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FLHJ67VEN 0121

SAMPLE

Important!

At Humana, it is important you are treated fairly.

Humana Inc. and its subsidiaries do not discriminate or exclude people because of their race, color, national origin, age, disability, sex, sexual orientation, gender, gender identity, ancestry, marital status or religion. Discrimination is against the law. Humana and its subsidiaries comply with applicable Federal Civil Rights laws. If you believe that you have been discriminated against by Humana or its subsidiaries, there are ways to get help.

- You may file a complaint, also known as a grievance:
Discrimination Grievances, P.O. Box 14618,
Lexington, KY 40512-4618
If you need help filing a grievance, call the number on your ID card or if you use a **TTY**, call **711**.
- You can also file a civil rights complaint with the **U.S. Department of Health and Human Services**, Office for Civil Rights electronically through their complaint portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by at **U.S. Department of Health and Human Services**, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, DC 20201, **1-800-368-1019, 800-537-7697 (TDD)**. Complaint forms are available at <https://www.hhs.gov/ocr/office/file/index.html>.
- **California residents:** You may also call California Department of Insurance toll-free hotline number: **1-800-927-HELP (4357)**, to file a grievance.

Auxiliary aids and services, free of charge, are available to you.

Call the number on your ID card (TTY: 711)

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

Language assistance services, free of charge, are available to you.
Call the number on your ID card (TTY: 711)

ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call the number on your ID card (TTY: 711)... ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al número que figura en su tarjeta de identificación (TTY: 711)... 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電會員卡上的電話號碼 (TTY: 711)... CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số điện thoại ghi trên thẻ ID của quý vị (TTY: 711)... 주의 : 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. ID 카드에 적혀 있는 번호로 전화해 주십시오 (TTY: 711)... PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tawagan ang numero na nasa iyong ID card (TTY: 711)... ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Наберите номер, указанный на вашей карточке-удостоверении (телетайп: 711)... ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele nimewo ki sou kat idantite manm ou (TTY: 711)... ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le numéro figurant sur votre carte de membre (ATS: 711)... UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Proszę zadzwonić pod numer podany na karcie identyfikacyjnej (TTY: 711)... ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para o número presente em seu cartão de identificação (TTY: 711)... ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero che appare sulla tessera identificativa (TTY: 711)... ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Wählen Sie die Nummer, die sich auf Ihrer Versicherungskarte befindet (TTY: 711)... 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。お手持ちのIDカードに記載されている電話番号までご連絡ください (TTY: 711)...

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با شماره تلفن روی کارت شناسایی تان تماس بگیرید (TTY: 711)...

Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'déé', t'áá jiik'eh, éí ná hóló, námboo ninaaltsoos yézhí, bee nées ho'dółzin bikáá'ígíí bee hółne' (TTY: 711)...

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم الهاتف الموجود على بطاقة الهوية الخاصة بك (TTY: 711).



Administrative Office:
3501 SW 160th Avenue
Miramar, FL 33027

Certificate of Insurance

Humana Health Insurance Company of Florida, Inc.

Policyholder:

Policy Number:

Effective Date:

Product Name:

In accordance with the terms of the *policy* issued to the *policyholder*, Humana Health Insurance Company of Florida, 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.

Please call 1-888-357-6767 for assistance regarding claims and information about coverage.

A handwritten signature in black ink that reads "Bruce Broussard".

Bruce Broussard
President

The insurance *policy* under which this *certificate* is issued is not a policy of Workers' Compensation insurance and does not replace 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**

This certificate contains a Deductible

Florida Compare Care resources from the Agency for Health Care Administration (AHCA) can be found at <http://www.floridahealthfinder.gov/>. The site includes helpful information about Florida healthcare, plans and facilities.

WARNING: LIMITED BENEFITS WILL BE PAID WHEN NON-NETWORK PROVIDERS ARE USED. *You should be aware that when you elect to utilize the services of a non-network provider for a covered non-emergency service, benefit payments to the provider are not based upon the amount the provider charges. The basis of the payment will be determined according to your policy's out-of-network reimbursement benefit. Non-network providers may bill insureds for any difference in the amount. YOU MAY BE REQUIRED TO PAY MORE THAN THE COINSURANCE OR COPAYMENT AMOUNT. Network providers have agreed to accept discounted payments for services with no additional billing to you other than coinsurance, copayment, and deductible amounts. You may obtain further information about the providers who have contracted with your insurance plan by consulting your insurer's website or contacting your insurer or agent directly.*

UNDERSTANDING YOUR COVERAGE

As *you* read the *certificate*, *you* will see some words are printed in italics. Italicized words may have different meanings in the *certificate* than in general. Please check the "Glossary" sections 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.

You must pay the health care provider any amount due that *we* do not pay. 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 amendment attached to the *certificate* to see when services or supplies are *covered expenses* or are non-covered expenses.

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 what *we* allow. For a *covered expense*, *we* will allow the total amount billed by the *qualified provider*, less any amounts such as:

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

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

UNDERSTANDING YOUR COVERAGE (continued)

Your choice of providers affects your benefits

We will pay a higher percentage most of the time if you see a *network provider*, so 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 *qualified 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 elect to utilize a *non-network provider* when you have the ability and opportunity to choose a *network provider*, so 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*.

If you do not have the ability and opportunity to choose a *network health care practitioner* to treat you when you are at a *network hospital*, *network ambulatory surgical center* or a *network urgent care center*, covered expenses provided to you by *non-network health care practitioners* working with these specified network facilities will be covered at the *network provider* benefit, subject to the *maximum allowable fee*.

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

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 *qualified provider*. You may also call our customer service department at the number listed on your ID card to determine if a *qualified 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*.

UNDERSTANDING YOUR COVERAGE (continued)

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 for the network provider copayment, deductible or coinsurance to apply.

Seeking urgent care

If you need urgent care, go to the nearest urgent care center or call an urgent care qualified provider. You must receive urgent care services from a network provider for the network provider copayment, deductible or coinsurance to apply.

Our relationship with qualified providers

Qualified providers are not our agents, employees or partners. All providers are independent contractors. Qualified 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 qualified providers regarding your medical condition or treatment options. Qualified providers act on your behalf when they order services. You and your qualified providers make all decisions about your health care, no matter what we cover. We are not responsible for anything said or written by a qualified 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 network 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 network providers may have capitation agreements. This means the network 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 network provider, such as a 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.*

UNDERSTANDING YOUR COVERAGE (continued)

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*.

SAMPLE

COVERED EXPENSES

This "Covered Expenses" section describes the services that will be considered *covered expenses* under the *policy*. Benefits will be paid for 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:

- *Preauthorization* requirements;
- *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* apply.

Preventive services

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

- Services with an A or B rating in the current recommendations of the U.S. Preventive Services Task Force (USPSTF).
- 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. Coverage includes:
 - A baseline mammogram for women 35 years of age or older, but younger than 40;
 - A mammogram every 2 years for women 40 years of age or older, but younger than 50;
 - A yearly mammogram for women 50 years of age or older; or
 - As recommended by their health care practitioner for preventive purposes.

For the recommended *preventive services* that apply to *your plan year*, refer to the www.healthcare.gov website 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* home and office visit services. You must incur the *health care practitioner's* services as the result of a *sickness* or *bodily injury*.

COVERED EXPENSES (continued)

Health care practitioner office visit

Covered expenses include:

- Home and office visits for the diagnosis and treatment of a *sickness or bodily injury*.
- Home and office visits for prenatal and post-delivery care.
- Home and 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.

Virtual visit services

We will pay benefits for *covered expenses* incurred by you for *virtual visits* for the diagnosis and treatment of a *sickness or bodily injury*. *Virtual visits* must be services that would otherwise be a *covered expense* if provided during a face-to-face consultation between a *covered person* and a *health care practitioner*.

Health care practitioner services at a retail clinic

We will pay benefits for *covered expenses* incurred by you for *health care practitioner* services at a *retail clinic* for a *sickness or bodily injury*.

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 care* benefits provided in a *hospital*, refer to the "Emergency services" provision of this section.

Hospital inpatient services

Covered expenses include:

COVERED EXPENSES (continued)

- 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 *confined*.
- Services and supplies, other than *room and board*, provided by a *hospital* while *confined*.

Health care practitioner inpatient services when provided in a hospital

Services that are payable as a *hospital* charge are not payable as a *health care practitioner* charge.

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.
- Services of an *assistant surgeon*.
- Services of a *surgical assistant*.
- Anesthesia administered by a *health care practitioner* or certified registered anesthetist attendant for 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 *health care practitioner* 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.

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*.

COVERED EXPENSES (continued)

Health care practitioner outpatient services when provided in a hospital

Services that are payable as a *hospital* charge are not payable as a *health care practitioner* charge.

Covered expenses include:

- Surgery performed on an *outpatient* basis.
- Services of an *assistant surgeon*.
- Services of a *surgical assistant*.
- Anesthesia administered by a *health care practitioner* or certified registered anesthetist attendant for a *surgery*.
- Services of a pathologist.
- Services of a radiologist.
- Post-delivery care including services rendered in an *outpatient* maternity center.

Hospital outpatient non-surgical services

Covered expenses include services provided in a *hospital's outpatient* department in connection with non-surgical services.

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*.

COVERED EXPENSES (continued)

- 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 that resulted in a *functional impairment*.

Covered expenses also include those services rendered in licensed birth centers.

The newborn will not be required to satisfy a separate *deductible* and/or *copayment* for *hospital* facility charges for the *confinement* period immediately following birth. A *deductible* and/or *copayment*, if applicable, will be required for any subsequent *hospital admission*.

Emergency services

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

Emergency care provided by a *non-network hospital* or a *non-network health care practitioner* will be covered at the *network provider* benefit, as specified in the "Emergency services" benefit on the "Schedule of Benefits," subject to the *maximum allowable fee*.

Covered expenses also include *health care practitioner* services for *emergency care*, 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*.

Benefits under this "Emergency services" provision are not available if the services provided do not meet the definition of *emergency care*.

Ambulance services

We will pay benefits for *covered expenses* incurred by you for licensed *ambulance* services to, from or between medical facilities for *emergency care*. We will also pay benefits for a newborn *dependent's* transportation to and from the nearest available facility staffed and equipped to treat the newborn's condition if the transportation is certified by the attending physician as necessary to protect the health and safety of the newborn *dependent*.

Ambulance services for *emergency care* provided by a *non-network provider* will be covered at the *network provider* benefit, as specified in the "Ambulance services" benefit on the "Schedule of Benefits," subject to the *maximum allowable fee*.

COVERED EXPENSES (continued)

Ambulatory surgical center services

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 that are payable as an *ambulatory surgical center* charge are not payable as a *health care practitioner* charge.

Covered expenses include:

- Surgery performed on an *outpatient* basis.
- Services of an *assistant surgeon*.
- Services of a *surgical assistant*.
- Anesthesia administered by a *health care practitioner* or certified registered anesthetist attendant for 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 purchase price is considered 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; and
- Repair or maintenance is not a result of misuse or abuse; and
- Repair cost is less than replacement cost.

COVERED EXPENSES (continued)

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

- Manufacturer's warranty is expired; and
- 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.

Free-standing facility services

Free-standing facility diagnostic laboratory and radiology services

We will pay benefits for *covered expenses* for services provided in a *free-standing facility*.

Health care practitioner services when provided in a free-standing facility

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

Free-standing facility advanced imaging

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

Home health care services

We will pay benefits for *covered expenses* incurred by *you* in connection with a *home health care plan* provided by a *home health care agency*. 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* of two hours or less will be counted as one visit. Each additional two hours or less is considered an additional visit.

Home health care *covered expenses* are limited to:

- Care provided by a *nurse*;
- Physical, occupational, respiratory or speech therapy;
- Medical social work and nutrition services;
- Medical supplies, except for durable medical equipment; and
- Laboratory services.

COVERED EXPENSES (continued)

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*;
- Charges for services of a home health aide;
- *Custodial care*; or
- The provision or administration of *self-administered injectable drugs*, unless otherwise determined by *us*.

Hospice services

We will pay benefits for *covered expenses* incurred by you for a *hospice care program*. 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*.

Hospice care benefits are payable as shown on the "Schedule of Benefits" for the following hospice services:

- *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 up to eight hours in any one day;
- 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;
- Part-time home health aide services for up to eight hours in any one day; and
- Medical supplies, drugs, and medicines 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;

COVERED EXPENSES (continued)

- Services by a licensed pastoral counselor to a member of his or her congregation. These are services in the course of the duties to which he or she is called as a pastor or minister; and
- Bereavement counseling services for *family members* not covered under the *policy*.

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 that 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;
- Limited to one splint in a six-month period; 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, and full dentures.

COVERED EXPENSES (continued)

Physical medicine and rehabilitative services

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 delay or 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;
- Massage therapy;
- Respiratory or pulmonary rehabilitation services; and
- Cardiac rehabilitation services.

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

Habilitative services

We will pay benefits for *covered expenses* incurred by *you* for the following *habilitative services* ordered and performed by a *health care practitioner* for a *covered person* with a *congenital anomaly*, developmental delay or defect:

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

The "Schedule of Benefits" shows the maximum number of visits for *habilitative services*, if any.

