

SERFF Tracking Number: HUMA-127179661 State: Arkansas
Filing Company: Humana Insurance Company State Tracking Number:
Company Tracking Number: AR-12-001
TOI: H16G Group Health - Major Medical Sub-TOI: H16G.001A Any Size Group - PPO
Product Name: CC2003 et al
Project Name/Number: 2012 Refresh /CC757 CC760 CC775

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-127179661 State: Arkansas

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

Co Tr Num: AR-12-001

State Status: Approved-Closed

Authors: Wendy Jeffries, Patricia
Richardson

Reviewer(s): Rosalind Minor

Disposition Date: 02/16/2012

Date Submitted: 02/16/2012

Disposition Status: Approved-
Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: 2012 Refresh

Project Number: CC757 CC760 CC775

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Group Market Type: Employer

Filing Status Changed: 02/16/2012

State Status Changed: 02/16/2012

Created By: Wendy Jeffries

Corresponding Filing Tracking Number:

PPACA: Non-Grandfathered Immed Mkt Reforms, Grandfathered Immed Mkt Reforms

PPACA Notes: null

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.

Status of Filing in Domicile: Not Filed

Date Approved in Domicile:

Domicile Status Comments: n/a

Market Type: Group

Group Market Size: Small and Large

Overall Rate Impact:

Deemer Date:

Submitted By: Wendy Jeffries

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Thank you for your attention to this filing. Should you have any questions, please do not hesitate to contact me.

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:	\$250.00
Retaliatory?	No
Fee Explanation:	5 forms * \$50/form = \$250
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Humana Insurance Company	\$250.00	02/16/2012	56411545

SERFF Tracking Number: HUMA-127179661

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	02/16/2012	02/16/2012

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Disposition

Disposition Date: 02/16/2012

Implementation Date:

Status: Approved-Closed

HHS Status: HHS Approved

State Review: Reviewed-No Actuary

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: HUMA-127179661 State: Arkansas
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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	Statement of Variability	Approved-Closed	Yes
Form	Schedule of Benefits	Approved-Closed	Yes
Form	Limitations and Exclusions	Approved-Closed	Yes
Form	Specialty Drug Benefit	Approved-Closed	Yes
Form	Prescription Drug Benefit	Approved-Closed	Yes
Form	Variable Options	Approved-Closed	Yes

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Form Schedule

Lead Form Number: SCH1-1800 02/12

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 02/16/2012	SCH1-1800 02/12	Certificate	Schedule of Benefits	Initial			040 PGN S1 02-12 a.pdf
Approved-Closed 02/16/2012	211100AR 02/11	Certificate	Limitations and Exclusions	Initial			130 PAR LE 02-12 a.pdf
Approved-Closed 02/16/2012	250000 04/10	Certificate	Specialty Drug Benefit	Initial			355 PGN SpecRx 02-12 a.pdf
Approved-Closed 02/16/2012	1800000 04/10	Certificate Amendmen t, Insert Page, Endorseme nt or Rider	Prescription Drug Benefit	Initial			360 PGN R Rx 02-12 a.pdf
Approved-Closed 02/16/2012	CC-VOS SCH2AR 02/12	Other	Variable Options	Initial			420 PAR VOSS2 02-12 a.pdf

[SCHEDULE OF BENEFITS]

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

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

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

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

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

SCH1-1100 04/10

Network provider verification

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

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

SCH1-1200 10/06

Individual [lifetime] maximum benefit

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

Individual [lifetime] maximum benefit	Maximum benefit amount
[<i>Network provider</i>] <i>individual [lifetime] maximum benefit</i> [per covered person]	[\$]
[<i>Non-network provider</i>] <i>individual [lifetime] maximum benefit</i> [per covered person]]	[\$]

[SCHEDULE OF BENEFITS (continued)]

