

<i>SERFF Tracking Number:</i>	<i>HUMA-126828996</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Humana Insurance Company</i>	<i>State Tracking Number:</i>	<i>46878</i>
<i>Company Tracking Number:</i>	<i>AR-10-003</i>		
<i>TOI:</i>	<i>H16G Group Health - Major Medical</i>	<i>Sub-TOI:</i>	<i>H16G.001A Any Size Group - PPO</i>
<i>Product Name:</i>	<i>CC2003 et al</i>		
<i>Project Name/Number:</i>	<i>DME updates/PC100</i>		

Filing at a Glance

Company: Humana Insurance Company

Product Name: CC2003 et al

TOI: H16G Group Health - Major Medical

Sub-TOI: H16G.001A Any Size Group - PPO

Filing Type: Form

SERFF Tr Num: HUMA-126828996 State: Arkansas

SERFF Status: Closed-Approved-
Closed State Tr Num: 46878

Co Tr Num: AR-10-003

Author: Wendy Jeffries

Date Submitted: 09/23/2010

State Status: Approved-Closed

Reviewer(s): Rosalind Minor

Disposition Date: 10/08/2010

Disposition Status: Approved-
Closed

Implementation Date:

Implementation Date Requested: On Approval

State Filing Description:

General Information

Project Name: DME updates

Project Number: PC100

Requested Filing Mode:

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 10/08/2010

Status of Filing in Domicile:

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Group

Group Market Size: Small and Large

Group Market Type: Employer

Explanation for Other Group Market Type:

State Status Changed: 10/08/2010

Created By: Wendy Jeffries

Corresponding Filing Tracking Number:

Deemer Date:

Submitted By: Wendy Jeffries

PPACA: Not PPACA-Related

Filing Description:

We respectfully submit for your review and approval on a general use basis the attached forms utilizing the matrix element concept. These forms are for use in the large group and small group market with our Humana Insurance Company Policy Series: CC2003-P, Certificate series: CC2003-C contract/certificate. Deleted languages is denoted with 3 blue carets (^^^) and new language is in blue font. Please be advised that it is not our intent to use variability to reduce any benefits or provisions below any statutory or regulatory requirement.

Thank you for your attention to this filing. Should you have any questions, please do not hesitate to contact me at 1-800-664-4140, ext. 1783, via fax to 502-508-1783 or E-mail to wjeffries@humana.com.

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Sincerely,
 Wendy Jeffries

Company and Contact

Filing Contact Information

Wendy Jeffries, Regional Contract Analyst wjeffries@humana.com
 321 W. Main Street 502-580-1783 [Phone]
 6th Floor, East Tower
 Louisville, KY 40202

Filing Company Information

Humana Insurance Company CoCode: 73288 State of Domicile: Wisconsin
 1100 Employers Boulevard Group Code: 119 Company Type: Life & Health
 Green Bay, WI 54344 Group Name: State ID Number:
 (800) 558-4444 ext. [Phone] FEIN Number: 39-1263473

Filing Fees

Fee Required? Yes
 Fee Amount: \$50.00
 Retaliatory? No
 Fee Explanation: Revision to 1 policy/certificate - \$50.00
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Humana Insurance Company	\$50.00	09/23/2010	39804574
Humana Insurance Company	\$50.00	10/07/2010	40397242

CHECK NUMBER	CHECK AMOUNT	CHECK DATE
	\$0.00	

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	10/08/2010	10/08/2010

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	Created By	Created On	Date Submitted	Responded By	Created On	Date Submitted
Pending Industry Response	Rosalind Minor	10/07/2010	10/07/2010	Wendy Jeffries	10/07/2010	10/07/2010

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Disposition

Disposition Date: 10/08/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	PPACA Uniform Compliance Summary	Approved-Closed	Yes
Supporting Document	Matrix Variability	Approved-Closed	Yes
Form	Covered Expenses	Approved-Closed	Yes
Form	Limitations and Exclusions	Approved-Closed	Yes

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Project Name/Number: DME updates/PC100

Objection Letter

Objection Letter Status Pending Industry Response

Objection Letter Date 10/07/2010

Submitted Date 10/07/2010

Respond By Date

Dear Wendy Jeffries,

This will acknowledge receipt of the captioned filing.

Objection 1

- Covered Expenses, 204000 05/05 (Form)
- Limitations and Exclusions, 211100AR 07/07 (Form)

Comment:

Our filing fees under Rule and Regulation 57 have been updated. Please review the General Instructions for ArkansasLH or Rule and Regulation 57.

The fee for this submission is \$50.00 per form for a total of \$100.00. Please submit an additional \$50.00 for this submission.

We will begin our review of this submission upon receipt of the additional filing fee.

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

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Project Name/Number: DME updates/PC100

Response Letter

Response Letter Status Submitted to State
Response Letter Date 10/07/2010
Submitted Date 10/07/2010

Dear Rosalind Minor,

Comments:

Response 1

Comments: Please note that an additional \$500 has been submitted.

Related Objection 1

Applies To:

- Covered Expenses, 204000 05/05 (Form)
- Limitations and Exclusions, 211100AR 07/07 (Form)

Comment:

Our filing fees under Rule and Regulation 57 have been updated. Please review the General Instructions for ArkansasLH or Rule and Regulation 57.

