill *you* receive for services provided by, or *materials* obtained from *non-network providers* may be significantly higher than the *reimbursement limit*. In addition to *deductibles, copayments* and *coinsurance*, *you* are responsible for the difference between the *reimbursement limit* and the amount the provider bills *you* for the services or *materials*. Any amount *you* pay to the provider in excess of the *reimbursement limit* will not apply to *your deductible* or *out-of-pocket limit*.

Severe vision problems mean the best-corrected acuity is:

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

Pediatric vision care benefit

We will pay benefits for *covered expenses* incurred by a *covered person* up to 21 for *pediatric vision care*. *Covered expenses* for *pediatric vision care* are:

- *Comprehensive eye exam*.

- Prescription lenses and standard lens options. The *network provider* of *materials* will show the *covered person* the selection of standard lens options covered by the *policy*. If a *covered person* selects a lens option that is not included in the standard lens option selection the *policy* covers, the *covered person* is responsible for the difference in cost between the *network provider* of *materials* reimbursement amount for covered standard lens options and the retail price of the lens options selected.

- Frames available from a selection of covered frames. The *network provider* of *materials* will show the *covered person* the selection of frames covered by the *policy*. If a *covered person* selects a frame that is not included in the frame selection the *policy* covers, the *covered person* is responsible for the difference in cost between the *network provider* of *materia*ls reimbursement amount for covered frames and the retail price of the frame selected.

- *Medically necessary* contact lenses under the following circumstances:

  - Visual acuity cannot be corrected to 20/70 in the better eye except by use of contact lenses;
  - Anisometropia greater than 3.50 diopters and aesthenopia or diplopia, with glasses;
  - Keratoconus supported by medical record documentation consistent with a two line improvement of visual acuity with contact lenses;
  - Monocular aphakia or binocular aphakia where the doctor certifies contact lenses are *medically necessary* for safety and rehabilitation to a productive life; or
  - High ametropia of either +10D or -10D in any meridian.

  Prior authorization is required for *medically necessary contact lenses*. *We* must be contacted by telephone at the customer service number on *your* identification card, by *electronic mail*, or in writing to request prior authorization. If prior authorization is not obtained, *you* will be responsible for a prior authorization penalty. The benefit payable for *medically necessary* contact lenses will be reduced 50%, after any applicable *deductible* and/or *coinsurance*. This prior authorization penalty will apply if *you* received the *medically necessary* contact lenses from a *network provider* or *non-network provider* when prior authorization is required and <u>not</u> obtained.

- *Medically necessary* eyeglasses under the following circumstances:

  - There is a change in correction of 0.5 diopters or greater in either sphere or cylinder power in either eye;
  - There is a shift in axis of greater than 10 degrees in either eye;
  - There is a change in the recipient's head size which warrants a new pair of eyeglasses;
  - The recipient has had an allergic reaction to the previous pair of eyeglasses; or
  - The original pair is lost, broken or irreparably damaged.

  Prior authorization is required for *medically necessary* eyeglasses. *We* must be contacted by telephone at the customer service number on *your* identification card, *electronic mail*, or in writing to request prior authorization. If prior authorization is not obtained, *you* will be responsible for a prior authorization penalty. The benefit payable for *medically necessary* eyeglasses will be reduced by 50% after applicable *deductible* and/or *coinsurance*. This prior authorization penalty will apply if *you* received the *medically necessary* eyeglasses from either a *network provider* or *non-network provider* when prior authorization is required and not obtained.

The "Schedule of Benefits –Pediatric Vision Care" reflects benefit limitations, if any.

Limitations and exclusions

In addition to the "Limitations and Exclusions" section of this *certificate* and any limitations specified in the "Schedule of Benefits – Pediatric Vision Care", benefits for *pediatric vision care* are limited as follows:

- In no event will benefits exceed the lesser of the limits of the *policy*, shown in the "Schedule of Benefits – Pediatric Vision Care" or in the "Schedule of Benefits" of this *certificate*.

- *Materials* covered by the *policy* that are lost, stolen, broken or damaged will only be replaced at normal intervals as specified in the "Schedule of Benefits – Pediatric Vision Care".

- Basic cost for lenses and frames covered by the *policy*. The *covered person* is responsible for lens options selected, including but not limited to:

  - Blended lenses;
  - Progressive multifocal lenses;
  - Photochromatic lenses; tinted lenses, sunglasses, prescription and plano;
  - Laminating of lens or lenses, or fashion or gradient tinting;
  - Groove, drill or notch, and roll and polish; or
  - Hi Index, aspheric and non-aspheric styles.

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

COVERED EXPENSES – PEDIATRIC VISION CARE (continued)

- 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/or *materials* required by an *employer* as a condition of employment.
- Safety lenses and frames.
- Contact lenses, when benefits for frames and lenses are received.
- Oversized 61 and above lens or lenses.
- 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".
- 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.
- Premium lens options.

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COVERED EXPENSES – BEHAVIORAL HEALTH

The "Covered Expenses – Behavioral Health" section describes the services that will be considered *covered expenses* for *mental health services* and *chemical dependency* services under the *policy*. Benefits for *mental health services* and *chemical dependency* services will be paid on a *maximum allowable fee* basis and as shown in the "Schedule of Benefits – Behavioral Health" subject to:

- The *deductible*, if applicable;
- Any *copayment*, if applicable;
- Any *coinsurance* percentage; and
- Any maximum benefit.

Refer to the "Limitations and Exclusions" section listed in this *certificate*. All terms and provisions of the *policy*, including *preauthorization* requirements specified in this *certificate*, are applicable to *covered expenses*

Acute inpatient services

We will pay benefits for *covered expenses* incurred by *you* for *acute inpatient services* for *mental health services* and *chemical dependency* services provided in a *hospital* or *health care treatment facility*.

The "Schedule of Benefits – Behavioral Health" reflects benefit limitations for *acute inpatient services* for *mental health services* and *chemical dependency* services, if any.

Acute inpatient facility services

We will pay benefits for *covered expenses* incurred by *you* for a *confinement* in a *hospital* or *health care treatment facility* for *mental health services* and *chemical dependency* services.

Acute inpatient health care practitioner services

We will pay benefits for *covered expenses* incurred by *you* for *mental health services* and *chemical dependency* services provided by a *health care practitioner* in a *hospital* or *health care treatment facility*.

Residential treatment

We will pay benefits for *covered expenses* incurred by *you* for *residential treatment* for *mental health services* and *chemical dependency* services.

The "Schedule of Benefits – Behavioral Health" reflects benefit limitations for *residential treatment* for *mental health services* and *chemical dependency* services, if any.

Residential treatment is designed to provide care to patients unable to adjust with the community environment and who require constant supervision and care but not on the acute care level generally associated with *hospital* inpatients.

When *you* are admitted to a *residential treatment facility*, *you* must at all times be under the guidance and supervision of a *health care practitioner* who is a recognized staff member of the *residential treatment facility*.

We will not pay *covered expenses* incurred by *you* except upon *your* completion of a phase of treatment in a *residential treatment facility*.

Outpatient therapy and office therapy services

We will pay benefits for *covered expenses* incurred by *you* for *mental health services* and *chemical dependency* services while not *confined* in a *hospital* or *health care treatment facility* for *outpatient* services, including *outpatient* services provided as part of an *intensive outpatient program*.

The "Schedule of Benefits – Behavioral Health" reflects the benefit limitations for *outpatient* care, including *outpatient* services provided as part of an *intensive outpatient program*, for *mental health services* and *chemical dependency* services, if any.
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COVERED EXPENSES - TRANSPLANT SERVICES

The "Covered Expenses – Transplant Services" section describes the services that will be considered *covered expenses* for transplant services under the *policy*. Benefits for transplant services will be paid on a *maximum allowable fee* basis and as shown in the "Schedule of Benefits – Transplant Services" subject to any applicable:

- *Deductible*;
- *Copayment*;
- *Coinsurance* percentage; and
- Maximum benefit.

Refer to the "Exclusions" provision in this section and the "Limitations and Exclusions" section listed in this *certificate* for transplant services not covered by the *policy*. All terms and provisions of the *policy*, including *preauthorization* requirements specified in this *certificate*, are applicable to *covered expenses*.

Organ transplant benefit

We will pay benefits for *covered expenses* incurred by *you* for an *organ transplant*. The *organ transplant* must be approved in advance by *us*, and is subject to the terms, conditions and limitations described below and contained in the *policy*. Please contact *our* Transplant Management Department or *our* designee when in need of these services.

For an *organ transplant* to be considered fully approved, *preauthorization* from *us* is required in advance of the *organ transplant*. *You* or *your health care practitioner* must notify *us* in advance of *your* need for an initial evaluation for the *organ transplant* in order for *us* to determine if the *organ transplant* will be covered. For approval of the *organ transplant* itself, *we* must be given a reasonable opportunity to review the clinical results of the evaluation before rendering a determination.

Once coverage for the *organ transplant* is approved, *we* will advise *your health care practitioner*. Benefits are payable only if the pre-transplant services, the *organ transplant* and post-discharge services are approved by *us*. Coverage for post-discharge services and treatment of complications after transplantation are limited to the *organ transplant treatment period*.

Corneal transplants and porcine heart valve implants, which are tissues rather than organs, are considered part of regular plan benefits and are subject to other applicable provisions of the *policy*.

Covered expenses

Covered expense for an *organ transplant* includes pre-transplant services, transplant inclusive of any chemotherapy and associated services, post-discharge services, and treatment of complications after transplantation of the following organs or procedures only:

- Heart;
- Lung(s);
- Liver;
- Kidney;
- *Bone marrow;*
- Intestine;
- Pancreas;
- Auto islet cell;
- Any combination of the above listed organs; and
- Any organ not listed above required by state or federal law.

The following are *covered expenses* for approved *organ transplants* and all related complications:

- *Hospital* and *health care practitioner* services.

- Organ acquisition and donor costs, including pre-transplant services, the acquisition procedure, and any complications resulting from the acquisition. Donor costs will not exceed the *organ transplant treatment period* and are not payable under the *policy* if they 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.

- Direct, non-medical costs for:

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

  Direct, non-medical costs include:

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

  All direct, non-medical costs for the *covered person* receiving the *organ transplant* and the designated caregiver(s) or support person(s) are limited to a combined maximum coverage per *organ transplant* as specified in the "Schedule of Benefits – Transplant Services" section in this *certificate*.

Exclusions

No benefit is payable for, or in connection with, an *organ transplant* if:

- It is *experimental* or *investigational*, or *for research purposes*.
- The expense relates to storage of cord blood and stem cells, unless it is an integral part of an *organ transplant* approved by *us*.
- *We* do not approve coverage for the *organ 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 *policy*.
- The expense relates to the donation or acquisition of an organ for a recipient who is not covered by *us*.
- The expense relates to an *organ transplant* performed outside of the United States and any care resulting from that *organ transplant*.
- A denied transplant is performed; this includes the pre-transplant evaluation, the transplant procedure, follow-up care, immunosuppressive drugs, and expenses related to complications of such transplant.
- *You* have not met pre-transplant criteria as established by *us*.

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LIMITATIONS AND EXCLUSIONS

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

- Treatment, services, supplies or *surgeries* that are not *medically necessary*, except *preventive services*.

- A *sickness* or *bodily injury* which is covered under any Workers' Compensation or similar law, if you are eligible for such coverage.

- Care and treatment while confined in a jail, holdover or regional jail when facilitated by a unit of local government or a regional jail authority for a *covered person* convicted of a felony.

- 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 insurance.

- *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 rendered by a standby physician, surgical assistant, assistant surgeon, physician assistant, registered nurse or certified operating room technician unless *medically necessary*.

- Any service which is not rendered or not substantiated in the medical records.

- Any expense incurred for services received outside of the United States while *you* are residing outside of the United States for more than six months in a *year* except as required by law for *emergency medical condition* services.

LIMITATIONS AND EXCLUSIONS (continued)

- Education or training, except for *diabetes self-management training* and habilitative services specified in the "Covered Expenses" section of this *certificate*.

- 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*.

- *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*, or *investigational* or *for research purposes*.

- Vitamins and dietary supplements, except:

  - Dietary formulas and supplements necessary for the treatment of inborn metabolic errors or genetic conditions, e.g. phenylketonuria (PKU), which are covered by the Prescription Drug Benefit attached to the *policy*.

  - Human milk fortifiers or 100% human-based diet, when prescribed for prevention of Necrotizing Enterocolitis and administered under the direction of a physician.

- Over-the-counter, non-prescription medications, unless for drugs, medicines or medications on the Women's Healthcare 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 (medications, drugs or hormones to stimulate growth) coverage for growth hormones may be available under the Prescription Drug Benefit, if any, attached to this *policy*.

LIMITATIONS AND EXCLUSIONS (continued)

- Prescription drugs and *self-administered injectable drugs*, except as otherwise covered in the certificate, unless administered to *you*:

  - While an *inpatient* in a *hospital*, *skilled nursing facility*, or *health care treatment facility*; or
  - 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*.

- Hearing aids, the fitting of hearing aids or advice on their care, except as otherwise provided within this *certificate*.

- Implantable hearing devices, except as otherwise provided within this *certificate*.

- Services received in an emergency room, unless required because of an *emergency medical condition*.

- 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.

- Sex change services, regardless of any diagnosis of gender role or psychosexual orientation problems.

- 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;
  - Lactation therapy, unless otherwise covered in this *certificate*; or
  - Sensory integration therapy.

LIMITATIONS AND EXCLUSIONS (continued)

- *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; or
  - Resulting from *congenital anomaly* of a covered *dependent* child which resulted in a *functional impairment*.

  Expense incurred for reconstructive *surgery* performed due to the presence of a psychological condition are not covered, unless the condition(s) described above are also met.

- Hair prosthesis, hair transplants or implants, and wigs.

- Dental services, appliances or supplies, including dental anesthesia, for treatment of the teeth, gums, jaws or alveolar processes, including 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 this *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 hyperkeratoses;
  - 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 hammer toe.

- *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.

- *Sickness* or *bodily injury* caused by the *covered person's*:

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

This exclusion does not apply to the extent inconsistent with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), such as a *sickness* or *bodily injury* due to 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 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 *health care practitioner*) and certain medical devices including:

    - 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, 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, 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.

LIMITATIONS AND EXCLUSIONS (continued)

- Lodging accommodations or transportation, except as otherwise provided within this *certificate*.

- 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 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 *health care practitioner* certifies in writing that the pregnancy would endanger the life of the mother.

- *Alternative medicine*.

- Acupuncture, unless:

  - The treatment is *medically necessary* and 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 provided by a Certified Nurse Midwife.

- Vision examinations or testing for the purposes of prescribing corrective lenses, except *comprehensive eye exams* provided under the "Covered Expenses – Pediatric Vision Care" section in this *certificate.*

- Orthoptic training (eye exercises) except as specified in the "Covered Expenses" section of this *certificate*.

- 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 this *certificate*.
  - Otherwise specified in the "Covered Expenses – Pediatric Vision Care" section in this *certificate*.

LIMITATIONS AND EXCLUSIONS (continued)

- *Covered expenses* for *residential treatment* provided in a *residential treatment facility* when the total phase of treatment has not been completed by *you*.

- 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 *policy*. Coverage will be extended as described in the "Extension of Benefits" section, if such coverage is required by state law.

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

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*.
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ELIGIBILITY AND EFFECTIVE DATES

Eligibility date

Employee eligibility date

The *employee* is eligible for coverage on the date:

- The eligibility requirements are satisfied as stated in the Employer Group Application, or as otherwise agreed to by the *policyholder* and *us*; and
- The *employee* is in an *active status*.

Dependent eligibility date

Each *dependent* is eligible for coverage on:

- The date the *employee* is eligible for coverage, if he or she has *dependents* who may be covered on that date;
- The date of the *employee's* marriage for any *dependents* (spouse or child) acquired on that date;
- The date of birth of the *employee's* natural-born child;
- The date of placement of child for the purpose of adoption by the *employee*;
- The date the *employee* files for the application for appointed legal guardianship of a child; or
- The date specified in a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN) for a child, or a valid court or administrative order for a spouse, which requires the *employee* to provide coverage for a child or spouse as specified in such orders.

The *employee* may cover his or her *dependents* only if the *employee* is also covered.

A *dependent* child who enrolls for other group coverage through any employment is no longer eligible for *group* coverage under the *policy*.

Enrollment

Employees and *dependents* eligible for coverage under the *policy* may enroll for coverage as specified in the enrollment provisions outlined below.

ELIGIBILITY AND EFFECTIVE DATES (continued)

Employee enrollment

The *employee* must enroll, as agreed to by the *policyholder* and *us,* within 31 days of the *employee's eligibility date* or within the time period specified in the "Special enrollment" provision.

The *employee* is a *late applicant* if enrollment is requested more than 31 days after the *employee's eligibility date* or later than the time period specified in the "Special enrollment" provision. A *late applicant* must wait to enroll for coverage during the *open enrollment period*, unless the *late applicant* becomes eligible for special enrollment as specified in the "Special enrollment" provision.

Health status will not be used to determine premium rates. *We* will not use *health status-related factors* to decline coverage to an eligible *employee* and *we* will administer this provision in a non-discriminatory manner.

Dependent enrollment

If electing *dependent* coverage, the *employee* must enroll eligible *dependents,* as agreed to by the *policyholder* and *us*, within 31 days of the *dependent's eligibility date* or within the time period specified in the "Special enrollment" provision.

The *dependent* is a *late applicant* if enrollment is requested more than 31 days after the *dependent's eligibility date* or later than the time period specified in the "Special enrollment" provision. A *late applicant* must wait to enroll for coverage during the *open enrollment period*, unless the *late applicant* becomes eligible for special enrollment as specified in the "Special enrollment" provision.

Health status will not be used to determine premium rates. *We* will not use *health status-related factors* to decline coverage to an eligible *dependent* and *we* will administer this provision in a non-discriminatory manner.

Newborn dependent enrollment

An *employee* who already has *dependent* child coverage in force prior to the newborn's date of birth must notify *us* within 31 days after the date of birth to enroll the newborn for coverage.

An *employee* who does not have *dependent* child coverage must elect *dependent* coverage and enroll the newborn *dependent,* as agreed to by the *policyholder* and *us*, within 31 days after the newborn's date of birth.

A newborn *dependent* is a *late applicant* if enrollment is requested more than 31 days after the date of birth. A *late applicant* must wait to enroll for coverage during the *open enrollment period*, unless the *late applicant* becomes eligible for special enrollment as specified in the "Special enrollment" provision.

Please note that the *employee's* newborn child will automatically be covered for the first 31 days following the child's birth.

