ILLINOIS

Regulatory Pre-enrollment Disclosure Guide for Group Health Products

- PPO
- Classic
- HMO
- POS

IL-14607-HH 10/06

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Guidance when you need it most

Table of Contents

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.

"Trust" means the Employers Health Insurance Benefits Trust, the trustee of which has been issued the policy.

"Trustee" means the policyholder, when the employer has agreed to participate in the trust. The trustee is the AmSouth Bank, Birmingham, Alabama, or its successor.

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

Employee enrollment

Each employee must complete the employee enrollment process to apply for coverage.

We reserve the right, based upon our underwriting procedures, to require an eligible employee and/or eligible dependent to submit evidence of health status. 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.

Enrollment date means:

- If you are not a late applicant, your enrollment date is the earlier of the following:
  - The first day your coverage is effective under the Contract; or
  - The first day of the waiting period for enrollment, if any waiting period is applicable.

- Your enrollment date is the first day your coverage is effective under the Contract, if:
  - You are a late applicant; or
  - You are enrolled on a special enrollment date.

The term enrollment date is used for the determination and application of the pre-existing condition limitation and creditable coverage, if relevant to your plan.

Late applicant means an employee or dependent who enrolls or applies for coverage more than 31 days after his/her eligibility date, or more than 31 days after the special enrollment date.

Special enrollment

Loss of other coverage

If you are an employee or dependent who was previously eligible for coverage under the Contract and had waived coverage, you may be eligible for the "Special Enrollment" provision.

You will not be considered a late applicant, if the following applies:

- You declined enrollment under the Contract at the time of initial enrollment because:

  - You were covered under a group health plan or other health insurance coverage at the time of eligibility and your coverage terminated as a result of:

    - Termination of employment or eligibility;
    - Reduction in number of hours of employment;
    - Divorce, legal separation or death of a spouse; or
    - Termination of your employer's or the participating employer's contribution for the coverage; 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 the group health plan, other health insurance coverage or COBRA continuation was your reason for declining enrollment; and

- You were covered under an alternate plan provided by the employer or the participating employer and you are replacing coverage with the Contract;

- You apply for coverage within 31 days after termination of coverage under the group health plan or other health insurance coverage or COBRA.

Dependent special enrollment period

The dependent Special Enrollment Period is a 31-day period from the special enrollment date.

If dependent coverage is available under the employer's or participating employer's Contract or added to the Contract, an employee who is a Covered Person can enroll eligible dependents during the Special Enrollment Period. 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 Period. The employee or dependent enrolling within 31 days from the special enrollment date will not be considered a late applicant.

The Pre-existing condition exclusion information is applicable to all PPO and Classic products. If you are considering enrollment in an HMO or POS plan, please refer to your plan summary to determine if the plan contains a pre-existing condition exclusion.

PRE-EXISTING CONDITION EXCLUSION

Benefits for the treatment of a pre-existing condition may be excluded.

A pre-existing condition means a sickness or bodily injury for which you have received medical attention during the six months prior to your enrollment date. For the purposes of this definition, medical attention means care, advice, examination, treatment, services, medication, procedures, tests, consultation, referral or diagnosis.

Health insurance benefits are excluded for a pre-existing condition for 12 consecutive months following your enrollment date, 18 months for late applicants.

The exclusion does not apply to: pregnancy; genetic information in the absence of a diagnosis of the condition related to the information; or newborn children or children adopted before the age of 18 if they are covered under the Contract within 31 days of the date of birth or date of placement for adoption. The pre-existing condition limitation shall not be applied to you if you were continuously covered for an aggregate period of 12 months under creditable coverage.

Creditable coverage

Creditable coverage means a Covered Person's prior coverage under any of the following:
- A group health plan, including church and governmental plans;
- Health insurance coverage;
- Medicare or Medicaid;
- The health plan for active military personnel, including TRICARE;
- The Indian Health Services or other tribal organization program;
- A state health benefits risk pool;
- The Illinois Children's Health Insurance Program;
- The Federal Employees Health Benefits Program;
- A non-federal, public health plan;
- A health benefit plan under section 5(e) of the Peace Corps Act; or

- State Children's Health Insurance Program.