Skilled nursing facility services

We will pay benefits for *covered expenses* incurred by *you* for charges made by a *skilled nursing facility* for *room and board* and for 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.

COVERED EXPENSES (continued)

Health care practitioner services when provided in a skilled nursing facility

Services that are payable as a *skilled nursing facility* charge are not payable as a *health care practitioner* charge.

Covered expenses include:

- Medical services furnished by an attending *health care practitioner* to you while you are confined in a *skilled nursing facility*;
- Consultation charges requested by the attending *health care practitioner* during a confinement in a *skilled nursing facility*;
- Services of a pathologist; and
- Services of a radiologist.

Specialty drug medical benefit

We will pay benefits for *covered expenses* incurred by you for *specialty drugs* provided by or obtained from a *qualified provider* in the following locations:

- *Health care practitioner's office*;
- *Free-standing facility*;
- *Urgent care center*;
- A home;
- *Hospital*;
- *Skilled nursing facility*;
- *Ambulance*; and
- Emergency room.

Specialty drugs may be subject to *preauthorization* requirements. Refer to the "Schedule of Benefits" in this *certificate* for *preauthorization* requirements and contact us prior to receiving *specialty drugs*.

Specialty drug benefits do not include the charge for the actual administration of the *specialty drug*. Benefits for the administration of *specialty drugs* are based on the location of the service and type of provider.

Transplant services and immune effector cell therapy

We will pay benefits for *covered expenses* incurred by you for covered transplants and *immune effector cell therapies* approved by the United States Food and Drug Administration, including but not limited to Chimeric Antigen Receptor Therapy (CAR-T). The transplant services and *immune effector cell therapy* must be preauthorized and approved by us.

COVERED EXPENSES (continued)

You or your health care practitioner must call our Transplant Department at 866-421-5663 to request and obtain preauthorization from us for covered transplants and immune effector cell therapies. We must be notified of the initial evaluation and given a reasonable opportunity to review the clinical results to determine if the requested transplant or immune effector cell therapy will be covered. We will advise your health care practitioner once coverage is approved by us. Benefits are payable only if the transplant or immune effector cell therapy is approved by us.

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

- Heart;
- Lung(s);
- Liver;
- Kidney;
- Stem cell;
- Intestine;
- Pancreas;
- Auto islet cell;
- Any combination of the above listed transplants; and
- Any transplant not listed above required by state or federal law.

Multiple solid organ transplants performed simultaneously are considered one transplant surgery. Multiple stem cell or immune effector cell therapy infusions occurring as part of one treatment plan is considered one event.

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

The following are covered expenses for an approved transplant or immune effector cell therapy and all related complications:

- Hospital and health care practitioner services.
- Acquisition of cell therapy products for immune effector cell therapy, acquisition of stem cells or solid organs for transplants and associated donor costs, including pre-transplant or immune effector cell therapy services, the acquisition procedure, and any complications resulting from the harvest and/or acquisition. Donor costs for post-discharge services and treatment of complications will not exceed the treatment period of 365 days from the date of discharge following harvest and/or acquisition.
- Non-medical travel and lodging costs for:
 - The covered person receiving the transplant or immune effector cell therapy, if the covered person lives more than 100 miles from the transplant or immune effector cell therapy facility designated by us; and

COVERED EXPENSES (continued)

- One caregiver or support person (two, when the *covered person* receiving the transplant or *immune effector cell therapy* is under 18 years of age), if the caregiver or support person lives more than 100 miles from the transplant or *immune effector cell therapy* facility designated by *us*.

Non-medical travel and lodging costs include:

- Transportation to and from the designated transplant or *immune effector cell therapy* facility where the transplant or *immune effector cell therapy* is performed; and
- Temporary lodging at a prearranged location when requested by the designated transplant or *immune effector cell therapy* facility and approved by *us*.

All non-medical travel and lodging costs for transplant and *immune effector cell therapy* are payable as specified in the "Schedule of Benefits" section in this *certificate*.

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

Urgent care services

We will pay benefits for *urgent care covered expenses* incurred by *you* for charges made by an *urgent care center* or an *urgent care qualified provider*.

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 EXPENSES (continued)

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 approved by *us*, for a *covered person* with bilateral severe to profound sensorineural deafness.

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.
- 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, or splints used for the treatment of temporomandibular joint disorder (see "Jaw joint benefit" provision for benefit limit).
- 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; and
 - 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*.

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

COVERED EXPENSES (continued)

- Hospitalization services and general anesthesia for dental treatment or *surgery* when provided to a *covered person* who is determined by a licensed dentist and their physician to require necessary dental treatment in a *hospital* or *ambulatory surgical center* due to a significantly complex dental condition or a developmental disability in which patient management in the dental office has proven to be ineffective; or has one or more medical conditions that would create significant or undue medical risk in the course of treatment delivery if not rendered in a *hospital* or *ambulatory surgical center*.
- 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.
- 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;
 - Prostheses and treatment of physical complications for all stages of mastectomy, including lymphedemas; and
 - Post-surgical follow-up care.

COVERED EXPENSES (continued)

- Reconstructive *surgery* resulting from:
 - A *bodily injury*, infection or other disease of the involved part, when a *functional impairment* is present; or
 - A *congenital anomaly* that resulted in a *functional impairment*.
- Enteral formulas, nutritional supplements and low protein modified foods for use at home by a *covered person* that are prescribed or ordered by a *health care practitioner* and are for the treatment of an inherited metabolic disease, e.g. phenylketonuria (PKU).
- Services for the *medically necessary* diagnosis and treatment of osteoporosis for high-risk individuals, including estrogen-deficient individuals who are at clinical risk for osteoporosis, individuals who have vertebral abnormalities, individuals who are receiving long-term glucocorticoid (steroid) therapy, individuals who have primary hyperparathyroidism, and individuals who have a family history of osteoporosis.
- *Covered expenses* for the treatment of cleft lip and cleft palate. This coverage includes medical, dental, speech therapy, audiology, and nutrition services when prescribed by the treating *health care practitioner*. The *health care practitioner* must certify that such services are *medically necessary* and consequent to treatment of the cleft lip or palate. This benefit is subject to all other terms and conditions applicable to other benefits.
- *Palliative care*.
- *Routine patient care* costs for a *covered person* participating in an approved Phase I, II, III or IV clinical trial.

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

Routine patient care costs do not include services or items that are:

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

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.

COVERED EXPENSES (continued)

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

- Federally funded or 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.

Cancer screenings and exams must be covered in compliance with the most recently published guidelines and recommendations established by any of the following:

- American Cancer Society;
- National Institutes of Health;
- National Cancer Institute;
- U.S. Public Health Service;
- Center for Disease Control;
- U.S. Preventive Services Task Force;
- National Comprehensive Cancer Network; or
- Other nationally recognized health care organizations.

- Treatment of Down syndrome through:

- Speech therapy;
- Occupational therapy;
- Physical therapy; and
- Applied behavior analysis provided by a certified behavior analyst, psychologist, psychotherapist, clinical social worker, marriage and family therapist, or mental health counselor.

COVERED EXPENSES - PEDIATRIC DENTAL

This "Covered Expenses - Pediatric Dental" section describes the services that will be considered *covered expenses* for *pediatric dental services* under the *policy*. 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.

All terms used in this benefit have the same meaning given to them in this *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 terms and provisions of the *policy* apply.

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, unless the biting or chewing injury is a result of an act of domestic violence or a medical condition (including both physical and mental health conditions).

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:

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

Covered person under this "Covered Expenses - Pediatric Dental" and the "Schedule of Benefits - Pediatric Dental" sections means a person, who is eligible and enrolled for benefits provided under the *policy* up to the end of the month following the date he or she attains age 19.

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*.

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.

COVERED EXPENSES - PEDIATRIC DENTAL (continued)

Palliative dental care means treatment used in a *dental emergency* or *accidental dental injury* to relieve, ease or alleviate the acute severity of dental pain, swelling or bleeding. *Palliative dental care* treatment usually is performed for 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.

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

- The actual cost for services;
- The fee most often charged in the geographical area where the service was performed;
- The fee 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 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; or
- The fee based on a percentage of the fee *Medicare* allows for the same or similar services provided in the same geographic area.

When you elect to utilize services from a *non-network provider* and you have the ability and opportunity to choose a *network provider*, the bill you receive for services provided by *non-network providers* may be significantly higher than the *reimbursement limit*. In addition to the *deductible*, *copayments* and *coinsurance*, you are 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 your *deductible* or *out-of-pocket limit*.

COVERED EXPENSES - PEDIATRIC DENTAL (continued)

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; and
- Any other appropriate diagnostic materials (may include x-rays, chart notes, treatment records, etc.) as requested by *us*.

Pediatric dental services 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 and comprehensive oral evaluations. Limited to 2 per year.
- Limited, problem focused oral evaluations. Limited to 2 per year.
- Periodontal evaluations. Limited to 2 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). Benefits are not available when a comprehensive oral evaluation is performed.
- Cleaning (prophylaxis), including all scaling and polishing procedures. Limited to 2 per year.
- Intra-oral complete series x-rays (at least 14 films, including bitewings) or panoramic x-ray. Limited to 1 every 5 years. 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.
- Bitewing x-rays. Limited to 2 sets 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. Limited to 2 per year.
- Application of sealants to the occlusal surface of permanent molars that are free of decay and restorations. Limited to 1 per tooth every 3 years.
- Installation of space maintainers for retaining space when a primary tooth is prematurely lost. *Pediatric dental services* do not include separate adjustment expenses.
- Recementation of space maintainers.

COVERED EXPENSES - PEDIATRIC DENTAL (continued)

- Removal of fixed space maintainers.
- Distal shoe space maintainer - fixed - unilateral.

Class II services

- Restorative services as follows:
 - Amalgam restorations (fillings). Multiple restorations on one surface are considered one restoration.
 - Composite restorations (fillings) on anterior teeth. Composite restorations on molar and bicuspid teeth are considered an alternate service and will be payable as a comparable amalgam filling. *You* 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.
 - 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.
- Miscellaneous services as follows:
 - *Palliative dental care* for a *dental emergency* for the treatment 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 problem focused oral evaluation is provided during the same visit.
 - Re-cementing inlays, onlays and crowns.

Class III services

- Restorative services as follows:
 - Initial placement of laboratory-fabricated restorations, for a permanent tooth, when the tooth, as a result of extensive decay or a traumatic injury, cannot be restored with a direct placement filling material. *Pediatric dental services* include inlays, onlays, crowns, veneers, core build-ups and posts, implant supported crowns, and abutments. Limited to 1 per tooth every 5 years. Inlays are considered an alternate service and will be payable as a comparable amalgam filling.
 - Replacement of inlays, onlays, crowns or other laboratory-fabricated restorations for permanent teeth. *Pediatric dental services* include the replacement of the existing major restoration 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.

COVERED EXPENSES - PEDIATRIC DENTAL (continued)

- Periodontic services as follows:

- Periodontal scaling and root planing. Limited to 1 per quadrant every 2 years.
- Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation. Limited to 1 per year. This service will reduce the number of cleanings available so that the total number of cleanings does not exceed 1 per year.
- Periodontal maintenance (at least 30 days following periodontal therapy), unless a cleaning (prophylaxis) is performed on the same day. Limited to 4 every year.
- Periodontal and osseous surgical procedures, including bone replacement, tissue regeneration, gingivectomy, and gingivoplasty. Limited to 1 per quadrant every 3 years.
- Occlusal adjustments when performed in conjunction with a periodontal surgical procedure. Limited to 1 per quadrant every 3 years.
- Clinical crown lengthening - hard tissue.
- Tissue graft procedures, including: pedicle soft tissue graft procedure; free soft tissue graft procedure (including donor site surgery); and subepithelial connective tissue graft procedures (including donor site surgery).

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.
- Retreatment of previous root canal therapy. 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 reimplantation bone graft, and surgical isolation.
- Partial pulpotomy for apexogenesis for permanent teeth.
- Vital pulpotomy for primary teeth.
- Pulp debridement, pulpal 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.

COVERED EXPENSES - PEDIATRIC DENTAL (continued)

- Initial placement of bridges, complete dentures and partial dentures. Limited to 1 every 5 years. *Pediatric dental services* include pontics, inlays, onlays, and crowns. Limited to 1 per tooth every 5 years.
- 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.
- Denture relines or rebases. Limited to 1 every 3 years after 6 months of installation.
- Post and core build-up in addition to partial denture retainers with or without core build up. Limited to 1 per tooth every 5 years.
- The following simple oral surgical services as follows:
 - Extraction of coronal remnants of a primary tooth.
 - Extraction of an erupted tooth or exposed root for permanent and primary teeth.
- Implant services, subject to *clinical review*. Dental implants and related services, including implant supported bridges and provisional implant crown. Limited to 1 per tooth every 5 years. *Pediatric dental services* do not include an implant if it is determined a standard prosthesis or restoration will satisfy the dental need.