SCH1-1300

[Network provider] benefit allowance

This certificate contains a [network provider] benefit allowance. This allowance applies to the first [\$] of covered expenses for services received [from network providers incurred] by [you] [a covered family] per year. [Benefits provided under this allowance are payable at 100% [after copayments, if any, and are not subject to the annual deductibles shown in this "Schedule of Benefits" section] [prior to satisfying the [deductible] [and] [out-of-pocket limit]].] [The allowance is not applied toward the [deductibles] [or] [out-of-pocket limits] shown in this "Schedule of Benefits".] [[The [network provider] benefit allowance is not applicable to[:] [copayments[:];],] [covered expenses that are covered in full:] covered expenses for [preventive services] [mental health services] [or] [chemical dependency services] [,] [specialty drugs [from a retail pharmacy or specialty pharmacy[:];],]] [or] [any benefits under the "Prescription Drug Benefit [Rider]" attached to the policy].]

[chemical dependency services] [,] [specialty drugs [from a retail pharmacy or specialty pharmacy[:];],]] [or] [any benefits under the "Prescription Drug Benefit [Rider]" attached to the policy]

Once the total amount of covered expenses for services [received from network providers] exceeds the allowance stated above, any additional covered expenses for services [from network providers] will be subject to the annual deductibles, [and] [out-of-pocket limits], if applicable, and payable at the benefit percentage shown within this "Schedule of Benefits" section.

SCH1-1400 02/11

Preauthorization requirements [and penalty] [for services received from a non-network provider]

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

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

[If any required preauthorization of services or supplies is not obtained, [you will be responsible for a preauthorization penalty.][no benefit will be payable] [the benefit payable for any covered expenses incurred for the services, will be reduced [by] [\$0 - \$3,000] [to] [0% - 50%][, after any applicable [deductibles] [or] [copayments]].] [For certain services and supplies, the benefit payable for any covered expenses will be reduced [by] [\$0 - \$3,000] [to] [0% - 50%][, after any applicable [deductibles] [or]

[SCHEDULE OF BENEFITS (continued)]

[*copayments*].] [For some services and supplies, no benefit will be payable if *preauthorization* is not obtained.] [[Visit *our* Website [at] [www.humana.com]] [or] [call the customer service telephone number on *your* identification card] to determine the benefit reduction that applies to each service or supply that requires *preauthorization*.] [If the rendered services are not covered expenses, no benefits are payable.] [The out-of-pocket amounts incurred by *you* due to these benefit reductions may not be used to satisfy any *out-of-pocket limits*.] [This *preauthorization* penalty will apply if *you* received the services from [[either] a *network provider*] [or] [a *non-network provider*] when *preauthorization* is required and not obtained.]

SCH1-1500 02/11

Annual deductible

An annual *deductible* is a specified dollar amount that *you* must pay for *covered expenses* per year before most benefits will be paid under the *policy*. [There are [individual] [and] [family] [Level 1] [*network provider*][,] [Level [1,2]] [*non-*][*network provider*] [and] [Level 2] [*non-network*] [*provider*] [*deductibles*.] The *deductible* amount(s) [for each] [*covered person*] [covered individual] [and each covered family] are as follows, and must be satisfied each *year*[, either individually or combined as a covered family]. [If *you* have elected to cover *your dependents* under this *policy*, benefits will be payable for a *covered person* once he or she has incurred [\$0 - \$40,000] of *covered expenses* that are applied to the family *deductible*.] [Once the family *deductible* is met, any remaining *deductible* for a *covered person* in the family will be waived for that *year*.] .] [If *you* have elected individual coverage under this *policy*, *your covered expenses* will apply toward the individual *deductible*.] [If *you* have elected to cover *your dependents* under this *policy*, *covered expenses* for [each *covered person*] [*you and your dependents*] accumulate toward the family *deductible* amount [and must be satisfied before benefits will be payable for *you and your dependents*].] [The entire family *deductible* amount must be satisfied before benefits will be payable for any *covered person*.] [*Copayments* do not apply toward the annual *deductible*.]