The fee for this submission is \$50.00 per form for a total of \$100.00. Please submit an additional \$50.00 for this submission.

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Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Sincerely,

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Form Schedule

Lead Form Number: 204000 05/05

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved- Closed	204000 05/05	Certificate	Covered Expenses	Initial			090 PAR CovExpGen
Approved- Closed	211100AR 07/07	Certificate	Limitations and Exclusions	Initial			04-10 (a1).pdf 130 PAR LE 04-10 (a1).pdf
10/08/2010							
10/08/2010							

[COVERED EXPENSES]

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

- *Deductible*;
- *Copayment*;
- *Coinsurance* percentage;
- [Benefit allowance;] [and]
- Maximum benefit.

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

204000 05/05

[Preventive services]

[Preventive services office visit]

Covered expenses include charges incurred for an office visit made to a *health care practitioner* for examinations and physicals to detect or prevent *sickness* [as recommended by the U.S. Preventive Services Task Force].]

Pediatric preventive services

Covered expenses include charges incurred by *you* for a *dependent* child for periodic preventive care review of such child's physical and emotional health from birth through 18 years of age, at approximately the following age intervals: birth, 2 weeks, 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months, 2 years, 3 years, 4 years, 5 years, 6 years, 8 years, 10 years, 12 years, 14 years, 16 years, and 18 years. *Covered expenses* for each visit shall include the following services in keeping with prevailing medical standards:

- A medical history;
- Physical examination;
- Developmental assessment and anticipatory guidance;
- Appropriate laboratory tests; and
- Appropriate immunizations. Benefits for eligible immunizations shall be exempt from *copayment*, *coinsurance*, *deductible* or dollar limit provisions of the plan, if any.

204150AR[WRJ1]

Preventive screenings and immunizations

Covered expenses include charges incurred by *you* for the following *preventive services* [as recommended by the United States Preventive Services Task Force]:

[COVERED EXPENSES (continued)]

- [[Laboratory][,] [radiology] [and/or] [endoscopic] services to detect or prevent *sickness*.]
- [A baseline mammogram for a [female] *covered person* between the ages of [35] [and] [40] and an annual mammogram for a [female] *covered person* [40] [years of age or older].]
- [Routine pap smear.]
- [A prostate specific antigen (PSA) test for a male *covered person* [40] [years of age or older.]]
- Routine immunizations for *covered persons* through[WRJ2] the age of 18. [TB tine tests and allergy desensitization injections are not considered routine immunizations.]
- [[Immunizations] [against influenza] [(flu shot)] [and] [pneumonia][,][as determined by us].]
- [Routine hearing screening.]
- [Routine vision screening (not including refractions).]

204200AR 07/07

[Health care practitioner [home and] office services]

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

[Health care practitioner [home and] office visit]

[*Covered expenses* include:

- [[Home and] office visits for the diagnosis and treatment of a *sickness* or *bodily injury*. [(Excludes *outpatient surgery*.)]]
- [[Home and] office visits for prenatal care.]
- [[Home and] office visits for *diabetes self-management training*.]
- [Diagnostic laboratory [and radiology].]
- [Plain film radiology.]
- [*Advanced imaging*.]
- [*Nuclear medicine*.]
- [Allergy testing.]
- [Allergy serum.]
- [Allergy injections.]
- [Injections other than allergy.]
- [*Surgery*, including anesthesia.]
- [Second surgical opinions.]
- [[Chemotherapy][,] [radiation therapy][,] [and] [dialysis].]

[*Covered expenses* for *health care practitioner* office visit services do not include [*advanced imaging*][,] [or] [*nuclear medicine*] [or] [plain film] radiology].]

204400 07/07

[Hospital services]

[COVERED EXPENSES (continued)]

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

For *emergency care* benefits provided in a *hospital*, refer to the "Emergency Services" provisions of the "Covered Expenses" section.]

Hospital inpatient services

Covered expenses include:

- Daily semi-private, ward, intensive care or coronary care *room and board* charges for each day of *confinement*. [Benefits for a private or single-bed room are limited to the *maximum allowable fee* charged for a semi-private room in the *hospital* while a registered bed patient.]
- Services and supplies, other than *room and board*, provided by a *hospital* to a registered bed patient.
- Inpatient services for a minimum of 48 hours following a mastectomy unless earlier discharge is consented to by the *covered person* and the attending *health care practitioner*. [WRJ3]

[Health care practitioner inpatient services [when provided in a hospital]

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

Covered expenses include:

- Medical services furnished by an attending *health care practitioner* to you while you are *hospital confined*.
- *Surgery* performed on an *inpatient* basis. [If several *surgeries* are performed during one operation, we will pay the *maximum allowable fee* for the [most complex] [primary] procedure.] [For each additional procedure we will pay:
 - [0-100%] of *maximum allowable fee* for the secondary procedure; and
 - [0-100%] of *maximum allowable fee* for the third and subsequent procedures.]

[If two surgeons work together as primary surgeons performing distinct parts of a single reportable procedure, we will pay each surgeon [0 - 100%] of the *maximum allowable fee* for the procedure.]