Implant supported removable denture for:

 - Edentulous arch – maxillary. Limited to 1 per tooth every 5 years.
 - Edentulous arch – mandibular. Limited to 1 per tooth every 5 years.
 - Partially edentulous arch – maxillary. Limited to 1 per tooth every 5 years.
 - Partially edentulous arch – mandibular. Limited to 1 per tooth every 5 years.
- Miscellaneous services as follows:
 - Recementing of bridges and implants.
 - Repairs of bridges, complete dentures, immediate dentures, partial dentures, and crowns.

COVERED EXPENSES - PEDIATRIC DENTAL (continued)

- 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, and periradicular surgical procedures, for *pediatric dental services*. General anesthesia is not considered a *pediatric dental service* if administered for 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.

Class IV services

Orthodontic treatment, not as a result of a *congenital anomaly*, when *medically necessary*.

Covered expenses for orthodontic treatment, not as a result of a *congenital anomaly*, include those that are:

- For the treatment of and appliances for tooth guidance, interception and correction.
- Related to covered orthodontic treatment, including:
 - X-rays.
 - Exams.
 - Space retainers.
 - Study models.

Covered expenses do not include services to alter vertical dimensions, restore or maintain the occlusion. Such procedures include equilibration, periodontal splinting, full mouth rehabilitation, and restoration for misalignment of teeth.

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.

COVERED EXPENSES - PEDIATRIC DENTAL (continued)

Pretreatment plan

We suggest that if dental treatment is expected to exceed \$300, *you or your 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 *your 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 *your 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 *your 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 *your dentist*, *we* recommend that *you* submit a new *treatment plan*.

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*. *You* will be responsible for any amount exceeding the *reimbursement limit*.

If *you* or *your dentist* decides 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 *coinsurance*. *You* will be responsible for any amount exceeding the *reimbursement limit*.

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.

COVERED EXPENSES - PEDIATRIC DENTAL (continued)

- Any expense for a service *we* consider *cosmetic*, unless it is due to an *accidental dental injury*.
- Expenses incurred for:
 - Precision or semi-precision attachments;
 - Overdentures and any endodontic treatment associated with overdentures;
 - Other customized attachments;
 - Any services for 3D imaging (cone beam images);
 - Temporary and interim dental services; or
 - Additional charges related to materials or equipment used in the delivery of dental care.
- Charges for services rendered:
 - In a dental facility or *health care treatment facility* sponsored or maintained by the *employer* under this plan or an employer of any *covered person* covered by the *policy*.
 - By an employee of any *covered person* covered by the *policy*.

For the purposes of this exclusion, *covered person* means the *employee* and the *employee's dependents* enrolled for benefits under the *policy* and as defined in the "Glossary" section.

- Any service related to:
 - Altering vertical dimension of teeth or changing the spacing and/or shape of the teeth;
 - Restoration or maintenance of occlusion;
 - Splinting teeth, including multiple abutments, or any service to stabilize periodontally weakened teeth;
 - Replacing tooth structures lost as a result of abrasion, attrition, erosion, or abfraction; or
 - Bite registration or bite analysis.
- Infection control, including 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 anesthesiologist.
- *Prescription* drugs or pre-medications, whether dispensed or prescribed.
- Any service that:
 - Is not eligible for benefits based on the *clinical review*;
 - Does not offer a favorable prognosis;
 - Does not have uniform professional acceptance; or
 - Is deemed to be experimental or investigational in nature.

COVERED EXPENSES - PEDIATRIC DENTAL (continued)

- 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.
- The following services when performed at the same time as a root canal:
 - Partial pulpotomy for apexogenesis;
 - Vital pulpotomy; or
 - Pulp debridement or pulpal therapy.

SAMPLE

COVERED EXPENSES - PEDIATRIC VISION CARE

This "Covered Expenses - Pediatric Vision Care" section describes the services that will be considered *covered expenses* for *pediatric vision care* under the *policy*. 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.

All terms used in this benefit have the same meaning given to them in this *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 terms and provisions of the *policy* apply.

Definitions

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; and 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 who is eligible and enrolled for benefits provided under the *policy* up to the end of the month following the date he or she attains age 19.

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

Reimbursement limit means the maximum fee allowed for *pediatric vision care*. *Reimbursement limit* for *pediatric vision care* is the lesser of:

- The actual cost for 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;

COVERED EXPENSES - PEDIATRIC VISION CARE

(continued)

- 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 a scale in terms of difficulty, work, risk, as well as the material and outside costs of providing the service, as adjusted to the geographical 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 & 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.

When you elect to utilize services from a *non-network provider* and you have the ability and opportunity to choose a *network provider*, 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* for *pediatric vision care*. *Covered expenses* for *pediatric vision care* are:

- *Comprehensive eye exam*.

COVERED EXPENSES - PEDIATRIC VISION CARE (continued)

- Prescription lenses and standard lens options, including polycarbonate, scratch coating, ultraviolet-coating, blended lenses, intermediate lenses, progressive lenses, photochromatic lenses, polarized lenses, fashion and gradient tinting, oversized lenses, glass-grey prescription sunglass lenses, anti-reflective coating, and hi-index lenses. If a *covered person* sees a *network provider*, the *network provider of materials* will show the *covered person* the selection of lens options covered by the *policy*. If a *covered person* selects a lens option that is not included in the lens option selection the *policy* covers, the *covered person* is responsible for the difference in cost between the *network provider of materials* reimbursement amount for covered lens options and the retail price of the lens options selected.
- Frames available from a selection of covered frames. If a *covered person* sees a *network provider*, 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 materials* reimbursement amount for covered frames and the retail price of the frame selected.
- Elective contact lenses available from a selection of covered contact lenses and *contact lens fitting and follow-up*. If a *covered person* sees a *network provider*, the *network provider of materials* will inform the *covered person* of the contact lens selection covered by the *policy*. If a *covered person* selects a contact lens that is not part of the contact lens selection the *policy* covers, the *covered person* is responsible for the difference in cost between the lowest cost contact lens available from the contact lens selection covered by the *policy* and the cost of the contact lens 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;
 - Keratoconus;
 - Aphakia;
 - High ametropia of either +10D or -10D in any meridian;
 - Pathological myopia;
 - Aniseikonia;
 - Aniridia;
 - Corneal disorders;
 - Post-traumatic disorders; or
 - Irregular astigmatism.
- *Low vision* services include the following:
 - Comprehensive *low vision* testing and evaluation;
 - *Low vision* supplementary testing; and
 - *Low vision* aids include the following:
 - Spectacle-mounted magnifiers;
 - Hand-held and stand magnifiers;
 - Hand-held or spectacle-mounted telescopes; and
 - Video magnification.

COVERED EXPENSES - PEDIATRIC VISION CARE

(continued)

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."

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:

- Orthoptic or vision training and any associated supplemental testing.
- Two or more pair of glasses, in lieu of bifocals or trifocals.
- Medical or surgical treatment of the eye, eyes or supporting structures.
- Any services and *materials* required by an *employer* as a condition of employment.
- Safety lenses and frames.
- Contact lenses, when benefits for frames and lenses are received.
- Cosmetic items.
- Any services or *materials* not listed in this benefit section as a covered benefit or in the "Schedule of Benefits - Pediatric Vision Care."
- Expenses for missed appointments.
- Any charge from a provider's 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.

COVERED EXPENSES - BEHAVIORAL HEALTH

This "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." Refer to the "Schedule of Benefits" for any service not specifically listed in the "Schedule of Benefits - Behavioral Health." Benefits are subject to any applicable:

- *Preauthorization* requirements;
- *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* apply, including *preauthorization* specified in this *certificate*.

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*.

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*, including *virtual visits*, in a *hospital* or *residential treatment facility*.

Emergency services

We will pay benefits for *covered expenses* incurred by you for *emergency care*, including the treatment and stabilization of an emergency condition for *mental health services* and *chemical dependency services*.

Emergency care provided by a *non-network hospital* or a *non-network health care practitioner* will be covered at the *network provider* benefit, as specified in the "Emergency services" benefit in the "Schedule of Benefits" or "Schedule of Benefits - Behavioral Health" sections of this *certificate*, subject to the *maximum allowable fee*.

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

Benefits under this "Emergency services" provision are not available if the services provided do not meet the definition of *emergency care*.

COVERED EXPENSES - BEHAVIORAL HEALTH (continued)

Urgent care services

We will pay benefits for *urgent care covered expenses* incurred by you for charges made by an *urgent care center* or an *urgent care qualified provider* for *mental health services* and *chemical dependency services*.

Outpatient services

We will pay benefits for *covered expenses* incurred by you for *mental health services* and *chemical dependency services*, including services in a *health care practitioner's office* or *retail clinic*, *outpatient therapy*, *outpatient services* provided as a part of an *intensive outpatient program*, *partial hospitalization*, and other *outpatient services*.

Skilled nursing facility services

We will pay benefits for *covered expenses* incurred by you in a *skilled nursing facility* for *mental health services* and *chemical dependency services*. *Your confinement to a skilled nursing facility* must be based upon a written recommendation of a *health care practitioner*.

Covered expenses also include *health care practitioner services* for *behavioral health* during your *confinement* in a *skilled nursing facility*.

Home health care services

We will pay benefits for *covered expenses* incurred by you, in connection with a *home health care plan*, for *mental health services* and *chemical dependency services*. 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*.

Home health care *covered expenses* include services provided by a *health care practitioner* who is a *behavioral health* professional, such as a counselor, psychologist or psychiatrist.

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*;
- Charges for services of a home health aide;
- *Custodial care*; or
- The provision or administration of *self-administered injectable drugs*, unless otherwise determined by *us*.

COVERED EXPENSES - BEHAVIORAL HEALTH (continued)

Specialty drug benefit

We will pay benefits for *covered expenses* incurred by you for *behavioral health specialty drugs* provided by or obtained from a *qualified provider* in the following locations:

- *Health care practitioner's office;*
- *Free-standing facility;*
- *Urgent care center;*
- *A home;*
- *Hospital;*
- *Skilled nursing facility;*
- *Ambulance; and*
- *Emergency room.*

Specialty drugs may be subject to *preauthorization* requirements. Refer to the "Schedule of Benefits" in this *certificate* for *preauthorization* requirements and contact us prior to receiving *specialty drugs*.

Specialty drug benefits do not include the charge for the actual administration of the *specialty drug*. Benefits for the administration of *specialty drugs* are based on location of the services and type of provider.

Residential treatment facility services

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

Autism spectrum disorders

We will pay benefits for *covered expenses* incurred by covered *dependents* who have been diagnosed as having a developmental disability.

Covered expenses include:

- Well-baby and well-child screening to diagnose the presence of *autism spectrum disorder*; and
- Treatment of *autism spectrum disorder* through:
 - Speech therapy;
 - Occupational therapy;
 - Physical therapy; and
 - Applied behavior analysis provided by a certified behavior analyst, psychologist, psychotherapist, clinical social worker, marriage and family therapist, or mental health counselor.

COVERED EXPENSES - PHARMACY SERVICES

This "Covered Expenses - Pharmacy Services" section describes *covered expenses* under the *policy* for *prescription* drugs, including *specialty drugs*, dispensed by a *pharmacy*. Benefits are subject to applicable *cost share* shown on the "Schedule of Benefits - Pharmacy Services" section of this *certificate*.

Refer to the "Limitations and Exclusions," "Limitations and Exclusions - Pharmacy Services," "Glossary" and "Glossary - Pharmacy Services" sections in this *certificate*. All terms and provisions of the *policy* apply, including *prior authorization* requirements specified in the "Schedule of Benefits - Pharmacy Services" of this *certificate*.

Coverage description

We will cover *prescription* drugs that are received by *you* under this "Covered Expenses - Pharmacy Services" section. Benefits may be subject to *dispensing limits*, *prior authorization* and *step therapy* requirements, if any.

Covered *prescription* drugs are:

- Drugs, medicines or medications and *specialty drugs* that under federal or state law may be dispensed only by *prescription* from a *health care practitioner*.
- Drugs, medicines or medications and *specialty drugs* included on *our drug list*.
- Insulin and *diabetes supplies*.
- *Self-administered injectable drugs* approved by *us*.
- Hypodermic needles, syringes or other methods of delivery when prescribed by a *health care practitioner* for use with insulin or *self-administered injectable drugs*. (Hypodermic needles, syringes or other methods of delivery used in conjunction with covered drugs may be available at no cost to *you*.)
- Enteral formulas and nutritional supplements for the treatment of phenylketonuria (PKU) or other inherited metabolic disease, or as otherwise determined by *us*.
- Spacers and/or peak flow meters for the treatment of asthma.
- Drugs, medicines or medications on the Preventive Medication Coverage *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.

COVERED EXPENSES - PHARMACY SERVICES (continued)

Restrictions on choice of providers

If we determine you are using *prescription* drugs in a potentially abusive, excessive, or harmful manner, we may restrict your coverage of *pharmacy* services in one or more of the following ways:

- By restricting your choice of *pharmacy* to a single *network pharmacy* store or physical location for *pharmacy* services;
- By restricting your choice of *pharmacy* for covered *specialty pharmacy* services to a specific *specialty pharmacy*, if the *network pharmacy* store or physical location for *pharmacy* services is unable to provide or is not contracted with us to provide covered *specialty pharmacy* services; and
- By restricting your choice of a prescribing *network health care practitioner* to a specific *network health care practitioner*.