Special enrollment

Special enrollment is available if the following apply:

- *You* have a change in family status due to:

  - Marriage;
  - 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 with the *employee* for the purpose of adoption, or any child for which the insured is a court appointed guardian; and
  - You enroll within 31 days after the *special enrollment date*; or

- You are an *employee* or *dependent* eligible for coverage under the *policy*, 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:

  - Termination of employment or eligibility;
  - Reduction in number of hours of employment;
  - Divorce, legal separation or death of a spouse;
  - Loss of dependent eligibility, such as attainment of 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;
  - An incurred claim meeting exceeding a lifetime limit on all benefits; or
  - 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 this *policy*; and
  - You enroll within 31 days after the *special enrollment date*; or

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

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

The *employee* or *dependent* is a *late applicant* if enrollment is requested later than the time period specified above. A *late applicant* must wait to enroll for coverage during the *open enrollment period*.

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 policy* or added to the *policy*, an *employee* who is a *covered person* can enroll eligible *dependents* during the special enrollment. An *employee*, who is otherwise eligible for coverage and had waived coverage under the *policy* when eligible, can enroll himself/herself and eligible *dependents* during the special enrollment.

The *employee* or *dependent* is a *late applicant* if enrollment is requested later than the time period specified above. A *late applicant* must wait to enroll for coverage during the *open enrollment period*.

Open enrollment

Eligible *employees* or *dependents*, that do not enroll for coverage under the *policy* following their *eligibility date* or *special enrollment date*, have an opportunity to enroll for coverage during the *open enrollment period*. The *open enrollment period* is also the opportunity for *late applicants* to enroll for coverage.

Eligible *employees* or *dependents*, including *late applicants*, must request enrollment during the *open enrollment period.* If enrollment is requested after the *open enrollment period*, the *employee* or *dependent* must wait to enroll for coverage during the next *open enrollment period*, unless they become eligible for special enrollment as specified in the "Special enrollment" provision.

Effective date

The provisions below specify the *effective date* of coverage for *employees* or *dependents* if enrollment is requested within 31 days of their *eligibility date* or within the time period specified in the "Special enrollment" provision. If enrollment is requested during an *open enrollment period*, the *effective date* of coverage is specified in the "Open enrollment effective date" provision.

Employee effective date

The *employee's effective date* provision is stated in the Employer Group Application. The *employee's effective date* of coverage may be the date immediately following completion of the *waiting period*, or the first of the month following completion of the *waiting period,* if enrollment is requested within 31 days of the *employee's eligibility date*. The *special enrollment date* is the *effective date* of coverage for an *employee* that requests enrollment within the time period specified in the "Special enrollment" provision. The *employee effective dates* specified in this provision apply to an *employee* who is not a *late applicant.*

Employee delayed effective date

If the *employee* is not in *active status* on the *eligibility date*, coverage will be effective the day after the *employee* returns to *active status*. The *employer* must notify *us* in writing or by *electronic mail* of the *employee's* return to *active status*.

Dependent effective date

The *dependent's effective date* is the date the *dependent* is eligible for coverage if enrollment is requested within 31 days of the *dependent's eligibility date*. The *special enrollment date* is the *effective date* of coverage for the *dependent* that requests enrollment within the time period specified in the "Special enrollment" provision. The *dependent effective dates* specified in this provision apply to a *dependent* who is not a *late applicant*.

In no event will the *dependent's effective date* of coverage be prior to the *employee's effective date* of coverage.

Newborn dependent effective date

The *effective date* of coverage for a newborn *dependent* is the date of birth if enrollment is requested within 31 days of the newborn's date of birth and the newborn is not a *late applicant*.

Premium is due within 31 days after the date of birth in order to have coverage continued beyond the first 31 days.

Open enrollment effective date

The *effective date* of coverage for an *employee* or *dependent*, including a *late applicant*, who requests enrollment during an *open enrollment period*, is the first day of the *policy year* as agreed to by the *policyholder* and *us*.

Benefit changes

Benefit changes will become effective on the date specified by *us*.

Retired employee coverage

Retired employee eligibility date

Retired *employees* are an eligible class of *employees* if requested on the Employer Group Application and if approved by *us*. An *employee* who retires while insured under this *policy* is considered eligible for retired *employee* medical coverage on the date of retirement if the eligibility requirements stated in the Employer Group Application are satisfied.

Retired employee enrollment

The *employer* must notify *us* of the *employee's* retirement within 31 days of the date of retirement. If *we* are notified more than 31 days after the date of retirement, the retired *employee* is a *late applicant*. A *late applicant* must wait to enroll for coverage during the *open enrollment period*, unless the *late applicant* becomes eligible for special enrollment as specified in the "Special enrollment" provision.

Retired employee effective date

The *effective date* of coverage for an eligible retired *employee* is the date of retirement for an *employee* who retires after the date *we* approve the *employer's* request for a retiree classification, provided *we* are notified within 31 days of the retirement. If *we* are notified more than 31 days after the date of retirement, the *effective date* of coverage for the *late applicant* is the date *we* specify.

Retired employee benefit changes

Additional or increased insurance or a decrease in insurance will become effective on the approved date of change.

REPLACEMENT OF COVERAGE

Applicability

The "Replacement of Coverage" section applies when an *employer's* previous group health plan not offered by *us* or *our* affiliates (Prior Plan) is terminated and replaced by coverage under the *policy* and:

- *You* are eligible to become insured for medical coverage on the effective date of the *policy*; and
- *You* were covered under the *employer's* Prior Plan on the day before the effective date of the *policy*.

Benefits available for *covered expense* under the *policy* will be reduced by any benefits payable by the Prior Plan during an extension period.

Delayed effective date

If any delayed *effective date* provision described in this *certificate* applies to *you* on the effective date of the *policy*, *we* will waive the provision. Medical coverage as set forth in this *certificate* is then provided to *you* until the earlier of the following dates:

- The last day of the 12 consecutive month period following the effective date of the *policy*; or
- The date *your* medical coverage would otherwise terminate according to the "Termination Provisions" section of this *certificate*.

If the "Delayed effective date" provision ceases to apply to *you* before the two bulleted items under this provision occur, *your* medical coverage will continue without interruption.

Deductible credit

Medical expense incurred while *you* were covered under the Prior Plan may be used to satisfy *your network provider deductible* amount under the *policy* if the expense incurred:

- Was applied to the deductible amount under the Prior Plan; and
- Qualifies as a *covered expense* under the *policy*; and
- Would have served to partially or fully satisfy the *deductible* amount under the *policy* for the *year* in which *your* coverage becomes effective.

This provision does not apply to *coinsurance* satisfied under the Prior Plan.

Waiting period credit

If the *employee* had not completed the initial *waiting period* under the *policyholder's* Prior Plan on the day that it ended, any period of time that the *employee* satisfied will be applied to the appropriate *waiting period* under the *policy*, if any. The *employee* will then be eligible for coverage under the *policy* when the balance of the *waiting period* has been satisfied.
221400KY S 11/12

TERMINATION PROVISIONS

Termination of insurance

The date of termination, as described in this "Termination Provisions" section, may be the actual date specified or the end of that month, as selected by *your employer* on the Employer Group Application (EGA).

You must notify *us* as soon as possible if *you* or *your dependent* no longer meets the eligibility requirements of the *policy*. Notice should be provided to *us* within 31 days of the change.

When *we* receive notification of a change in eligibility status in advance of the effective date of the change, insurance will terminate on the actual date specified by the *employer* and/or *employee* or at the end of that month, as selected by *your employer* on the EGA. In the event of cancellation, *we* will return promptly the unearned portion of premium paid.

When *we* receive notification of a change in eligibility status more than 31 days after the date of the change, retroactive premium credit will be limited to one month's premium. Unearned premium received for coverage after the date *we* make the change effective, will be promptly returned.

Otherwise, insurance terminates on the earliest of the following:

- The date the *group policy* terminates;
- The end of the grace period for which required premium was due to *us* and not received by *us*;
- The date the *employee* terminated employment with the *employer*;
- The date the *employee* is no longer qualified as an *employee*;
- The date that *you* fail to be in an eligible class of persons as stated in the EGA;
- The date that *you* entered full-time military, naval or air service;
- The date that the *employee* retired, except if the EGA provides coverage for a retiree class of *employees* and the retiree is in an eligible class of retirees, selected by the *employer*;
- The date of an *employee* request for termination of insurance for the *employee* or *dependents*;
- For a *dependent*, the date the *employee's* insurance terminates;
- For a *dependent*, the date the *employee* ceases to be in a class of *employees* eligible for *dependent* insurance;
- The date *your dependent* no longer qualifies as a *dependent*;
- For any benefit, the date the benefit is deleted from the *policy*; or

- *We* will give a 30 day advance written notice of cancellation, if *we* determine that fraud or an intentional misrepresentation of a material fact has been committed by *you.* For more information on fraud and intentional misrepresentation, refer to the "Fraud" provision in the "Miscellaneous Provisions" section of this *certificate*.

Any dissatisfaction may be expressed to *us* through the established appeals process set out in the "Appeal Procedures" section of this *certificate*.

Termination for cause

We will give a 30-days advance written notice if *we* 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* the *maximum allowable fee* for those services.

- If *you* or the *policyholder* perpetrate fraud and/or intentional misrepresentation 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 and/or alteration of a claim, identification card or other identification.

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EXTENSION OF BENEFITS

Extension of health insurance for total disability

We extend limited health insurance benefits if:

- The *policy* terminates while *you* are *totally disabled* due to a *bodily injury* or *sickness* that occurs while the *policy* is in effect; and
- *Your* coverage is not replaced by other group coverage providing substantially equivalent or greater benefits than those provided for the disabling conditions by the *policy*.

Benefits are payable only for those expenses incurred for the same *sickness* or *bodily injury* which caused *you* to be *totally disabled*. Insurance for the disabling condition continues, but not beyond the earliest of the following dates:

- The date coverage for *your* disabling condition has been obtained under another group coverage;
- The date *your health care practitioner* certifies *you* are no longer *totally disabled*;
- The date any maximum benefit is reached; or
- The last day of a 12 consecutive month period following the date the *policy* terminated.

Extension of coverage for hospital confinement

We extend limited coverage if the *policy* terminates while *you* are *hospital confined* due to a *bodily injury* or *sickness* that occurs while the *policy* is in effect.

Benefits are payable only for those expenses incurred for the same *sickness* or *bodily injury* which caused *you* to be *hospital confined*. Coverage during the *hospital confinement* continues without premium payment, but not beyond the earliest of the following dates:

- The date *you* are discharged from the *hospital confinement*;
- The date any maximum benefit is reached; or
- The last day of a 12 consecutive month period following the date the *policy* terminated.

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CONTINUATION

Continuation options in the event of termination

If health insurance terminates:

- It may be continued as described in the "State continuation of health insurance" provision;
- It may be continued as described in the "Continuation of coverage for dependents" provision, if applicable; or
- It may be continued under the continuation provisions as provided by the Consolidated Omnibus Budget Reconciliation Act (COBRA), if applicable.

A complete description of the "State continuation of health insurance" and "Continuation of coverage for dependents" provisions follow.

State continuation of health insurance

A *covered person* whose coverage terminates under the *policy* shall have the right to continuation coverage under the *policy* as follows.

An *employee* may elect to continue his or her coverage. If the *employee* was insured for *dependent* coverage when his or her health insurance terminated, the *employee* may choose to continue health insurance for any *dependent* who was insured by the *policy*. The same terms with regard to the availability of continued health insurance described below will apply to *dependents*.

In order to be eligible for this option,

- The *employee* must have been continuously covered under the *policy*, or any group coverage it replaced, for at least three consecutive months prior to termination;
- The *policyholder* must notify *us* that the *covered person* has terminated coverage under the *policy*; and
- Written application and payment of the premium is received from the *covered person* within 31 days after receiving notification from *us* of his or her right to continuation.

We must give the *covered person* written notice of the right to continue coverage under the *policy* upon notice from the *policyholder* that the *covered person* has terminated coverage under the *policy*. *We* will mail or deliver written notice to the last known address of the *covered person*, which shall constitute the giving of notice as required.

Written application and payment of the first premium for continuation must be made within 31 days after the *covered person* has been given the required notice by *us*. No evidence of insurability is required to obtain continuation.

If *we* fail to provide written notice as soon as practicable after being notified of *our* failure to provide written notice, *you* will have an additional 60 days after written notice is received.

There is no right to continuation if:

- The *covered person* is, or could be, covered by *Medicare*;
- The *covered person* is, or could be, covered by similar benefits under another group coverage, either on an insured or uninsured basis; or
- Similar benefits are provided for, or available to, the *covered person* under any state or federal law.

If this state continuation option is selected, continuation will be permitted for a maximum of 18 months. Continuation shall terminate on the earliest of:

- The date 18 months after the date on which the *group* coverage would have otherwise terminated because of termination of employment or membership in the *group*;
- The date timely premium payments are not made on *your* behalf; or
- The date the *policy* terminates in its entirety and is not replaced by another group coverage within 31 days.

If the *policy* terminates in its entirety before the end of the continuation period and is replaced by another group coverage, the *covered person's* coverage will continue until the time otherwise specified.

Continuation of coverage for dependents

Continuation of coverage is available for *dependents* who are no longer eligible for the health insurance provided by the *policy* because of:

- The death of the covered *employee*;
- The retirement of the covered *employee*; or
- The severance of the family relationship.

Continuation of coverage is also available to a covered *dependent* child who is no longer eligible for health insurance provided by the *policy* due to attaining the limiting age of the *policy*.

Each *dependent* may choose to continue these benefits for up to 18 months after the date the coverage would have normally terminated.

CONTINUATION (continued)

In order to be eligible for this option,

- The *dependent* must have been continuously covered under the *policy*, or any group coverage it replaced, for at least three consecutive months prior to termination, except in the case of an infant under one year of age; and

- The covered *employee* or *dependent* must give the *policyholder* written notice within 31days of the death or retirement of the *employee*, severance of the family relationship or the attainment of the limiting age by a covered *dependent* child that might activate this continuation option; and

- The *policyholder* must notify *us* of the death or retirement of the *employee*, severance of the family relationship or the attainment of the limiting age by a covered *dependent* child; and

- Written application and payment of the premium is received from the *dependent* within 31 days after receiving notification from *us* of his or her right to continuation.

We must give the *dependent* written notice of the right to continue coverage under the *policy* upon notice from the *policyholder* that the *dependent's* coverage terminated, or may terminate, under the *policy* as a result of the death or retirement of the *employee*, severance of the family relationship or the attainment of the limiting age by a covered *dependent* child. *We* will mail or deliver written notice to the last known address of the *dependent*, which shall constitute the giving of notice as required.

Written application and payment of the first premium for continuation must be made within 31 days after the *dependent* has been given the required notice by *us*. No evidence of insurability is required to obtain continuation.

If *we* fail to provide written notice as soon as practicable after being notified of *our* failure to provide written notice, *you* will have an additional 60 days after written notice is received.

The option to continue coverage is <u>not</u> available if:

- The termination of coverage occurred because the *dependent* failed to pay the required premium contribution within 31 days after being notified by *us* of his or her right to continuation coverage;

- The *policy* terminates in its entirety and is not replaced by another group coverage within 31 days;

- A *dependent* is, or could be, covered under *Medicare*;

- A *dependent* is, or could be, covered for similar benefits under another group coverage, either on an insured or uninsured basis;

- The *dependent* was not continuously covered by the *policy*, or any group coverage it replaced, for at least three months prior to the date coverage terminates, except in the case of an infant under one year of age; or

CONTINUATION (continued)

- The *dependent* elects to continue his or her coverage under the terms and conditions described in (COBRA).

Continued coverage terminates on the earliest of the following dates:

- The last day of the 18 months period following the date the *dependent* was no longer eligible for coverage;
- The date timely premium payments are not made on *your* behalf; or
- The date the *policy* terminates and is not replaced by another group coverage within 31 days.

The *covered person* is responsible for sending *us* written application and the premium payments for those individuals who choose to continue their coverage. Premiums must be paid each month in advance for coverage to continue. If the *covered person* fails to make proper payment of the premiums to *us*, *we* are relieved of all liability for any coverage that was continued.
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MEDICAL CONVERSION PRIVILEGE

Eligibility

Subject to the terms below, if *your* medical coverage under the *policy* terminates, a Conversion Policy is available without medical examination. *You* must have been continuously covered under the *policy* or any group health plan it replaced for at least 90 days and:

- *Your* coverage ends because the *employee's* employment terminated;
- *You* are a covered *dependent* whose coverage ends due to the *employee's* marriage ending via legal annulment, dissolution of marriage or divorce;
- *You* are the surviving covered *dependent* , in the event of the *employee's* death or at the end of any survivorship continuation as provided by the *policy*; or
- *You* have been a covered *dependent* child but no longer meet the definition of *dependent* under the *policy*; and
- *Your* coverage under the *policy* is not terminated because of fraud or material misrepresentation.

Only persons covered under the *policy* on the date coverage terminates are eligible to be covered under the Conversion Polic*y*.

The Conversion Policy may be issued covering each former *covered person* on a separate basis or it may be issued covering all former *covered persons* together. However, if conversion is due to dissolution of marriage by annulment or final divorce decree, only those persons who cease to be a *dependent* of the *employee* are eligible to exercise the medical conversion privilege.

The *policyholder* must notify *us* that the *covered person* has terminated membership with the group plan. *We* will then give written notice of the right to conversion to any *covered person* entitled to conversion. Proper notice will be mailed or delivered to the last known address of the *covered person*.

Written application and payment of the first premium for conversion must be made within 31 days after the date coverage terminates or within 31 days after the *covered person* has been given the required notice. No evidence of insurability is required to obtain conversion.

If the *group policy* terminates, due to nonpayment of premium, *we* will notify each *covered person* of their right to continuation within 15 business days after the end of the grace period.

If *we* fail to provide written notice as soon as practicable after being notified of *our* failure to provide written notice, *you* will have an additional 60 days after written notice is received.

MEDICAL CONVERSION PRIVILEGE (continued)

This privilege does not apply when the *employer's* participation in the *policy* terminates and medical coverage is replaced within 31 days by another group insurance plan.

Overinsurance - duplication of coverage

We may refuse to issue a Conversion Policy if *we* determine that *you* would be overinsured. The Conversion Policy will not be available if it would result in overinsurance or duplication of benefits. *We* will use *our* standards to determine overinsurance.

Conversion policy

The Conversion Policy which *you* may apply for will be the Conversion Policy customarily offered by *us* as a conversion from group coverage or as mandated by state law.

The Conversion Policy is a new policy and not a continuation of *your* terminated coverage. The Conversion Policy benefits will be substantially similar from those provided under *your group* coverage. The benefits that may be available to *you* will be described in an Outline of Coverage provided to *you* when *you* request an application for conversion from *us*.

Effective date and premium

You have 31 days after the date *your* coverage terminates under the *policy* to apply and pay the required premium for *your* Conversion Policy. The premium must be paid in advance. *You* may obtain application forms from *us* via the internet or by request in writing. The Conversion Policy will be effective on the day after *your group* medical coverage ends, if *you* enroll and pay the first premium within 31 days after the date *your* coverage ends.

