



Discrimination is Against the Law

Humana Inc. and its subsidiaries comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Humana Inc. and its subsidiaries do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Humana Inc. and its subsidiaries provide:

- 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.
- Free language services to people whose primary language is not English when those services are necessary to provide meaningful access, such as translated documents or oral interpretation.

If you need these services, call 1-866-427-7478 or, if you use a TTY, call 711.

If you believe that Humana Inc. and its subsidiaries have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Discrimination Grievances
P.O. Box 14618
Lexington, KY 40512-4618

If you need help filing a grievance, call 1-866-427-7478 or, if you use a TTY, call 711.

You can also file a civil rights complaint with the **U.S. Department of Health and Human Services**, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services

200 Independence Avenue, SW

Room 509F, HHH Building

Washington, D.C. 20201

1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>

Multi-Language Interpreter Services

English: ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call (TTY: 711).

Español (Spanish): ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al (TTY: 711).

繁體中文 (Chinese): 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 (TTY: 711)。

Tiếng Việt (Vietnamese): CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số (TTY: 711).

한국어 (Korean): 주의 : 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. (TTY: 711) 번으로 전화해 주십시오.

Tagalog (Tagalog – Filipino): PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa (TTY: 711).

Русский (Russian): ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните (телетайп: 711).

Kreyòl Ayisyen (French Creole): ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele (TTY: 711).

Français (French): ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le (ATS : 711).

Polski (Polish): UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer (TTY: 711).

Português (Portuguese): ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para (TTY: 711).

Italiano (Italian): ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero (TTY: 711).

Deutsch (German): ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: (TTY: 711).

日本語 (Japanese):

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。

(TTY : 711) まで、お電話にてご連絡ください。

فارسی (Farsi):

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

Diné Bizaad (Navajo): Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'déé', t'áá jiik'eh, éí ná hóló, koji' hódíłnih (TTY: 711).

العربية (Arabic):

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم (رقم هاتف الصم والبكم: 711).

UTAH Regulatory Pre-enrollment Disclosure Guide for Group Health Products

PPO
Indemnity



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INTRODUCTION

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

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

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

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

"Contract" means the document describing the benefits we provide, as agreed to by us and the Contractholder. The Contract may also be known as a policy or master group contract.

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

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

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

ENROLLMENT

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

We reserve the right to require an eligible employee and/or eligible dependent to submit evidence of health status. Health status will not be used to determine the premium rates of non-grandfathered products offered through a small employer group health plan. We will not use health status-related factors to decline medical coverage to an eligible employee or eligible dependent. We will administer this provision in a non-discriminatory manner.

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

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

Special enrollment

Special enrollment is available if the following apply:

- You have a change in family status due to:
 - Marriage;
 - Divorce;
 - A Qualified Medical Child Support Order (QMCSO);
 - A National Medical Support Notice (NMSN);
 - The birth of a natural born child; or
 - The adoption of a child or placement of a child with the employee for the purpose of adoption; and
 - You enroll within 31 days after the special enrollment date; or
- You are an employee or dependent eligible for coverage under the Contract, and:
 - You previously declined enrollment stating you were covered under another group health plan or other health insurance coverage; and
 - Loss of eligibility of such other coverage occurs, regardless of whether you are eligible for, or elect COBRA; and
 - You enroll within 31 days after the special enrollment date.
- Loss of eligibility of other coverage includes, but is not limited to:
 - Termination of employment or eligibility;
 - Reduction in number of hours of employment;
 - Divorce, legal separation or death of a spouse;
 - Loss of dependent eligibility, such as attainment of the limiting age;
 - Termination of your employer's contribution for the coverage;
 - Loss of individual HMO coverage because you no longer reside, live or work in the service area;