We will determine if we will allow you to change a selected *network provider*. Only *prescriptions* obtained from the *network pharmacy* store or physical location or *specialty pharmacy* to which you have been restricted will be eligible to be considered *covered expenses*. Additionally, only *prescriptions* prescribed by the *network health care practitioner* to whom you have been restricted will be eligible to be considered *covered expenses*.

About our drug list

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

Access to medically necessary contraceptives

In addition to *preventive services*, contraceptives on our *drug list* and non-formulary contraceptives may be covered at no *cost share* when your *health care practitioner* contacts us. We will defer to the *health care practitioner's* recommendation that a particular method of contraception or FDA-approved contraceptive is determined to be *medically necessary*. The *medically necessary* determination made by your *health care practitioner* may include severity of side effects, differences in permanence and reversibility of contraceptives, and ability to adhere to the appropriate use of the contraceptive item or service.

COVERED EXPENSES - PHARMACY SERVICES (continued)

Access to non-formulary drugs

A drug not included on *our drug list* is a non-formulary drug. If a *health care practitioner* prescribes a clinically appropriate non-formulary drug, *you* can request coverage of the non-formulary drug through a standard exception request or an expedited exception request. If *you* are dissatisfied with *our* decision of an exception request, *you* have the right to an external review as described in the "Non-formulary drug exception request external review" provision of this section.

Non-formulary drug standard exception request

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

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

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

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

If *we* deny a standard exception request, *you* have the right to an external review as described in the "Non-formulary drug exception request external review" provision of this section.

Non-formulary drug expedited exception request

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

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

COVERED EXPENSES - PHARMACY SERVICES (continued)

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

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

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

- Without unreasonable delay; and
- For the duration of the exigent circumstance.

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

If *we* deny an expedited exception request, *you* have the right to an external review as described in the "Non-formulary drug exception request external review" provision of this section.

Non-formulary drug exception request external review

You or *your* appointed representative, or *your* prescribing *health care practitioner* have the right to an external review by an independent review organization if *we* deny a non-formulary drug standard or expedited exception request. To request an external review, refer to the exception request decision letter for instructions or call the customer service number on *your* ID card for assistance.

The final external review decision by the independent review organization to either uphold the denied exception request or grant the exception request will be provided orally or in writing to *you*, *your* appointed representative, or the prescribing *health care practitioner* no later than:

- 24 hours after receipt of an external review request if the original exception request was expedited.
- 72 hours after receipt of an external review request if the original exception request was standard.

If the independent review organization grants the exception request, *we* will cover the prescribed, clinically appropriate non-formulary drug for *you* for:

- The duration of the *prescription*, including refills, when the original request was a standard exception request.
- The duration of the exigent circumstance when the original request was an expedited exception request.

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

COVERED EXPENSES - PHARMACY SERVICES (continued)

Step therapy exception request

Your health care practitioner may submit to us a written step therapy exception request for a clinically appropriate prescription drug. The health care practitioner should use the prior authorization form on our Website at www.humana.com or call the customer service telephone number on your ID card.

From the time a *step therapy* exception request is received by *us*, *we* will either approve or deny the request within:

- 24 hours for an expedited request.
- 72 hours for a standard request.

A covered *prescription* drug on *our drug list* will not be subject to *step therapy* if:

- The *covered person* has previously been approved to receive the *prescription* drug by completing step therapy required by a prior health carrier; and
- The *covered person* provides *us* documentation from the prior health carrier that approved the *prescription* drug indicating the prior health carrier paid for the *prescription* drug during the 90 days immediately before the request for coverage under this *certificate*.

A written *step therapy* exception request will be approved when the request includes the prescribing *health care practitioner's* written statement and supporting documentation that:

- The *prescription* drug requiring *step therapy* has been ineffective in the treatment of *your* disease or medical condition; or
- Based on sound clinical evidence or medical and scientific evidence, the *prescription* drug requiring *step therapy*:
 - Is expected or likely to be ineffective based on *your* known relevant clinical characteristics and the known characteristics of the *prescription* drug regimen; or
 - Will cause or will likely cause an adverse reaction in or physical harm to *you*.

If *we* deny a *step therapy* exception request, *we* will provide *you* or *your* appointed representative, and *your* prescribing *health care practitioner*:

- The reason for the denial;
- An alternative covered medication; and
- The right to appeal *our* decision as described in the "Complaint and Appeals Procedures" section of this *certificate*.

LIMITATIONS AND EXCLUSIONS

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*.

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

- Treatments, services, supplies or *surgeries* that are not *medically necessary*, except *preventive services*.
- A *sickness* or *bodily injury* for which benefits are paid or received under any Workers' Compensation or similar law.
- Care and treatment given in a *hospital* owned or run by any government entity, unless *you* are legally required to pay for such care and treatment. However, care and treatment provided by military *hospitals* to *covered persons* who are armed services retirees and their dependents are not excluded.
- Any service furnished while *you* are *confined* in a *hospital* or institution owned or operated by the United States government or any of its agencies for any military service-connected *sickness* or *bodily injury*.
- Services, or any portion of a service, for which no charge is made.
- Services, or any portion of a service, *you* would not be required to pay for, or would not have been charged for, in the absence of *this insurance*.
- Any portion of the amount *we* determine *you* owe for a service that the provider waives, rebates or discounts, including *your copayment, deductible or coinsurance*.
- *Sickness* or *bodily injury* for which *you* are in any way paid or entitled to payment or care and treatment by or through a government program.
- Any service not ordered by a *health care practitioner*.
- Private duty nursing.
- Services rendered by a standby physician or certified operating room technician unless *medically necessary*.
- Any service not rendered by the billing provider.
- Any service not substantiated in the medical records of the billing provider.
- Expenses for services, *prescriptions*, equipment or supplies received outside the United States or from a foreign provider, unless:
 - For *emergency care*;

LIMITATIONS AND EXCLUSIONS (continued)

- The *employee* is traveling outside the United States due to employment with the *employer* sponsoring the *policy* and the services are not covered under any Workers' Compensation or similar law; or
- The *employee* and *dependents* live outside the United States and the *employee* is in *active status* with the *employer* sponsoring the *policy*.
- Education or training, except for *diabetes self-management training* and *habilitative services*.
- Educational or vocational therapy, testing, services or schools, including therapeutic boarding schools and other therapeutic environments. Educational or vocational videos, tapes, books and similar materials are also excluded.
- Services provided by a *covered person's family member*.
- *Ambulance* services for routine transportation to, from, or between medical facilities and/or a *health care practitioner's office*.
- Any drug, biological product, device, medical treatment, or procedure which is *experimental, investigational* or *for research purposes*.
- Vitamins, except for *preventive services* with a *prescription* from a *health care practitioner*, dietary supplements, and dietary formulas, except *enteral formulas*, nutritional supplements or low protein modified food products for the treatment of an *inherited metabolic disease*, e.g. phenylketonuria (PKU).
- Over-the-counter, non-prescription medications, unless for drugs, medicines or medications or supplies on the Preventive Medication Coverage *drug list* with a *prescription* from a *health care practitioner*.
- Over-the-counter medical items or supplies that can be provided or prescribed by a *health care practitioner* but are also available without a written order or *prescription*, except for *preventive services*.
- Immunizations required for foreign travel for a *covered person* of any age.
- Growth hormones, except as otherwise specified in the pharmacy services sections of this *certificate*.
- *Prescription* drugs and *self-administered injectable drugs*, except as specified in the "Covered Expenses - Pharmacy Services" section in this *certificate* or unless administered to *you*:
 - While an *inpatient* in a *hospital, skilled nursing facility, health care treatment facility, or residential treatment facility*;
 - By the following, when deemed appropriate by *us*:
 - A *health care practitioner*:
 - During an office visit; or
 - While an *outpatient*; or

LIMITATIONS AND EXCLUSIONS (continued)

- 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; implantable hearing devices, except for cochlear implants as otherwise stated in this *certificate*.
- Services received in an emergency room, unless required because of *emergency care*.
- Weekend non-emergency *hospital admissions*, specifically *admissions* to a *hospital* on a Friday or Saturday at the convenience of the *covered person* or his or her *health care practitioner* when there is no cause for an emergency *admission* and the *covered person* receives no *surgery* or therapeutic treatment until the following Monday.
- *Hospital inpatient* services when you are in *observation status*.
- *Infertility services*; or reversal of elective sterilization.
- In vitro fertilization regardless of the reason for treatment.
- Services for or in connection with a transplant or *immune effector cell therapy* if:
 - The expense relates to storage of cord blood and stem cells, unless it is an integral part of a transplant approved by *us*.
 - Not approved by *us*, based on *our* established criteria.
 - Expenses are eligible to be paid under any private or public research fund, government program except *Medicaid*, or another funding program, whether or not such funding was applied for or received.
 - The expense relates to the transplantation of any non-human organ or tissue, unless otherwise stated in the *policy*.
 - The expense relates to the donation or acquisition of an organ or tissue for a recipient who is not covered by *us*.
 - The expense relates to a transplant or *immune effector cell therapy* performed outside of the United States and any care resulting from that transplant or *immune effector cell therapy*. This exclusion applies, even if the *employee* and *dependents* live outside the United States and the *employee* is in *active status* with the *employer* sponsoring the *policy*.
- Services provided for:
 - Immunotherapy for recurrent abortion;
 - Chemonucleolysis;
 - Sleep therapy;
 - Light treatments for Seasonal Affective Disorder (S.A.D.);
 - Immunotherapy for food allergy;
 - Prolotherapy; or
 - Sensory integration therapy.
- *Cosmetic surgery* and cosmetic services or devices.

LIMITATIONS AND EXCLUSIONS (continued)

- Hair prosthesis, hair transplants or implants and wigs.
- Dental services, appliances or supplies 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 hyperkeratosis;
 - The treatment of tarsalgia, metatarsalgia, or bunion, except surgically;
 - The cutting of toenails, except the removal of the nail matrix;
 - Heel wedges, lifts, or shoe inserts; and
 - Arch supports (foot orthotics) or orthopedic shoes, except for diabetes or 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.
- Services relating to a *sickness* or *bodily injury* as a result of:
 - Engagement in an illegal profession or occupation; or
 - Commission of or an attempt to commit a criminal act.

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

- Expenses for any membership fees or program fees, including 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;

LIMITATIONS AND EXCLUSIONS (continued)

- Personal comfort items including cervical pillows, gravity lumbar reduction chairs, swimming pools, whirlpools, spas or saunas;
 - Medical equipment including:
 - Blood pressure monitoring devices, unless prescribed by a *health care practitioner* for *preventive services* and ambulatory blood pressure monitoring is not available to confirm diagnosis of hypertension;
 - PUVA lights; and
 - Stethoscopes;
 - Communication system, telephone, television or computer systems and related equipment or similar items or equipment;
 - Communication devices, except after surgical removal of the larynx or a diagnosis of permanent lack of function of the larynx.
- Duplicate or similar rentals or purchases of *durable medical equipment* or *diabetes equipment*.
 - Therapy and testing for treatment of allergies, including services related to clinical ecology, environmental allergy and allergic immune system dysregulation and sublingual antigen(s), extracts, neutralization tests and/or treatment unless such therapy or testing is approved by:
 - The American Academy of Allergy and Immunology; or
 - The Department of Health and Human Services or any of its offices or agencies.
 - Lodging accommodations or transportation.
 - Communications or travel time.
 - Bariatric *surgery*, any services or complications related to bariatric *surgery*, and other weight loss products or services.
 - *Sickness* or *bodily injury* for which no-fault medical payment or expense coverage benefits are paid or payable under any automobile, homeowners, premises or any other similar coverage.
 - Elective medical or surgical abortion unless:
 - The pregnancy would endanger the life of the mother; or
 - The pregnancy is a result of rape or incest.
 - *Alternative medicine*.
 - Acupuncture, unless:
 - The treatment is *medically necessary*, appropriate and is provided within the scope of the acupuncturist's license; and
 - *You* are directed to the acupuncturist for treatment by a licensed physician.

LIMITATIONS AND EXCLUSIONS (continued)

- Services rendered in a premenstrual syndrome clinic or holistic medicine clinic.
- Services of a midwife, unless provided by a Licensed Midwife or 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/vision training (eye exercises).
- Radial keratotomy, refractive keratoplasty or any other *surgery* or procedure to correct myopia, hyperopia or stigmatic error.
- The purchase or fitting of eyeglasses or contact lenses, except as:
 - The result of an *accident* or following cataract *surgery* as stated in this *certificate*.
 - Otherwise specified in the "Covered Expenses - Pediatric Vision Care" section in this *certificate*.
- Services and supplies which are:
 - Rendered in connection with mental illnesses not classified in the International Classification of Diseases of the U. S. Department of Health and Human Services; or
 - Extended beyond the period necessary for evaluation and diagnosis of learning and behavioral disabilities or for mental retardation.
- Marriage counseling.
- Expenses for employment, school, sport or camp physical examinations or for the purposes of obtaining insurance.
- Expenses for care and treatment of non-covered procedures or services.
- Expenses for treatment of complications of non-covered procedures or services.
- Expenses incurred for services prior to the *effective date* or after the termination date of *your* coverage under the *policy*. Coverage will be extended as described in the "Extension of Benefits" section, as required by state law.
- *Pre-surgical/procedural testing* duplicated during a *hospital confinement*.