- [Services of a surgical assistant and/or assistant surgeon when *medically necessary*.] [Surgical assistants and/or assistant surgeons will be paid at [0 – 100%] of the *covered expense* for *surgery*.]
- Services of a physician assistant (P.A.), registered nurse (R.N.) or a certified operating room technician when *medically necessary*. [Physician assistants, registered nurses and certified operating room technicians will be paid at [0 – 100%] of the *covered expense* for the *surgery*.]

[COVERED EXPENSES (continued)]

- Anesthesia administered by a *health care practitioner* or certified registered anesthetist attendant to a *surgery*.
- Consultation charges requested by the attending *health care practitioner* during a *hospital confinement*. [The benefit is limited to [one – unlimited] consultation[s] by any one consultant per specialty during a *hospital confinement*.]
- Services of a pathologist.
- Services of a radiologist.
- Services performed on an emergency basis in a *hospital* if the *sickness* or *bodily injury* being treated results in a *hospital confinement*.]

[[Hospital] outpatient services

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

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

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

[[Hospital] outpatient surgical services

Covered expenses include[:]

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

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

Services which are payable as a *hospital* [or *ambulatory surgical center*] charge are not payable as a *health care practitioner* charge.

Covered expenses include:

- *Surgery* performed on an *outpatient* basis. [If several *surgeries* are performed during one operation, we will pay the *maximum allowable fee* for the [most complex] [primary] procedure.] [For each additional procedure we will pay:
 - [0-100%] of *maximum allowable fee* for the secondary procedure; and

[COVERED EXPENSES (continued)]

- [0-100%] of *maximum allowable fee* for the third and subsequent procedures.]

[If two surgeons work together as primary surgeons performing distinct parts of a single reportable procedure, *we* will pay each surgeon [0 - 100%] of the *maximum allowable fee* for the procedure.]

- [Services of a surgical assistant and/or assistant surgeon when *medically necessary*.] [Surgical assistants and/or assistant surgeons will be paid at [0 – 100%] of the *covered expense* for *surgery*.]
- Services of a physician assistant (P.A.), registered nurse (R.N.) or a certified operating room technician when *medically necessary*. [Physician assistants, registered nurses and certified operating room technicians will be paid at [0 – 100%] of the *covered expense* for the *surgery*.]
- Anesthesia administered by a *health care practitioner* or certified registered anesthetist attendant for a *surgery*.
- Services of a pathologist.
- Services of a radiologist.

[*Covered expenses for health care practitioner outpatient services do not include [advanced imaging][,] [or] [nuclear medicine] [or] [plain film] radiology[.].*]

[Hospital] outpatient non-surgical services

Covered expenses include[:]

- Services provided in a *hospital's outpatient* department in connection with non-surgical services.
- [Services provided in a *free-standing facility* in connection with non-surgical services.]
- Services provided for laboratory and pathological tests, x-rays, chemotherapy, radiation treatment and renal dialysis.[WRJ4]

[*Covered expenses for hospital non-surgical services do not include [advanced imaging][,] [or] [nuclear medicine] [or] [plain film] radiology[.].*]

[[Hospital] [outpatient] advanced imaging

We will pay benefits for covered expenses incurred by you for [outpatient] advanced imaging [in a hospital's outpatient department] [or] [in a free-standing facility].

[[Hospital] [outpatient] [plain film] radiology

We will pay benefits for covered expenses incurred by you for [outpatient] [plain film] radiology [in a hospital's outpatient department] [or] [in a free-standing facility].

[[Hospital] [outpatient] nuclear medicine

[COVERED EXPENSES (continued)]

We will pay benefits for *covered expenses* incurred by you for [outpatient] *nuclear medicine* [in a hospital's outpatient department] [or] [in a free-standing facility].]

205450AR 07/07

Pregnancy and newborn benefit

We will pay benefits for *covered expenses* incurred by a [covered person] [covered employee or covered dependent] [spouse]] for a pregnancy.

Covered expenses include:

- A minimum stay of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated cesarean section. If an earlier discharge is consistent with the most current protocols and guidelines of the American College of Obstetricians and Gynecologists or the American Academy of Pediatrics and is consented to by the mother and the attending *health care practitioner*, a post-discharge office visit to the *health care practitioner* or a home health care visit within the first 48 hours after discharge is also covered, subject to the terms of this *certificate*.
- For a newborn, [hospital confinement during the first 48 hours or 96 hours following birth, as applicable and listed above] for:
 - Hospital charges for routine nursery care;
 - The *health care practitioner's* charges for circumcision of the newborn child; and
 - The *health care practitioner's* charges for routine examination of the newborn before release from the hospital.
- If the covered newborn must remain in the hospital past the mother's *confinement*, services and supplies received for:
 - A *bodily injury* or *sickness*;
 - Care and treatment for premature birth; and
 - Medically diagnosed birth defects and abnormalities.

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

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

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

205500 03/09

[Emergency services]

[COVERED EXPENSES (continued)]

[We will pay benefits for *covered expenses* incurred by *you* for *emergency care*, including the treatment and stabilization of an emergency medical condition. [*Covered expenses* include medical screening examinations provided in a *hospital* emergency facility to determine whether a medical emergency condition exists.]

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

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

[*Covered expenses* for emergency services do not include [*advanced imaging*][,] [or] [*nuclear medicine*] [or [*plain film*] radiology].]