Creditable coverage does not include any of the following:
- Accident only coverage, disability income insurance, or any combination thereof;
- Supplemental coverage to liability insurance;
- Liability insurance, including general liability insurance and automobile liability insurance;
- Workers' compensation or similar insurance;
- Automobile medical payment insurance;
- Credit-only insurance;
- Coverage for on site medical clinics;
- Benefits if offered separately:
  - Limited scope dental and vision;
  - Long-term care, nursing home care, home health care, community based care, or any combination thereof; and
  - Other similar, limited benefits;
- Benefits if offered as independent, non-coordinated benefits:
  - Specified disease or illness coverage; and
  - Hospital indemnity or other fixed indemnity insurance;
- Benefits offered as a separate policy:
  - Medicare supplement insurance;
  - Supplemental coverage to the health plan for active military personnel, including TRICARE; and
  - Similar supplemental coverage provided to group health plan coverage.

Portability of creditable coverage

You are eligible for portability of creditable coverage if your coverage was continuous without a break of more than 63 days between the termination of coverage under creditable coverage and the enrollment date under the Contract. For those eligible for trade adjustment assistance (TAA) under the 2002 Trade Act, the lapse between the loss of group coverage and the second COBRA election period will not be counted toward determining whether there has been a 63-day break in coverage. The pre-existing condition exclusion period will be reduced by the number of days of coverage that you had under the creditable coverage.

If on a particular day you have creditable coverage from more than one source, all the creditable coverage on that day will be counted as one day. Any day of the waiting period for a plan or policy is not counted as creditable coverage.

Notice to us of creditable coverage

You must submit certification of creditable coverage to us. Upon request and authorization from you, we can contact your prior health plan(s) for your creditable coverage certification.

MEDICAL LIMITATIONS AND EXCLUSIONS

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

- Treatments, services, supplies or surgeries that are not medically necessary, except for the specified routine preventive services as outlined in the "Schedule of Benefits" and described in the "Covered Expenses" section of the certificate.

- A sickness or bodily injury arising out of, or in the course of, any employment for wage, gain or profit.

- A sickness or bodily injury, which is covered under any Workers' Compensation or similar law. This limitation also applies to a Covered Person who is not covered by Workers' Compensation and lawfully chose not to be.

- Care and treatment given in a hospital owned or run by any government entity, unless you are legally required to pay for such care and treatment. However, care and treatment provided by military hospitals to Covered Persons who are armed services retirees and their dependents are not excluded.

- Any service furnished while you are confined in a hospital or institution owned or operated by the United States government or any of its agencies for any military service-connected sickness or bodily injury.

- Any service you would not be legally required to pay for in the absence of this insurance.

- Sickness or bodily injury for which you are in any way paid or entitled to payment or care and treatment by or through a government program.

- Any service not ordered by a health care practitioner.

- Services provided to you, if you do not comply with the HMO/POS Contract's requirements. These include services:
  - Not provided by a network provider, unless required for emergency care {*this applies to HMO plans and some POS plans*};
  - Received in an emergency room, unless required because of emergency care;
  - Which require preauthorization if preauthorization was not obtained;
  - Which require a primary care physician referral if a referral was not obtained {*this applies only to some HMO and POS plans*}.

- 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 or not substantiated in the medical records.

- For PPO, Classic and POS plans any expense incurred for services received outside of the United States while you are residing outside of the United States for more than six months in a year except as required by law for emergency care services.

- Education or training, except for diabetes self-management training.

- Educational or vocational therapy, testing, services or schools, including therapeutic boarding schools and other therapeutic environments. Educational or vocational videos, tapes, books and similar materials are also excluded.

- Medical services provided by a Covered Person's family member.