LIMITATIONS AND EXCLUSIONS - PHARMACY SERVICES

This "Limitations and Exclusions – Pharmacy Services" section describes the limitations and exclusions under the *policy* that apply to *prescription* drugs, including *specialty drugs*, dispensed by a *pharmacy*. Please refer to the "Limitations and Exclusions" section of this *certificate* for additional limitations.

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

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

- *Legend drugs*, which are not deemed *medically necessary* by *us*.
- *Prescription* drugs not included on the *drug list*.
- Any amount exceeding the *default rate*.
- *Specialty drugs* for which coverage is not approved by *us*.
- Drugs not approved by the FDA.
- Any drug prescribed for intended use other than for:
 - Indications approved by the FDA; or
 - Off-label indications recognized through peer-reviewed medical literature or standard reference compendium.
- 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, investigational* or *for research purposes*,even though a charge is made to *you*.
- Allergen extracts.
- Therapeutic devices or appliances, including:
 - Hypodermic needles and syringes (except when prescribed by a *health care practitioner* for use with insulin and *self-administered injectable drugs*, whose coverage is approved by *us*);
 - Support garments;
 - Test reagents;
 - Mechanical pumps for delivery of medications; and
 - Other non-medical substances.

LIMITATIONS AND EXCLUSIONS - PHARMACY SERVICES

(continued)

- Dietary supplements and nutritional products, except enteral formulas and nutritional supplements for the treatment of phenylketonuria (PKU) or other inherited metabolic disease. Refer to the "Covered Expenses" section of the *certificate* for coverage of low protein modified foods.
- Non-prescription, over-the-counter minerals, except as specified on the Preventive Medication Coverage *drug list* when obtained from a *network pharmacy* with a *prescription* from a *health care practitioner*.
- Growth hormones for idiopathic short stature or any other condition, unless there is a laboratory confirmed diagnosis of growth hormone deficiency, or as otherwise determined by *us*.
- Herbs and vitamins, except prenatal (including greater than one milligram of folic acid), pediatric multi-vitamins with fluoride and vitamins on the Preventive Medication Coverage *drug list* when obtained from a *network pharmacy* with a *prescription* from a *health care practitioner*.
- Any drug used for the purpose of weight loss.
- Any drug used for cosmetic purposes, including:
 - Dermatologicals or hair growth stimulants; or
 - Pigmenting or de-pigmenting agents.
- Any drug or medicine that is lawfully obtainable without a *prescription* (over-the-counter drugs), except:
 - Insulin; and
 - Drugs, medicines or medications and supplies on the Preventive Medication Coverage *drug list* when obtained from a *network pharmacy* with a *prescription* from a *health care practitioner*.
- Compounded drugs that:
 - Are prescribed for a use or route of administration that is not FDA-approved or compendia supported;
 - Are prescribed without a documented medical need for specialized dosing or administration;
 - Only contain ingredients that are available over-the-counter;
 - Only contain non-commercially available ingredients; or
 - Contain ingredients that are not FDA-approved, including bulk compounding powders.
- Abortifacients (drugs used to induce abortions).
- *Infertility services* including medications.
- Any drug prescribed for impotence and/or sexual dysfunction.
- Any drug, medicine or medication that is consumed or injected at the place where the *prescription* is given, or dispensed by the *health care practitioner*.

LIMITATIONS AND EXCLUSIONS - PHARMACY SERVICES (continued)

- 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 on an *inpatient* basis by the facility.
Inpatient facilities include:
 - *Hospital*;
 - *Skilled nursing facility*; or
 - *Hospice facility*.
- Injectable drugs, including:
 - Immunizing agents, unless for *preventive services* determined by *us* to be dispensed by or administered in a *pharmacy*;
 - Biological sera;
 - Blood;
 - Blood plasma; or
 - *Self-administered injectable drugs* or *specialty drugs* for which *prior authorization* or *step therapy* is not obtained from *us*.
- *Prescription* fills or refills:
 - In excess of the number specified by the *health care practitioner*; or
 - Dispensed more than one year from the date of the original order.
- Any portion of a *prescription* fill or refill that exceeds a 90-day supply when received from a *mail order pharmacy* or a retail *pharmacy* that participates in *our* program, which allows *you* to receive a 90-day supply of a *prescription* fill or refill.
- Any portion of a *prescription* fill or refill that exceeds a 30-day supply when received from a retail *pharmacy* that does *not* participate in *our* program, which allows *you* to receive a 90-day supply of a *prescription* fill or refill.
- Any portion of a *specialty drug prescription* fill or refill that exceeds a 30-day supply, unless otherwise determined by *us*.
- Any portion of a *prescription* fill or refill that:
 - Exceeds *our* drug-specific *dispensing limit*;
 - Is dispensed to a *covered person*, whose age is outside the drug-specific age limits defined by *us*;
 - Is refilled early, as defined by *us*; or
 - Exceeds the duration-specific *dispensing limit*.
- Any drug for which *we* require *prior authorization* or *step therapy* and it is not obtained.
- Any drug for which a charge is customarily not made.

LIMITATIONS AND EXCLUSIONS - PHARMACY SERVICES

(continued)

- Any drug, medicine or medication received by *you*:
 - Before becoming covered; or
 - After the date *your* coverage has ended.
- Any costs related to the mailing, sending or delivery of *prescription* drugs.
- Any intentional misuse of this benefit, including *prescriptions* purchased for consumption by someone other than *you*.
- Any *prescription* fill or refill for drugs, medicines or medications that are lost, stolen, spilled, spoiled, or damaged.
- Drug delivery implants and other implant systems or devices.
- 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*.

SAMPLE

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 birth of a child born to an *employee's* covered dependent child;
- The date a foster child is placed in the *employee's* home;
- The date of placement of the child for the purpose of adoption by the *employee*; 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.

Enrollment

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

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.

ELIGIBILITY AND EFFECTIVE DATES (continued)

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.

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.

Newborn, adopted and foster dependent enrollment

A newborn *dependent* will be automatically covered from the date of birth to 31 days of age. A newborn adopted child will be covered from the moment of birth if a written agreement to adopt the child has been entered into by the *employee* prior to the birth of the child, whether or not such agreement is enforceable. Coverage for a newborn adopted child is not available in the event the child is not ultimately placed in the residence of the *employee*. An adopted *dependent*, that is not a newborn, will be automatically covered from the date of adoption or date of placement of the child with the *employee* for the purpose of adoption, whichever occurs first, for 31 days. A foster *dependent* will be automatically covered from the date of placement of the child for 31 days. No additional premium will be charged for the first 31 days of coverage if notice is given to *us* within 31 days after the birth of the newborn *dependent*, date of adoption or date of placement of the adopted *dependent* or date of placement of the foster *dependent*.

If *dependent* child coverage is in force as of the newborn's date of birth in the case of newborn *dependents* and newborn adopted children, the earlier of the date of adoption or date of placement of the child with the *employee* for purposes of adoption in the case of adopted *dependents*, or the date of placement of the foster child, coverage will continue beyond the initial 31 days. *You* must notify *us* to make sure *we* have accurate records to administer benefits.

If *dependent* child coverage is not in force, *you* must enroll the *dependent* child within 60 days after the date of birth of the newborn *dependent* and newborn adopted child, date of adoption or date of placement of the adopted *dependent*, or date of placement of the foster *dependent*. *We* will provide at least a 45-day notice of the additional premium *you* must pay for *dependent* child coverage.

If enrollment is requested more than 60 days after the date of birth, date of adoption or date of placement with the *employee* for the purpose of adoption or date of placement of the foster child, the *dependent* 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.

ELIGIBILITY AND EFFECTIVE DATES (continued)

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 date of placement of a child with the *employee* for the purpose of adoption or date of placement of a foster child; 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 the limiting age;
 - Termination of your employer's contribution for the coverage;
 - Loss of individual HMO coverage because you no longer reside, live or work in the service area;
 - Loss of group HMO coverage because you no longer reside, live or work in the service area, and no other benefit package is available;
 - The plan no longer offers benefits to a class of similarly situated individuals; or
- You had COBRA continuation coverage under another plan at the time of eligibility, and:
 - Such coverage has since been exhausted; and
 - You stated at the time of the initial enrollment that coverage under COBRA was your reason for declining enrollment; and
 - You enroll within 31 days after the *special enrollment date*; or
- You were covered under an alternate plan provided by the *employer* that terminates, and:
 - You are replacing coverage with the *policy*; and
 - You enroll within 31 days after the *special enrollment date*; or

ELIGIBILITY AND EFFECTIVE DATES (continued)

- 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*, who 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.

ELIGIBILITY AND EFFECTIVE DATES (continued)

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* who 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*.

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* who 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, adopted and foster dependent effective date

The *effective date* of coverage for a newborn *dependent* is the date of birth if the newborn is not a *late applicant*.

The *effective date* of coverage for an adopted *dependent* is the date of adoption or the date of placement with the *employee* for the purpose of adoption, whichever occurs first, if the *dependent* child is not a *late applicant*. In the case of a newborn adopted *dependent*, the *effective date* of coverage will be the birth date of the child if a written agreement for adoption has been entered into by the *employee*. Otherwise, the *effective date* of coverage will be the date of the adopted *dependent's* placement in the home of the *employee*. No coverage will be provided under this provision for a child who is not ultimately placed in the *employee's* home.

The *effective date* of coverage for a foster *dependent* is the date of placement with the *employee* if the foster child is not a *late applicant*. Coverage for the foster *dependent* will terminate the date the *employee* no longer has legal custody of the child.

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*.

ELIGIBILITY AND EFFECTIVE DATES (continued)

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 the *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.

REPLACEMENT OF COVERAGE

Applicability

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

Deductible and out-of-pocket limit credit

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

- Incurred in the same calendar year the *policy* first becomes effective; and
- Applied to the network deductible or out-of-pocket limit amount 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.

Out-of-pocket limit

Any medical expense amount applied to the Prior Plan's network *out-of-pocket* limit or stop-loss limit will be credited to your *network provider out-of-pocket limit* under the *policy* if the medical expense was incurred in the same calendar year the *policy* first becomes effective.

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 and *your employer* must notify *us* as soon as possible if *you* or *your dependent* no longer meets the eligibility requirements of the *policy*. Notice must 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* or *employee* or at the end of that month, as selected by *your employer* on the EGA.

When *we* receive the *employer's* request to terminate coverage retroactively, the *employer's* termination request is their representation to *us* that *you* did not pay any premium or make contribution for coverage past the requested termination date.

Otherwise, insurance terminates on the earliest of the following:

- The date the *group policy* terminates;
- The end of the period for which required premium was paid to *us*;
- The date the *employee* terminated employment with the *employer*;
- The date the *employee* is no longer qualified as an *employee*;
- The date *you* fail to be in an eligible class of persons as stated in the EGA;
- The date the *employee* entered full-time military, naval or air service;
- The date 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 a newborn child born to an *employee's* covered *dependent* child, the date he or she is 18 months of age;

TERMINATION PROVISIONS (continued)

- For any benefit, the date the benefit is deleted from the *policy*; or
- The date 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*.

Termination for cause

We will 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 or intentional misrepresentation on claims, identification cards or other identification in order to obtain services or a higher level of benefits. This includes the fabrication or alteration of a claim, identification card or other identification.

EXTENSION OF BENEFITS

Extension of health insurance for total disability

When the *policy* terminates, *we* will pay claims for *covered expenses* received before the date the *policy* terminated. *We* will not pay claims for services received after the *policy* terminated, except as described below.

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.

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 *your health care practitioner* certifies *you* are no longer *totally disabled*; or
- The date any maximum benefit is reached; or
- The last day of a 12 consecutive month period following the date *the policy* terminated.

No insurance is extended to a child born as a result of a *covered person's* pregnancy.

For pregnancy, maternity benefits will continue until the date of delivery, provided the pregnancy began after *your* effective date and prior to the termination of the *policy*. This extension will not be based on *total disability*.

The "Extension of health insurance for total disability" provision does not apply to covered retired persons.

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; 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" provision follows.

State continuation of health insurance

The following provisions apply only to *small employer groups* who are not currently protected by the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985.

If a *covered person* is no longer eligible for the insurance benefits provided by the *small employer group policy* because of one of the *qualifying events* described below, that person may choose to continue these benefits under the *group policy* as a *qualified beneficiary*. He or she will then be responsible for payment of the appropriate premium for the continued coverage, including any portion that the *employer* may have paid on his or her behalf. The *qualified beneficiary* will be responsible for sending us the premium payments to continue their insurance.