- Loss of group HMO coverage because you no longer reside, live or work in the service area, and no other benefit package is available;
- The plan no longer offers benefits to a class of similarly situated individuals; or
- You had COBRA continuation coverage under another plan at the time of eligibility, and:
 - Such coverage has since been exhausted; and
 - You stated at the time of the initial enrollment that coverage under COBRA was your reason for declining enrollment; and
 - You enroll within 31 days after the special enrollment date; or
- You were covered under an alternate plan provided by the employer that terminates, and:
 - You are replacing coverage with the Contract; and
 - You enroll within 31 days after the special enrollment date; or
- You are an employee or dependent eligible for coverage under the Contract, and:
 - Your Medicaid coverage or your Children’s Health Insurance Program (CHIP) coverage terminated as a result of loss of eligibility; and
 - You enroll within 60 days after the special enrollment date; or
- You are an employee or dependent eligible for coverage under the Contract, and
 - You become eligible for a premium assistance subsidy under Medicaid or CHIP; and
 - You enroll within 60 days after the special enrollment date.
- You previously waived coverage and enroll for coverage within 30 days from the date you are eligible to receive premium assistance through Utah’s Premium Partnership for Health Insurance and are:
 - A qualified beneficiary (an individual who is approved to receive premium assistance) who is eligible for coverage as an employee under the plan; or
 - A dependent of the qualified beneficiary.

Dependent special enrollment

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

If dependent coverage is available under the employer's Contract or added to the Contract, an employee who is a Covered Person can enroll eligible dependents during the applicable special enrollment. An employee, who is otherwise eligible for coverage and had waived coverage under the Contract when eligible, can enroll himself/herself and eligible dependents during the special enrollment. The employee and/or dependent enrolling within the time period specified in the “Special enrollment” provision after the special enrollment date will not be considered a late applicant.

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

MEDICAL LIMITATIONS AND EXCLUSIONS

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

- For a grandfathered plan, treatments, services, supplies or surgeries that are not medically necessary, except for the specified routine preventive services as outlined in the "Schedule of Benefits" and described in the "Covered Expenses" section of the certificate.
- For a non-grandfathered plan, treatments, services, supplies or surgeries that are not medically necessary, except for the preventive services required by the U.S. Department of Health and Human Services (HHS). For a list of these recommended services refer to the HHS website at www.healthcare.gov.
- A sickness or bodily injury arising out of, or in the course of, any employment for wage, gain or profit. This exclusion applies whether or not a Covered Person has Workers' Compensation coverage. For a non-grandfathered small employer plan, this exclusion does not apply to an employee that is sole proprietor, partner, or corporate officer if the sole proprietor, partner or corporate officer is not eligible to receive Workers' Compensation benefits.
- Care and treatment given in a hospital owned or run by any government entity, unless you are legally required to pay for such care and treatment. However, care and treatment provided by military hospitals to Covered Persons who are armed services retirees and their dependents are not excluded.
- Any service furnished while you are confined in a hospital or institution owned or operated by the United States government or any of its agencies for any military service-connected sickness or bodily injury.
- Any service you would not be legally required to pay for in the absence of this coverage.
- Sickness or bodily injury for which you are in any way paid or entitled to payment or care and treatment by or through a government program.
- Any service not ordered by a health care practitioner.
- Private duty nursing.
- Services rendered by a standby physician, surgical assistant, assistant surgeon, physician assistant, registered nurse or certified operating room technician unless medically necessary.
- Any service which is not rendered by the billing provider.
- Any service not substantiated in the medical records of the billing provider.
- For PPO and Indemnity plans, any expenses for services, prescriptions, equipment or supplies received outside the United States or from a foreign provider unless:
 - For emergency care;
 - The employee is traveling outside the United States due to employment with the employer sponsoring the contract and the services are not covered under any Workers' Compensation or similar law; or
 - The employee and dependent live outside the United States and the employee is in active status with the employer sponsoring the contract.