The premium for the Conversion Policy will be the premium charged by *us* as of the effective date based upon the Conversion Policy form, classification of risk, age and benefit amounts selected. The premium may change as provided in the Conversion Policy.
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COORDINATION OF BENEFITS

This coordination of benefits (COB) provision applies when a person has health care coverage under more than one *plan*. The order of benefit determination rules below determine which *plan* will pay as the *primary plan*. The *primary plan* pays first without regard to the possibility another *plan* may cover some expenses. A *secondary plan* pays after the *primary plan* and may reduce the benefits it pays so that payments from all *plans* do not exceed 100% of the total *allowable expense*.

Definitions

The following definitions are used exclusively in this provision.

Plan means any of the following that provide benefits or services for medical or dental care or treatment. However, if separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered part of the same *plan* and there is no COB among those separate contracts.

Plan includes:

- Group insurance, closed panel or other forms of group or group-type coverage (whether insured or uninsured);
- Hospital indemnity benefits in excess of $200 per day;
- Medical care components of group long-term care contracts, such as skilled nursing care;
- *Medicare* or other governmental benefits, as permitted by law.

Plan does not include:

- Individual or family insurance;
- Closed panel or other individual coverage (except for group-type coverage);
- Hospital indemnity benefits of $200 or less per day;
- School accident type coverage;
- Benefits for non-medical care components of group long-term care contracts;
- *Medicare* supplement policies;
- A state plan under *Medicaid*; and
- Coverage under other governmental plans, unless permitted by law.

Each contract for coverage is a separate *plan*. If a *plan* has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate *plan*.

COORDINATION OF BENEFITS (continued)

Notwithstanding any statement to the contrary, for the purposes of COB, prescription drug coverage under a Prescription Drug Benefit Rider, if applicable, will be considered a separate *plan* and will therefore only be coordinated with other prescription drug coverage.

Primary/secondary means the order of benefit determination stating whether this *plan* is *primary* or *secondary* covering the person when compared to another *plan* also covering the person.

When this *plan* is *primary*, its benefits are determined before those of any other *plan* and without considering any other *plan's* benefits. When this *plan* is *secondary*, its benefits are determined after those of another *plan* and may be reduced because of the *primary plan's* benefits.

Allowable expense means a health care service or expense, including deductibles and copayments, that is covered at least in part by any of the *plans* covering the person. When a *plan* provides benefits in the form of services (e.g. an HMO), the reasonable cash value of each service will be considered an *allowable expense* and a benefit paid. An expense or service that is not covered by any of the *plans* is not an *allowable expense*. The following are examples of expenses or services that are not *allowable expenses*:

- If a *covered person* is confined in a private *hospital* room, the difference between the cost of a semi-private room in the *hospital* and the private room, (unless the patient's stay in a private *hospital* room is *medically necessary* in terms of generally accepted medical practice, or one of the *plans* routinely provides coverage for *hospital* private rooms) is not an *allowable expense*.

- If a person is covered by two or more *plans* that compute their benefits payments on the basis of usual and customary fees, any amount in excess of the highest usual and customary fees for a specific benefit is not an *allowable expense*.

- If a person is covered by two or more *plans* that provide benefits or services on the basis of negotiated fees, any amount in excess of the highest of the fees is not an *allowable expense*.

- If a person covered by one *plan* that calculates its benefits or services on the basis of usual and customary fees and another *plan* that provides its benefits or services on the basis of negotiated fees, the *primary plan's* payment arrangement shall be the *allowable expense* for all *plans*.

- The amount a benefit is reduced by the *primary plan* because a *covered person* does not comply with the *plan* provisions. Examples of these provisions are second surgical opinions, precertification of *admissions* and preferred provider arrangements.

Benefit reserve means the savings recorded by a *plan* for claims paid for a *covered person* as a *secondary plan* rather than as a *primary plan*.

Claim determination period means a calendar year. However, it does not include any part of a year during which a person has no coverage under this *plan*, or before the date this COB provision or a similar provision takes effect.

Closed panel plan is a *plan* that provides health benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the *plan*, and that limits or excludes benefits for services provided by other providers, except in the cases of emergency or referral by a panel member.

Custodial parent means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

Order of determination rules

General

When two or more *plans* pay benefits, the rules for determining the order of payment are as follows:

- The *primary plan* pays or provides its benefits as if the *secondary plan* or *plans* did not exist.

- A *plan* that does not contain a COB provision that is consistent with applicable promulgated regulation is always *primary*. There is one exception: coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the *plan* provided by the contract holder. Examples of these types of situations are major medical coverage's that are superimposed over base *plan* hospital and surgical benefits, and insurance type coverage's that are written in connection with a *closed panel plan* to provide out-of-network benefits.

- A *plan* may consider the benefits paid or provided by another *plan* in determining its benefits only when it is *secondary* to that other *plan*.

Rules

The first of the following rules that describes which *plan* pays its benefits before another *plan* is the rule to use.

- **Non-dependent or *dependent***. The *plan* that covers the person other than as a *dependent*, for example as an *employee*, member, subscriber or retiree is *primary* and the *plan* that covers the person as a *dependent* is *secondary*. However, if the person is a *Medicare* beneficiary and, as a result of federal law, *Medicare* is *secondary* to the *plan* covering the person as a *dependent*; and *primary* to the *plan* covering the person as other than a *dependent* (e.g. retired *employee*); then the order of benefits between the two *plans* is reversed so that the *plan* covering the person as an *employee*, member, subscriber or retiree is *secondary* and the other *plan* is *primary*.

COORDINATION OF BENEFITS (continued)

- **Child covered under more than one *plan***. The order of benefits when a child is covered by more than one *plan* is:

  - The *primary plan* is the *plan* of the parent whose birthday is the earlier in the year if:

    - The parents are married;
    - The parents are not separated (whether or not they have been married); or
    - A court decree awards joint custody with out specifying that one part has the responsibility to provide health care coverage.

  - If both the parents have the same birthday, the *plan* that covered either of the parents longer is *primary*.

  - If the specific terms of a court decree state that one parent is responsible for the child's health care expenses or health care coverage and the *plan* of that parent has actual knowledge of those terms, that *plan* is *primary*. This rule applies to *claim determination periods* or plan years commencing after the *plan* is given notice of the court decree.

  - If the parents are not married, or are separated (whether or not they ever have been married) or are divorced, the order of benefits is:

    - The *plan* of the *custodial parent*;
    - The *plan* of the spouse of the *custodial parent*;
    - The *plan* of the non-*custodial parent*; and then
    - The *plan* of the spouse of the non-*custodial parent*.

- **Active or inactive *employee***. The *plan* that covers a person as an *employee* who is neither laid off nor retired, is *primary*. The same would hold true if a person is a *dependent* of a person covered as a retiree and an *employee*. If the other *plan* does not have this rule, and if, as a result, the *plans* do not agree on the order of benefits, this rule is ignored.

- **Continuation coverage**. If a person whose coverage is provided under a right of continuation provided by federal or state law also is covered under another *plan*, the *plan* covering the person as an *employee*, member, subscriber or retiree (or as that person's *dependent*) is *primary*, and the continuation coverage is *secondary*. If the other *plan* does not have this rule, and if, as a result, the *plans* do not agree on the order of benefits, this rule is ignored.

- **Longer or shorter length of coverage**. The *plan* that covered the person as an *employee*, member, subscriber or retiree longer is *primary*.

  To determine the length of time a person has been covered under a plan, two (2) plans shall be treated as one (1) if the covered person was eligible under the second within twenty-four (24) hours after the first ended;

Changes during a coverage period that do not constitute the start of a new plan include:

- A change in scope of a plan's benefits;
- A change in the entity that pays, provides or administers the plan's benefits; or
- A change from one (1) type of plan to another.

The person's length of time covered under a plan is measured from the person's first date of coverage under that plan. If that date is not readily available for a group plan, the date the person first became a member of the group shall be used as the date from which to determine the length of time the person's coverage under the present plan has been in force.

If the preceding rules do not determine the *primary plan*, the *allowable expenses* shall be shared equally between the *plans* meeting the definition of *plan* under this provision. In addition, this *plan* will not pay more that it would have had it been *primary*.

Effects on the benefits of this plan

When this *plan* is *secondary*, benefits may be reduced to the difference between the *allowable expense* (determined by the *primary plan*) and the benefits paid by any *primary plan* during the *claim determination period*. Payment from all *plans* will not exceed 100% of the total *allowable expense*.

The difference between the benefit payments that this *plan* would have paid had it been the *primary plan*, and the benefit payments that it actually paid or provided shall be recorded as a benefit reserve for the *covered person* and used by this *plan* to pay an *allowable expense*, not otherwise paid during the *claim determination period*. As each claim is submitted, this *plan* will:

- Determine its obligation to pay or provide benefits under its contract;
- Determine whether a benefit reserve has been recorded for the *covered person*; and
- Determine whether there are any unpaid *allowable expenses* during the *claim determination period*.

If there is a benefit reserve, the *secondary plan* will use the *covered person's* benefit reserve to pay up to 100% of total *allowable expenses* incurred during the *claim determination period*. At the end of the *claim determination period*, the benefit reserve returns to zero. A new benefit reserve must be created for each new *claim determination period*.

The benefits of the *secondary plan* shall be reduced when the sum of the benefits payable that would be payable under the other *plans*, in the absence of a coordination of benefits provision, whether or not a claim is made, exceeds the allowable expenses in *claim determination period*, with a reduction of benefits as follows:

- The benefits of the *secondary plan* shall be reduced so that they and the benefits payable under the other *plans* do not total more than the *allowable expenses*; and
- Each benefit is reduced in proportion and charged against any applicable benefit limit of the *plan*.

If a person is covered by more than one *secondary plan*, the order of benefit determination rules decide the order in which *secondary plans* benefits are determined in relation to each other. Each *secondary plan* takes into consideration the benefits of the *primary plan* or plans and the benefits of any other plan, which has its benefits determined before those of that *secondary plan*.

For purposes of determining benefits payable, if the *covered person* could have enrolled in *Medicare* Part B, but does not, the amount payable under *Medicare* Part B is assumed to be the amount the *covered person* would have received if he or she enrolled for it.

Equal Sharing. If the preceding rules do not determine the *primary plan*, the *allowable expenses* shall be shared equally between the *plans* meeting the definition of *plan* under this regulation. However, this *plan* will not pay more than it would have paid had it been *primary*.

If a *covered person* is enrolled in two or more *closed panel plans* and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one *closed panel plan*, COB shall not apply between that *plan* and the other *closed panel plan*

Notice to covered persons

If *you* are covered by more than one health benefit plan, *you* should file all claims with each *plan*.

Miscellaneous provisions

A *secondary plan* that provides benefits in the form of services may recover the reasonable cash value of the services from the *primary plan*, to the extent that benefits for the services are covered by the *primary plan* and have not already been paid or provided by the *primary plan*.

A *plan* with order of benefit determination requirements that comply with this administrative regulation may coordinate its benefits with a *plan* that is "excess" or "always secondary" or that uses order of benefit determination requirements that do not comply with those contained in this administrative regulation on the following basis:

- If the complying *plan* is the *primary plan*, it shall pay or provide its benefits first;

- If the complying *plan* is the *secondary plan*, it shall pay or provide its benefits first, but the amount of the benefits payable shall be determined as if the complying *plan* were the *secondary plan*. In that situation, the payment shall be the limit of the complying *plan's* liability; and

- If the non-complying *plan* does not provide the information needed by the complying *plan* to determine its benefits within a reasonable time after it is requested to do so, the complying *plan* shall assume that the benefits of the non-complying *plan* are identical to its own, and shall pay its benefits accordingly. If, within two (2) years of payment, the complying *plan* receives information as to the actual benefits of the non-complying *plan*, it shall adjust payments accordingly.

If the non-complying *plan* reduces its benefits so that the *covered person* receives less in benefits than he would have received had the complying *plan* paid or provided its benefits as the *secondary plan* and the non-complying *plan* paid or provided its benefits as the *primary plan*, and governing state law allows the right of subrogation set forth under the *policy*, then the complying *plan* shall advance to or on behalf of the *covered person* an amount equal to the difference.

The complying *plan* shall not advance more than the complying *plan* would have paid had it been the *primary plan* less any amount it previously paid for the same expense or service, and:

- In consideration of the advance, the complying *plan* shall be subrogated to all rights of the *covered person* against the non-complying *plan*; and
- The advance by the complying *plan* shall also be without prejudice to any claim it may have against a non-complying *plan* in the absence of subrogation.

Coordination of benefits differs from subrogation. Provisions for one may be included in health care benefits contracts without compelling the inclusion or exclusion of the other.

If the *plans* cannot agree on the order of benefits within thirty calendar days after the *plans* have received all of the information needed to pay the claim, the *plans* shall immediately pay the claim in equal shares and determine their relative liabilities following payment, except that no *plan* shall be required to pay more than it would have paid had it been *primary*.

Severability

If any provision of this administrative regulation or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of this administrative regulation and the application of that provision to other persons or circumstances shall not be affected thereby.

Right to receive and release needed information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this *plan* and other *plans*. *We* may get the facts *we* need from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under this *plan* and other *plans* covering the person claiming benefits. *We* need not tell, or get the consent of, any person to do this. Each person claiming benefits under this *plan* must give *us* any facts *we* need to apply those rules and determine benefits payable.

COORDINATION OF BENEFITS (continued)

Facility of payment

A payment made under another *plan* may include an amount that should have been paid under this *plan*. If it does, *we* may pay that amount to the organization that made the payment. That amount will then be treated as though it were a benefit paid under this *plan*. *We* will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means a reasonable cash value of the benefits provided in the form of services.

Right of recovery

If the amount of the payments made by *us* is more than *we* should have paid under this COB provision, *we* may recover the excess from one or more of the persons *we* have paid or for whom we have paid; or any other person or organization that may be responsible for the benefits or services provided for the *covered person*. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

Cooperation required

The *covered person* shall cooperate by providing information and executing any documents to preserve *our* right and shall have the affirmative obligation of notifying *us* that claims are being made against responsible parties to recover for injuries for which *we* have paid. If the *covered person* enters into litigation or settlement negotiations regarding the obligations of the other party, the *covered person* must not prejudice, in any way, *our* rights to recover an amount equal to any benefits *we* have provided or paid for the *injury or sickness*. Failure of the *covered person* to provide *us* such notice or cooperation, or any action by the *covered person* resulting in prejudice to *our* rights will be a material breach of this *policy* and will result in the *covered person* being personally responsible to make repayment. In such an event, *we* may deduct from any pending or subsequent claim made under the *policy* any amounts the *covered person* owes *us* until such time as cooperation is provided and the prejudice ceases.

Legal actions and limitations

No action at law or in equity may be brought to recover under the *policy* until at least 60 days after written proof of claim has been filed with *us*. If action is to be taken after the 60-day period, it must be taken within 3 years of the date written proof of claim was required to be filed.
226790KY S 11/12

COORDINATION OF BENEFITS FOR MEDICARE ELIGIBLES

Definitions

Medicare Part A means the *Medicare* program that provides hospital insurance benefits.

Medicare Part B means the *Medicare* program that provides medical insurance benefits.

Medicare Part D means the *Medicare* program that provides prescription drug benefits.

General coordination of benefits with Medicare

If *you* are covered under both *Medicare* and this *certificate*, federal law mandates that *Medicare* is the secondary plan in most situations. But when permitted by law, this plan is the secondary plan. In all cases, coordination of benefits with *Medicare* will conform to federal statutes and regulations. If *you* are enrolled in *Medicare*, *your* benefits under this *certificate* will be coordinated to the extent benefits are payable under *Medicare*, as allowed by federal statutes and regulations.

You are considered to be eligible for *Medicare* on the earliest date coverage under *Medicare* could have become effective for *you*.

Coordination of benefits with Medicare Part B

If *you* are eligible for *Medicare Part B*, but are not enrolled, *your* benefits under the *policy* may be coordinated as if *you* were enrolled in *Medicare Part B*. *We* may not pay benefits to the extent that benefits would have been payable under *Medicare Part B*, if *you* had enrolled. Therefore, it is important that *you* enroll in *Medicare Part B* if *you* are eligible to do so.
227200KY S 11/12

CLAIMS

Notice of claim

Network providers will submit claims to *us* on *your* behalf. If *you* utilize a *non-network provider* for *covered expenses*, *you* must submit a notice of claim to *us*. Notice of claim must be given to *us* in writing or by *electronic mail* as required by *your* plan, or as soon as is reasonably possible thereafter. Notice must be sent to *us* at *our* mailing address shown on *your* identification documentation or at *our* Website at www.humana.com.

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

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

If *you* receive services outside the United States or from a foreign provider, *you* must also submit the following information along with *your* complete claim:

- *Your* proof of payment to the provider for the services received outside the United States or from a foreign provider;
- Complete medical information and medical records;
- *Your* proof of travel outside of the United States, such as airline tickets or passport stamps, if *you* traveled to receive the services; and
- The foreign provider's fee schedule if the provider uses a billing agency.

The forms necessary for filing proof of loss are available at www.humana.com. When requested by *you*, *we* will send *you* the forms for filing proof of loss. If the requested forms are not sent to *you* within 15 days, *you* will have met the proof of loss requirements by sending *us* a written or *electronic* statement of the nature and extent of the loss containing the above elements within the time limit stated in the "Proof of loss" provision.

Proof of loss

You must give written or *electronic* proof of loss within 90 days after the date of loss. *Your* claims will not be reduced or denied if it was not reasonably possible to give such proof. In any event, written or *electronic* notice must be given within one year after the date proof of loss is otherwise required, except if *you* were legally incapacitated.

Right to require medical examinations

We have the right to require a medical examination on any *covered person* for whom a claim is pending as often as *we* may reasonably require. If *we* require a medical examination, it will be performed at *our* expense. *We* also have a right to request an autopsy in the case of death, if state law so allows.

To whom benefits are payable

If *you* receive services from a *network provider*, *we* will pay the provider directly for all *covered expenses*. *You* will not have to submit a claim for payment.

All benefit payments for services rendered by a *non-network provider* are due and owing solely to the *covered person*. Assignment of benefits is prohibited; however, *you* may request that *we* direct a payment of selected medical benefits to the health care provider on whose charge the claim is based. If *we* consent to this request, *we* will pay the health care provider directly. Such payments will not constitute the assignment of any legal obligation to the *non-network provider*. If *we* decline this request, *we* will pay *you* directly, and *you* are then responsible for all payments to the *non-network provider(s)*.

If any *covered person* to whom benefits are payable is a minor or, in *our* opinion, not able to give a valid receipt for any payment due him or her, such payment will be made to his or her parent or legal guardian. However, if no request for payment has been made by the parent or legal guardian, *we* may, at *our* option, make payment to the person or institution appearing to have assumed his or her custody and support.

Time of payment of claims

Payments due under the *policy* will be paid no more than 30 days after receipt of written or *electronic* proof of loss.

Right to request overpayments

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

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

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

Right to collect needed information

You must cooperate with *us* and when asked, assist *us* by:

- Authorizing the release of medical information including the names of all providers from whom *you* received medical attention;
- Obtaining medical information and/or records from any provider as requested by *us*;
- Providing information regarding the circumstances of *your sickness*, *bodily injury* or *accident*;
- Providing information about other insurance coverage and benefits, including information related to any *bodily injury* or *sickness* for which another party may be liable to pay compensation or benefits; and
- Providing information *we* request to administer the *policy*.