[Authorized non-network hospital and health care practitioner services]

[*Covered expenses* incurred by *you* for authorized *non-network hospital* services and authorized *non-network health care practitioner* services will be payable at the *network provider* benefit percentage when the services cannot be obtained through *network providers*.

[*Covered expenses* incurred by out-of-area *covered persons* will be payable at the *network provider* benefit percentage.]]
205700 07/07

Ambulance

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

[*Ambulance* service for *emergency care* provided by a *non-network provider* will be covered at the *network provider* benefit percentage, subject to the *maximum allowable fee*.] [*Non-network providers* have not agreed to accept discounted or negotiated fees, and may bill *you* for charges in excess of the *maximum allowable fee*.] [*You* may be required to pay any amount not paid by *us*.]
205750 05/05

[Ambulatory surgical center]

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

[COVERED EXPENSES (continued)]

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

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

Covered expenses include:

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

- [0-100%] of *maximum allowable fee* for the secondary procedure; and
- [0-100%] of *maximum allowable fee* for the third and subsequent procedures.]

[If two surgeons work together as primary surgeons performing distinct parts of a single reportable procedure, *we* will pay each surgeon [0 - 100%] of the *maximum allowable fee* for the procedure.]

- [Services of a surgical assistant and/or assistant surgeon when *medically necessary*.] [Surgical assistants and/or assistant surgeons will be paid at [0 – 100%] of the *covered expense* for *surgery*.]
- Services of a physician assistant (P.A.), registered nurse (R.N.) or a certified operating room technician when *medically necessary*. [Physician assistants, registered nurses and certified operating room technicians will be paid at [0 – 100%] of the *covered expense* for the *surgery*.]
- Anesthesia administered by a *health care practitioner* or certified registered anesthetist attendant to a *surgery*.
- Services of a pathologist.
- Services of a radiologist.

[*Covered expenses* for *health care practitioner outpatient* services provided in an *ambulatory surgical center* do not include [advanced imaging][,] [or] [nuclear medicine] [or] [plain film] radiology].
205800 07/07

Durable medical equipment [and diabetes equipment]

We will pay benefits for *covered expenses* incurred by *you* for [medically necessary] durable medical equipment [and diabetes equipment]. [Covered expense includes oxygen and rental of equipment for its administration.]

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

[COVERED EXPENSES (continued)]

to purchase the *durable medical equipment* [or *diabetes equipment*], any amount paid as rent for such equipment will be credited toward the purchase price.

^^^

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

- [Manufacturer's warranty is expired][;]
- [Repair or maintenance is not a result of misuse or abuse][;]
- [Maintenance is not more frequent than every six months][;] [and]
- [Repair cost is less than replacement cost][;]]

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

- [Manufacturer's warranty is expired][;]
- [Replacement cost is less than repair cost][;] [and]
- [Replacement is not due to lost or stolen equipment, or misuse or abuse of the equipment][;] [or]
- [Replacement is required due to a change in *your* condition that makes the current equipment non-functional][.]

205900 04/10

[[Prosthetic[s]] [and] [orthotic[s]] [devices] [and] [supplies]]

We will pay benefits for *covered expenses* incurred by *you* for [initial] [prosthetic] [and] [orthotic] [devices] [and] [supplies][, including but not limited to limbs and eyes]. [Coverage will be provided for prosthetic devices necessary to restore the minimal basic function of a lost limb or eye.] [Replacement is a *covered expense* if due to pathological changes or growth.] [*Covered expense* includes repair of the prosthetic device if not covered by the manufacturer.]

[*Covered expense* includes casts, splints, trusses, crutches, orthotics and braces. Orthotics must be custom made [or custom fit and made] of rigid or semi-rigid material.]

[Regardless of indication, no coverage is provided for:

- [Fabric supports;]
- [Replacement orthotics and braces;]
- [Oral splints and appliances;] [or]
- [Dental splints and dental braces].]

205950 05/05

[Free-standing facility services]

[[Free-standing outpatient non-surgical services]

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

[COVERED EXPENSES (continued)]

[Covered expenses for outpatient non-surgical services do not include [advanced imaging][,] [or] [nuclear medicine] [or] [plain film] radiology[.]]

[Health care practitioner services provided in a free-standing facility]

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

[Free-standing [outpatient] advanced imaging]

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

[Free-standing [outpatient] [plain film] radiology]

We will pay benefits for *covered expenses* incurred by you for [outpatient] [plain film] radiology in a *free-standing facility*.]

[Free-standing [outpatient] nuclear medicine]

We will pay benefits for *covered expenses* incurred by you for [outpatient] *nuclear medicine* in a *free-standing facility*.]

206250 07/07

Home health care

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

[The "Schedule of Benefits" shows the maximum number of visits allowed by a representative of a *home health care agency*, if any.] [A visit by any representative of a *home health care agency* of [two - eight] hours or less will be counted as one visit.]

Home health care *covered expenses* include:

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

Home health care *covered expenses* do not include:

[COVERED EXPENSES (continued)]

- [Charges for mileage or travel time to and from the *covered person's* home;]
- [Wage or shift differentials for any representative of a *home health care agency*;]
- [Charges for supervision of *home health care agencies*;]
- [Charges for services of a home health aide;]
- [*Custodial care*;] or
- [The provision or administration of *self-administered injectable drugs*, unless otherwise determined by *us*.]