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

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

- Vitamins, dietary supplements, and dietary formulas (except enteral formulas for the treatment of genetic metabolic diseases, e.g. phenylketonuria (PKU), unless otherwise covered by a Prescription Drug Benefit attached to the Contract).

- Over the counter, non-prescription medications.

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

- Medication, drugs or hormones to stimulate growth unless there is a laboratory confirmed diagnosis of growth hormone deficiency, as determined by us.

- Treatment of nicotine habit or addiction, including, but not limited to, nicotine patches, hypnosis, smoking cessation classes or tapes.

- Prescription drugs and self-administered injectable drugs, unless administered to you:
  - While an inpatient in a hospital, skilled nursing facility, or health care treatment facility;
  - By a health care practitioner during an office visit; or
  - By a home health care agency as part of a covered home health care plan when approved by us.

- Hearing aids, the fitting of hearing aids or advice on their care; implantable hearing devices.

- 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.

- No benefits will be provided for:
  - Immunotherapy for recurrent abortion;
  - Chemonucleolysis;
  - Biliary lithotripsy;
  - Home uterine activity monitoring;
  - Sleep therapy;
  - Light treatments for Seasonal Affective Disorder (S.A.D.);
  - Immunotherapy for food allergy;
  - Prolotherapy;
  - Cranial banding;
  - Hyperhydrosis surgery;
  - Lactation therapy; or
  - Sensory integration therapy.

- Cosmetic surgery and cosmetic services or devices, unless for reconstructive surgery:
  - Resulting from a bodily injury, infection or other disease of the involved part, when functional impairment is present; or
  - Resulting from congenital disease or anomaly of a covered dependent child, which resulted in a functional impairment.

  A functional impairment is defined as a direct measurable reduction of physical performance of an organ or body part. Expense incurred for reconstructive surgery performed due to the presence of a psychological condition are not covered, unless the condition(s) described above are also met.

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

- Dental services, appliances or supplies for treatment of the teeth, gums, jaws or alveolar processes, including but not limited to, any oral surgery or periodontic surgery and preoperative and postoperative care, 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;
  - The provision of heel wedges, lifts, or shoe inserts; and
  - The provision of arch supports or orthopedic shoes, unless medically necessary because of diabetes or hammertoe.

- Custodial care and maintenance care.

- Any loss caused by:
  - War or any act of war, whether declared or not;
  - Insurrection; or
  - Any act of armed conflict, or any conflict involving armed forces of any authority.

- Sickness or bodily injury caused by the Covered Person's:
  - Engaging in an illegal occupation; or
  - Commission of or an attempt to commit a criminal act.

- Expenses for health clubs or health spas, aerobic and strength conditioning, work-hardening programs or weight loss or similar programs, and all related material and product for these programs.

- Expenses for services that are primarily and customarily used for environmental control or enhancement (whether or not prescribed by a health care practitioner) and certain medical devices including, but not limited to:
  - Common household items including air conditioners, air purifiers, water purifiers, vacuum cleaners, waterbeds, hypoallergenic mattresses or pillows or exercise equipment;
  - Motorized transportation equipment (e.g. scooters), escalators, elevators, ramps or modifications or additions to living/working quarters or transportation vehicles;
  - Personal hygiene equipment including bath/shower chairs, transfer equipment or supplies or bed side commodes;
  - Personal comfort items including cervical pillows, gravity lumbar reduction chairs, swimming pools, whirlpools, spas or saunas;
  - Medical equipment including blood pressure monitoring devices, breast pumps, 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.

- 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.

- Sickness or bodily injury for which medical payment or expense coverage benefits are paid or payable under any homeowners, premises or any other similar coverage.

- Elective medical or surgical abortion unless:
  - The pregnancy would endanger the life of the mother; or
  - The pregnancy is a result of rape or incest; or
  - The fetus has been diagnosed with a lethal or otherwise significant abnormality.

- Alternative medicine.

- Acupuncture, unless:
  - The treatment is medically necessary and appropriate and is provided within the scope of the acupuncturist's license;
  - You are directed to the acupuncturist for treatment by a licensed physician; and
  - The acupuncture is performed in lieu of generally accepted anesthesia practices.