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

Exhaustion of time limits

If *we* fail to complete a claim determination or appeal within the time limits set forth in the *policy*, the claim shall be deemed to have been denied and *you* may proceed to the next level in the review process outlined under the "Grievance Procedures" section of this *certificate*.

Recovery rights

You as well as *your dependents* agree to the following, as a condition of receiving benefits under the *policy*.

Duty to cooperate in good faith

You are obligated to cooperate with *us* and *our* agents in order to protect *our* recovery rights. Cooperation includes promptly notifying *us* that *you* may have a claim, providing *us* relevant information, and signing and delivering such documents as *we* or *our* agents reasonably request to secure *our* recovery rights. *You* agree to obtain *our* consent before releasing any party from liability for payment of medical expenses. *You* agree to provide *us* with a copy of any summons, complaint or any other process serviced in any lawsuit in which *you* seek to recover compensation for *your* injury and its treatment.

You will do whatever is necessary to enable *us* to enforce *our* recovery rights and will do nothing after loss to prejudice *our* recovery rights.

You agree that *you* will not attempt to avoid *our* recovery rights by designating all (or any disproportionate part) of any recovery as exclusively for pain and suffering.

In the event that *you* fail to cooperate with *us*, *we* shall be entitled to recover from *you* any payments made by *us*.

Duplication of benefits/other insurance

We will not provide duplicate coverage for benefits under the *policy* when a person is covered by *us* and has, or is entitled to, benefits as a result of their injuries from any other coverage including, but not limited to, first party uninsured or underinsured motorist coverage, any no-fault insurance, medical payment coverage (auto, homeowners or otherwise), workers compensation settlement or awards, other group coverage (including student plans), direct recoveries from liable parties, premises medical pay or any other insurer providing coverage that would apply to pay *your* medical expenses, except another "plan", as defined in the "Coordination of Benefits" section (e.g., group health coverage), in which case priority will be determined as described in the "Coordination of Benefits" section.

Where there is such coverage, *we* will not duplicate other coverage available to *you* and shall be considered secondary, except where specifically prohibited. Where double coverage exists, *we* shall have the right to be repaid from whomever has received the overpayment from *us* to the extent of the duplicate coverage.

We will not duplicate coverage under the *policy* whether or not *you* have made a claim under the other applicable coverage.

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

Workers' compensation

If benefits are paid by *us* and *we* discover that a determination by the Workers Compensation Board for treatment of *bodily injury* or *sickness* arose from or was sustained in the course of, any occupation or employment for compensation, profit or gain, *we* have the right to recover as described below. *We* will exercise *our* right to recover. *We* will exercise *our* right to recover against *you.*

As a condition of receiving benefits from *us, you* hereby agree that, in consideration for the coverage provided by the *policy*, *you* will notify *us* of any Workers' Compensation claim *you* make, and that *you* agree to reimburse *us* as described above.

Right of subrogation

As a condition to receiving benefits from *us*, *you* agree to transfer to *us* any rights *you* may have to make a claim, take legal action or recover any expenses paid under the *policy*. *We* will be subrogated to *your* rights to recover from any funds paid or payable as a result of a personal injury claim or any reimbursement of expenses by:

- Any legally liable person or their carrier;
- Any uninsured motorist or underinsured motorist coverage;
- Medical payments/expense coverage under any automobile, homeowners, premises or similar coverages;
- Workers' Compensation or other similar coverage;
- No-fault or other similar coverage.

We may enforce *our* subrogation rights by asserting a claim to any coverage to which *you* may be entitled.

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

Right of reimbursement

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

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

If, after the inception of coverage with *us*, *you* recover payment from and release any legally responsible person, their insurer, or any uninsured motorist, underinsured motorist, medical payment/expense, Workers' Compensation, no-fault, or other similar insurer from liability for future medical expenses relating to a *sickness* or *bodily injury*, *we* shall have a continuing right to reimbursement from *you* to the extent of the benefits *we* provided with respect to that *sickness* or *bodily injury*. This right, however, shall apply only to the extent of such payment and only to the extent not limited or precluded by law in the state whose laws govern the *policy*, including any made whole or similar rule.

The obligation to reimburse *us* in full exists, regardless of whether the settlement, compromise, or judgment designates the recovery as including or excluding medical expenses.

Assignment of recovery rights

The *policy* contains an exclusion for *sickness* or *bodily injury* for which there is medical payment/expenses coverage provided under any automobile, homeowner's, premises or other similar coverage.

If *your* claim against the other insurer is denied or partially paid, *we* will process *your* claim according to the terms and conditions of the *policy*. If payment is made by *us* on *your* behalf, *you* agree to assign to *us* the right *you* have against the other insurer for medical expenses *we* pay.

If benefits are paid under the *policy* and *you* recover under any automobile, homeowner's, premises or similar coverage, *we* have the right to recover from *you*, or whomever *we* have paid, an amount equal to the amount *we* paid.

Cost of legal representation

The costs of *our* legal representation in matters related to *our* recovery rights shall be borne solely by *us*. The costs of legal representation incurred by *you* shall be borne solely by *you*, unless *we* were given timely notice of the claim and an opportunity to protect *our* own interests and *we* failed or declined to do so.
229700KY S 06/14

INTERNAL APPEAL AND EXTERNAL REVIEW

Definitions

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

- A determination that an item or service is *experimental* or *investigational* or not *medically necessary;*
- A determination of *your* eligibility for group coverage under the *policy*;
- A determination that the benefit is not covered;
- Any rescission of coverage.

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

Commissioner means the Commissioner of the Kentucky Department of Insurance.

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

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

Independent Review Entity (IRE) means an entity assigned by the *commissioner* to conduct an independent *external review* of an *adverse benefit determination* and a *final adverse benefit determination*.

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

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

Urgent-care claim means a claim for *covered expenses* that in the opinion of a physician with knowledge of a covered person's medical condition application of the time periods for making non-urgent care determinations:

- Could seriously jeopardize the life or health of the *covered person,* including an unborn child of the *covered person* when pregnant, or the ability of the *covered person* to regain maximum function; or result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part; or

- In the opinion of a physician with knowledge of the *covered person*'s medical condition, would subject the *covered person* to severe pain that cannot be adequately managed without the service that is the subject of the claim.

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

Contact information

You may contact the *commissioner* and the Kentucky Consumer Protection Division for assistance at any time using the contact information below:

Kentucky Department of Insurance
215 West Main Street
Frankfort, KY 40601

(Mailing address)
P.O. Box 517
Frankfort, KY 40602-0515

Phone number: 502-564-3630;
Toll Free (KY only): 800-595-6053;
TTY: 800-648-6056

Kentucky Consumer Protection Division
P.O. Box 517
Frankfort, KY 40602-0517

Filing a complaint

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

Internal appeals

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

Humana Insurance Company
ATTN: Grievance Department
P.O. Box 14546
Lexington, KY 40512-4546

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

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

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

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

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

Time periods for decisions on appeal

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

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

Exhaustion of remedies

You or *your authorized representative* will have exhausted the administrative remedies under the plan and may request an *external review*:

- When the internal appeals process under this section is complete;
- If *we* fail to make a timely determination or notification of and internal appeal;
- *You* or *your authorized representative* and Humana jointly agree to waive the internal appeal process; or
- If *we* fail to adhere to all requirements of the internal appeal process, except for failures that are based on de minimis violations.

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

External review

Within 4 months after *you* or *your authorized representative* receives notice of a *final adverse benefit determination*, *you* or *your authorized representative* may request an *external review*. The request for *external review* must be made in writing to *us*. *You* or *your authorized representative* may be assessed a $25 filing fee that will be refunded if the *adverse benefit determination* is overturned. The fee will be waived if the payment of the fee would impose undue financial hardship. The annual limit on filing fees for each *covered person* within a single *year* will not exceed $75.

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

If the request qualifies for an *external review, we* will notify *you* or *your authorized representative* in writing of the assignment of an *IRE* and the right to submit additional information. Additional information must be submitted within the first 5 business days of receipt of the letter. *You* or *your authorized representative* will be notified of the determination within 21 calendar days from receipt of all information required from *us*. An extension of up to 14 calendar days may be allowed if agreed by the *covered* person and *us*. This request for an *external review* will not exceed 45 days of the receipt of the request.

Expedited external review

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

- At the same time *you* request an expedited internal appeal of an *adverse benefit determination* for an *urgent-care claim* or when *you* are receiving an ongoing course of treatment; or
- When *you* receive an *adverse benefit determination* or *final adverse benefit determination* of:

    - An *urgent-care claim*;
    - An admission, availability of care, continued stay or health care service for which *you* received emergency services, but *you* have not been discharged from the facility; or
    - An *experimental* or *investigational* treatment if the treating physician certifies, in writing, that the recommended service would be significantly less effective if not promptly initiated.

An *adverse benefit determination* of any rescission of coverage is not available for *external review*.

If the request qualifies for an expedited *external review*, an *IRE* will be assigned. *We* will contact the *IRE* by telephone for acceptance of the assignment. *You* or *your authorized representative* will be notified within 24 hours of receiving the request. An extension of up to 24 hours may be allowed if agreed by the *covered person* or their *authorized representative* and *us*. This request for an expedited *external review* will not exceed 72 hours of the receipt of the request.

Legal actions and limitations

No lawsuit with respect to plan benefits may be brought after the expiration of three (3) years after the latter of:

- The date on which *we* first denied the service or claim; paid less than *you* believe appropriate; or failed to timely pay the claim; or
- 180 days after a final determination of a timely filed appeal.

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DISCLOSURE PROVISIONS

Discount programs

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

Wellness programs

From time to time *we* may offer directly, or enter into agreements with third parties who administer wellness programs that may be available to *you.* Through these wellness programs, *you* may earn rewards by:

- Participating in wellness activities that do not require *you* to meet a standard related to a health factor, such as membership in a fitness center, certain preventive testing or attending a no-cost health education seminar. These are considered "participatory wellness program" activities; or

- Attaining certain wellness goals that are related to a health factor, such as completing a 5k event, lowering blood pressure or ceasing the use of tobacco. These are considered "health-contingent wellness program" activities.

The rewards may include, non-insurance benefits such as merchandise, gift cards, debit cards, discounts or contributions to *your* health spending account. Rewards received for an activity that is not wellness, educational and informational will not exceed $25 per *year*. *We* are not responsible for any rewards provided by third parties that are non-insurance benefits or for *your* receipt of such reward(s).

The rewards may also include discounts or credits toward premium or a reduction in *copayments*, *deductibles* or *coinsurance*, as permitted under applicable state and federal laws. Such insurance premium or benefit rewards may be made available at the individual or *group* health plan level.

The rewards may be taxable income. *You* may consult a tax advisor for further guidance.

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

We are committed to helping *you* achieve *your* best health. Rewards for participating in a wellness program are available to all *covered persons*. If *you* think *you* might be unable to meet a standard for a reward under a wellness program, *you* might qualify for an opportunity to earn the same reward by different means. Contact *us* at the number listed on *your* identification card or in the marketing literature issued by the wellness program administrator and *we* will work with *you* (and, if *you* wish, with *your health care practitioner*) to find a wellness program with the same reward that is right for *you* in light of *your* health status.

The wellness program administrator or *we* may require proof in writing from *your health care practitioner* that *your* medical condition prevents *you* from taking part in the available activities.

The decision to participate in wellness program activities is voluntary and *you* may decide to participate anytime during the *year*. Refer to the marketing literature issued by the wellness program administrator for their program's eligibility, rules and limitations.

Shared savings program

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

We have a Shared Savings Program that may allow *you* to share in discounts *we* have obtained from *non-network providers*.

Although *our* goal is to obtain discounts whenever possible, *we* cannot guarantee that services rendered by *non-network providers w*ill be discounted. The *non-network provider* discounts in the Shared Savings Program may not be as favorable as *network provider* discounts.

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

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

However, if *you* would like to inquire in advance to determine if a *non-network provider* participates in the Shared Savings Program, please contact *our* customer service department at the telephone number shown on *your* identification card. Please note provider arrangements in the Shared Savings Program are subject to change without notice. *We* cannot guarantee that the provider from whom *you* received treatment is still participating in the Shared Savings Program at the time treatment is received. Discounts are dependent upon availability and cannot be guaranteed.

We reserve the right to modify, amend or discontinue the Shared Savings Program at any time.
231100KY S 06/13

MISCELLANEOUS PROVISIONS

Entire contract

The entire contract is made up of the *policy*, the application of the *policyholder*, incorporated by reference herein, and the applications or enrollment forms, if any, of the *covered persons*. All statements made by the *policyholder* or by a *covered person* are considered to be representations, not warranties. This means that the statements are made in good faith. No statement will void the *policy*, reduce the benefits it provides or be used in defense to a claim unless it is contained in a written or *electronic* application or enrollment form and a copy is furnished to the person making such statement or his or her beneficiary.

Additional policyholder responsibilities

In addition to responsibilities outlined in the *policy*, the *policyholder* is responsible for:

- Collection of premium; and
- Providing access to:

    - Benefit plan documents;
    - Renewal notices and *policy* modification information;
    - Product discontinuance notices; and
    - Information regarding continuation rights.

No *policyholder* has the power to change or waive any provision of the *policy*.

Certificates of insurance

A *certificate* setting forth a statement of insurance protection to which the *employee* and the *employee's* covered *dependents* are entitled will be available at www.humana.com or in writing when requested. The *policyholder* is responsible for providing *employees* access to the *certificate*.

This *certificate* is part of the *policy* that controls *our* obligations regarding coverage. No document that is viewed as being not consistent with the *policy* shall take precedence over it. This is true, also, when this *certificate* is incorporated by reference into a summary description of plan benefits prepared and distributed by the administrator of a group health plan subject to ERISA. This *certificate* is not subject to the ERISA style and content conventions that apply to summary plan descriptions. So if the terms of a summary plan description appear to differ with the terms of this *certificate* respecting coverage, the terms of this *certificate* will control.

MISCELLANEOUS PROVISIONS (continued)

Incontestability

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

After *you* are insured without interruption for two years, *we* cannot contest the validity of *your* coverage except for:

- Nonpayment of premium; or
- Any fraud or intentional misrepresentation of a material fact made by *you*.

At any time, *we* may assert defenses based upon provisions in the *policy* which relate to *your* eligibility for coverage under the *policy*.

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

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

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*.

Clerical error or misstatement

If it is determined that information about a *covered person* was omitted or misstated in error, an adjustment may be made in premiums and/or coverage in effect. This provision applies to *you* and to *us*.

MISCELLANEOUS PROVISIONS (continued)

Modification of policy

The *policy* may be modified at any time by agreement between *us* and the *policyholder* 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 *policy*. No agent has authority to modify the *policy*, waive any of the *policy* provisions, extend the time of premium payment, or bind *us* by making any promise or representation.

The *policy* may be modified by *us* at anytime without prior consent of, or notice to, the *policyholder* when the changes are:

- Allowed by state or federal law or regulation;
- Directed by the state agency that regulates insurance;
- Benefit increases that do not impact premium; or
- Corrections of clerical errors or clarifications that do not reduce benefits.

Modifications due to reasons other than those listed above, may be made by *us*, upon renewal of the *policy*, in accordance with state and federal law. The *policyholder* will be notified in writing or *electronically* at least 31 days prior to the effective date of such changes.

Premium contributions

Your employer must pay the required premiums to *us* as they become due. *Your employer* may require *you* to contribute toward the cost of *your* insurance. Failure of *your employer* to pay any required premium to *us* when due may result in the termination of *your* insurance.

Premium rate change

We reserve the right to change any premium rates in accordance with applicable law upon notice to the *employer*. *We* will provide notice to the *employer* of any such premium changes. Questions regarding changes to premium rates should be addressed to the *employer*.

Assignment

The *policy* and its benefits may not be assigned by the *policyholder*.

Conformity with statutes

Any provision of the *policy* which is not in conformity with applicable state law(s) or other applicable law(s) shall not be rendered invalid, but shall be construed and applied as if it were in full compliance with the applicable state law(s) and other applicable law(s).
233300KY S 11/12

GLOSSARY

Terms printed in italic type in this *certificate* have the meaning indicated below. Defined terms are printed in italic type wherever found in this *certificate*.

A

Accident means a sudden event that results in a *bodily injury* or *dental injury* and is exact as to time and place of occurrence.

Active status means the *employee* is performing all of his or her customary duties whether performed at the *employer's* business establishment, some other location which is usual for the *employee's* particular duties or another location when required to travel on the job:

- On a regular *full-time* basis or for the number of hours per week shown on the Employer Group Application;
- For 48 weeks a year; and
- Is maintaining a bona fide *employer-employee* relationship with the *policyholder* of the *group policy* on a regular basis.

Each day of a regular vacation and any regular non-working holiday are deemed *active status*, if the *employee* was in *active status* on his or her last regular working day prior to the vacation or holiday. An *employee* is deemed to be in *active status* if an absence from work is due to a *sickness* or *bodily injury*, provided the individual otherwise meets the definition of *employee*.

Acute inpatient services means care given in a *hospital* or *health care treatment facility* which:

- Maintains permanent full-time facilities for *room and board* of resident patients;
- Provides emergency, diagnostic and therapeutic services with a capability to provide life-saving medical and psychiatric interventions;
- Has physician services, appropriately licensed behavioral health practitioners and skilled nursing services available 24-hours a day;
- Provides direct daily involvement of the physician; and
- Is licensed and legally operated in the jurisdiction where located.

Acute inpatient services are utilized when there is an immediate risk to engage in actions which would result in death or harm to self or others or there is a deteriorating condition in which an alternative treatment setting is not appropriate.

Admission means entry into a facility as a registered bed patient according to the rules and regulations of that facility. An *admission* ends when *you* are discharged, or released, from the facility and are no longer registered as bed patient.

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

Alternative medicine, for the purposes of this definition, includes: acupressure, aromatherapy, ayurveda, biofeedback, faith healing, guided mental imagery, herbal medicine, holistic medicine, homeopathy, hypnosis, macrobiotics, massage therapy, naturopathy, ozone therapy, reflexotherapy, relaxation response, rolfing, shiatsue and yoga.

Ambulance means a professionally operated vehicle, provided by a licensed ambulance service, equipped for the transportation of a sick or injured person to or from the nearest medical facility qualified to treat the person's *sickness* or *bodily injury*. Use of the *ambulance* must be *medically necessary* and/or ordered by a *health care practitioner*.

Ambulatory surgical center means an institution which meets all of the following requirements:

- It must be staffed by physicians and a medical staff which includes registered nurses.
- It must have permanent facilities and equipment for the primary purpose of performing *surgery*.
- It must provide continuous physicians' services on an *outpatient* basis.
- It must admit and discharge patients from the facility within a 24-hour period.
- It must be licensed in accordance with the laws of the jurisdiction where it is located. It must be operated as an *ambulatory surgical center* as defined by those laws.
- It must not be used for the primary purpose of terminating pregnancies, or as an office or clinic for the private practice of any physician or dentist.