206300 03/09

Hospice

We will pay benefits for *covered expenses* incurred by you for a *hospice care program*. A *health care practitioner* must certify that the *covered person* is terminally ill with a life expectancy of [six – 24] months or less.

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

Hospice care benefits are payable as shown on the "Schedule of Benefits" for the following hospice services, subject to the *individual [lifetime] maximum benefit* and any other maximum(s):

- *Room and board* at a hospice[, when it is for management of acute pain or for an acute phase of chronic symptom management];
^^^
- Part-time nursing care provided by or supervised by a registered nurse (R.N.) [for up to] [one - 12] [hours in any one day];
^^^
- [Counseling for the terminally ill *covered person* and his/her immediate covered family members by a licensed:
 - Clinical social worker; or
 - Pastoral counselor.]

[This counseling is limited to a total of [one - 20] family session[s].] [This counseling must be provided within [3-24] months following the *covered person's* death.]

- Medical social services provided to the terminally ill *covered person* or his/her immediate covered family members under the direction of a *health care practitioner*, including:
 - Assessment of social, emotional and medical needs, and the home and family situation; and
 - Identification of the community resources available.
- Psychological and dietary counseling;
^^^
- [Physical therapy];
^^^
- Part-time home health aide services [for up to] [one – 12] hours in any one day]; and

[COVERED EXPENSES (continued)]

^^^

- Medical supplies, drugs, and medicines prescribed by a *health care practitioner* for *palliative care*.

Hospice care *covered expenses* do not include:

- A *confinement* not required for acute pain control or other treatment for an acute phase of chronic symptom management;

^^^

- Services by volunteers or persons who do not regularly charge for their services; [and]

^^^

- Services by a licensed pastoral counselor to a member of his or her congregation. These are services in the course of the duties to which he or she is called as a pastor or minister[.];] [and]

^^^

- [Bereavement counseling services for family members not covered under this *policy*].

206400 05/055

In-vitro fertilization benefit

We will pay benefits for *covered expenses* incurred by *you* for in-vitro fertilization procedures. Benefits will be subject to the following:

- *Your* oocytes are fertilized with the sperm of *your* spouse; and
 - *You* and *your* spouse have a history of unexplained infertility of at least two years' duration; or
 - The infertility is associated with one or more of the following medical conditions:
 - Endometriosis;
 - Exposure in utero to Diethylstilbestrol, commonly known as DES;
 - Blockage of or removal of one or both fallopian tubes (lateral or bilateral salpingectomy) not as a result of voluntary sterilization; or
 - Abnormal male factors contributing to the infertility; and
- The in-vitro fertilization procedures are performed at a medical facility, licensed or certified by the Arkansas Department of Health as an in-vitro fertilization clinic. If no such facility is licensed or certified in this state or no such licensing program is operational, then coverage will be provided for such procedures performed at a facility that conforms to the American College of Obstetricians and Gynecologists' guidelines for in-vitro fertilization.
- *You* have been unable to obtain successful pregnancy through any less costly applicable infertility treatment for which coverage is unavailable under this *policy*.

Cryopreservation, the procedure whereby the embryos are frozen for later implantation, is included as an in-vitro fertilization procedure.

[COVERED EXPENSES (continued)]

206450AR[WRJ5]

Jaw joint benefit

We will pay benefits for *covered expenses* incurred by *you* during a plan of treatment for any jaw joint problem, including [temporomandibular joint disorder,] [craniomaxillary disorder,] [craniomandibular disorder,] [head and neck neuromuscular disorder] [or] [other conditions of the joint linking the jaw bone and the skull,] subject to the maximum benefit shown on the "Schedule of Benefits", if any. [Expenses covered under this jaw joint benefit are not covered under any other provision of this *certificate*.]

The following are *covered expenses*:

- [A single examination including a history, physical examination, muscle testing, range of motion measurements, and psychological evaluation, as necessary;]
- [Diagnostic x-rays;]
- [Physical therapy of necessary frequency and duration, limited to a multiple modality benefit when more than one therapeutic treatment is rendered on the same date of service;]
- [Therapeutic injections;]
- [Appliance therapy utilizing an appliance which does not permanently alter tooth position, jaw position or bite. Benefits for reversible appliance therapy will be based on the *maximum allowable fee* for use of a single appliance, regardless of the number of appliances used in treatment. The benefit for the appliance therapy will include an allowance for all jaw relation and position diagnostic services, office visits, [adjustments,] training, repair, and replacement of the appliance;] [and]
- [Surgical procedures][.]

Covered expenses do not include charges for:

- Computed Tomography (CT) scans or magnetic resonance imaging except in conjunction with surgical management;
- Electronic diagnostic modalities;
- Occlusal analysis; or
- Any irreversible procedure, including, but not limited to: orthodontics, occlusal adjustment, crowns, onlays, fixed or removable partial dentures, full dentures.

206500 05/05

Physical medicine and rehabilitative services benefit

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

[COVERED EXPENSES (continued)]

- [Physical therapy services;]
- [Occupational therapy services;]
- [Spinal manipulations[,]/]adjustments [and modalities][without anesthesia] [performed in a *health care practitioner's* office[,], [or] on an *inpatient* or *outpatient* basis [or in a *rehabilitation facility*];]
- [Speech therapy or speech pathology services;]
- [Audiology services;]
- [Cognitive rehabilitation services;]
- [Respiratory or pulmonary therapy services;] [and]
- [Cardiac rehabilitation services][.]