- Services rendered in a premenstrual syndrome clinic or holistic medicine clinic.

- Chiropractic services or spinal manipulations.

- Services of a midwife, unless provided by a Certified Nurse Midwife.

- Vision examinations or testing for the purposes of prescribing corrective lenses; orthoptic training (eye exercises); radial keratotomy, refractive keratoplasty or any other surgery or procedure to correct myopia, hyperopia or stigmatic error; or, 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).

- 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.

  Specifically excluded are marriage counseling and services for autism.

- 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, if such coverage is 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.

- For HMO plans, any care, treatment, services, equipment or supplies received outside of the service area:
  - If you could have reasonably foreseen or anticipated their need prior to departure from the service area; and
  - Which are not authorized by us or to the extent they exceed the maximum allowable fee.

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

- Home health care does 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.

- Hospice care does 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;
  - 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.

- Regardless of indication, no coverage is provided for:
  - Fabric supports;
  - Replacement orthotics and braces;
  - Oral splints and appliances; or
  - Dental splints and dental braces.

- The following are not considered covered expenses:
  - Repair or maintenance of durable medical equipment or diabetes equipment; or
  - Duplicate or similar rentals or purchases of durable medical equipment or diabetes equipment as determined by us.

- No benefit is payable for, or in connection with, an organ transplant if:
  - It is experimental or investigational, or for research purposes as defined elsewhere in the certificate, and
  - The Office of Health Care Technology Assessment, within the Agency for Health Care Policy and Research within the federal Department of Health and Human Services, deems the procedure to be either experimental or investigational; or
  - There is insufficient data or experience to determine whether the procedure is clinically acceptable.
  - 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.
  - 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.

- The following exclusion applies to plans that <u>do not</u> include coverage for infertility services:
  - In-vitro fertilization; any medical or surgical treatment of infertility; infertility evaluations; infertility services; sex change services; or reversal of elective sterilization.

- The following exclusions are applicable to plans that include coverage for infertility services:
  - Reversal of voluntary sterilization;
  - Payment for medical services rendered to a surrogate for purposes of child birth;
  - Costs associated with cryo preservation and storage of sperm, eggs and embryos; provided, subsequent procedures of a medical nature necessary to make use of the cryo preserved substance will not be similarly excluded if deemed non-experimental and non-investigational;
  - Selected termination of an embryo; provided that where the life of the mother would be in danger were all embryos to be carried to full term, the termination is covered;
  - Non-medical costs of an egg or sperm donor;
  - Travel costs for travel within one hundred (100) miles of the covered person's home address as filed with us. Travel costs not medically necessary, not mandated or required by us;
  - Infertility treatments deemed experimental in nature as determined by the written determination of the American Society for Reproductive Medicine. Except, where infertility treatment includes elements that are not experimental in nature along with those which are, to the extent services may be delineated and separately charged, those services that are not experimental in nature will be covered.
  - Infertility treatments rendered to dependents under the age of 18.
  - Sex change services.

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

No benefit is provided for:

- Legend drugs which are not recommended and not deemed necessary by a health care practitioner;

- 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 labeled "Caution-Limited by Federal Law to Investigational Use" or any experimental drug, medicine or medication, even though a charge is made to you;

- Allergen extracts;

- Therapeutic devices or appliances, including:
  - Hypodermic needles and syringes (except needles and syringes for use with insulin, and self-administered injectable drugs whose coverage is approved by us);
  - Support garments;
  - Test reagents;
  - Mechanical pumps for delivery of medications; and
  - Other non-medical substances;

- Dietary supplements; (except for formulas or low protein modified foods necessary for the treatment of phenylketonuria or certain other heritable diseases of amino and organic acids);

- Nutritional products;

- Fluoride supplements;

- Minerals;

- Growth hormones (medications, drugs or hormones to stimulate growth), unless medically necessary {*this does not apply to RX Impact Allowance*};