Autism spectrum disorders means a physical, mental, or cognitive illness or disorder which includes any of the pervasive developmental disorders as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders ("DMS"), published by the American Psychiatric Association, including Autistic disorder, Asperger's disorder, and Pervasive Developmental disorder Not Otherwise Specified.

B

Behavioral health means *mental health services* and *chemical dependency* services.

Bodily injury means bodily damage other than a *sickness*, including all related conditions and recurrent symptoms. However, bodily damage resulting from infection or muscle strain due to athletic or physical activity is considered a *sickness* and not a *bodily injury*.

Bone marrow means the transplant of human blood precursor cells which are administered to a patient following high-dose, ablative or myelosuppresive chemotherapy. Such cells may be derived from bone marrow, circulating blood, or a combination of bone marrow and circulating blood obtained from the patient in an autologous transplant or from a matched related or unrelated donor or cord blood. If chemotherapy is an integral part of the treatment involving an *organ transplant* of *bone marrow*, the term *bone marrow* includes the harvesting, the transplantation and the chemotherapy components.

C

Certificate means this benefit plan document that outlines the benefits, provisions and limitations of the *policy*.

Chemical dependency means the abuse of, or psychological or physical dependence on, or addiction to alcohol or a controlled substance.

Coinsurance means the amount expressed as a percentage of the *covered expense* that *you* must pay. The percentage of the *covered expense* that *we* pay is shown in the "Schedule of Benefits" sections.

Concentra means a designated network provider providing urgent care services to covered persons.

Confinement or ***confined*** means *you* are admitted as a registered bed patient as the result of a *health care practitioner's* recommendation. It does not mean detainment in *observation status*.

Congenital anomaly means an abnormality of the body that is present from the time of birth.

Copayment means the specified dollar amount that *you* must pay to a provider for *covered expenses* regardless of any amounts that may be paid by *us* as shown in the "Schedule of Benefits" sections.

Cosmetic surgery means *surgery* performed to reshape normal structures of the body in order to improve or change *your* appearance or self-esteem.

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

Covered expense means:

Medically necessary services to treat a *sickness* or *bodily injury* such as:

- Procedures;
- *Surgeries*;
- Consultations;
- Advice;
- Diagnosis;
- Referrals;
- Treatment;
- Supplies;
- Drugs;
- Devices or
- Technologies;

- *Preventive services;*
- *Pediatric dental services*;
- *Pediatric vision care*;
- *Prescription* drugs as specified in the "Prescription Drug Benefit Rider"; or
- *Specialty drugs* as specified in the "Specialty Drug Benefit".

To be considered a *covered expense*, services must be:

- Ordered by a *health care practitioner*;
- Authorized, furnished or prescribed by a *qualified provider*;
- For the benefits described herein, subject to any maximum benefit and all other terms, provisions limitations and exclusions of the *policy*; and
- Incurred when *you* are insured for that benefit under the *policy* on the date that the service is rendered.

Covered person means the *employee* and/or the *employee's dependents* who are enrolled for benefits provided under the *policy.*

Custodial care means services given to *you* if:

- *You* need services including, assistance with dressing, bathing, preparation and feeding of special diets, walking, supervision of medication which is ordinarily self administered, getting in and out of bed, maintaining continence; or

- The services *you* require are primarily to maintain, and not likely to improve, *your* condition; or

- The services involve the use of skills which can be taught to a layperson and do not require the technical skills of a *nurse*.

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

- *You* are under the care of a *health care practitioner*;
- The *health care practitioner* prescribed services are to support or maintain *your* condition; or
- Services are being provided by a *nurse*.

D

Deductible means the amount of *covered expenses* that *you*, either individually or combined as a covered family, must pay per *year* before *we* pay benefits for certain specified services.

Some plans may have a *network provider* benefit allowance prior to the applicability of the *deductible*(s). Please refer to the "Schedule of Benefits" section for more information.

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

Dependent means a covered *employee's*:

- Legally recognized spouse;

- Natural born child, step-child, legally adopted child, child placed for adoption, or any child for which the insured is a court appointed guardian, whose age is less than the limiting age; or

- Child whose age is less than the limiting age and for whom the *employee* has received a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN) to provide coverage, if the *employee* is eligible for family coverage until:

    - Such QMCSO or NMSN is no longer in effect; or
    - The child is enrolled for comparable health coverage, which is effective no later than the termination of the child's coverage under the *policy*.

Under no circumstances shall *dependent* mean a grandchild, great grandchild, foster child or *emancipated minor* unless the insured has applied for guardianship or is a court appointed guardian, including where the grandchild, great grandchild, foster child or *emancipated minor* meets all of the qualifications of a dependent as determined by the Internal Revenue Service.

The limiting age means the birthday the *dependent* child attains age 26. Each *dependent* child is covered to the limiting age regardless if the child is:

- Married;
- A tax dependent;
- A student;
- Employed;
- Residing with or receives financial support from *you*; or
- Eligible for other coverage through employment.

A covered *dependent* child who becomes an employee eligible for other group coverage through employment is no longer eligible as a *dependent* for coverage under the *policy*.

A covered *dependent* child who attains the limiting age while insured under the *policy* remains eligible if the covered *dependent* child is:

- Permanently mentally or physically handicapped; and
- Incapable of self-sustaining employment; and
- Unmarried.

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

A handicapped *dependent* child, as defined in the bulleted items above, who attained the limiting age while insured under the *employer's* previous group medical plan (Prior Plan) is eligible for coverage under the *policy*. Please refer to the "Replacement of Coverage" section of this *certificate*.

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

Diabetes equipment means blood glucose monitors, including monitors designed to be used by blind individuals; insulin pumps and associated accessories; insulin infusion devices; and podiatric appliances for the prevention of complications associated with diabetes.

Diabetes self-management training means the training provided to a *covered person* after the initial diagnosis of diabetes for care and management of the condition including nutritional counseling and use of *diabetes equipment* and supplies. It also includes training when changes are required to the self-management regime and when new techniques and treatments are developed.

Diabetes supplies means test strips for blood glucose monitors; visual reading and urine test strips; lancets and lancet devices; insulin and insulin analogs; injection aids; syringes; prescriptive and nonprescriptive oral agents for controlling blood sugar levels; glucagon emergency kits; and alcohol swabs.

Durable medical equipment means equipment that meets all of the following criteria:

- It is prescribed by a *health care practitioner*;
- It can withstand repeated use;
- It is primarily and customarily used for a medical purpose rather than being primarily for comfort or convenience;
- It is generally not useful to *you* in the absence of *sickness* or *bodily injury*;
- It is appropriate for home use or use at other locations as necessary for daily living;
- It is related to and meets the basic functional needs of *your* physical disorder;
- It is not typically furnished by a *hospital* or s*killed nursing facility*; and
- It is provided in the most cost effective manner required by *your* condition, including, at *our* discretion, rental or purchase.

E

Effective date means the date *your* coverage begins under the *policy*.

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

Electronic mail means a computerized system that allows a user of a network computer system and/or computer system to send and receive messages and documents among other users on the network and/or with a computer system.

Electronic signature means an electronic sound, symbol, or process attached to or logically associated with a record and executed or adopted by a person with the intent to sign the record.

Eligibility date means the date the *employee* or *dependent* is eligible to participate in the plan.

Emancipated minor means a child who has not yet attained full legal age, but who has been declared by a court to be emancipated.

Emergency medical condition means services provided in a *hospital* emergency facility for a *bodily injury* or *sickness* manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of that individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment of bodily functions; or
- Serious dysfunction of any bodily organ or part.

With respect to a pregnant woman who is having contractions:

- A situation in which there is inadequate time to effect a safe transfer to another hospital before delivery; or
- A situation in which transfer may pose a threat to the health or safety of the woman or the unborn child.

Emergency medical condition does <u>not</u> mean services for the convenience of the *covered person* or the provider of treatment or services.

Employee means a person who is in *active status* for the *employer* on a *full-time* basis. The *employee* must be paid a salary or wage by the *employer* that meets the minimum wage requirements of *your* state or federal minimum wage law for work done at the *employer's* usual place of business or some other location which is usual for the *employee's* particular duties.

Employee also includes a sole proprietor, partner or corporate officer where:

- The *employer* is a sole proprietorship, partnership or corporation; and

- The sole proprietor, partner or corporate officer is actively performing activities relating to the business, and gains their livelihood from the sole proprietorship, partnership or corporation and is in an *active status* at the *employer's* usual place of business or some other location which is usual for the sole proprietor's, partner's or corporate officer's particular duties.

If specified on the Employer Group Application and approved by *us*, *employee* includes retirees of the *employer*. A retired *employee* is not required to be in *active status* to be eligible for coverage under this *policy*.

Employer means the sponsor of this *group* insurance plan, or any subsidiary or affiliate described in the Employer Group Application.

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

- Root canal therapy and root canal fillings;
- Periadacular *surgery*;
- Apicoectomy;
- Partial pulpotomy; or
- Vital pulpotomy.

Experimental or ***investigational*** or ***for research purposes*** means a drug, biological product, device, treatment or procedure that meets any one of the following criteria, as determined by *us*:

- Cannot be lawfully marketed without the final approval of the United States Food and Drug Administration (FDA) and which lacks such final FDA approval for the use or proposed use, unless (a) found to be accepted for that use in the most recently published edition of the United States Pharmacopeia-Drug Information for Healthcare Professional (USP-DI) or in the most recently published edition of the American Hospital Formulary Service (AHFS) Drug Information, or (b) identified as safe, widely used and generally accepted as effective for that use as reported in nationally recognized peer reviewed medical literature published in the English language as of the date of service; or (c) is mandated by state law;

- Is a device required to receive Premarket Approval (PMA) or 510K approval by the FDA but has not received a PMA or 510K approval;

- Is not identified as safe, widely used and generally accepted as effective for the proposed use as reported in nationally recognized peer reviewed medical literature published in the English language as of the date of service;

- Is the subject of a National Cancer Institute (NCI) Phase I, II or III trial or a treatment protocol comparable to a NCI Phase I, II or III trial, or any trial not recognized by NCI regardless of phase; or

- Is identified as not covered by the Centers for Medicare and Medicaid Services (CMS) Medicare Coverage Issues Manual, a CMS Operational Policy Letter or a CMS National Coverage Decision, except as required by state or federal law.

F

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

Free standing facility means any licensed public or private establishment other than a *hospital* which has permanent facilities equipped and operated to provide laboratory and diagnostic laboratory, *outpatient* radiology, *advanced imaging*, chemotherapy, inhalation therapy, radiation therapy, lithotripsy, physical, cardiac, speech and occupational therapy, or renal dialysis services. An appropriately licensed birthing center is also considered a *free-standing facility*.

Full-time, for an *employee*, means a work week of the number of hours shown on the Employer Group Application.

Functional impairment means a direct and measurable reduction in physical performance of an organ or body part.

G

Group means the persons for whom this insurance coverage has been arranged to be provided.

H

Health care practitioner means a practitioner professionally licensed by the appropriate state agency to diagnose or treat a *sickness* or *bodily injury* and who provides services within the scope of that license. Including, Chiropractors, Dentists, Nurse Practitioner, Registered Nurse First Assistant, Optometrists, Osteopaths, Physicians, Pharmacists, Podiatrists, Physical Therapist, Occupational Therapist, Physicians Assistant and Licensed Psychologist or Licensed Clinical Social Worker.

Health care treatment facility means a facility, institution or clinic, duly licensed by the appropriate state agency to provide medical services or *behavioral health* services, and is primarily established and operating within the scope of its license.

Health insurance coverage means medical coverage under any hospital or medical service policy or certificate, hospital or medical service plan contract or health maintenance organization (HMO) contract offered by a health insurance issuer. "Health insurance issuer" means an insurance company, insurance service, or insurance organization (including an HMO) that is required to be licensed to engage in the business of insurance in a state and that is subject to the state law that regulates insurance.

Health status-related factor means any of the following:

- Health status or medical history;
- Medical condition, either physical or mental;
- Claims experience;
- Receipt of health care;
- Genetic information;
- Disability; or,
- Evidence of insurability, including conditions arising out of acts of domestic violence.

Hearing aid and related services means any wearable, non-disposable instrument or device designed to aid or compensate for impaired hearing, including any parts, attachments, or accessories (excluding batteries and cords). Services to assess, select, and adjust/fit the hearing aid to ensure optimal performance, as prescribed by a licensed audiologist and dispensed by a licensed audiologist or hearing instrument specialist.

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

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

Home health care plan means a plan of care and treatment for *you* to be provided in *your* home. To qualify, the *home health care plan* must be established and approved by a *health care practitioner*. The services to be provided by the plan must require the skills of a *nurse*, or another *health care practitioner* and must not be for *custodial care*.

Hospice care program means a coordinated, interdisciplinary program provided by a hospice designed to meet the special physical, psychological, spiritual and social needs of a terminally ill *covered person* and his or her immediate covered family members, by providing *palliative care* and supportive medical, nursing and other services through at-home or *inpatient* care. A hospice must be licensed by the laws of the jurisdiction where it is located and must be run as a hospice as defined by those laws. It must provide a program of treatment for at least two unrelated individuals who have been medically diagnosed as having no reasonable prospect for cure for their *sickness* and, as estimated by their physicians, are expected to live less than 18 months as a result of that *sickness*.

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

- It must provide, for a fee, medical care and treatment of sick or injured patients on an *inpatient* basis;
- It must provide or operate, either on its premises or in facilities available to the *hospital* on a pre-arranged basis, medical, diagnostic and surgical facilities;
- Care and treatment must be given by and supervised by physicians. Nursing services must be provided on a 24-hour basis and must be given by or supervised by registered nurses;
- It must be licensed by the laws of the jurisdiction where it is located. It must be operated as a *hospital* as defined by those laws;
- It must not be primarily a:

    - Convalescent, rest or nursing home; or
    - Facility providing custodial, educational or rehabilitative care.

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

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

I

Individual lifetime maximum benefit means the maximum amount of benefits payable by *us* for all *covered expenses* incurred by *you*. Once the *individual lifetime maximum benefit* is reached, benefits are not payable and will not be reinstated.

Infertility services means any diagnostic evaluation, treatment, supply, medication, or service provided to achieve pregnancy or to achieve or maintain ovulation. This includes:

- Artificial insemination;
- In vitro fertilization;
- Gamete Intrafallopian Transfer (GIFT);
- Zygote Intrafallopian Transfer (ZIFT);
- Tubal ovum transfer;
- Embryo freezing or transfer;
- Sperm storage or banking;
- Ovum storage or banking;
- Embryo or zygote banking;
- Diagnostic and/or therapeutic laparoscopy;
- Hysterosalpingography;
- Ultrasonography;
- Endometrial biopsy; and
- Any other assisted reproductive techniques or cloning methods.

Inpatient means *you* are *confined* as a registered bed patient.

Intensive outpatient program means *outpatient* services providing:

- Group therapeutic sessions greater than one hour a day, three days a week;
- *Behavioral health* therapeutic focus;
- Group sessions centered on cognitive behavioral constructs, social/occupational/educational skills development and family interaction;
- Additional emphasis on recovery strategies, monitoring of participation in 12-step programs and random drug screenings for the treatment of *chemical dependency*; and
- Physician availability for medical and medication management.

Intensive outpatient program does not include services that are for:

- *Custodial care*; or
- Day care.

J

K

L

Late applicant means an *employee* or *dependent* who requests enrollment for coverage under the *policy* 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*.

Level 1 means a *network healthcare practitioner* focused on internal medicine, pediatrics or family medicine/general practice who provides initial care services to *covered persons*.

Level 2 means a *network healthcare practitioner* who has received training in a specific medical field other than those listed under *Level 1*.

M

Maintenance care means services and supplies furnished mainly to:

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

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

- The fee negotiated with *network providers*;
- The fee calculated using the same method to determine payments for *non-network provider* services; or
- The fee paid by *Medicare* for the same services.

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

Medicaid means a state program of medical care for needy persons, as established under Title 19 of the Social Security Act of 1965, as amended.

Medically necessary means health care services that a *health care practitioner* exercising prudent clinical judgment would provide to his or her patient for the purpose of preventing, evaluating, diagnosing or treating a *sickness* or *bodily injury* or its symptoms. Such health care service must be:

- In accordance with nationally recognized standards of medical practice;
- Clinically appropriate in terms of type, frequency, extent, site, and duration, and considered effective for the patient's *sickness* or *bodily injury*;
- Not primarily for the convenience of the patient, physician or other health care provider; and
- Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the patient's *sickness* or *bodily injury*.

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

Medicare means a program of medical insurance for the aged and disabled, as established under Title 18 of the Social Security Act of 1965, as amended.

Mental health services means those diagnoses and treatments related to the care of a *covered person* who exhibit a mental, nervous or emotional conditions classified in the Diagnostic and Statistical Manual of Mental Disorders, except for pervasive development disorder.

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

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

N

Network health care practitioner means a *health care practitioner* who has signed a direct agreement with *us* as an independent contractor or who has been designated by *us* as an independent contractor to provide services to all *covered persons*. *Network health care practitioner* designation by *us* may be limited to specified services.

Network hospital means a *hospital* which has signed a direct agreement with *us* as an independent contractor or has been designated by *us* as an independent contractor to provide services to all *covered persons*. *Network hospital* designation by *us* may be limited to specified services.

Network provider means a *hospital*, *health care treatment facility*, physician, or any other health services provider who has signed an agreement with *us* as an independent contractor or who been designated by *us* as an independent contractor to provide services to all *covered persons*. *Network provider* designation by *us* may be limited to specified services.

Non-network health care practitioner means a *health care practitioner* who has not been designated as a *network health care practitioner* by *us*.

Non-network hospital means a *hospital* which has not been designated as a *network hospital* by *us*.

Non-network provider means a *hospital*, *health care treatment facility*, physician, or any other health services provider who has not been designated as a *network provider* by *us*.

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

O

Observation status means a stay in a *hospital* or *health care treatment facility* for less than 24 hours if:

- *You* have not been admitted as a resident *inpatient*;
- *You* are physically detained in an emergency room, treatment room, observation room or other such area; or
- *You* are being observed to determine whether *confinement* will be required.

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

Oral surgery means procedures to correct diseases, injuries and defects of the jaw and mouth structures. These procedures include, the following:

- Surgical removal of full bony impactions;
- Mandibular or maxillary implant;
- Maxillary or mandibular frenectomy;
- Alveolectomy and alveoplasty;
- Orthognathic *surgery*;
- *Surgery* for treatment of temporomandibular joint syndrome/dysfunction; and
- Periodontal surgical procedures, including gingivectomies.

Organ transplant means only the services, care, and treatment received for or in connection with the pre-approved transplant of the organs identified in the "Covered Expenses - Transplant Services" section, which are determined by *us* to be *medically necessary* services and which are not *experimental,* or *investigational*, or *for research purposes*. Transplantation of multiple organs, when performed simultaneously, is considered one *organ transplant*.