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

206600 04/10

Skilled nursing facility

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

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

206800 05/05

Urgent care services

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

206900

Additional [medical services] [covered expenses]

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

- [Blood and blood plasma which is not replaced by donation; administration of the blood and blood products including blood extracts or derivatives.]
- [Oxygen and rental of equipment for its administration.]
- [Initial prosthetic devices or supplies, including but not limited to limbs and eyes. Coverage will be provided for prosthetic devices necessary to restore the minimal basic function of a lost limb or eye. Replacement is a *covered expense* if due to pathological changes or growth.] [*Covered expense* includes repair of the prosthetic device if not covered by the manufacturer.]

[COVERED EXPENSES (continued)]

- [Cochlear implants, when approved by *us*, for a *covered person*:
 - 18 years of age or older with bilateral severe to profound sensorineural deafness; or
 - 12 months to 17 years of age with profound bilateral sensorineural deafness.

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

- The existing device malfunctions and cannot be repaired;
 - Replacement is due to a change in the *covered person's* condition that makes the present device non-functional; or
 - The replacement or upgrade is not for cosmetic purposes.]
- [Casts, splints, trusses, [crutches,] [orthotics] and braces. [Orthotics must be custom made [or custom fit and made] of rigid or semi-rigid material.]]

[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 special supplies, dispensed up to a [30-90 -day] supply, when prescribed by *your* attending *health care practitioner*:
 - Surgical dressings;
 - Catheters;
 - Colostomy bags, rings and belts; and
 - Flotation pads.]
 - [The initial pair of eyeglasses or contacts needed due to cataract *surgery* or an *accident* if the eyeglasses or contacts were not needed prior to the *accident*.]

- [Dental treatment only if:
 - The charges are incurred for treatment of a *dental injury* to a *sound natural tooth*; [and]
 - The *pre-existing condition* exclusion period, if applicable, has been satisfied[;] [and][.]
 - [The treatment begins within [30 - 90] days after the date of the *dental injury*;] [and]
 - [The treatment is completed within [6 - 12] months after the date of the *dental injury*.]

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

- [Certain oral surgical operations as follows:
 - [Excision of partially or completely impacted teeth;]
 - Excisions of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth when

[COVERED EXPENSES (continued)]

- such conditions require pathological examinations;
- Surgical procedures required to correct accidental injuries of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
 - Reduction of fractures and dislocation of the jaw;
 - External incision and drainage of cellulitis;
 - Incision of accessory sinuses, salivary glands or ducts;
 - Frenectomy (the cutting of the tissue in the midline of the tongue); and
 - Orthognathic surgery for a congenital anomaly, *bodily injury* or *sickness* causing a *functional impairment*.]
- [Elective [vasectomy] [or] [tubal ligation].]
 - For a *covered person*, who is receiving benefits in connection with a mastectomy, service for:
 - Reconstructive *surgery* of the breast on which the mastectomy has been performed;
 - *Surgery* and reconstruction on the non-diseased breast to achieve symmetrical appearance; and
 - Prosthesis and treatment of physical complications for all stages of mastectomy, including lymphedemas.
 - [Enteral formulas, nutritional supplements and low protein modified foods for use at home by a *covered person* that are prescribed or ordered by a *health care practitioner* and are for the treatment of an inherited metabolic disease, e.g. phenylketonuria (PKU) [, unless otherwise covered in the Prescription Drug Benefit [Rider][, if any,] attached to this *policy*].]
 - Coverage for general anesthesia in connection with dental procedures, when performed in a hospital or ambulatory surgical facility and certified by a health care practitioner for:
 - A dependent under the age of 7;
 - A covered person with a serious mental condition or a significant behavioral problem; or
 - A covered person with a serious physical condition.[WRJ6]
 - [Injections of drugs or medicines.]
 - [Private duty nursing [while *you* are *hospital confined*].]
 - [Nutritional counseling for the treatment of obesity, which includes *morbid obesity*[,] [limited to [1 – 10] visits per year].]

207000AR 04/10

Page: 1

[WRJ1] AR Insurance Code 23-79-141

Page: 2

[WRJ2] AR Insurance Code 23-79-140

Page: 3

[WRJ3] AR Insurance Code 23-99-405

Page: 5

[WRJ4] AR Insurance Code 23-86-108

Page: 13

[WRJ5] AR Insurance Code 23-86-118 – In-vitro has to be in the covered expenses.

Page: 16

[WRJ6] HB 1452 and HB 2640

[LIMITATIONS AND EXCLUSIONS]

[Pre-existing condition limitation]

Health insurance benefits [are excluded] [are limited to the first [\$1 – \$10,000] of *covered expenses* incurred] for a *pre-existing condition* for [six – 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 before the age of 18 if they are covered under the *policy* within 90 days of the date of birth or date of placement for adoption.
- Children adopted before the age of 18 if they are covered under the *policy* within 60 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 [6-12] months under *creditable 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 *policy*. The *pre-existing condition* exclusion period will be reduced by the number of days of coverage that *you* had under the *creditable coverage*.