- Education or training, except for diabetes self-management training and habilitative services.
- Educational or vocational therapy, testing, services or schools, including therapeutic boarding schools and other therapeutic environments. Educational or vocational videos, tapes, books and similar materials are also excluded.
- Services provided by a Covered Person's family member.
- 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 and the plan is non-grandfathered (non-grandfathered religious employers may elect to not provide contraceptive coverage).
- Immunizations required for foreign travel for a Covered Person of any age.
- Growth hormones (medications, drugs or hormones to stimulate growth) unless specified in the pharmacy services section of the certificate.
- For a grandfathered plan, treatment of nicotine habit or addiction, including but not limited to, nicotine patches, hypnosis, smoking cessation classes or electronic media.
- Prescription drugs and self-administered injectable drugs, unless administered to you:
 - While an inpatient in a hospital, skilled nursing facility, health care treatment facility, or residential treatment facility; or
 - By the following, when deemed appropriate by us:
 - A health care practitioner:
 - During an office visit; or
 - While an outpatient; or
 - A home health care agency as part of a covered home health care plan.
- Hearing aids, the fitting of hearing aids or advice on their care; implantable hearing devices, except for cochlear implants as otherwise stated in the *certificate*.
- Services received in an emergency room, unless required because of emergency care.
- Weekend non-emergency hospital admissions, specifically admissions to a hospital on a Friday or Saturday at the convenience of the Covered Person or his or her health care practitioner when there is no cause for an

emergency admission and the Covered Person receives no surgery or therapeutic treatment until the following Monday.

- Hospital inpatient services when you are in observation status.
- Infertility services; or reversal of elective sterilization.
- Sex change services, regardless of any diagnosis of gender role or psychosexual orientation problems.
- No benefits will be provided for:
 - Immunotherapy for recurrent abortion;
 - Chemonucleolysis;
 - Biliary lithotripsy;
 - Sleep therapy;
 - Light treatments for Seasonal Affective Disorder (S.A.D.);
 - Immunotherapy for food allergy;
 - Prolotherapy; or
 - Sensory integration therapy.
- Cosmetic surgery and cosmetic services or devices, unless for reconstructive surgery as disclosed in the certificate.
- Hair prosthesis, hair transplants or implants, and wigs.
- Dental services, appliances or supplies for treatment of the teeth, gums, jaws or alveolar processes, including but not limited to, any oral surgery, endodontic services or periodontics, implants and related procedures, orthodontic procedures, and any dental services related to a bodily injury or sickness unless otherwise stated in the certificate.
- The following types of care of the feet:
 - Shock wave therapy of the feet;
 - The treatment of weak, strained, flat, unstable or unbalanced feet;
 - Hygienic care, and the treatment of superficial lesions of the feet, such as corns, calluses, or hyperkeratoses;
 - The treatment of tarsalgia, metatarsalgia, or bunion, except surgically;
 - The cutting of toenails, except the removal of the nail matrix;
 - Heel wedges, lifts, or shoe inserts; and
 - Arch supports (foot orthotics) or orthopedic shoes, except for diabetes or hammertoe.
- Custodial care and maintenance care.
- Any loss contributed to, or caused by:
 - War or any act of war, whether declared or not; or
 - Any conflict involving armed forces of any authority.
- Sickness or bodily injury caused by the Covered Person's voluntary participation in a felony, riot or insurrection.

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).

- Illegal activities, limited to losses related directly to the covered person's voluntary participation.
- Expenses for any membership fees or program fees paid by you, including but not limited to, health clubs, health spas, aerobic and strength conditioning, work-hardening programs and weight loss or surgical programs, and any materials or products related to these programs.
- Surgical procedures for the removal of excess skin and/or fat in conjunction with or resulting from weight loss or weight loss surgery.
- Expenses for services that are primarily and customarily used for environmental control or enhancement (whether or not prescribed by a health care practitioner) and certain medical devices including, but not limited to:
 - Common household items including air conditioners, air purifiers, water purifiers, vacuum cleaners, waterbeds, hypoallergenic mattresses or pillows or exercise equipment;
 - Motorized transportation equipment (e.g. scooters), escalators, elevators, ramps or modifications or additions to living/working quarters or transportation vehicles;
 - Personal hygiene equipment including bath/shower chairs, transfer equipment or supplies or bed side commodes;
 - Personal comfort items including cervical pillows, gravity lumbar reduction chairs, swimming pools, whirlpools, spas or saunas;
 - For a grandfathered plan, medical equipment including blood pressure monitoring devices, PUVA lights, stethoscopes, and breast pumps, except hospital grade breast pumps used for a dependent under one year of age during a hospital admission;
 - For a non-grandfathered plan, medical equipment including blood pressure monitoring devices, PUVA lights and stethoscopes;
 - Communication system, telephone, television or computer systems and related equipment or similar items or equipment;
 - Communication devices, except after surgical removal of the larynx or a diagnosis of permanent lack of function of the larynx.
- Duplicate or similar rentals or purchases of durable medical equipment or diabetes equipment.
- Therapy and testing for treatment of allergies including, but not limited to, services related to clinical ecology, environmental allergy and allergic immune system dysregulation and sublingual antigen(s), extracts, neutralization tests and/or treatment unless such therapy or testing is approved by:
 - The American Academy of Allergy and Immunology; or
 - The Department of Health and Human Services or any of its offices or agencies.
- Lodging accommodations or transportation.
- Communications or travel time.
- Any treatment, including but not limited to surgical procedures:
 - For obesity, which includes morbid obesity; or
 - For obesity, which includes morbid obesity, for the purpose of treating a sickness or bodily injury caused by, complicated by, or exacerbated by the obesity.