Persons eligible to continue are called *qualified beneficiaries*. *Qualified beneficiary* means, any individual who, on the day before the *qualifying event* for the *covered person*, is a beneficiary under the *group health plan* by virtue of the individual being; the covered *employee*, except if the *employee* is terminated for gross misconduct, the spouse of the covered *employee*, or the *dependent child* of the covered *employee*.

Qualifying events, notification requirements and the period of time for which coverage may be continued are as follows:

Qualifying events mean, with respect to any *covered person*, any of the following events which, but for the election of continuation of coverage, would result in a loss of coverage to a *qualified beneficiary*:

- The death of the covered *employee*.
- The termination or reduction of hours of the covered *employee's* employment, except that termination of an *employee* for gross misconduct does not constitute a *qualifying event*. The *employer's* decision to terminate for gross misconduct is conclusive as to the carrier.
- The divorce or legal separation of the covered *employee* from the covered *employee's* spouse.
- A covered *employee's* becoming entitled to benefits under either Part A or Part B of Title XVIII of the United States Social Security Act (*Medicare*).

CONTINUATION (continued)

- A *dependent* child's ceasing to be a *dependent* child under the requirements of the *group* health plan.
- A retiree or the spouse or child of a retiree losing coverage within one year before or after commencement of a bankruptcy proceeding under title XI of the United States Code by the *employer* from whose employment the covered *employee* retired.

Coverage under the *group* health plan must, at a minimum, extend for the period beginning on the date of the *qualifying event* and ending not earlier than the earliest of the following:

- The date that is 18 months after the date on which the *qualified beneficiary's* benefits under the *group* health plan would otherwise have ceased because of a *qualifying event*.
- The date on which coverage ceases under the *group* health plan by reason of a failure to make timely payment of the applicable premium with respect to any *qualified beneficiary*.
- The date a *qualified beneficiary* becomes covered under any other group health plan.
- The date a *qualified beneficiary* is entitled to benefits under either Part A or Part B of Title XVIII of the Social Security Act (*Medicare*).
- The date the *policy* terminates.

A *qualified beneficiary* must notify *us* within 63 days of the *qualifying event*. Within 14 days of receipt of the notice of a *qualifying event*, *we* will provide a form on which to indicate election of continued coverage and premium notice form. The form and premium payment must be returned to *us* within 30 days of receipt.

CONTINUATION OF COVERAGE FOR ACTIVE MILITARY SERVICE

Coverage and premium

Continuation of coverage is available for an *employee* and their covered *dependents* while the *employee* is called to *active duty* or *state active duty*. The *employee* will have the same premium in effect for other insureds under the same *policy*.

Notification

The *employee*, or an appropriate military authority, must notify the *employer* that the *employee* wishes to continue coverage before reporting for *active duty* or *state active duty*.

This notice is not required if impossible or unreasonable (such as an immediate call-up in a natural disaster emergency) or if military necessity precludes it.

Reinstatement of coverage

The *employee* is not required to continue coverage while on *active duty* or *state active duty*. If coverage is not continued, the *employee* will have 63 days to request reinstatement upon returning to work with the same *employer*. There will be no waiting period, nor may any condition existing at the time of call-up prevent them from reinstatement.

Continuation

If health insurance terminates:

- It may be continued as described in the Uniformed Services Employment and Reemployment Rights Act (USERRA);
- It may be continued as described in the "State continuation of health insurance" provision; or
- It may be continued under the continuation provisions as provided by the Consolidated Omnibus Budget Reconciliation Act (COBRA), if applicable.

Definitions

The following terms are used in this provision:

Active duty: full-time duty in the active military service of the United States.

State active duty: those periods when the Governor orders the National Guard into service, typically in response to natural disasters or civic disorders.

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 contracts, health maintenance organization (HMO) contracts, closed panel or other forms of group or group-type coverage (whether insured or uninsured);
- Medical care components of long-term care contracts, such as skilled nursing care;
- Homeowners coverage;
- Medical benefits under group or individual contracts, including "No Fault" and Medical Payments coverages; and
- *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;
- 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*.

Notwithstanding any statement to the contrary, for the purposes of COB, prescription drug coverage under this *plan* 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.

COORDINATION OF BENEFITS (continued)

Allowable expense means a health care service or expense, including deductibles, if any 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 is 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.

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 has 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.

COORDINATION OF BENEFITS (continued)

- 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 coverages that are superimposed over base *plan* hospital and surgical benefits, and insurance type coverages 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*.
- **Dependent 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 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 without specifying that one parent 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*;

COORDINATION OF BENEFITS (continued)

- 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*.

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 than 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*.

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*.

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.

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.

COORDINATION OF BENEFITS (continued)

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.

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. 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.

SAMPLE

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 within 90 days after a covered loss starts or as soon as reasonably possible. Notice must be sent to *us* at *our* mailing address shown on *your* identification documentation or to *your* agent. Notice should include the name of the *covered person* and the policy number.

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 *you* incur such loss. *Your* claims will not be reduced or denied if it was not reasonably possible to give such proof within that time period.

Your claims may be reduced or denied if written or *electronic* proof of loss is not provided to *us* within one year after the date proof of loss is required, unless *your* failure to timely provide that proof of loss is due to *your* legal incapacity as determined by an appropriate court of law.

CLAIMS (continued)

Claims processing procedures

Qualified provider services are subject to *our* claims processing procedures. We use *our* claims processing procedures to determine payment of *covered expenses*. *Our* claims processing procedures include claims processing edits and claims payment policies, as determined by *us*. *Your qualified provider* may access *our* claims processing edits and claims payment policies on *our* Website at www.humana.com by clicking on "For Providers" and "Claims Resources."

Claims processing procedures include the interaction of a number of factors. The amount determined to be payable for a *covered expense* may be different for each claim because the mix of factors may vary. Accordingly, it is not feasible to provide an exhaustive description of the claims processing procedures, but examples of the most commonly used factors are:

- The complexity of a service;
- Whether a service is one of multiple same-day services such that the cost of the service to the *qualified provider* is less than if the service had been provided on a different day. For example:
 - Two or more *surgeries* performed the same day;
 - Two or more endoscopic procedures performed during the same day; or
 - Two or more therapy services performed the same day;
- Whether a *co-surgeon, assistant surgeon, surgical assistant*, or any other *qualified provider*, 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;
- Whether the service is reasonably expected to be provided for the diagnosis reported;
- Whether a service was performed specifically for *you*; or
- Whether services can be billed as a complete set of services under one billing code.

We develop *our* claims processing procedures in *our* sole discretion based on *our* review of correct coding initiatives, national benchmarks, industry standards, and industry sources such as the following, including any successors of the same:

- *Medicare* laws, regulations, manuals and other related guidance;
- Federal and state laws, rules and regulations, including instructions published in the Federal Register;
- National Uniform Billing Committee (NUBC) guidance including the UB-04 Data Specifications Manual;
- American Medical Association's (AMA) Current Procedural Terminology (CPT®) and associated AMA publications and services;
- Centers for Medicare & Medicaid Services' (CMS) Healthcare Common Procedure Coding System (HCPCS) and associated CMS publications and services;
- International Classification of Diseases (ICD);
- American Hospital Association's Coding Clinic Guidelines;
- Uniform Billing Editor;
- American Psychiatric Association's (APA) Diagnostic and Statistical Manual of Mental Disorders (DSM) and associated APA publications and services;
- Food and Drug Administration guidance;
- Medical and surgical specialty societies and associations;

CLAIMS (continued)

- Industry-standard utilization management criteria and/or care guidelines;
- *Our* medical and pharmacy coverage policies; and
- Generally accepted standards of medical, behavioral health and dental practice based on credible scientific evidence recognized in published peer reviewed literature.

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

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

You should discuss *our* claims processing edits, claims payment policies and medical or pharmacy coverage policies and their availability with any *qualified provider*, who is a *non-network provider*, prior to receiving any services. *You* or *your qualified provider* may access *our* claims processing edits and claims payment policies on *our* Website at www.humana.com by clicking "Coverage policies." *Our* medical and pharmacy coverage policies may be accessed on *our* Website at www.humana.com under "Medical Resources" by clicking "Coverage Policies." *You* or *your qualified provider* may also call *our* toll-free customer service number listed on *your* identification card to obtain a copy of a claims processing edit, claims payment policy or coverage policy.

Right to require medical examinations

We have the right to require a medical examination on any *covered person* in order to process a claim. If *we* require a medical examination, it will be performed at *our* expense. In the case of a death, *we* also have a right to request an autopsy to process a claim, 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 *covered expenses* rendered by a *non-network provider* are due and owing solely to the *covered person*. *You* may request that *we* direct a payment of selected medical benefits to the health care provider on whose charge the claim is based. Such payments will not constitute the assignment of any legal obligation to the *non-network provider*.

CLAIMS (continued)

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

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

Right to request overpayments

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

- Made in error;
- Made to *you* or any party on *your* behalf, where *we* determine that such payment made is greater than the amount payable under the *policy*;
- 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* in processing a claim by:

- Authorizing the release of medical information including the names of all providers from whom *you* received medical attention;
- Obtaining medical information 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;
- Providing copies of claims and settlement demands submitted to third parties in relation to a *bodily injury* or *sickness*; and
- Disclosing details of liability settlement agreements reached with third parties in relation to a *bodily injury* or *sickness*.

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.

CLAIMS (continued)

Exhaustion of time limits

If *we* fail to complete a claim determination within 120 days after receiving a claim, *you* are not required, but have the right to, submit a complaint as outlined under the "Complaint and Appeal Procedures" section of this *certificate* or as required by law.

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 served 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, 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.

CLAIMS (continued)

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* determine that the benefits are paid or received under any Workers' Compensation or similar law, *we* have the right to recover as described below.

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

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

- The Workers' Compensation benefits are in dispute or are made by means of settlement or compromise;
- The amount of Workers' Compensation due to medical or health care is not agreed upon or defined by *you* or the Workers' Compensation carrier; or
- Medical or health care benefits are specifically excluded from the Workers' Compensation settlement or compromise.

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

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, including self-insured entities;

CLAIMS (continued)

- 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; and
- No-fault or other similar coverage.

We may enforce *our* subrogation rights by asserting a claim to any coverage to which *you* may be entitled. We shall have first priority to recover benefits we have paid from any funds that are paid or payable as a result of any *sickness* or *bodily injury*, regardless of whether available funds are sufficient to fully compensate *you* for your *sickness* or *bodily injury*.

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 judgement. 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.

The obligation to reimburse *us* in full exists, regardless of whether the settlement, compromise or judgement 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.

CLAIMS (continued)

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*. *We* shall not be responsible to contribute to the cost of legal fees or expenses incurred by *you* under any Common Fund or similar doctrine 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.

SAMPLE

COMPLAINT AND APPEAL PROCEDURES

There are situations when *covered persons* have questions about their coverage or are dissatisfied with policy services. Any *covered person* who has an inquiry or complaint regarding a matter arising under a *covered person's certificate* should contact 1-800-448-6262. Such inquiries and complaints will be handled in a timely manner.

Definitions

Appeal means a request for reconsideration of an *adverse determination*.

Adverse determination means a denial, reduction, termination of, or failure to provide or make payment:

- In whole or in part for a benefit;
- Based on eligibility to participate in the plan; or
- Based on *rescission* of coverage.

Expedited appeal means a request for review of an *adverse determination* when the standard timeframe for an *appeal* would seriously jeopardize *your* life or health or would jeopardize *your* ability to regain maximum function.

Grievance means a written complaint submitted by *you* or *your* authorized representative regarding dissatisfaction with any aspect of the plan, other than a claim or service denial, including a previous problem that is not resolved to *your* satisfaction.

Grievance process

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

A Grievance Specialist will review the *grievance*. *You* will be notified of a final decision not later than 60 days after *our* receipt of the *grievance*.

Appeal process

If *you* are dissatisfied with *our* determination of *your* claim, *you* may *appeal* the decision. *You* should *appeal* in writing to the address given on the denial letter *you* received or to *us* at the following address:

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

The *appeal* must be submitted to *us* within 180 days of receiving written notice of an *adverse determination*. Such *appeals* will be handled on a timely basis and appropriate records will be kept on all *appeals*.

COMPLAINT AND APPEAL PROCEDURES (continued)

We will review the *appeal* within five business days after receipt. *You* will be notified of a final decision involving an *adverse determination* involving a claim denial in writing within 60 days after *our* receipt of the *appeal* (30 days in the case of an *adverse determination* involving medical necessity, pre-service or concurrent review).

All *expedited appeals* are to be investigated and a decision provided to *you, your* authorized representative, or a provider acting on *your* behalf within 72 hours after receiving the request for review.

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

Agency for Health Care Administration
2727 Mahan Drive
Tallahassee, FL 32308
1-888-419-3456 / 1-800-955-8771 Florida Relay Service (TDD number)

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

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

Exhaustion of remedies

Upon completion of the internal *appeal* process available to *you* under state or federal law, *you* will have exhausted *your* administrative remedies under the *policy*. If *we* fail to adhere to all requirements of the internal *appeal* process with respect to a claim, except for failures that are based on a minimal error, *you* are deemed to have exhausted the internal *appeal* process and *you* may request an external review. After exhaustion of the internal *appeal* process, *you* may pursue any other legal remedies available which may include bringing civil action under ERISA Section 502(a) for judicial review of *our* determination.