Organ transplant treatment period means 365 days from the date of discharge from the *hospital* following an *organ transplant* received while *you* were covered by *us*.

Out-of-pocket limit means the amount of *covered expenses* which must be paid by *you*, either individually or combined as a covered family, per *year* before a benefit percentage will be increased.

Outpatient means *you* are not *confined* as a registered bed patient.

Outpatient surgery means *surgery* performed in a *health care practitioner's* office, *ambulatory surgical center*, or the *outpatient* department of a *hospital*.

P

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

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

- Periodontal maintenance;
- Scaling and root planing;
- Gingivectomy;
- Gingivoplasty; or
- Osseous *surgery*.

Policy means the document describing the benefits *we* provide as agreed to by *us* and the *policyholder*.

Policyholder means the legal entity identified as the *policyholder* on the face page of the *policy* who establishes, sponsors and endorses an employee benefit plan for insurance coverage.

Pre-surgical/procedural testing means:

- Laboratory tests or radiological examinations done on an *outpatient* basis in a *hospital* or other facility accepted by the *hospital* before *hospital confinement* or *outpatient surgery* or procedure;
- The tests must be accepted by the *hospital* or *health care practitioner* in place of like tests made during *confinement*; and
- The tests must be for the same *bodily injury* or *sickness* causing *you* to be *hospital confined* or to have the *outpatient surgery* or procedure.

Preauthorization means approval by *us,* or *our* designee, of a service prior to it being provided. Certain services require medical review by *us* in order to determine eligibility for coverage.

Preauthorization is granted when such a review determines that a given service is a *covered expense* according to the terms and provisions of the *policy*.

Preventive services means services in the following recommendations appropriate for *you* during *your* plan *year*:

- Services with an A or B rating in the current recommendations of the U. S. Preventive Services Task Force (USPSTF). The recommendations by the USPSTF for breast cancer screenings, mammography and preventions issued prior to November 2009 will be considered current.

- Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC).

- Preventive care for infants, children and adolescents provided in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA).

- Preventive care for women provided in the comprehensive guidelines supported by HRSA.

For the recommended *preventive services* that apply to *your* plan *year*, refer to the U.S. Department of Health and Human Services (HHS) website at www.healthcare.gov or call the customer service telephone number on *your* identification card.

Q

Qualified provider means a person, facility or any other health care provider:

- That is licensed by the appropriate state agency to:
  - Diagnose or treat a *sickness* or *bodily injury*;
  - Provide *preventive services*;
  - Provide *pediatric dental services*; or
  - Provide *pediatric vision care*;
- That provides services within the scope of their license; and
- Whose primary purpose is to provide health care services.

A *qualified provider* does not include a *residential treatment facility*.

R

Registered nurse first assistant means a nurse who:

- Holds a current active registered nurse licensure;
- Is certified in perioperative nursing; and
- Has successfully completed and holds a degree or certificate from a recognized program, which shall consist of:
  - The Association of Operating Room Nurses, Inc., Core curriculum for the registered nurse first assistant; and
  - One (1) year of post basic nursing study, which shall include at least forty-five (45) hours of didactic instruction and one hundred twenty (120) hours of clinical internship or its equivalent of two (2) college semesters.
- A registered nurse who was certified prior to 1995 by the Certification Board of Perioperative Nursing shall not be required to fulfill the requirements of the third bulleted paragraph of this subsection.

Rehabilitation facility means any licensed public or private establishment which has permanent facilities that are equipped and operated primarily to render physical and occupational therapies, diagnostic services and other therapeutic services.

Rescission, ***rescind*** or ***rescinded*** means a cancellation or discontinuance of coverage that has a retroactive effect.

Residential treatment facility means an institution which:

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

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

Respite care means a period of rest or relief. *Respite care* provides a caregiver temporary relief from the responsibilities of caring for individuals diagnosed with *Autism spectrum disorders*.

Room and board means all charges made by a *hospital* or other *health care treatment facility* on its own behalf for room and meals and all general services and activities needed for the care of registered bed patients.

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

S

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

Serious mental condition or significant behavioral problem means in relation to general anesthesia for dental procedures a condition identified by a diagnostic code from the most recent edition of the:

- International Classification of Diseases-Clinical Modification (ICD-CM), codes 290-299.9 and 300-319; or
- Diagnostic and Statistical Manual of Mental Disorders; and
- The person must also require dental care be performed in a *hospital* or *ambulatory surgical facility* because:

    - Their diagnosis reasonably infers they will be unable to cooperate; or
    - Airway, breathing, circulation of blood may be compromised.

Serious physical condition means a disease (or condition) requiring on-going medical care that may cause compromise of the airway, breathing or circulation of blood while receiving dental care unless performed in a *hospital* or *ambulatory surgical facility*.

Sickness means a disturbance in function or structure of the body which causes physical signs or physical symptoms and which, if left untreated, will result in a deterioration of the health state of the structure or system(s) of the body. The term also includes: (a) pregnancy; (b) any medical complications of pregnancy; and (c) *behavioral health*.

Skilled nursing facility means a licensed institution (other than a *hospital*, as defined) which meets all of the following requirements:

- It must provide permanent and full-time bed care facilities for resident patients;
- It must maintain, on the premises and under arrangements, all facilities necessary for medical care and treatment;
- It must provide such services under the supervision of physicians at all times;
- It must provide 24-hours-a-day nursing services by or under the supervision of a registered nurse; and
- It must maintain a daily record for each patient.

A *skilled nursing facility* is not, except by incident, a rest home, a home for the care of the aged, or engaged in the care and treatment of *chemical dependency*.

Small employer means an *employer* who employed an average of two but not more than 50 *employees* on business days during the preceding calendar year and who employs at least two *employees* on the first day of the *year*. All subsidiaries or affiliates of the *policyholder* are considered one *employer* when the conditions specified in the "Subsidiaries or Affiliates" section of the *policy* are met.

Sound natural tooth means a tooth that:

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

Special enrollment date means the date of:

- Change in family status after the *eligibility date*;
- Loss of other coverage under another group health plan or other *health insurance coverage*;
- COBRA exhaustion;
- Loss of coverage under *your employer's* alternate plan;
- Termination of your *Medicaid* coverage or your Children's Health Insurance Program (CHIP) coverage as a result of loss of eligibility; or
- Eligibility for a premium assistance subsidy under *Medicaid* or CHIP.

To be eligible for special enrollment, *you* must meet the requirements specified in the "Special enrollment" provision within the "Eligibility and Effective Dates" section of this *certificate*.

Surgery means services categorized as Surgery in the Current Procedural Terminology (CPT) Manuals published by the American Medical Association. The term *surgery* includes: excision or incision of the skin or mucosal tissues or insertion for exploratory purposes into a natural body opening; insertion of instruments into any body opening, natural or otherwise, done for diagnostic or other therapeutic purposes; and treatment of fractures.

T

Telehealth services means the use of interactive audio, video, or other electronic media to deliver health care. It includes the use of electronic media for diagnosis, consultation, treatment, transfer of medical data, and medical education. A telehealth consultation shall not be reimbursable if it is provided through the use of an audio-only telephone, facsimile machine, or electronic mail.

Total disability or ***totally disabled*** means *your* continuing inability, as a result of a *bodily injury* or *sickness*, to perform the material and substantial duties of any job for which *you* are or become qualified by reason of education, training or experience.

The term also means a *dependent's* inability to engage in the normal activities of a person of like age. If the *dependent* is employed, the *dependent* must be unable to perform his or her job.

U

Urgent care means those health care services that are appropriately provided for an unforeseen condition of a kind that usually requires attention without delay but that does not pose a threat to life, limb or permanent health of the *covered person*.

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

V

W

Waiting period means the period of time, elected by the *policyholder*, that must pass before an *employee* is eligible for coverage under the *policy*.

We, us or ***our*** means the offering company as shown on the cover page of the *policy* and *certificate*.

X

Y

Year means the period of time which begins on any January 1st and ends on the following December 31st. When *you* first become covered by the *policy*, the first *year* begins for *you* on the *effective date* of *your* insurance and ends on the following December 31st.

You or ***your*** means any *covered person*.

Z

SPECIALTY DRUG BENEFIT

This "Specialty Drug Benefit" section describes services that will be considered *covered expenses* for *specialty drugs* under the *policy*.

Notwithstanding any other provisions of the *policy*, expenses covered under this "Specialty Drug Benefit" are not covered under any other provision of the *policy*, except as specified in the "Prescription Drug Benefit" section.

Any *network pharmacy* or *network provider* expenses incurred by *you* under provisions of this benefit apply toward *your out-of-pocket limit* as described in the "Schedule of Benefits" of the *certificate*.

All terms used in this benefit have the same meaning given to them in this *certificate* and in any "Prescription Drug Benefit" section of this *certificate*, unless otherwise specifically defined in this benefit section. All other terms, provisions, limitations and exclusions of the *policy*, unless otherwise stated, are applicable.

Definitions

Network pharmacy means a *pharmacy* that has signed a direct agreement with *us* or has been designated by *us* to provide:

- Covered *pharmacy* services; or
- Covered *specialty pharmacy* services;

as defined by *us*, to *covered persons*, including covered *prescriptions* or refills delivered to *your* home or health care provider.

Non-network pharmacy means a *pharmacy* that has not signed a direct agreement with *us* or has not been designated by *us* to provide:

- Covered *pharmacy* services; or
- Covered *specialty pharmacy* services;

as defined by *us*, to *covered persons*, including covered *prescriptions* or refills delivered to *your* home or health care provider.

SPECIALTY DRUG BENEFIT (continued)

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

- Require nursing services or special programs to support patient compliance;
- Require disease-specific treatment programs;
- Have limited distribution requirements; or
- Have special handling, storage or shipping requirements.

Specialty drug list means a list of *specialty drugs* specified by *us*. This list indicates applicable *dispensing limits* and/or any *preauthorization*/*prior authorization* or *step therapy* requirements. Visit *our* Website at www.humana.com or call the customer service telephone number on *your* identification card to obtain the *specialty drug list*. This list is subject to change without notice.

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

Covered expenses

We will pay benefits for *covered expenses* incurred by *you* for *specialty drugs* included on *our specialty drug list*, when obtained from a *pharmacy* as specified in the "Specialty drug pharmacy benefit" provision. The following are *covered expenses* for *specialty drugs*:

- *Prescription* drugs, medicines, medications, *self-administered injectable drugs* or biologicals that under federal or state law may be dispensed only by *prescription* from a *health care practitioner* and are included on *our specialty drug list*.

- Hypodermic needles, syringes or other method of delivery necessary for administration of the *specialty drug*, if included with the charge for the *specialty drug*. (These may be available at no cost to *you.*)

Notwithstanding any other provisions of the *policy*, *we* may decline coverage or, if applicable, exclude from the *specialty drug list* any and all *prescriptions* until the conclusion of a review period not to exceed six months following FDA approval for the use and release of the *prescriptions* into the market.

We will also pay benefits for *covered expenses* incurred by *you* for *specialty drugs* received in medical places of service specified in the "Specialty drug medical benefit" provision.

Benefits for *specialty drugs* may be subject to *dispensing limits*, *preauthorization*/*prior authorization* and *step therapy* requirements, if any. *Prior authorization* and *step therapy* may be required for *specialty drugs* obtained from a *pharmacy*. *Preauthorization* may be required for *specialty drugs* received in medical places of service. Please contact *us* or *our* designee prior to:

- Obtaining *specialty drugs* from a *pharmacy*; or
- Receiving *specialty drugs* in medical places of service specified in the "Specialty drug medical benefit" provision.

Any charge for the administration of a *specialty drug* is not covered under this benefit or under the "Prescription Drug Benefit" section of the *certificate*. Payment for the administration of *specialty drugs* is addressed in the "Schedule of Benefits" section of the *certificate*.

Schedule of benefits – specialty drugs

Specialty drug pharmacy benefit

You are responsible for any and all *copayments* for *specialty drugs* obtained from a *pharmacy*, according to the "Specialty pharmacy and retail pharmacy" schedule in this provision. *We* share the cost of *covered expenses* for *specialty drugs* as shown in the "Specialty pharmacy and retail pharmacy" schedule in this provision.

If the dispensing *pharmacy's* charge is less than *your copayment*, *you* will be responsible for the lesser amount. *Your copayment* is made on a per *prescription* or refill basis and will not be adjusted if *we* receive any retrospective volume discounts or *prescription* drug rebates.

You are responsible for the following:

Specialty pharmacy and retail pharmacy	**Up to 30-day supply**
Network pharmacy designated by *us* as a preferred provider of *specialty drugs*	25% *copayment* per *specialty drug prescription* or refill
Network pharmacy	35% *copayment* per *specialty drug prescription* or refill

SPECIALTY DRUG BENEFIT (continued)

Non-network pharmacy

When a *non-network pharmacy* is used, *you* must pay for the *prescription* or refill at the time it is dispensed. *You* must file a claim for reimbursement with *us*, as described in *your certificate*. *You* are responsible for 50% of the *default rate*. *You* are also responsible for 100% of the difference between the *default rate* and the *non-network pharmacy's* charge. Any amount *you* pay to a *non-network pharmacy* does not apply toward *your out-of-pocket limit.* The charge received from a *non-network pharmacy* for a *prescription* or refill may be higher than the *default rate*.

Specialty drug medical benefit

Benefits for *specialty drugs* received in medical places of service are paid on a *maximum allowable fee* basis and as shown below in the schedules, subject to any applicable:

- *Deductible*, as specified in the "Annual deductible" provision in the "Schedule of Benefits" of the *certificate*;
- *Copayment*;
- *Coinsurance* percentage;
- Any *out-of-pocket limit*, as specified in the "Schedule of Benefits" of the *certificate*.

Benefits are payable as follows:

Office visit, free-standing facility and urgent care center

Network provider	$50 *copayment* per visit
Non-network provider	50% benefit payable after *non-network provider deductible* The *non-network provider coinsurance* and *deductible* do not accumulate toward any *out-of-pocket limit*.

Home health care

Network provider designated by *us* as a preferred provider of *specialty drugs*	100% benefit payable
Network provider	$50 *copayment* per visit
Non-network provider	50% benefit payable after *non-network provider deductible* The *non-network provider copayment*, *coinsurance* and *deductible* do not accumulate toward any *out-of-pocket limit*.

Limitations and exclusions

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

- *Specialty drugs* which are not included on *our specialty drug list*.
- Any amount exceeding the *default rate* for *specialty drugs*.
- *Specialty drugs* for which coverage is not approved by *us*.
- Any portion of a *specialty drug* that exceeds a 30-day supply for *specialty drugs* obtained from a *network pharmacy* or *non-network pharmacy*, unless otherwise determined by *us*.

PRESCRIPTION DRUG BENEFIT

This "Prescription Drug Benefit" section describes *covered expenses* for *prescription* drugs under the *policy*.

Notwithstanding any other provisions of the *policy*, expenses for *prescription* drugs covered under this "Prescription Drug Benefit" are not covered under any other provision of the *policy*, except for *specialty drugs* as specified in the "Specialty drug pharmacy benefit" provision in the "Specialty Drug Benefit" section.

Any expenses incurred by *you* under provisions of this benefit for *covered expenses* of *prescription* drugs and *specialty drugs* will apply toward *your* maximum *out-of-pocket limit*.

All terms used in this benefit have the same meaning given to them in the *certificate*, unless otherwise specifically defined in this benefit. All other terms, provisions, limitations and exclusions of the *policy*, unless otherwise stated, are applicable.

Prescription drug cost sharing

You are responsible for any and all *cost share*, when applicable, according to the "Schedule of benefits - prescription drugs" provision of this benefit.

If the dispensing *pharmacy's* charge is less than the *copayment*, *you* will be responsible for the lesser amount.

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

Definitions

The following terms are used in this benefit:

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

Copayment means the amount to be paid by *you* toward the cost of each separate *prescription* or refill of a covered *prescription* drug when dispensed by a *pharmacy*.

Cost share means any *copayment* and/or percentage amount that *you* must pay per *prescription* drug or refill.

Default rate means the rate or amount equal to the *Medicare* reimbursement rate for the *prescription* or refill.

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

Drug list means a list of *prescription* drugs, medicines, medications, and supplies specified by *us*. The *drug list* identifies drugs as level 1, level 2, level 3, or level 4 and indicates applicable *dispensing limits* and/or any *prior authorization* or *step therapy* requirements. There is also a Women's Healthcare Drug List. Visit *our* Website at www.humana.com or call the customer service telephone number on *your* identification card to obtain the *drug lists*. The *drug lists* are subject to change without notice.

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

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

Level 1 drugs means a category of *prescription* drugs, medicines or medications within the *drug list* that are designated by *us* as level 1.

Level 2 drugs means a category of *prescription* drugs, medicines or medications within the *drug list* that are designated by *us* as level 2.

Level 3 drugs means a category of *prescription* drugs, medicines or medications within the *drug list* that are designated by *us* as level 3.

Level 4 drugs means a category of *prescription* drugs, medicines or medications within the *drug list* that are designated by *us* as level 4.

Mail order pharmacy means a *pharmacy* that provides covered *mail order pharmacy* services, as defined by *us*, and delivers covered *prescriptions* or refills through the mail to *covered persons*.

Network pharmacy means a *pharmacy* that has signed a direct agreement with *us* or has been designated by *us* to provide:

- Covered *pharmacy* services; or
- Covered *mail order pharmacy* services,

as defined by *us*, to *covered persons*, including covered *prescriptions* or refills delivered to *your* home.

Non-network pharmacy means a *pharmacy* that has not signed a direct agreement with *us* or has not been designated by *us* to provide:

- Covered *pharmacy* services; or
- Covered *mail order pharmacy* services,

as defined by *us*, to *covered persons*, including covered *prescriptions* or refills delivered to *your* home.

Orphan drug means a drug or biological used for the diagnosis, treatment, or prevention of rare diseases or conditions, which:

- Affects less than 200,000 persons in the United States; or

- Affects more than 200,000 persons in the United States. However, there is no reasonable expectation that the cost of developing the drug or biological and making it available in the United States will be recovered from the sales of that drug or biological in the United States.

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

Pharmacy means a licensed establishment where *prescription* medications are dispensed by a *pharmacist*.

Prescription means a direct order for the preparation and use of a drug, medicine or medication. The *prescription* must be given by a *health care practitioner* to a *pharmacist* for *your* benefit and used for the treatment of a *sickness* or *bodily injury* which is covered under this plan or for drugs, medicines or medications on the Women's Healthcare Drug List. The drug, medicine or medication must be obtainable only by *prescription* or must be obtained by *prescription* for drugs, medicines or medications on the Women's Healthcare Drug List. The *prescription* may be given to the *pharmacist* verbally, *electronically* or in writing by the *health care practitioner*. The *prescription* must include at least:

- *Your* name;
- The type and quantity of the drug, medicine or medication prescribed, and the directions for its use;
- The date the *prescription* was prescribed; and
- The name and address of the prescribing *health care practitioner*.