- 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.
- Services rendered in a premenstrual syndrome clinic or holistic medicine clinic.
- Services of a midwife, unless the midwife is licensed.
- Vision examinations or testing for the purposes of prescribing corrective lenses, except comprehensive eye exams provided under the "Covered Expenses – Pediatric Vision Care" section in the certificate.
- Orthoptic/vision training (eye exercises).
- Radial keratotomy, refractive keratoplasty or any other surgery or procedure to correct myopia, hyperopia or stigmatic error.
- For a plan that does not include benefits for pediatric vision care, the purchase or fitting of eyeglasses or contact lenses, except as the result of an accident or following cataract surgery as stated in the certificate.
- For a plan that includes benefits for pediatric vision care, the purchase or fitting of eyeglasses or contact lenses, except as:
 - The result of an accident or following cataract surgery as stated in the contract.
 - Otherwise specified in the "Covered Expenses – Pediatric Vision Care" section in the certificate.
- Mental health services for the following conditions when diagnosed as the primary or substantial reason or need for treatment:
 - Marital or family problem;
 - Social, occupational, religious, or social maladjustment;
 - Conduct disorder;
 - Chronic adjustment disorder;
 - Psychosexual disorder;
 - Chronic organic brain syndrome;
 - Personality disorder;
 - Specific developmental disorder or learning disability; or
 - An intellectual disability.

- Services and supplies which are:
 - Rendered in connection with mental illnesses not classified in the International Classification of Diseases of the U.S. Department of Health and Human Services; or
 - Extended beyond the period necessary for evaluation and diagnosis of learning and behavioral disabilities or for mental retardation.
- Marriage counseling.
- Court-ordered behavioral health services.
- Expenses for employment, school, sport or camp physical examinations or for the purposes of obtaining insurance.
- Expenses for care and treatment of non-covered procedures or services.
- Expenses for treatment of complications of non-covered procedures or services.
- Expenses incurred for services prior to the effective date or after the termination date of your coverage under the Contract. Coverage will be extended as described in the "Extension of Benefits" section of the certificate, as required by state law.
- Expenses incurred by you for the treatment of any jaw joint problem, including temporomandibular joint disorder, craniomaxillary disorder, craniomandibular disorder, head and neck neuromuscular disorder or other conditions of the joint linking the jaw bone and the skull.
- Pre-surgical/procedural testing duplicated during a hospital confinement.
- Home health care for:
 - Charges for mileage or travel time to and from the Covered Person's home;
 - Wage or shift differentials for any representative of a home 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.
- Hospice care for:
 - A confinement not required for acute pain control or other treatment for an acute phase of chronic symptom management;
 - Services by volunteers or persons who do not regularly charge for their services;
 - Services by a licensed pastoral counselor to a member of his or her congregation. These are services in the course of the duties to which he or she is called as a pastor or minister; and
 - Bereavement counseling services for family members not covered under the Contract.
- Orthotics if:
 - Replacement orthotics;
 - Dental braces; or