The waiting period for a plan or policy is counted as *creditable coverage* and will not be counted toward determining whether there has been a 63-day break in coverage. 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.

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.

Notice

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.]
211100AR 07/07

[Other] [limitations and exclusions]

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

211200 05/05

[LIMITATIONS AND EXCLUSIONS (continued)]

- [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 this *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.]
211600 07/07
- [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*.]
212000 07/07
- [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.]
- [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][90 days] 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.]
212600 07/07

[LIMITATIONS AND EXCLUSIONS (continued)]

- [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, nutritional supplements or low protein modified food products for the treatment of an inherited metabolic disease, e.g. phenylketonuria (PKU)[, unless otherwise covered by a Prescription Drug Benefit [Rider] attached to the *policy*]].]

• [Over the counter, non-prescription medications.]
213250 03/09

- [Immunizations required for foreign travel for a *covered person* of any age.]
- [Growth hormones (medications, drugs or hormones to stimulate growth) [unless there is a laboratory confirmed diagnosis of growth hormone deficiency,] [or as otherwise determined by us].]
- [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*][,] [or] [*skilled nursing facility*][,] [or] [*health care treatment facility*][;] [or] [*residential treatment facility*];
 - By the following, when deemed appropriate by *us*:
 - A *health care practitioner*:
 - During an office visit; or
 - While an *outpatient*; or
 - A *home health care agency* as part of a covered *home health care plan* [when approved by *us*].]

213700AR 03/09

- [[Hearing aids][,] [the fitting of hearing aids] [or] [advice on their care][;] [implantable hearing devices][, except for cochlear implants as otherwise stated in this *certificate*].]
- [Services received in an emergency room, unless required because of *emergency care*.]
- [Weekend non-emergency *hospital admissions*, specifically *admissions* to a *hospital* on a Friday or Saturday at the convenience of the *covered person* or his or her *health care practitioner* when there is

[LIMITATIONS AND EXCLUSIONS (continued)]

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*, except for in-vitro fertilization as otherwise stated in this *certificate*] [;] [or] [reversal of elective sterilization].]
- [Surrogate parenting.]
214100AR 07/07
- [Sex change services, regardless of any diagnosis of gender role or psychosexual orientation problems.]
- [Services for the evaluation and treatment of sexual dysfunctions or inadequacies, regardless of the cause.]
- [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, unless otherwise determined by us;]
 - [Hyperhidrosis 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 a *functional impairment* is present[.][; or]]
 - [Resulting from congenital disease or anomaly of a covered *dependent* child which resulted in a *functional impairment*.]

Expenses 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].]
214400 03/09

[LIMITATIONS AND EXCLUSIONS (continued)]

- [[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 this *certificate*.]
- [The following types of care of the feet:
 - [Shock wave therapy of the feet;]
 - [The treatment of weak, strained, flat, unstable or unbalanced feet;]
 - [Hygienic care, and the treatment of superficial lesions of the feet, such as corns, calluses, or hyperkeratoses;]
 - [The treatment of tarsalgia, metatarsalgia, or bunion, except surgically;]
 - [The cutting of toenails, except the removal of the nail matrix;]
 - [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 hammer toe].]
- [[*Custodial care*] [and] [*maintenance care*].]
- [Any loss contributed to, or caused by:
 - [War or any act of war, whether declared or not;]
 - [Insurrection;] [or]
 - [Any conflict involving armed forces of any authority].]
- [*Sickness* or *bodily injury* caused by the *covered person's*:
 - [Engagement in an illegal occupation][;] [or]
 - [Commission of or an attempt to commit a criminal act].]

This exclusion does not apply to the extent inconsistent with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), such as a *sickness* or *bodily injury* due to an act of domestic violence or a medical condition (including both physical and mental health conditions).]

214900 11/08

- [Expenses for any membership fees or program fees paid by *you*, including but not limited to [health clubs] [,] [health spas][,] [concierge] [or] [boutique physician programs] [,] [aerobic] [and] [strength conditioning][,] [work-hardening programs] [,] [and] [weight loss or surgical programs][;] [and any materials or products related to these programs].]
- [Surgical procedures for the removal of excess skin and/or fat in conjunction with or resulting from weight loss or a weight loss *surgery*.]
- [Expenses for services that are primarily and customarily used for environmental control or enhancement (whether or not prescribed by a *health care practitioner*) and certain medical devices including, but not limited to:

[LIMITATIONS AND EXCLUSIONS (continued)]

- [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.]]
- [Equipment or devices not specifically designed and intended for the care and treatment of a *sickness* or *bodily injury*.]
- [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.]
215300 04/10
- [Communications or travel time.]
- [Any treatment, including but not limited to surgical procedures[:][,]
 - For obesity[, which includes *morbid obesity*][; or] [, unless qualified as *morbid obesity* and *medically necessary*.]
 - [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[, which includes *morbid obesity*][.]]