Prior authorization means the required prior approval from *us* for the coverage of *prescription* drugs, medicines and medications, including the dosage, quantity and duration, as appropriate for *your* diagnosis, age and sex. Certain *prescription* drugs, medicines or medications may require *prior authorization*. Visit *our* Website at www.humana.com or call the customer service telephone number on *your* identification card to obtain a list of *prescription* drugs, medicines and medications that require *prior authorization*.

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

- Require nursing services or special programs to support patient compliance;
- Require disease-specific treatment programs;
- Have limited distribution requirements; or
- Have special handling, storage or shipping requirements.

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

Step therapy means a type of *prior authorization*. *We* may require *you* to follow certain steps prior to *our* coverage of some high-cost drugs, medicines or medications. *We* may require *you* to try a similar drug, medicine or medication that has been determined to be safe, effective and less costly for most people with *your* condition. Alternatives may include over-the-counter drugs, *generic medications* and *brand-name medications*. Step therapy prior authorization requirements may be overridden if a comprehensive review determines the patient may not be able to tolerate the required step therapy alternative.

PRESCRIPTION DRUG BENEFIT (continued)

Coverage description

We will cover *prescription* drugs that are received by *you* under this "Prescription Drug Benefit". Benefits may be subject to *dispensing limits*, *prior authorization* and *step therapy* requirements, if any.

Covered *prescription* drugs are:

- Drugs, medicines or medications that under federal or state law may be dispensed only by *prescription* from a *health care practitioner*.
- Drugs, medicines or medications that are included on the *drug list*.
- Insulin and *diabetes supplies*.
- Hypodermic needles or syringes when prescribed by a *health care practitioner* for use with insulin or *self-administered injectable drugs*. (Hypodermic needles and syringes used in conjunction with covered drugs may be available at no cost to *you*).
- *Self-administered injectable drugs* approved by *us*.
- Enteral formulas and nutritional supplements for the treatment of phenylketonuria (PKU) or other inherited metabolic disease, or as otherwise determined by *us*.
- Human milk fortifiers when prescribed for prevention of Necrotizing Enterocolitis and administered under the direction of a physician.
- Eye drops, as identified on the *drug list*, including one additional bottle every three months when the initial prescription includes the request for the additional bottle and states it is needed for use in a day care center or school.
- Spacers and/or peak flow meters for the treatment of asthma.
- Drugs, medicines or medications on the Women's Healthcare Drug List with a *prescription* from a *health care practitioner*.

Notwithstanding any other provisions of the *policy*, *we* may decline coverage or, if applicable, exclude from the *drug list* any and all *prescriptions* until the conclusion of a review period not to exceed six months following FDA approval for the use and release of the *prescriptions* into the market.

Schedule of benefits - prescription drugs

You are responsible for the following:

PRESCRIPTION DRUG BENEFIT (continued)

Retail pharmacy **Up to 30-day supply**

Level 1 drugs	$10 *copayment* per *prescription* or refill
Level 2 drugs	$30 *copayment* per *prescription* or refill
Level 3 drugs	$50 *copayment* per *prescription* or refill
Level 4 drugs	25% *copayment* per *prescription* or refill

Some retail *pharmacies* participate in *our* program, which allows *you* to receive a 90-day supply of a *prescription* or refill. *Your* cost is 3 times the applicable *copayment* as outlined above. *Self-administered injectable drugs* are limited to a 30-day supply from a retail *pharmacy*, unless otherwise determined by *us*.

Mail order pharmacy **Up to 90-day supply**

Excludes *specialty drugs*

Level 1 drugs, *level 2 drugs*, and *level 3 drugs*	2.5 times the applicable *copayment*, as outlined above under **Retail pharmacy** per *prescription* or refill
Level 4 drugs	25% *copayment* per *prescription* or refill

Your cost share for covered orally administered anticancer medications for the treatment of cancer will not exceed $100 per *prescription* or refill. The limited *cost share* is based on the amount allowed by state law and will be revised without notice at your group's renewal based on adjustments to state law.

Drugs, medicines or medications on the Women's Healthcare Drug List from a *network pharmacy* are covered in full.

If *you* request a *brand-name medication* when a *generic medication* is available, *your cost share* is greater. *You* are responsible for the applicable *generic medication copayment* and 100% of the difference between the amount *we* would have paid the dispensing *pharmacy* for the *brand-name medication* and the amount *we* would have paid the dispensing *pharmacy* for the *generic medication*. If the prescribing *health care practitioner* determines that the *brand-name medication* is *medically necessary*, *you* are only responsible for the applicable *copayment* of a *brand-name medication*.

Non-network pharmacy

When a *non-network pharmacy* is used, *you* must pay for the *prescription* or refill at the time it is dispensed. *You* must file a claim for reimbursement with *us*, as described in *your certificate*. In addition to any applicable *copayments* and percentage amounts shown above, *you* are responsible for 30% of the *default rate*. *You* are also responsible for 100% of the difference between the *default rate* and the *non-network pharmacy's* charge. Any amount *you* pay over the *default rate* and any applicable *copayments* and percentage amounts *you* pay to a *non-network pharmacy* do not apply toward *your out-of-pocket limit*, if any. The charge received from a *non-network pharmacy* for a *prescription* or refill may be higher than the *default rate*.

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*.
- Any amount exceeding the *default rate*.
- Drugs and/or ingredients 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 *policy*.
- 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*.
- Allergen extracts.

- Therapeutic devices or appliances, including, but not limited to:

  - Hypodermic needles and syringes (except needles and syringes 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 inborn metabolic errors or genetic conditions. Refer to the "Covered Expenses" section of the *certificate* for coverage of low protein modified foods.

- Nutritional products, except human milk fortifiers when prescribed for prevention of Necrotizing Enterocolitis and administered under the direction of a physician.

- Minerals.

- Growth hormones (medications, drugs or hormones to stimulate growth) for idiopathic short stature.

- Growth hormones (medications, drugs or hormones to stimulate growth), unless there is a laboratory confirmed diagnosis of growth hormone deficiency, or as otherwise determined by *us*.

- Herbs and vitamins, except prenatal (including greater than one milligram of folic acid) and pediatric multi-vitamins with fluoride.

- 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; or
  - Available in prescription strength without a *prescription*.

- Compounded drugs in any dosage form, except when prescribed for pediatric use or as otherwise determined by *us*.

- *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 otherwise determined by *us*;
  - Biological sera;
  - Blood;
  - Blood plasma; or
  - *Self-administered injectable drugs* for which coverage is not approved by *us*.

- *Prescription* 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* 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* or refill.

- Any portion of a *prescription* 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* or refill.

- Any portion of a *self-administered injectable drug* that exceeds a 30-day supply, unless otherwise determined by *us*.

- Any portion of a *prescription* 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 *prior authorization* or *step therapy* is required, as determined by *us*, and 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 this benefit, including *prescriptions* purchased for consumption by someone other than *you.*

- Any *prescription* or refill for drugs, medicines or medications that are lost, stolen, spilled, spoiled, or damaged.

- Drug delivery implants, except drugs, medicines or medications on the Women's Healthcare Drug List with a *prescription* from a *health care practitioner*.

- Any drug or biological that has received designation as an *orphan drug*, unless approved by *us*.

- 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.*

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*.

BEHAVIORAL HEALTH AMENDMENT

This amendment is made part of the *policy* to which it is attached.

All terms used in this amendment have the same meaning given to them in the *certificate* unless otherwise specifically defined in this amendment. Except as modified below all terms, conditions and limitations of the *policy* apply.

If *your* plan is effective prior to 07/01/2014, this amendment will apply to *your* current plan as of *your* plan renewal date on or after 07/01/2014. If *your* plan is effective after 07/01/2014, this amendment is applicable to *your* current plan as of *your* plan's effective date.

The following provision replaces the "Acute inpatient services" provision and "Acute inpatient facility services" in the "Covered Expenses-Behavioral Health" section:

Acute inpatient services

We will pay benefits for *covered expenses* incurred by *you* due to an *admission* or *confinement* for *acute inpatient services* for *mental health services* and *chemical dependency* services provided in a *hospital* or *health care treatment facility*.

The following provision is added to the "Covered Expenses-Behavioral Health" section:

Partial hospitalization

We will pay benefits for *covered expenses* incurred by *you* for *partial hospitalization* for *mental health services* and *chemical dependency* services in a *hospital* or *health care treatment facility*. *Covered expenses* for *partial hospitalization* are payable the same as *acute inpatient services*.

The following provision is added to the "Covered Expenses-Behavioral Health" section:

Residential treatment facility

We will pay benefits for *covered expenses* incurred by *you* due to an *admission* or *confinement* for *mental health services* and *chemical dependency* services provided in a *residential treatment facility*.

The following provision replaces the "Acute inpatient health care practitioner services" in the "Covered Expenses-Behavioral Health" section:

Acute inpatient, partial hospitalization and residential treatment facility health care practitioner services

We will pay benefits for *covered expenses* incurred by *you* for *mental health services* and *chemical dependency* services provided by a *health care practitioner* while *confined* in a *hospital*, *health care treatment facility* or *residential treatment facility*.

The following provision replaces the "Outpatient therapy and office therapy services" provision in the "Covered Expenses-Behavioral Health" section:

Outpatient services

We will pay benefits for *covered expenses* incurred by *you* for *outpatient mental health services* and *chemical dependency* services, including *outpatient* therapy, therapy in a *health care practitioner's* office and *outpatient* services provided as part of an *intensive outpatient program*, while not *confined* in a *hospital*, *residential treatment facility* or *health care treatment facility*.

Refer to the "Schedule of Benefits" and "Schedule of Benefits – Behavioral Health" to see what *your* benefits are for *mental health services* and *chemical dependency* services.

BEHAVIORAL HEALTH AMENDMENT (continued)

The following definition replaces the definition of *health care treatment facility* in the "Glossary" section:

Health care treatment facility means a facility, institution or clinic, duly licensed by the appropriate state agency to provide medical services or *behavioral health* services, and is primarily established and operating within the scope of its license.

The following definition replaces the definition of *residential treatment facility* in the "Glossary" section:

Residential treatment facility means an institution that:

- Is licensed as a 24-hour residential facility for *behavioral health* treatment, although not licensed as a *hospital*;
- Provides a multidisciplinary treatment plan in a controlled environment, under the supervision of a physician who is able to provide treatment on a daily basis;
- Provides supervision and treatment by a Ph.D. psychologist, licensed therapist, psychiatric nursing staff or registered nurse;
- Provides programs such as social, psychological, family counseling and rehabilitative training, age appropriate for the special needs of the age group of patients, with focus on reintegration back into the community; and
- Provides structured activities throughout the day and evening, for a minimum of 6 hours a day.

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

The following definition replaces the definition of *room and board* in the "Glossary" section:

Room and board means all charges made by a *hospital*, *residential treatment facility* for *behavioral health* services or other *health care treatment facility* on its own behalf for room and meals and all general services and activities needed for the care of registered bed patients.

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HUMANA HEALTH PLAN, INC

FEDERAL NOTICES

The following pages contain important information about certain federal laws. There may be differences between the Certificate of Insurance and this Notice packet. There may also be differences between this notice packet and state law. You are eligible for the rights more beneficial to you.

This section includes notices about:

Federal legislation

- **Women's health and cancer rights act**
- **Statement of rights under the newborns' and mothers' health Protection act**
- **Medical child support orders**
- **General notice of COBRA continuation of coverage rights**
- **Tax equity and fiscal responsibility act of 1982 (TEFRA)**
- **Family and medical leave act (FMLA)**
- **Uniformed services employment and reemployment rights act of 1994 (USERRA)**
- **Your rights under ERISA**
- **Patient protection act**

FEDERAL NOTICES (continued)

Federal legislation

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

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

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

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

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

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

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

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

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

FEDERAL NOTICES (continued)

Medical child support orders

An individual who is a child of a covered employee shall be enrolled for coverage under the group health plan in accordance with the direction of a Qualified Medical Child Support Order (QMCSO) or a National Medical Support Notice (NMSO).

A QMCSO is a state-court order or judgment, including approval of a settlement agreement that:

- Provides for support of a covered employee's child;
- Provides for health care coverage for that child;
- Is made under state domestic relations law (including a community property law);
- Relates to benefits under the group health plan; and
- Is "qualified," i.e., it meets the technical requirements of ERISA or applicable state law.

QMCSO also means a state court order or judgment enforcing state Medicaid law regarding medical child support required by the Social Security Act §1908 (as added by Omnibus Budget Reconciliation Act of 1993).

An NMSO is a notice issued by an appropriate agency of a state or local government that is similar to a QMCSO requiring coverage under the group health plan for a dependent child of a non-custodial parent who is (or will become) a covered person by a domestic relations order providing for health care coverage.

Procedures for determining the qualified status of medical child support orders are available at no cost upon request from the plan administrator.

General notice of COBRA continuation coverage rights

Introduction

You are getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

FEDERAL NOTICES (continued)

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary". You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you to lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced; or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you to lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a "dependent child".

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the employer, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

FEDERAL NOTICES (continued)

When is COBRA coverage available?

The plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- Commencement of a proceeding in bankruptcy with respect to the employer; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs.

How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

- ***Disability extension of 18-month period of continuation coverage*** - If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage;

- ***Second qualifying event extension of 18-month period of continuation coverage*** - If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

FEDERAL NOTICES (continued)

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period". Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting your group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep your plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information:

Humana
Billing/Enrollment Department
101 E Main Street
Louisville, KY 40201
1-800-872-7207

FEDERAL NOTICES (continued)

Important notice for individuals entitled to Medicare tax equity and fiscal responsibility act of 1982 (TEFRA) options

Where an employer employs more than 20 people, the Tax Equity And Fiscal Responsibility Act of 1982 (TEFRA) allows covered employees in active service who are age 65 or older and their covered spouses who are eligible for Medicare to choose one of the following options:

- ***Option 1*** - The benefits of their group health plan will be payable first and the benefits of Medicare will be payable second.
- ***Option 2*** - Medicare benefits only. The employee and his or her dependents, if any, will not be insured by the group health plan.

The employer must provide each covered employee and each covered spouse with the choice to elect one of these options at least one month before the covered employee or the insured spouse becomes age 65. All new covered employees and newly covered spouses age 65 or older must be offered these options. If Option 1 is chosen, its issue is subject to the same requirements as for an employee or dependent that is under age 65.

Under TEFRA regulations, there are two categories of persons eligible for Medicare. The calculation and payment of benefits by the group health plan differs for each category.

- ***Category 1*** Medicare eligibles are:

    - Covered employees in active service who are age 65 or older who choose Option 1;
    - Age 65 or older covered spouses; and
    - Age 65 or older covered spouses of employees in active service who are either under age 65 or age 70 or older;

- ***Category 2*** Medicare eligibles are any other covered persons entitled to Medicare, whether or not they enrolled. This category includes, but is not limited to:

    - Retired employees and their spouses; or
    - Covered dependents of a covered employee, other than his or her spouse.

Calculation and payment of benefits

For covered persons in Category 1, benefits are payable by the policy without regard to any benefits payable by Medicare. Medicare will then determine its benefits.

For covered persons in Category 2, Medicare benefits are payable before any benefits are payable by the policy. The benefits of the policy will then be reduced by the full amount of all Medicare benefits the covered person is entitled to receive, whether or not the eligible individual is actually enrolled for Medicare Benefits.

FEDERAL NOTICES (continued)

Family and Medical Leave Act (FMLA)

If an employee is granted a leave of absence (Leave) by the employer as required by the Federal Family and Medical Leave Act, s/he may continue to be covered under the plan for the duration of the Leave under the same conditions as other employees who are currently employed and covered by the plan. If the employee chooses to terminate coverage during the Leave, or if coverage terminates as a result of nonpayment of any required contribution, coverage may be reinstated on the date the employee returns to work immediately following the end of the Leave. Charges incurred after the date of reinstatement will be paid as if the employee had been continuously covered.

Uniformed services employment and reemployment rights act of 1994 (USERRA)

Continuation of benefits

Effective October 13, 1994, federal law requires health plans offer to continue coverage for employees that are absent due to service in the uniformed services and/or dependents.

Eligibility

An employee is eligible for continuation under USERRA if he or she is absent from employment because of voluntary or involuntary performance of duty in the Armed Forces, Army National Guard, Air National Guard, or commissioned corps of the Public Health Service. Duty includes absence for active duty, active duty for training, initial active duty for training, inactive duty training and for the purpose of an examination to determine fitness for duty.

An employee's dependents that have coverage under the plan immediately prior to the date of the employee's covered absence are eligible to elect continuation under USERRA.

If continuation of Plan coverage is elected under USERRA, the employee or dependent is responsible for payment of the applicable cost of coverage. If the employee is absent for not longer than 31 days, the cost will be the amount the employee would otherwise pay for coverage. For absences exceeding 30 days, the cost may be up to 102% of the cost of coverage under the plan. This includes the employee's share and any portion previously paid by the employer.

Duration of coverage

If elected, continuation coverage under USERRA will continue until the earlier of:

- 24 months beginning the first day of absence from employment due to service in the uniformed services; or
- The day after the employee fails to apply for a return to employment as required by USERRA, after the completion of a period of service.

Under federal law, the period coverage available under USERRA shall run concurrently with the COBRA period available to an employee and/or eligible dependent.

Other information

Employees should contact their employer with any questions regarding coverage normally available during a military leave of absence or continuation coverage and notify the employer of any changes in marital status, or change of address.

Your rights under the Employee Retirement Income Security Act of 1974 (ERISA)

Under ERISA, all plan participants covered by ERISA are entitled to certain rights and protections, as described below. Notwithstanding anything in the group health plan or group insurance policy, following are a covered person's minimum rights under ERISA. ERISA requirements do not apply to plans maintained by governmental agencies or churches.

Information about the plan and benefits

Plan participants may:

- Examine, free of charge, all documents governing the plan. These documents are available in the plan administrator's office;

- Obtain, at a reasonable charge, copies of documents governing the plan, including a copy of any updated summary plan description and a copy of the latest annual report for the plan (Form 5500), if any, by writing to the plan administrator;

- Obtain, at a reasonable charge, a copy of the latest annual report (Form 5500) for the plan, if any, by writing to the plan administrator.

FEDERAL NOTICES (continued)

As a plan participant, you will receive a summary of any material changes made in the plan within 210 days after the end of the plan year in which the changes are made unless the change is a material reduction in covered services or benefits, in which case you will receive a summary of the material reduction within 60 days after the date of its adoption.

If the plan is required to file a summary annual financial report, you will receive a copy from the plan administrator.

Responsibilities of plan fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the plan. These people, called "fiduciaries" of the plan, have a duty to act prudently and in the interest of plan participants and beneficiaries.

No one, including an employer, may discharge or otherwise discriminate against a plan participant in any way to prevent the participant from obtaining a benefit to which the participant is otherwise entitled under the plan or from exercising ERISA rights.