- Oral or dental splints and appliances, unless custom made for the treatment of documented obstructive sleep apnea.
- Repair or replacement of a prosthetic device when covered by the manufacturer.
- Repair or maintenance of durable medical equipment or diabetes equipment, unless the:
 - Manufacturer's warranty is expired;
 - Repair or maintenance is not a result of misuse or abuse;
 - Maintenance is not more frequent than every six months; and
 - Repair cost is less than replacement cost.
- Replacement of purchased durable medical equipment and diabetes equipment unless the:
 - Manufacturer's warranty is expired;
 - Replacement cost is less than repair cost; and
 - Replacement is not due to lost 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.
- Reconstructive surgery due to a psychological condition.
- Routine costs for an approved clinical trial do not include services or items that are:
 - Experimental, investigational or for research purposes;
 - Provided only for data collection and analysis that is not directly related to the clinical management of the covered person; or
 - Inconsistent with widely accepted and established standards of care for a diagnosis.
- An organ transplant if:
 - It is experimental, investigational, or for research purposes.
 - The expense relates to storage of cord blood and stem cells, unless it is an integral part of an organ transplant approved by us.
 - We do not approve coverage for the organ transplant, based on our established criteria.
 - Expenses are eligible to be paid under any private or public research fund, government program except Medicaid, or another funding program, whether or not such funding was applied for or received.
 - The expense relates to the transplantation of any non-human organ or tissue, unless otherwise stated in the Contract.
 - The expense relates to the donation or acquisition of an organ for a recipient who is not covered by us.
 - The expense relates to an organ transplant performed outside of the United States and any care resulting from that organ transplant.
 - A denied transplant is performed; this includes the pre-transplant evaluation, the transplant procedure, follow-up care, immunosuppressive drugs, and expenses related to complications of such transplant.
 - You have not met pre-transplant criteria as established by us.
- For a plan that includes benefits for pediatric dental:
 - Any expense arising from the completion of forms.
 - Any expense due to your failure to keep an appointment.
 - Any expense for a service we consider cosmetic, unless it is due to an accidental dental injury.
 - Expenses incurred for:

- Precision or semi-precision attachments.
 - Overdentures and any endodontic treatment associated with overdentures.
 - Other customized attachments.
 - Any services for 3D imaging (cone beam images).
 - Temporary and interim dental services.
 - Additional charges related to materials or equipment used in the delivery of dental care.
- Charges for services rendered:
- In a dental facility or health care treatment facility sponsored or maintained by the employer under this plan or an employer of any covered person covered by the contract.
 - By an employee of any covered person covered by the contract.

For the purposes of this exclusion, covered person means the employee and the employee's dependents enrolled for benefits under the contract and as defined in the "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.
 - Bite registration or bite analysis.
- Infection control, including but not limited to, sterilization techniques.
- Expenses incurred for services performed by someone other than a dentist, except for scaling and teeth cleaning and the topical application of fluoride, which can be performed by a licensed dental hygienist. The treatment must be rendered under the supervision and guidance of the dentist in accordance with generally accepted dental standards.
- Any hospital, surgical or treatment facility, or for services of an anesthesiologist or anesthetist.
- Prescription drugs or pre-medications, whether dispensed or prescribed.
- Any service that:
- Is not eligible for benefits based on the clinical review.
 - Does not offer a favorable prognosis.
 - Does not have uniform professional acceptance.
 - Is deemed to be experimental or investigational in nature.
- Preventive control programs including, but not limited to, oral hygiene instructions, plaque control, take-home items, prescriptions and dietary planning.
- Replacement of any lost, stolen, damaged, misplaced or duplicate major restoration, prosthesis or appliance.
- Any caries susceptibility testing, laboratory tests, saliva samples, anaerobic cultures, sensitivity testing or charges for oral pathology procedures.