- Herbs and vitamins, except prenatal (including greater than one milligram of folic acid) and pediatric multi-vitamins with fluoride;

- Anabolic steroids {*this does not apply to RX Impact Allowance*};

- Anorectic or any drug used for the purpose of weight control {*this does not apply to RX Impact Allowance*};

- Any drug used for cosmetic purposes, including but not limited to:
  - Tretinoin, e.g. Retin A, except if *you* are under the age of 45 or are diagnosed as having adult acne;
  - Dermatologicals or hair growth stimulants; or
  - Pigmenting or de-pigmenting agents, e.g. Solaquin;

  {*this does not apply to RX Impact Allowance*}

- Any drug or medicine that is:
  - Lawfully obtainable without a prescription (over the counter drugs), except insulin; or
  - Available in prescription strength without a prescription;

- Compounded drugs in any dosage form; except when prescribed for pediatric use for children up to 19 years of age;

- Progesterone crystals or powder in any compounded dosage form;

- Abortifacients (drugs used to induce abortions) {*this does not apply to RX Impact Allowance*};

- Medications for the treatment of infertility, unless specifically referenced in the certificate;

- Any drug prescribed for impotence and/or sexual dysfunction, e.g. Viagra {*this does not apply to RX Impact Allowance*};

- 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;
  - Biological sera;
  - Blood;
  - Blood plasma; or
  - Self-administered injectable drugs for which coverage is not approved by us;

- Prescription refills:
  - In excess of the number specified by the health care practitioner; or
  - Dispensed more than one year from the date of the original order;

- Any portion of a prescription or refill that exceeds a 30-day supply, unless otherwise indicated in the certificate (or a 90-day supply for a prescription or refill that is received from a mail order pharmacy);

- Any portion of a prescription or refill that:
  - Exceeds our drug specific dispensing limit, e.g. IMITREX; or
  - Is dispensed to a Covered Person whose age is outside the drug specific age limits defined by us;
  - Exceeds the duration-specific dispensing limit;

- Any drug for which prior authorization is required, as determined by us, and not obtained {*this does not apply to RX Impact Allowance*};

- Any drug for which a charge is customarily not made;

- Any drug, medicine or medication received by you:
  - Before becoming covered under the prescription drug rider; or
  - After the date your coverage under the prescription drug rider has ended;

  {*this does not apply to HDHP plans*};

- 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 or refill for drugs, medicines or medications that are lost, stolen, spilled, spoiled or damaged;

- Any service, supply or therapy to eliminate or reduce a dependency on, or addiction to tobacco and tobacco products, including but not limited to nicotine withdrawal therapies, programs, services or medications;

- Drug delivery implants;

- Treatment for onychomycosis (nail fungus) {*this does not apply to RX Impact Allowance*};

- For Prescription Drug Products other than RX Impact Allowance: More than one prescription for the same drug or therapeutic equivalent medication prescribed by one or more health care practitioners and dispensed by one or more pharmacies until you have used, or should have used, at least 75% of the previous prescription, unless the drug or therapeutic equivalent medication is purchased through a mail order pharmacy, in which case you have used, or should have used 66% of the previous prescription. (Based on the dosage schedule prescribed by the health care practitioner);

- For the RX Impact Allowance Prescription Drug Product: More than one prescription within a 23-day period for the same drug or therapeutic equivalent medication prescribed by one or more health care practitioners and dispensed by one or more pharmacies, unless received from a mail order pharmacy. For drugs received from a mail order pharmacy, more than one prescription within a 20-day period for a 1-30 day supply; or a 60-day period for a 61-90 day supply. (Based on the dosage schedule prescribed by the health care practitioner);

- Any drug or biological that has received designation as an orphan drug, unless approved by us;

- Any copayment 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, or

- For HMO plans and some POS plans, prescriptions filled at a non-network pharmacy, except for prescriptions required during an emergency.

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 sometimes 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/members/home.asp** 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 (also known as usual, customary, and reasonable charges) for a covered expense 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.