Continue group health plan coverage

Participants may be eligible to continue health care coverage for themselves, their spouse or dependents if there is a loss of coverage under the group health plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review the COBRA notice in this document regarding the rules governing COBRA continuation coverage rights.

Claims determinations

If a claim for a plan benefit is denied or disregarded, in whole or in part, participants have the right to know why this was done, to obtain copies of documents relating to the decision without charge and to appeal any denial within certain time schedules.

Enforce your rights

Under ERISA, there are steps participants may take to enforce the above rights. For instance:

- If a participant requests a copy of plan documents and does not receive them within 30 days, the participant may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until the participant receives the materials, unless the materials were not sent because of reasons beyond the control of the plan administrator;

- If a claim for benefits is denied or disregarded, in whole or in part, the participant may file suit in a state or Federal court;

- If the participant disagrees with the plan's decision, or lack thereof, concerning the qualified status of a domestic relations order or a medical child support order, the participant may file suit in Federal court;

- If plan fiduciaries misuse the plan's money, or if participants are discriminated against for asserting their rights, they may seek assistance from the U.S. Department of Labor, or may file suit in a Federal court.

The court will decide who should pay court costs and legal fees. If the participant is successful, the court may order the person sued to pay costs and fees. If the participant loses, the court may order the participant to pay the costs and fees.

Assistance with questions

- Contact the group health plan human resources department or the plan administrator with questions about the plan;

- For questions about ERISA rights, contact the nearest area office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or:

The Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue N.W.
Washington, D.C. 20210;

- Call the publications hotline of the Employee Benefits Security Administration to obtain publications about ERISA rights.

FEDERAL NOTICES (continued)

Patient Protection Act

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

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

Appeal and External Review Notice

The following pages contain important information about Humana's claims procedures, internal appeals and external review. There may be differences between the Certificate of Insurance and this Notice packet. There may also be differences between this notice packet and state law. You are eligible for the rights more beneficial to you.

Federal standards

The Employee Retirement Income Security Act of 1974 (ERISA) established minimum requirements for claims procedures. The Patient Protection and Affordable Care Act (PPACA) including all regulation enforcing PPACA established additional requirements for claims procedures, internal appeal and *external review* processes. Humana complies with these standards. In addition to the procedures below, you should also refer to your insurance benefit plan documents (e.g., the Certificate of Insurance or Evidence of Coverage).

Definitions

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

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

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

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

Clinical peer reviewer is:

- An expert in the treatment of your medical condition that is the subject of an *external review*;
- Knowledgeable about the recommended healthcare service or treatment through recent or current actual clinical experience treating patients with the same or similar to your medical condition;
- Holds a non-restricted license in a state of the United States and, for physicians, a current certification by a recognized American medical specialty board in the area or areas appropriate to the subject of the *external review*;

- Has no history of disciplinary actions or sanctions, including loss of staff privileges or participation restrictions, that have been taken or are pending by any hospital, governmental agency or unit, or regulatory body that raise a substantial question as to the *clinical peer reviewer's* physical, mental or professional competence or moral character; and

- Does not have a material professional, family or financial conflict of interest with the *claimant*, Humana and any of the following:

    - The healthcare provider, the healthcare provider's medical group or independent practice association recommending the healthcare service or treatment;
    - The facility at which the recommended healthcare service or treatment would be provided; or
    - The developer or manufacturer of the principal drug, device, procedure or other therapy being recommended.

Commissioner means the Commissioner of Insurance.

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

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

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

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

Group health plan means an employee welfare benefit plan to the extent the plan provides medical care to employees or their dependents directly (self insured) or through insurance (including HMO plans), reimbursement or otherwise.

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

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

Appeal and External Review Notice (continued)

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

- Peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff;

- Peer-reviewed medical literature, including literature relating to therapies reviewed and approved by a qualified institutional review board, biomedical compendia and other medical literature that meet the criteria of the National Institutes of Health's Library of Medicine for indexing in Index Medicus (Medline) and Elsevier Science Ltd. for indexing in Excerpta Medicus (EMBASE);

- Medical journals recognized by the Secretary of Health and Human Services;

- The following standard reference compendia:

    - The American Hospital Formulary Service–Drug Information;
    - Drug Facts and Comparisons;
    - The American Dental Association Accepted Dental Therapeutics; and
    - The United States Pharmacopoeia–Drug Information;

- Findings, studies or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes, including:

    - The federal Agency for Healthcare Research and Quality;
    - The National Institutes of Health;
    - The National Cancer Institute;
    - The National Academy of Sciences;
    - The Centers for Medicare & Medicaid Services;
    - The federal Food and Drug Administration; and
    - Any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health care services; or

- Any other *medical or scientific evidence* that is comparable to the sources listed above.

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

- You are or were covered under the plan at the time a service was recommended, requested, or provided;

- The service is covered under the plan except when we determine the service is:

    - Not covered because it does not meet plan requirements for medical necessity, appropriateness, healthcare setting, level of care or effectiveness; or
    - Experimental or investigational for a particular medical condition and is not explicitly listed as an excluded benefit under the plan.

Appeal and External Review Notice (continued)

- In the case of experimental or investigational treatment:
  - Your treating physician has certified one of the following situations is applicable:
    - Standard services have not been effective in improving your condition;
    - Standard services are not medically appropriate for you; or
    - There is no available standard service covered by the plan that is more beneficial to you than the recommended or requested service.
  - The treating physician certifies in writing:
    - The recommended service is likely to be more beneficial to you, in the physician's opinion, than any available standard services; or
    - Scientifically valid studies using accepted protocols demonstrate the service is likely to be more beneficial to you than any available standard services and the physician is a licensed, board certified or board eligible physician qualified to practice in the area of medicine appropriate to treat your condition.
- The internal appeals process has been exhausted as specified under the "Exhaustion of remedies" section;
- You have provided all information required to process an *external review*; including:
  - An *external review* request form provided with the *adverse benefit determination* or *final adverse benefit determination*; and
  - Release forms authorizing us to disclose protected health information that is pertinent to the *external review*.

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

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

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

- Could seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function; or
- In the opinion of a physician with knowledge of the covered person's medical condition, would subject the covered person to severe pain that cannot be adequately managed without the service that is the subject of the claim.

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

Claim procedures

Discretionary authority

With respect to paying claims for benefits or determining eligibility for coverage under a policy issued by Humana, Humana as administrator for claims determinations and as ERISA claims review fiduciary, shall have full and exclusive discretionary authority to:

- Interpret plan provisions;
- Make decisions regarding eligibility for coverage and benefits; and
- Resolve factual questions relating to coverage and benefits.

Submitting a claim

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

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

Claims submissions must be timely. Claims must be filed as soon as reasonably possible after they are incurred, and in no event later than the period of time described in the benefit plan document.

Claims submissions must be complete and delivered to the designated address. At a minimum they must include:

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

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

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

Failure to provide necessary information

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

Authorized representatives

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

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

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

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

Claims decisions

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

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

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

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

Appeal and External Review Notice (continued)

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

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

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

  Humana will provide notice of the plan's *urgent-care claim* determination as soon as possible but no more than 48 hours after the earlier of:

  - The plan receives the specified information; or
  - The end of the period afforded the *claimant* to provide the specified additional information.

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

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

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

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

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

Initial denial notices

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

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

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

If an *adverse benefit determination* is based on medical necessity, experimental treatment or similar exclusion or limitation, the notice will provide an explanation of the scientific or clinical basis for the determination, free of charge. The explanation will apply the terms of the plan to the covered person's medical circumstances.

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

Appeal and External Review Notice (continued)

Contact information

For questions about your rights, this notice, or assistance, you can contact: Humana, Inc. at www.humana.com or the Employee Benefits Security Administration at 1-866-444-EBSA (3272).

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

Kentucky Department of Insurance
215 West Main Street
Frankfort, KY 40601

Mailing address:
P.O. Box 517
Frankfort, KY 40602-0517

Phone: 502-564-3630 or 502-564-6034 or 800-595-6053 or
TTY: 800-648-6056
Fax: 502-564-6090

Email: David.Wilhoite@ky.gov; Rodney.Hugle@ky.gov
Website: http://insurance.ky.gov
or
http://insurance.ky.gov/Home.aspx?Div_id=4

Appeal and External Review Notice (continued)

Internal appeals and external review of adverse benefit determinations

Internal appeals

A *claimant* must appeal an *adverse benefit determination* within 180 days after receiving written notice of the denial (or partial denial). An appeal may be made by a *claimant* by means of written application to Humana, in person, or by mail, postage prepaid.

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

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

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

On appeal, a *claimant* may review relevant documents and may submit issues and comments in writing. A *claimant* on appeal may, upon request, discover the identity of medical or vocational experts whose advice was obtained on behalf of the plan in connection with the *adverse benefit determination* being appealed, as permitted under applicable law.

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

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

Appeal and External Review Notice (continued)

Time periods for decisions on appeal

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

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

Appeals denial notices

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

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

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

In addition to the information provided in the notice, a *claimant* has the right to request the diagnosis and treatment codes and descriptions upon which the determination is based.

Appeal and External Review Notice (continued)

Exhaustion of remedies

Upon completion of the internal appeals process under this section, a *claimant* will have exhausted his or her administrative remedies under the plan. If Humana fails to adhere to all requirement of the internal appeal process, except for failures that are based on a minimal error, the claim shall be deemed to have been denied and the *claimant* may request an *external review*.

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

External review

Within four months after a *claimant* receives notice of an *adverse benefit determination* or *final adverse benefit determination* the *claimant* may request an *external review* if the determination concerns treatment that is *experimental, investigational* or not *medically necessary* or the determination concerns a rescission of coverage. The request for *external review* must be made in writing to the *commissioner*. The *claimant* may be assessed a $25 filing fee that will be refunded if the *adverse benefit determination* is overturned. This fee may be waived with proof of financial hardship. The annual limit on filing fees for any *claimant* within a single plan year will not exceed $75. Please refer to the section titled "Expedited external review" if the *adverse benefit determination* involves an *urgent-care claim* or an ongoing course of treatment.

Within one business day after the receipt of a request for *external review*, the *commissioner* will send a copy of the request to Humana. Within five business days, we will complete a *preliminary review* of the request.

Within one business day after we complete the *preliminary review*, we will notify the *claimant* and the *commissioner* in writing whether:

- The request is complete and is eligible for *external review*;
- The request is not complete and the information or materials needed to make the request complete; or
- The request is not eligible for *external review*, the reasons for ineligibility and the *claimant's* right to appeal to the *commissioner*. If appealed, the *commissioner* may determine that the request is eligible for *external review*.

Within one business day after the *commissioner* receives notice that the request is eligible for *external review*, the *commissioner* will:

- Impartially assign an *IRO* from a list compiled and maintained by the *commissioner* to conduct the *external review*;
- Provide Humana with the name of the *IRO*. Within five business days after the date of receipt of this notice, we will provide the *IRO* with all documents and information we considered in making the *adverse benefit determination* or *final adverse benefit determination*;

Appeal and External Review Notice (continued)

- Notify the *claimant* in writing of the following:

    - The eligibility of the request and acceptance for *external review*; and
    - The right to submit additional information in writing to the *IRO* and the time limits to submit the information.

Any information received by the *IRO* will be forwarded to Humana within one business day of receipt. Upon receipt of additional information, we may reconsider the *adverse benefit determination* or *final adverse benefit determination*. If we reverse the *adverse benefit determination* or *final adverse benefit determination,* the *external review* will be terminated and we will provide coverage for the service. We will immediately notify the *claimant*, the *IRO*, and the *commissioner* in writing of our decision.

The *IRO* will review all of the information received including, if available and considered appropriate the following:

- Your medical records;

- The attending healthcare professional's recommendation;

- Consulting reports from appropriate healthcare professionals and other documents submitted by Humana, the *claimant*, and treating provider;

- The terms of the coverage under the plan;

- The most appropriate practice guidelines, which will include applicable *evidence-based standards* and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards and associations;

- Any applicable clinical review criteria developed and used by Humana; and

- The opinion of the *IRO's clinical peer reviewer* or reviewers after considering the information and documents listed above.

Appeal and External Review Notice (continued)

If the *external review* involves experimental or investigational treatment, within one business day after the *IRO* receives notice of assignment to conduct the *external review*, the *IRO* will select one or more *clinical peer reviewers* to conduct the *external review*. The *clinical peer reviewer* will review all of the information and within 20 days after being selected, will provide a written opinion to the *IRO* on whether the service should be covered. The written opinion will include:

- A description of the medical condition;
- A description of the indicators relevant to determining whether there is sufficient evidence to demonstrate that the service is more likely than not to be beneficial to you than any available standard services;
- The adverse risks of the service would not be substantially increased over those of available standard services;
- A description and analysis of any *medical or scientific evidence*, or *evidence-based standard* considered in reaching the opinion;
- Information on whether the reviewer's rationale for the opinion is based on either:
    - The service has been approved by the federal Food and Drug Administration, if applicable, for the condition; or
    - *Medical or scientific evidence* or *evidence-based standards* demonstrate that the expected benefits of the service is more likely than not to be beneficial to you than any available standard health care service and the adverse risks of the service would not be substantially increased over those of available standard services.

The *IRO's* decision to either uphold or reverse the *adverse benefit determination* or *final adverse benefit determination* will be provided in writing to the *claimant*, the *commissioner* and Humana within*:*

- 20 days after receipt of each *clinical peer reviewer* opinion for an experimental or investigational treatment; or
- 45 days after receipt of the request for an *external review.*

In the case of experimental or investigational treatment, if a majority of *clinical peer reviewers* recommend the service should be covered, the *IRO* will make a decision to reverse the *adverse benefit determination* or *final adverse benefit determination.* If a majority of *clinical peer reviewers* recommend the service should not be covered, the *IRO* will make a decision to uphold the *adverse benefit determination* or *final adverse benefit determination.* If the *clinical peer reviewers* are evenly split, the *IRO* will obtain the opinion of an additional *clinical peer reviewer* in order for the *IRO* to make a decision.

Appeal and External Review Notice (continued)

The *IRO's* written notice of the decision will include:

- A general description of the reason for the request for *external review*;
- The date the *IRO* received the assignment from the *commissioner* to conduct the *external review*;
- The date the *external review* was conducted;
- The date of the *IRO's* decision;
- The principal reason for the decision, including applicable *evidence-based standards*, if any, used as a basis for the decision;
- The rationale for the decision;
- References to the evidence or documentation, including the *evidence-based standards*, considered in reaching the decision; and
- In the case of experimental or investigational treatment, the written opinion and rational for the recommendation of each *clinical peer reviewer*.

Immediately upon our receipt of the *IRO's* decision reversing the *adverse benefit determination* or *final adverse determination*, we will approve the service.

Expedited external review

You may request an expedited *external review* from the *commissioner*:

- At the same time you request an expedited internal appeal of an *adverse benefit determination* for an *urgent-care claim* or when you are receiving an ongoing course of treatment; or
- When you receive an *adverse benefit determination* or *final adverse benefit determination* of:

    - An *urgent-care claim*;
    - An admission, availability of care, continued stay or health care service for which you received emergency services, but you have not been discharged from the facility; or
    - An experimental or investigational treatment if the treating physician certifies, in writing, that the recommended service would be significantly less effective if not promptly initiated.

The *commissioner* will immediately send a copy of the request to Humana and upon receipt; we will immediately complete a *preliminary review* of the request. We will immediately notify the *claimant* and the *commissioner* of the *preliminary review* determination. If we determine the request is not eligible, the notice will advise you of your right to appeal to the *commissioner*. If appealed, the *commissioner* may determine that the request is eligible for *external review*.

Immediately after the commissioner receives notice that the request is eligible for *external review*, the *commissioner* will:

- Impartially assign an *IRO* to conduct the expedited *external review*.
- Provide Humana with the name of the *IRO* and we will immediately provide the *IRO* with all necessary documents and information.

Appeal and External Review Notice (continued)

The *IRO* will review all of the information received including, if available and considered appropriate, the following:

- Your medical records;
- The attending healthcare professional's recommendation;
- Consulting reports from appropriate healthcare professionals and other documents submitted by Humana, the *claimant* and treating provider;
- The terms of the coverage under the plan;
- The most appropriate practice guidelines, which will include *evidence-based standards* and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards and associations;
- Any applicable clinical review criteria developed and used by Humana; and
- The opinion of the *IRO's clinical peer reviewer* or reviewers after considering the information and documents listed above.

If the expedited *external review* request involves experimental or investigational treatment, within one business day after the *IRO* receives notice of assignment to conduct the *external review*, the *IRO* will select one or more *clinical peer reviewers* to conduct the *external review*. The *clinical peer reviewer* will:

- Review all of the information noted above including whether:
    - The recommended service has been approved by the federal Food and Drug Administration, if applicable, for the condition; or
    - Medical or scientific evidence or *evidence-based standards* demonstrate that the expected benefits of the recommended service is more likely than not to be beneficial to you than any available standard service and the adverse risks of the recommended service would not be substantially increased over those of available standard services.
- Provide an opinion to the *IRO* as expeditiously as your condition or circumstances require, but in no event more than five calendar days after being selected.

The *IRO's* decision to either uphold or reverse the *adverse benefit determination* or *final adverse benefit determination* will be provided orally or in writing to the *claimant*, the *commissioner* and Humana within:

- 48 hours after receipt of each *clinical peer reviewer* opinion of an expedited *external review* for an experimental or investigational treatment; or
- 72 hours after the date of receipt of the request for an expedited *external review.*

In the case of experimental or investigational treatment, if a majority of *clinical peer reviewers* recommend the service should be covered, the *IRO* will make a decision to reverse the *adverse benefit determination* or *final adverse benefit determination*. If a majority of *clinical peer reviewers* recommend the service should not be covered, the *IRO* will make a decision to uphold the *adverse benefit determination* or *final adverse benefit determination*. If the *clinical peer reviewers* are evenly split, the *IRO* will obtain the opinion of an additional *clinical peer reviewer* in order for the *IRO* to make a decision.

The *IRO* will send written confirmation within 48 hours of an oral decision and will include:

- A general description of the reason for the request for an expedited *external review*;
- The date the *IRO* received the assignment from the *commissioner* to conduct the expedited *external review*;
- The date the expedited *external review* was conducted;
- The date of the *IRO's* decision;
- The principal reason for the decision, including applicable *evidence-based standards*, if any, used as a basis for the decision;
- The rationale for the decision;
- References to the evidence or documentation, including the *evidence-based standards*, considered in reaching the decision, except in the case of experimental or investigational treatment; and
- In the case of experimental or investigational treatment, the written opinion and rational for the recommendation of each *clinical peer reviewer*.

Immediately upon receipt of the *IRO's* decision reversing the *adverse benefit determination* or *final adverse benefit determination*, we will approve the service.

Legal actions and limitations

No lawsuit may be brought with respect to plan benefits until all remedies under the plan have been exhausted.

No lawsuit with respect to plan benefits may be brought after the expiration of the applicable limitations period stated in the benefit plan document. If no limitation is stated in the benefit plan document, then no such suit may be brought after the expiration of the applicable limitations under applicable law.