- The following services when performed at the same time as a root canal:
 - Partial pulpotomy for apexogenesis.
 - Vital pulpotomy.
 - Pulp debridement or pupal therapy.
- For a plan that includes benefits for pediatric vision care, benefits are limited as follows:
 - In no event will benefits exceed the lesser of the limits of the contract, shown in the "Schedule of Benefits – Pediatric Vision Care" or in the "Schedule of Benefits" of the certificate.
 - Materials covered by the contract that are lost, stolen, broken or damaged will only be replaced at normal intervals as specified in the "Schedule of Benefits – Pediatric Vision Care".
 - Basic cost for frames covered by the contract. The covered person is responsible for lens options selected, including but not limited to:
 - Blended lenses;
 - Sunglasses, prescription and plano;
 - Laminating of lens or lenses; or
 - Groove, drill or notch, and roll and polish.
- For a plan that includes benefits for pediatric vision care, unless specifically stated otherwise, no benefits will be provided for, or on account of, the following items:
 - Orthoptic or vision training and any associated supplemental testing.
 - Two or more pair of glasses, in lieu of bifocals or trifocals.
 - Medical or surgical treatment of the eye, eyes or supporting structures.
 - Any services and materials required by an employer as a condition of employment.
 - Safety lenses and frames.
 - Contact lenses, when benefits for frames and lenses are received.
 - Cosmetic items.
 - Any services or materials not listed in this benefit section as a covered benefit or in the "Schedule of Benefits – Pediatric Vision Care".
 - Expenses for missed appointments.
 - Any charge from a providers' office to complete and submit claim forms.
 - Treatment relating to or caused by disease.
 - Non-prescription materials or vision devices.
 - Costs associated with securing materials.
 - Pre- and post-operative services.
 - Orthokeratology.
 - Maintenance of materials.
 - Refitting or change in lens design after initial fitting.
 - Artistically painted lenses.
 - Premium lens options.

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

PRESCRIPTION DRUG LIMITATIONS AND EXCLUSIONS

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

- Legend drugs, which are not deemed medically necessary by us.
- Prescription drugs not included on the drug list.
- Any amount exceeding the default rate.
- Specialty drugs for which coverage is not approved by us.
- Drugs and/or ingredients not approved by the FDA, including bulk compounding ingredients.
- Any drug prescribed for intended use other than for:
 - Indications approved by the FDA; or
 - Off-label indications recognized through peer-reviewed medical literature.
- Any drug prescribed for a sickness or bodily injury not covered under the Contract.
- Any drug, medicine or medication that is either:
 - Labeled "Caution-limited by federal law to investigational use"; or
 - Experimental, investigational or for research purposes,even though a charge is made to you.
- Allergen extracts.
- Therapeutic devices or appliances, including, but not limited to:
 - Hypodermic needles and syringes (except when prescribed by a health care practitioner for use with insulin and self-administered injectable drugs, whose coverage is approved by us);
 - Support garments;
 - Test reagents;
 - Mechanical pumps for delivery of medications; and
 - Other non-medical substances.
- Dietary supplements, 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.
- Nutritional products.
- Fluoride supplements {this does not apply to non-grandfathered plans}.
- Minerals.

- Growth hormones for idiopathic short stature or any other condition, unless there is a laboratory confirmed diagnosis of growth hormone deficiency, or as otherwise determined by us.
- Herbs and vitamins, except prenatal (including greater than one milligram of folic acid) and pediatric multi-vitamins with fluoride and vitamins on the Preventive Medication Coverage drug list.
- Anabolic steroids {this does not apply to RxImpact or to non-grandfathered small employer plans}.
- Anorectic or any drug used for the purpose of weight control {this does not apply to RxImpact}.
- Any drug used for cosmetic purposes, including but not limited to:
 - Dermatologicals or hair growth stimulants; or
 - Pigmenting or de-pigmenting agents {this does not apply to RxImpact}.
- Any drug or medicine that is:
 - Lawfully obtainable without a prescription (over the counter drugs), except insulin and drugs or medicines on the Preventive Medication Coverage drug list; or
 - Available in prescription strength without a prescription.
- Compounded drugs in any dosage form, except when prescribed for pediatric use for children up to 19 years of age, or as otherwise determined by us.
- Abortifacients (drugs used to induce abortions) {this does not apply to RxImpact}.
- Infertility services including medications.
- Any drug prescribed for impotence and/or sexual dysfunction {this does not apply to RxImpact}.
- Any drug, medicine or medication that is consumed or injected at the place where the prescription is given, or dispensed by the health care practitioner.
- The administration of covered medication(s).
- Prescriptions that are to be taken by or administered to you, in whole or in part, while you are a patient in a facility where drugs are ordinarily provided by the facility on an inpatient basis. Inpatient facilities include, but are not limited to:
 - Hospital;
 - Skilled nursing facility; or
 - Hospice facility.
- Injectable drugs, including, but not limited to:
 - Immunizing agents, unless otherwise determined by us;
 - Biological sera;
 - Blood;
 - Blood plasma; or
 - Self-administered injectable drugs or specialty drugs for which coverage is not approved by us.