Note: 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 will not apply to your out-of-pocket limit, copayment limit, or deductible, if any.

MODIFICATION OF COVERAGE

The Contract may be modified at any time by agreement between us and the Contractholder or participating employer 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, or waive any of the Contract provisions, to extend the time of premium payment, or bind us by making any promise or representation.

The Contract may be modified by us at anytime without prior consent of, or notice to, the Contractholder or participating employer when the changes are:

- Required by state or federal law;
- Required by filing of forms with the Insurance Department of the state; or
- For an increase in benefits without any increase in premium.

Modifications to the Contract, due to reasons other than those listed above, can be made by us at anytime with the consent of the Contractholder or participating employer, provided the Contractholder or participating employer is issued notice of such changes in writing or electronically, at least 31 days prior to the effective date of such changes. Although Contractholder or participating employer consent is not required, the payment of premium after the effective date of such change constitutes the Contractholder's or participating employer's consent to change.

EMPLOYER / PARTICIPATING EMPLOYER RESPONSIBILITIES

In addition to responsibilities outlined in the Contract, the employer or participating employer is responsible for:
- Collection of premium; and
- Distribution of benefit plan documents; and
- Distribution of renewal notices and policy modification information.

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

RENEWAL OR TERMINATION OF COVERAGE

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

The Contractholder or participating employer may terminate the insurance 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 or participating employer and us.

The Contractholder or participating employer 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 or participating employer 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 or participating employer. 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 as follows:

- The Contractholder or participating employer fails to remit premium when due, except that coverage continues during the grace period applicable to the due but unpaid premium.

- The Contractholder or participating employer has failed to comply with our minimum underwriting, participation and/or contribution requirements, as specified on the Employer Group Application. The participating employer will be notified at least 60 days prior to the date of termination.

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

- The Contractholder or participating employer 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 or participating employer for instances of fraud or intentional misrepresentation of a material fact.

- If we decide to discontinue offering a particular group health Contract:

    - The Contractholder or participating employer and the employees will be notified by us of such discontinuation at least 90 days prior to the date of discontinuation of such coverage; and
    - The Contractholder or participating employer will be given the option to purchase any other group Contract providing medical benefits that are 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 or participating employers and the employees covered by such Contracts and the Commissioner of Insurance will be notified by us 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 date the participating employer's participation under the policy terminates, if applicable;
- The Covered Person no longer meets the eligibility requirements of the plan. You and the employer or participating 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 insurance 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 or participating employer 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.

SMALL EMPLOYER POLICY RATING FACTORS

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

Rate guarantee

Humana's general practice for rate guarantee is that each small employer group's initial medical rates are guaranteed for 12 months from the effective date of coverage. Thereafter, a minimum of 31 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 be effective on the date the change in coverage becomes effective.

Rate disclosure

Each participating employer group will be placed in one of two classes of “Humana Products”, one with all the small employer groups on our records and the other with the block of business acquired from other carriers. Each participating employer group’s rate will be based on two factors. The first factor takes into account the benefit plan, coverage type, geographic location and demographics (such as age, occupation, industry, gender, family status, case size, etc. as permitted by state requirements) of each participating employer group. Also, it may vary based on eligibility for Medicare and/or Workers’ Compensation coverage. This factor is established based on overall experience of all participating employer groups insured under that product in the class and would be the same for any group with the same characteristics. Changes in any of your group case characteristics may affect this factor.

The second factor, each participating employer group’s actual and potential medical claims utilization, may cause that rate to be above or below an established index rate. The index rate is defined as the arithmetic average of the lowest premium rate and corresponding highest premium rate within the class (i.e. highest rate plus lowest rate divided by two equals index rate), for groups with similar case characteristics and benefit plan. This factor may cause an increase of up to 25% over the index rate or decrease of up to 25% below the index rate; the portion of a renewal rate increase attributable to this factor shall be no more than 15% in a 12 month period. The index rate for the two classes may be different. Case size will be determined by the number of medical lives upon enrollment and periodically thereafter.