[LIMITATIONS AND EXCLUSIONS (continued)]

- [Bariatric surgery, any services or complications related to bariatric surgery, and other weight loss products or services.]
- [Sickness or bodily injury for which medical payment or expense coverage benefits are paid or payable under any homeowners, premises or any other similar coverage.]
- [Elective medical or surgical abortion unless:
 - The 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.] [Services and supplies for: [acupressure,] [acupuncture,] [aromatherapy,] [ayurveda,] [biofeedback,] [faith healing,] [guided mental imagery,] [herbal medicine,] [holistic medicine,] [homeopathy,] [hypnosis,] [macrobiotics,] [massage therapy,] [naturopathy,] [ozone therapy,] [reflexotherapy,] [relaxation response,] [rolfing,] [shiatsu[,]] [and] [yoga[,]] [and other forms of alternative medicine not specifically stated as a covered expense.]]
215800 04/10
- [Acupuncture, [unless:
 - [The treatment is [medically necessary and] appropriate and is provided within the scope of the acupuncturist's license;] [and]
 - [You are directed to the acupuncturist for treatment by a licensed physician;] [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].]
- [Pregnancy [of a child] [other than a dependent daughter]. Any medical complications of pregnancy [, or for a pregnancy which is the result of rape or incest] are not excluded.]
- [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 this certificate).]]
216300 04/09
- [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.]

[LIMITATIONS AND EXCLUSIONS (continued)]

- [Marriage counseling.]
- [Services for pervasive development disorder.]
- [*Court-ordered behavioral health* services[.][, when such order is the result of, or arises out of a conduct by the *covered person* which is or would be criminal activity under the laws of the state or the Federal Government.]]
- [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.]
216650 07/07
- [Expenses for treatment of complications of non-covered procedures or services.]
- [[Expenses incurred for services prior to the *effective date* or after the termination date of *your* coverage under the *policy*.] [Coverage will be extended as described in the "Extension of Benefits" section, if such coverage is required by state law.]]
- [*Pre-surgical/procedural testing* duplicated during a *hospital confinement*.]
216880AR 07/07

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*.

216900 04/04

SERFF Tracking Number: HUMA-126828996 State: Arkansas
 Filing Company: Humana Insurance Company State Tracking Number: 46878
 Company Tracking Number: AR-10-003
 TOI: H16G Group Health - Major Medical Sub-TOI: H16G.001A Any Size Group - PPO
 Product Name: CC2003 et al
 Project Name/Number: DME updates/PC100

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	10/08/2010
Comments:	See attached		
Attachments:	AR-10-003 Certification of Compliance-Rule & Regulation 19.pdf AR-10-003 Certificate of Compliance-Bulletin 9-85.pdf		
Bypassed - Item:	Application	Approved-Closed	10/08/2010
Bypass Reason:	only updating cert/policy.		
Comments:			
Bypassed - Item:	PPACA Uniform Compliance Summary	Approved-Closed	10/08/2010
Bypass Reason:	n/a		
Comments:			
Satisfied - Item:	Matrix Variability	Approved-Closed	10/08/2010
Comments:	See attached		
Attachment:	AR Matrix Filing Variability Statement.pdf		

TO: State of Arkansas
Office of the Commissioner of Insurance
1200 West Third Street
Little Rock, AR 72201-1904

FORM: See Form Schedule tab for a list of forms.

CERTIFICATION OF COMPLIANCE
Arkansas Rule and Regulation 19

I, J. Gregory Catron, an officer of Humana Insurance Company, hereby certify that I have authority to bind and obligate the company by the filing of this form. I further certify that, to the best of my knowledge, information and belief:

- (a) The accompanying form as identified above does comply with all applicable provisions of the Arkansas Rule and Regulation 19; and
- (b) The form does meet the Flesch reading ease test for a score of 40 for all applicable policies, certificates and certificate riders unless the Commissioner of Insurance of the State of Arkansas requires a lower score;



J. Gregory Catron
Vice President and Assistant General Counsel
Humana Insurance Company

September 23, 2010
Date

Individual responsible for this filing:

Wendy Jeffries
Contract Analyst
Product Compliance

TO: Arkansas Department of Insurance
1200 West Third Street
Little Rock, AR 72201-1904

RE: GROUP HEALTH INSURANCE FORMS FILING
HUMANA INSURANCE COMPANY
POLICY SERIES: CC2003
NAIC#: 73288
FEIN#: 39-1263473
INTERNAL FILING NUMBER: AR-10-003

CERTIFICATION OF COMPLIANCE

I have reviewed or supervised the review of the policy forms contained in this filing and hereby certify to the best of my knowledge and belief that they are in compliance with Bulletin 9-85 of the state of Arkansas.



(Signature)

J. Gregory Catron
Vice President and Assistant General Counsel
Humana Insurance Company

09/23/2010

(Date)

Individual responsible for this filing:

Wendy Jeffries
Contract Analyst
Product Compliance

Statement of Variability

- All numbers (excluding matrix element numbers) are variable. Numbers within a provision determined by the laws of the governing jurisdiction will be varied only within the confines of the law.
- Matrix elements may vary to the extent that such paragraphs may be included, omitted or transferred to another position to suit the needs of a particular policyholder subject to: (a) any statutory or regulatory requirements; and (b) the condition that the language and benefit be within the intent and framework of the particular provisions.
- Items which customarily vary according to the policyholder's specific plan of insurance.
- The Variable Options form includes benefit levels stated as "Level 1" and "Level 2". These terms may be replaced with terms that describe the provider and/or network arrangements appropriate to each plan.

We also reserve the right to amend the attached to fix any minor typographical errors we may have neglected to find prior to submitting for approval and amend the language to clarify the intent within the confines of the law.