- Prescription refills:
 - In excess of the number specified by the health care practitioner; or
 - Dispensed more than one year from the date of the original order.
- Any portion of a prescription 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.
- Specialty drug refills obtained from a pharmacy which is not designated by us as a preferred provider of specialty drugs.
- Any drug for which we require prior authorization or step therapy and it is not obtained.
- Any drug for which a charge is customarily not made.
- Any drug, medicine or medication received by you:
 - Before becoming covered; or
 - After the date your coverage has ended.
- Any costs related to the mailing, sending or delivery of prescription drugs.
- Any intentional misuse of the prescription drug benefit, including prescriptions purchased for consumption by someone other than you.
- Any prescription fill or refill for drugs, medicines or medications that are lost, stolen, spilled, spoiled or damaged.
- Drug delivery implants and other implant systems or devices.
- Treatment for onychomycosis (nail fungus) {this does not apply to RxImpact or to non-grandfathered small employer plans}.
- Any amount you paid for a prescription that has been filled, regardless of whether the prescription is revoked or changed due to adverse reaction or change in dosage or prescription.

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

HIGH DEDUCTIBLE HEALTH PLAN REQUIREMENT

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

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

PREAUTHORIZATION REQUIREMENTS FOR COVERAGE

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

MAXIMUM ALLOWABLE FEE

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

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

- The fee charged by the provider for the services;
- The fee that has been negotiated with the provider whether directly or through one or more intermediaries or shared savings contracts for the services;
- The fee established by us by comparing rates from one or more regional or national databases or schedules for the same or similar services from a geographical area determined by us;
- The fee based upon rates negotiated by us or other payors with one or more network providers in a geographic area determined by us for the same or similar services;
- The fee based upon the provider's cost for providing the same or similar services as reported by such provider in its most recent publicly available Medicare cost report submitted to the Centers for Medicare and Medicaid Services (CMS) annually; or

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

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

- The fee negotiated with network providers;
- The fee calculated using the same method to determine payments for non-network provider services; or
- The fee paid by Medicare for the same services.

The bill you receive for services from non-network providers may be significantly higher than the maximum allowable fee. In addition to deductibles, copayments and coinsurance, if any, 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 or any amount in excess of the percentages below will not apply to any out-of-pocket limit, copayment limit, or deductible, if any:

- If several surgeries are performed during one operation, we will allow the maximum allowable fee for the most complex procedure. For each additional procedure we will allow:
 - 50% of the maximum allowable fee for the secondary procedure; and
 - 25% of the maximum allowable for the third and subsequent procedures.
- If two surgeons work together as primary surgeons performing distinct parts of a single reportable procedure, we will allow each surgeon 62.5% of the maximum allowable fee for the procedure;
- We will allow a surgical assistant and/or an assistant surgeon when medically necessary at 20% of the maximum allowable fee for a surgery;
- We will allow a physician assistant (P.A.), a registered nurse (R.N.) or a certified operating room technicians at 10% of the maximum allowable fee for the surgery.

MODIFICATION OF COVERAGE

The Contract may be modified by us, upon renewal of the Contract, as permitted by state and federal law. A large employer Contractholder will be notified in writing or electronically at least 31 days prior to the effective date of the change. A small employer Contractholder will be notified in writing or electronically at least 60 days prior to the effective date of the change.

The Contract may be modified by agreement between us and the Contractholder without the consent of any Covered Person or any beneficiary. No modification will be valid unless approved by our President, Secretary or Vice-President. The approval must be endorsed on or attached to the Contract. No agent has authority to modify the Contract, waive any of the Contract provisions, extend the time of premium payment, or bind us by making any promise or representation.