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

Legal actions and limitations

No legal action may be brought to recover on this *policy* within 60 days after written proof of loss has been given as required by this *policy*. No such action may be brought after the expiration of the applicable statute of limitations from time written proof of loss is required to be given.

DISCLOSURE PROVISIONS

Employee assistance program

We may provide *you* access to an employee assistance program (EAP). The EAP may include confidential, telephonic consultations and work-life services. The EAP provides *you* with short-term, problem solving services for issues that may otherwise affect *your* work, personal life or health. The EAP is designed to provide *you* with information and assistance regarding *your* issue and may also assist *you* with finding a medical provider or local community resource.

The services provided by the EAP are not *covered expenses* or insured benefits under the *policy*, therefore the *copayments*, *deductible* or *coinsurance* do not apply. However, there may be additional costs to *you*, if *you* obtain services from a professional or organization the EAP has recommended or has referred *you* to. The EAP does not provide medical care. *You* are not required to participate in the EAP before using *your* insured benefits under the *policy*, and the EAP services are not coordinated with *covered expenses* under the *policy*. The decision to participate in the EAP is voluntary, and *you* may participate at any time during the *year*. Refer to the marketing literature for additional information.

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 participatory or health-contingent wellness programs to *you*.

"Participatory" wellness programs do not require *you* to meet a standard related to a health factor. Examples of participatory wellness programs may include, membership in a fitness center, certain preventive testing, or attending a no-cost health education seminar.

"Health-contingent" wellness programs require *you* to attain certain wellness goals that are related to a health factor. Examples of health-contingent wellness programs may include, completing a 5k event, lowering blood pressure, reduction in weight and body mass index or ceasing the use of tobacco.

DISCLOSURE PROVISIONS (continued)

The rewards may include, payment for all or a portion of a participatory wellness program, merchandise, gift cards, debit cards, discounts or contributions to *your* health spending account. *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, premium discounts, premium rebates 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. Some wellness programs may be offered only to *covered persons* with particular health factors. If *you* think *you* might be unable to meet a standard for a reward under a health-contingent wellness program, *you* might qualify for an opportunity to earn the same reward by different means. Contact *us* at the number listed on *your* ID card or in the marketing literature issued by the wellness program administrator for more information.

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 if eligible, *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* may obtain services from *network providers* who participate in the Preferred Provider Organization network, or *non-network providers* who do not participate in the Preferred Provider Organization network. If *you* choose a *network provider*, *your* out-of-pocket expenses are normally lower than if *you* choose a *non-network provider*.

If *you* choose to obtain services from a *non-network provider*, the services may be eligible for a discount to *you* under the Shared Savings Program. It is not necessary for *you* to inquire in advance about services that may be discounted. When processing *your* claim, *we* will automatically determine if the services are subject to the Shared Savings Program and calculate *your deductible* and *coinsurance* on the discounted amount. Whether the services are subject to the Shared Savings Program is at *our* discretion, and *we* apply the discounts in a non-discriminatory manner. *Your* Explanation of Benefits statement will reflect any savings with a remark code that the services have been discounted. *We* cannot guarantee that services rendered by *non-network providers* will be discounted. The *non-network provider* discounts in the Shared Savings Program may not be as favorable as *network provider* discounts.

DISCLOSURE PROVISIONS (continued)

If *you* would like to inquire in advance to determine if services rendered by a *non-network provider* may be subject to the Shared Savings Program, please contact *our* customer service department at the telephone number shown on *your* ID card. Provider arrangements in the Shared Savings Program are subject to change without notice. *We* cannot guarantee that the services *you* receive from a *non-network provider* are still subject to the Shared Savings Program at the time services are 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.

SAMPLE

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.

We may refuse to renew, terminate, or rescind coverage if the information *you* provide is fraudulent, or if *you* make an intentional misrepresentation of a material fact. 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 signed by the *policyholder* or *covered person* 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
- Distributing and providing *covered persons* access to:
 - Benefit plan documents and the Summary of Benefits and Coverage (SBC);
 - Renewal notices and *policy* modification information;
 - Discontinuance notices; and
 - Information regarding continuation rights.

No *policyholder* may change or waive any provision of the *policy*.

Certificates of insurance

We will furnish to the *policyholder*, for delivery to each *employee* or *covered person* of the *group*, a *certificate* containing the *group number* and setting forth the essential features of the insurance coverage of such *employee* or *covered person* and those to whom benefits are payable. If *dependents* are included in the coverage, only one *certificate* needs to be issued for each family unit.

No document inconsistent 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 by the administrator of a group health plan subject to ERISA. If the terms of a summary plan description differ with the terms of this *certificate*, the terms of this *certificate* will control.

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*.

MISCELLANEOUS PROVISIONS (continued)

After two years from the *effective date* of *your* coverage, only fraud or intentional misrepresentation of a material fact on the enrollment form may be used to void coverage or deny any claim.

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 when a new application or enrollment form effectuating coverage is completed.

Third party beneficiary

This *policy* is between *your employer* and *us*. *Covered persons* are third party beneficiaries. There are no other third party beneficiaries. Providers are not third party beneficiaries.

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 45-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*.

Modification of policy

The *policy* may be modified by *us*, upon renewal of the *policy*, as permitted by state and federal law. The *policyholder* will be notified in writing or *electronically* at least 60 days prior to the effective date of the change.

The *policy* may be modified 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.

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

MISCELLANEOUS PROVISIONS (continued)

Discontinuation of coverage

If *we* decide to discontinue offering a particular group health policy:

- The *policyholder* and the *employees* will be notified of such discontinuation at least 90 days prior to the date of nonrenewal of such coverage; and
- The *policyholder* will be given the option to purchase all other group health plans providing medical benefits that are being offered by *us* at such time.

If *we* cease doing business in the *small employer* group market, the *policyholders*, *covered persons* and the Commissioner of Insurance will be notified of such discontinuation at least 180 days prior to the date of nonrenewal of such coverage.

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 a 45-day advance written 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).

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, having a normal workweek of 25 or more hours;
- 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 mean 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 a 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 supplements and medicine, holistic medicine, homeopathy, hypnosis, macrobiotics, naturopathy, ozone therapy, reflexotherapy, relaxation response, rolfing, shiatsu, yoga, and chelation therapy.

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*.

GLOSSARY (continued)

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.

Assistant surgeon means a *health care practitioner* who assists at *surgery* and is a Doctor of Medicine (MD), Doctor of Osteopathic Medicine (DO), Doctor of Podiatric Medicine (DPM) or where state law requires a specific *health care practitioner* be treated and reimbursed the same as an MD, DO or DPM.

Autism spectrum disorder means any of the following disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association: a) autistic disorder; b) asperger's syndrome; and c) 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 to restore normal hematological and immunological functions following ablative or non-ablative therapy with curative or life-prolonging intent. 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, from a medically acceptable related or unrelated donor, or cord blood. If chemotherapy is an integral part of the treatment involving a 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 describes the benefits, provisions and limitations of the *policy*. This *certificate* is part of the *policy* and is subject to the terms 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* we pay is shown in the "Schedule of Benefits" sections.

GLOSSARY (continued)

Confinement or **confined** means *you* are a registered bed patient as the result of a *health care practitioner's* recommendation. It does not mean *you* are 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 *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.

Co-surgeon means one of two or more *health care practitioners* furnishing a single *surgery* which requires the skill of multiple surgeons, each in a different specialty, performing parts of the same *surgery* simultaneously.

Covered expense means:

- *Medically necessary* services to treat a *sickness* or *bodily injury*, such as:
 - Procedures;
 - *Surgeries*;
 - Consultations;
 - Advice;
 - Diagnosis;
 - Referrals;
 - Treatment;
 - Supplies;
 - Drugs, including *prescription* and *specialty drugs*;
 - Devices; or
 - Technologies;
- *Preventive services*;
- *Pediatric dental services*; or
- *Pediatric vision care*.

To be considered a *covered expense*, services must be:

- Ordered by a *health care practitioner*;
- Authorized or prescribed by a *qualified provider*;
- Provided or furnished 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* 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, and maintaining continence;

GLOSSARY (continued)

- 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 *covered expenses*. Any amount *you* pay exceeding the *maximum allowable fee* is not applied to the individual or family *deductibles*.

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, unless the biting or chewing injury is a result of an act of domestic violence or a medical condition (including both physical and mental health conditions).

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.

Dependent means a covered *employee's*:

- Legally recognized spouse or *domestic partner*;
- Natural born child, step-child, *foster child*, legally adopted child, or child placed for adoption, whose age is less than the *limiting age*;
- 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*.
- Child in court-ordered temporary or other custody;
- Newborn child of a covered *dependent* child. Coverage for such child terminates 18 months after the date of birth or the date as determined by the "Termination of coverage" provision, whichever is earliest;
- Great-grandchild if the parent of a minor child delegates to any grandparent residing in this state, caregiving authority regarding the minor child when hardship prevents the parent from caring for the child. Coverage for such child terminates 18 months after the date of birth or the date as determined by the "Termination of coverage" provision, whichever is the earliest.

GLOSSARY (continued)

- *Domestic partner's* natural born child, step-child, foster child, legally adopted child, or child placed for adoption whose age is less than the limiting age;

The *domestic partner's* child cannot qualify as a *dependent* prior to the *employee's domestic partner* becoming a qualified *dependent*.

The limiting age means the end of the month 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 or working outside of the network area;
- Residing with or receiving financial support from *you*; or
- Eligible for other coverage through employment.

A covered *dependent* child who attains the limiting age while insured under the *policy* remains eligible if the covered *dependent* child is:

- Incapable of self-sustaining employment by reason of mental retardation or physical handicap; and
- Chiefly dependent upon the *employee*, spouse or *domestic partner* for support and maintenance.

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

You must furnish satisfactory proof to *us*, upon *our* request, that the 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.

Dependent adult child

If the covered *employee* has a *dependent* adult child who has attained the limiting age of 26 and meets the following requirements, coverage may be available for that *dependent* adult child until the end of the calendar year in which they reach age 30.

To be eligible for coverage, a *dependent* adult child must satisfy the following requirements:

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

A *dependent* adult child, as defined in the bulleted items above, ceases to be eligible for coverage under this provision:

- On the last day of the calendar year following the *dependent* adult child's attainment of the limiting age; or
- When the *dependent* adult child no longer meets the requirements listed above.

GLOSSARY (continued)

A *dependent* adult child who takes a *medically necessary leave of absence* from an accredited educational institution while in full-time status, will continue to be eligible for coverage until the earlier of the following:

- Up to one year after the first day of the *medically necessary leave of absence*, unless the *dependent* adult child continues to meet the eligibility requirements stated above; or
- The date coverage would otherwise terminate under this *certificate*.

We must receive written certification from the *dependent* adult child's *health care practitioner* that the *dependent* adult child has a serious *bodily injury* or *sickness* requiring a *medically necessary leave of absence*.

You must furnish satisfactory proof to us, upon our request, that the above conditions continuously exist. If satisfactory proof is not submitted to us, the *dependent* adult 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 agents for controlling blood sugar levels; prescriptive non-insulin injectable agents for controlling blood sugar levels; glucagon emergency kits; and alcohol swabs.

Distant site means the location of a *health care practitioner* at the time a *telehealth* or *telemedicine* service is provided.

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

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;

GLOSSARY (continued)

- 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 *skilled 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.

Emergency care 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.

Emergency care does not 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, having a normal work week of 25 or more hours and who has met the *waiting period*, if any, elected by the *policyholder*. 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;
- The sole proprietorship or other entity (other than a partnership) has at least one common-law employee (other than the business owner and his or her spouse); and

GLOSSARY (continued)

- The sole proprietor, partner or corporate officer is actively performing activities relating to the business, 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* also includes retirees of the *employer*. A retired *employee* is not required to be in *active status* to be eligible for coverage under the *policy*.

Employee may also include independent contractors of the *employer* if the *employer* includes the independent contractor under the *employer's* group health plan.

Employer means the sponsor of this *group* insurance plan or any subsidiary or affiliate described in the Employer Group Application. An *employer* must either employ at least one common-law employee or be a partnership with a bona fide partner who provides services on behalf of the partnership. A business owner and his or her spouse are not considered common-law employees for this purpose if the entity is considered to be wholly owned by one individual or one individual and his or her spouse.

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

- Root canal therapy and root canal fillings;
- Periradicular *surgery*;
- Apicoectomy;
- Partial pulpotomy; or
- Vital pulpotomy.

Experimental, 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 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; (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

GLOSSARY (continued)

- Is identified as not covered by the Centers for Medicare & 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 *domestic partner*. It also means *your* or *your* spouse's or *domestic partner'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 having a normal workweek of 25 or more hours.

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

Habilitative services mean health care services and devices that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Health care practitioner means a practitioner professionally licensed by the appropriate state agency to provide *preventive services* or diagnose or treat a *sickness* or *bodily injury* and who provides services within the scope of that license.