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

EMPLOYER RESPONSIBILITIES

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

- Collection of premium; and
- Providing access to:
 - Benefit plan documents;
 - Renewal notices and Contract modification information; and
 - Information regarding continuation rights.

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

RENEWAL OR TERMINATION OF COVERAGE

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

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

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

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

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

- The Contractholder fails to pay us any premium due, except coverage will continue during the grace period.
- The Contractholder has failed to comply with our minimum, participation or contribution requirements, as specified in the underwriting requirements of the Employer Group Application.
- The Contractholder has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact. We may terminate the Contract immediately, by giving written or electronic notice to the Contractholder for instances of fraud or intentional misrepresentation of a material fact.
- We decide to discontinue offering a particular group health Contract:
 - The Contractholder and the employees will be notified of such discontinuation at least 90 days prior to the date of discontinuation of such coverage; and
 - The large employer Contractholder will be given the option to purchase any other group Contract providing medical benefits that is being offered by us at such time.
 - The small employer Contractholder will be given the option to purchase all other group Contracts providing medical benefits that is being offered by us at such time.
- We cease to do business in either the small employer or the large employer group medical market, as applicable and as allowed by the state requirements. If we cease doing business in the small employer or the

large employer group market, the Contractholders, Covered Persons and the Commissioner of Insurance will be notified of such discontinuation at least 180 days prior to the date of discontinuation of such coverage.

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

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

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

- If you allow an unauthorized person to use your identification card or if you use the identification card of another Covered Person. Under these circumstances, the person who receives the services provided by use of the identification card will be responsible for paying us the maximum allowable fee for those services.
- If you or the Contractholder perpetrate fraud and/or intentional misrepresentation on claims, identification cards or other identification in order to obtain services or a higher level of benefits. This includes, but is not limited to, the fabrication and/or alteration of a claim, identification card or other identification.

FRAUD

Health insurance fraud is a criminal offense that can be prosecuted. Any person(s) who willingly and knowingly engages in an activity intended to defraud us by filing a claim or form that contains a false or deceptive statement may be guilty of insurance fraud.

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

SMALL EMPLOYER CONTRACT RATING FACTORS

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

Rate guarantee

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

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

Rate disclosure

For non-grandfathered plans sold or renewing before 1/1/2014 and renewing after 1/1/2014:

Each Contractholders group rate will be based on two factors. The first factor takes into account the demographics of your Contractholders group (such as age, occupation, industry, gender, group size, as permitted by state requirements), benefit plan, coverage type, and geographic location, and may also vary based on eligibility for Medicare and/or Workers' Compensation coverage.

The first factor also includes a wellness premium discount or wellness premium credit. The discount or credit is calculated for each employer group based upon the percentage of employees meeting the required status within the wellness program. The initial new business medical rate will also be adjusted to reflect the group level premium discount based on the percentage of employees meeting the required status within the wellness program 3 months after a group begins coverage. If a group qualifies for a new business premium discount, the discount will be applied to the groups next premium bill after the 3 month calculation.

The second factor used to develop a Contractholders group rate is the Group Experience Factor. This factor takes into account your Contractholders group claims experience as permitted by state requirements and may cause your rate to be up to 86% higher than the lowest possible base rate charged for all small groups and is in lieu of a pool rate. The Group Experience Factor is applied uniformly, consistently, and equitably to the rates charged for all employees, members, enrollees, and dependents in the small group. A renewal rate is affected by both factors. The percentage increase in the Group Experience Factor at renewal will not exceed fifteen percent (15%) from one rating period to the next.

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

For non-grandfathered groups sold or renewing 1/1/2014 and after:

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

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

Insured by Humana Insurance Company

This policy has exclusions and limitations. For costs and complete detail of coverage, call or write your insurance agent or the company whichever is applicable.

Utah Adoption Indemnity Benefit Disclosure Notice

This notice is to inform enrollees that Humana Insurance Company does not allow substitution of the adoption indemnity benefit for infertility treatment coverage.