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.

GLOSSARY (continued)

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.

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 medical professionals, including *health care practitioners* 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 that is 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 operated 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 18 months or less 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. The requirement for provision or operation of surgical facilities does not apply to a *hospital* that is primarily for the rehabilitation of physical disability. Claims may not be denied for care or services provided for the treatment of a physical disability by a licensed *hospital* accredited by one of the organizations listed below even if such *hospital* lacks major surgical facilities;

GLOSSARY (continued)

- 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; and
- It must not be primarily a:
 - Convalescent, rest or nursing home; or
 - Facility providing custodial or educational 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

Immune effector cell therapy means immune cells or other blood products that are engineered outside of the body and infused into a patient. *Immune effector cell therapy* may include acquisition, integral chemotherapy components and engineered immune cell infusion.

Infertility services mean any 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; 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.

GLOSSARY (continued)

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 or more than 60 days for a newborn, adopted child or foster child after his or her *eligibility date*, later than the time period specified in the "Special enrollment" provision, or after the *open enrollment period*.

Level 1 network health care practitioner means a *network health care practitioner* practicing in a *health care treatment facility* or *retail clinic*:

- With a specialty of pediatric or internal medicine; or
- Who is a general practitioner, nurse practitioner, physician assistant, or registered nurse.

Level 2 network health care practitioner means a *network health care practitioner*, practicing in a *health care treatment facility*, who has received training in a specific medical field other than those listed in the *level 1 network health care practitioner* definition.

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.

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

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;

GLOSSARY (continued)

- The fee established by *us* by comparing rates from one or more regional or national databases or schedules for the same or similar services from a geographical area determined by *us*;
- The fee based upon rates negotiated by *us* or other payors with one or more *network providers* in a geographic area determined by *us* for the same or similar services;
- The fee based upon the provider's cost for providing the same or similar services as reported by such provider in its most recent publicly available *Medicare* cost report submitted to the Centers for Medicare & Medicaid Services (CMS) annually; or
- The fee based on a percentage determined by *us* of the fee *Medicare* allows for the same or similar services provided in the same geographic area.

Maximum allowable fee for a covered expense 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 *maximum allowable fee for a covered expense*, other than *emergency care services provided by non-network provider*; or
- The fee paid by *Medicare* for the same services.

When you elect to utilize services from a *non-network provider* and you have the ability and opportunity to choose a *network provider*, 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 *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;
- Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the patient's *sickness* or *bodily injury*; and
- Performed in the least costly site.

GLOSSARY (continued)

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.

Medically necessary leave of absence means a leave of absence for a *dependent* adult child, who is no longer enrolled for sufficient course credits to maintain full-time status as defined by an accredited secondary school, college or university, or licensed technical school, or had any other change in enrollment at such institution.

The *medically necessary leave of absence* must:

- Begin due to a *bodily injury* or *sickness*;
- Be determined necessary by the *dependent* adult child's *health care practitioner*, who must send *us* written certification; and
- Cause the *dependent* adult child to lose full-time student status as defined in the definition of "*dependent*."

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 mean those diagnoses and treatments related to the care of a *covered person* who exhibits mental, nervous or emotional conditions classified in the Diagnostic and Statistical Manual of Mental Disorders.

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 greater 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 been designated as such or has signed an agreement with *us* as an independent contractor, or who has been designated by *us* to provide services to all *covered persons*. *Network health care practitioner* designation by *us* may be limited to specified services.

Network hospital means a *hospital* which has been designated as such or has signed an agreement with *us* as an independent contractor, or has been designated by *us* 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*, *health care practitioner*, or other health services provider who is designated as such or has signed an agreement with *us* as an independent contractor, or who has been designated by *us* to provide services to all *covered persons*. *Network provider* designation by *us* may be limited to specified services.

GLOSSARY (continued)

Non-network health care practitioner means a *health care practitioner* who has not been designated by *us* as a *network health care practitioner*.

Non-network hospital means a *hospital* which has not been designated by *us* as a *network hospital*.

Non-network provider means a *hospital, health care treatment facility, health care practitioner, or other health services provider* who has not been designated by *us* as a *network provider*.

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

O

Observation status means *hospital outpatient services provided to you to help the health care practitioner decide if you need to be admitted as an inpatient*.

Open enrollment period means no less than a 31-day period of time, occurring annually for the *group*, during which the *employees* have 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.

Originating site means the location of a *covered person* at the time a *telehealth or telemedicine* service is being furnished.

Out-of-pocket limit means the amount of any *copayments, deductibles and coinsurance* for *covered expenses*, which *you* must pay, either individually or combined as a *covered family*, per *year* before a benefit percentage is increased. Any amount *you* pay exceeding the *maximum allowable fee* is not applied to the *out-of-pocket limits*.

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*.

GLOSSARY (continued)

Partial hospitalization means *outpatient* services provided by a *hospital* or *health care treatment facility* in which patients do not reside for a full 24-hour period and:

- Has a comprehensive and intensive interdisciplinary psychiatric treatment for minimum of 5 hours a day, 5 days per week under the supervision of a psychiatrist for *mental health services* or a psychiatrist or addictionologist for *chemical dependency*, and patients are seen by a psychiatrist or addictionologist, as applicable, at least once a week;
- Provides for social, psychological and rehabilitative training programs with a focus on reintegration back into the community and admits children and adolescents who must have a treatment program designed to meet the special needs of that age range; and
- Has physicians and appropriately licensed behavioral health practitioners readily available for the emergent and urgent needs of the patients.

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

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

Partial hospitalization does not include services that are for:

- *Custodial care*; or
- *Day care*.

Pediatric dental services mean the following services:

- Ordered by a *dentist*; and
- Described in the "Pediatric dental" provision in the "Covered Expenses – Pediatric Dental" section.

Pediatric vision care means the services and *materials* specified in the "Pediatric vision care benefit" provision in the "Covered Expenses – Pediatric Vision Care" section.

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 surgical procedures.

Policy means the legal agreement between *us* and the *policyholder*, including the Employer Group Application and *certificate*, together with any riders, amendments and endorsements.

GLOSSARY (continued)

Policyholder means the legal entity identified as the *policyholder* on the face page of the *policy* or "Certificate of Insurance" 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*.

Prescription means a direct order for the preparation and use of a drug, medicine or medication. The *prescription* must be written by a *health care practitioner* and provided 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 Preventive Medication Coverage *drug list*. The drug, medicine or medication must be obtainable only by *prescription* or must be obtained by *prescription* for drugs, medicines or medications on the Preventive Medication Coverage *drug list*. The *prescription* may be given to the *pharmacist* verbally, *electronically* or in writing by the *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*.

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).
- 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 www.healthcare.gov website or call the customer service telephone number on your ID card. Refer to the "Preventive services" provision in the "Covered Expenses" section which includes *preventive services* covered by the *policy*.

GLOSSARY (continued)

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.

R

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 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.

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

GLOSSARY (continued)

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, or *congenital anomaly* following birth and care resulting from prematurity is not considered *routine nursery care*.

Routine patient care means all health care services, including drugs, items, devices and services that would otherwise be covered under the *certificate* if those health care services were not provided in connection with an approved cancer clinical trial, including the following:

- Absent a cancer clinical trial;
- Required only for the provision of the investigational drug, item, device or service;
- Required for clinical appropriate monitoring of the investigational item of service; and
- Needed for the reasonable, necessary care resulting from the investigations of the drug, item, device or service, including the diagnosis or treatment of complications.

S

Self-administered injectable drugs mean 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*.

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*.

GLOSSARY (continued)

Small employer means, in connection with a health benefit plan with respect to a calendar year and plan year, any person, self-employed individual, independent contractor, firm, corporation, partnership, or association that is actively engaged in business, has its principal place of business in Florida, employed an average of at least one but not more than 50 *employees* on business days during the preceding calendar year the majority of whom were employed in Florida, employs at least one *employee* on the first day of the plan year, and is not formed primarily for purposes of purchasing insurance. In determining the number of *employees*, companies that are an affiliated group as defined in s. 1504(a) of the Internal Revenue Code of 1986, as amended, are considered a single *employer*. An independent contractor or self-employed individual is considered a *small employer* only if all of the conditions and criteria established in this section 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*.

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:

- Be injected, infused or require close monitoring by a *health care practitioner* or clinically trained individual;
- 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.

Stem cell means the transplant of human blood precursor cells. Such cells may be derived from bone marrow, circulating blood, or a combination of bone marrow and circulating blood obtained from the patient in an autologous transplant, from a matched related or unrelated donor, or cord blood. The *stem cell* transplant includes the harvesting, integral chemotherapy components and the *stem cell* infusion. A *stem cell* transplant is commonly referred to as a bone marrow transplant.

GLOSSARY (continued)

Surgery means procedures categorized as Surgery in either the:

- Current Procedural Terminology (CPT) manuals published by the American Medical Association; or
- Healthcare Common Procedure Coding System (HCPCS) Level manual published by the Centers for Medicare & Medicaid Services (CMS).

The term *surgery* includes:

- Excision or incision of the skin or mucosal tissues;
- 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;
- Treatment of fractures;
- Procedures to repair, remove or replace any body part or foreign object in or on the body; and
- Endoscopic procedures.

Surgical assistant means a *health care practitioner* who assists at *surgery* and is not a Doctor of Medicine (MD), Doctor of Osteopathic Medicine (DO) or Doctor of Podiatric Medicine (DPM), or where state law does not require that specific *health care practitioners* be treated and reimbursed the same as an MD, DO or DPM.

T

Telehealth means an audio and video real-time interactive communication between a *covered person* at an *originating site* and a *health care practitioner* at a *distant site*. *Telehealth* services must comply with the following, as applicable:

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

Telemedicine means services, other than *telehealth*, provided via telephonic or *electronic* communications. *Telemedicine* services must comply with the following, as applicable:

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

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.

GLOSSARY (continued)

U

Urgent care means health care services provided on an *outpatient* basis for an unforeseen condition that usually requires attention without delay but 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.

V

Virtual visit means *telehealth* or *telemedicine* services.

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*. The *waiting period* cannot exceed 90 days.

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

GLOSSARY – PHARMACY SERVICES

All terms used in the "Schedule of Benefits - Pharmacy Services," "Covered Expenses - Pharmacy Services" and "Limitations and Exclusions - Pharmacy Services" sections have the same meaning given to them in the "Glossary" section of this *certificate*, unless otherwise specifically defined below:

A

B

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

C

Coinsurance means the amount expressed as a percentage of the *covered expense* that you must pay toward the cost of each separate *prescription* fill or refill dispensed by a *pharmacy*.

Copayment means the specified dollar amount to be paid by you toward the cost of each separate *prescription* fill or refill dispensed by a *pharmacy*.

Cost share means any applicable *prescription drug deductible*, *copayment* and *coinsurance* that you must pay per *prescription* fill or refill.

D

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

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

Drug list means a list of covered *prescription* drugs, medicines or medications and supplies specified by *us*.

E

GLOSSARY – PHARMACY SERVICES (continued)

F

G

Generic drug 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*.

H

I

J

K

L

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 mean a category of *prescription* drugs, medicines or medications within the *drug list* that are designated by *us* as level 1.

Level 2 drugs mean a category of *prescription* drugs, medicines or medications within the *drug list* that are designated by *us* as level 2.

Level 3 drugs mean a category of *prescription* drugs, medicines or medications within the *drug list* that are designated by *us* as level 3.

Level 4 drugs mean a category of *prescription* drugs, medicines or medications within the *drug list* that are designated by *us* as level 4.

Level 5 drugs mean a category of *prescription* drugs, medicines or medications within the *drug list* that are designated by *us* as level 5. The *prescription* drugs in this category are highest-cost/high-technology drugs and *specialty drugs*.

GLOSSARY – PHARMACY SERVICES (continued)

M

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

N

Network pharmacy means a *pharmacy* that has signed a direct agreement with *us* or has been designated by *us* to provide:

- Covered *pharmacy* services;
- Covered *specialty pharmacy* services; or
- Covered *mail order pharmacy* services,

as defined by *us*, to *covered persons*, including covered *prescription* fills or refills delivered to *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;
- Covered *specialty pharmacy* services; or
- Covered *mail order pharmacy* services,

as defined by *us*, to *covered persons*, including covered *prescription* fills or refills delivered to *your* home or health care provider.

O

P

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* drugs, medicines or medications are dispensed by a *pharmacist*.

Prescription drug deductible means the specified dollar amount for *prescription* drug covered expenses which *you*, either individually or combined as a covered family, must pay per year before *we* pay *prescription* drug benefits under the *policy*. These expenses do not apply toward any other *deductible*, if any, stated in the *policy*.

GLOSSARY – PHARMACY SERVICES (continued)

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

Q

R

S

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

Step therapy means a requirement for *you* to first try certain drugs, medicines or medications or *specialty drugs* to treat *your* medical condition before *we* will cover another *prescription* drug, medicine, medication or *specialty drug* for that condition.

T

U

V

W

X

Y

Z

SAMPLE

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