[Any expense incurred by *you* for *covered expenses* that may be applied to any *deductible* under this provision will be applied [equally] toward the satisfaction of [both *network provider* and] *non-network provider deductible*.] [Any expense incurred by *you* for *covered expenses* that may be applied to the *non-network provider deductible* will also be applied toward the satisfaction of the *network provider deductible*.] [Any expense incurred by *you* for *covered expenses* provided by a *network provider* will be applied to the *network provider deductible*.] [Any expense incurred by *you* for *covered expenses* provided by a *non-network provider* will be applied to the *non-network provider deductible*.] [*Network provider deductible* and *non-network provider deductible* amounts accumulate separately, never to exceed the *non-network provider deductible* amount.]

[If *you* are enrolled in a high deductible health plan (HDHP) in which the *deductible* is based on the minimum deductible amount allowed by the IRS for an HDHP, the *deductible* of the *policy* will be revised without notice at *your group's* next renewal, based on IRS adjustments.]

[If two or more *covered persons* of the same family are injured in the same *accident* and incur *covered expenses* as a result of such *accident*, only one *deductible* will be deducted from the total *covered expenses* resulting from the *accident* in the *year* in which the *accident* occurs.]

[SCHEDULE OF BENEFITS (continued)]

[Only one *deductible* will be deducted from the total *covered expenses* incurred as a result of a multiple birth of two or more *dependents*. The *covered expenses* must be incurred in the same *year* as the birth and result from:

- Premature birth;
- A congenital abnormality; or
- *Sickness or bodily injury* occurring within 31 days after the birth.]

[The maximum family *deductible* per year is [#] [times the] individual *deductible*[s].]

Deductible	Deductible amount
[[Level 1] Individual [<i>non-</i>][<i>network provider</i>] <i>deductible</i>]	[\$]
[[Level 1] Family [<i>non-</i>][<i>network provider</i>] <i>deductible</i>]	[\$]
[[Level 2] Individual [<i>non-</i>] <i>network provider deductible</i>]	[\$]
[[Level 2] Family [<i>non-</i>] <i>network provider deductible</i>]	[\$]
[Individual <i>non-network provider deductible</i>]	[\$]
[Family <i>non-network provider deductible</i>]	[\$]
[Combined individual <i>network provider</i> and <i>non-network provider deductible</i>]	[\$]
[Combined family <i>network provider</i> and <i>non-network provider deductible</i>]	[\$]

SCH1-1600 02/11

Annual deductible carryover

[SCHEDULE OF BENEFITS (continued)]

If a *covered person* incurs *covered expenses* during the last three months of the current year that are applied toward the satisfaction of the [Level 1] [individual] [network provider] [deductible][,] [and] [or] [the [Level [1,2]] [individual] [non-][network provider] deductible] [and] [or] [the [Level 2] [individual] [non-network provider] deductible[(s)]] for that year, those same *covered expenses* will also be applied toward the satisfaction of the [Level 1] [individual] [network provider] [deductible] [,] [and] [or] [the [Level [1,2]] [individual] [non-][network provider] deductible] [and] [the [Level 2] [individual] [non-network provider] deductible[(s)]] of the next year[, respectively]. [This *deductible* carryover does not apply to any family *deductible(s)*.]

SCH1-1700 02/11

Out-of-pocket limit

The *out-of-pocket limit* is the amount of *covered expenses*[, excluding expenses used to satisfy [deductibles] [and] [copayments],] that must be paid by *you*[, either individually or combined as a covered family,] per year before a benefit percentage will be increased. [There [are] [is a] [is an] [individual] [and] [family] [Level 1] [network provider][,] [Level [1,2]] [non-][network provider] [and] [Level 2] [non-network] [provider] *out-of-pocket limit*[s].]

[After the [Level 1] individual [network provider] *out-of-pocket limit* has been satisfied in a year, the [Level 1] [network provider] benefit percentage for *covered expenses* for that *covered person* will be payable at the rate of 100% for the rest of the year, subject to any maximum benefit and all other terms, provisions, limitations and exclusions of the *policy*.] [After the family [Level 1] [network provider] *out-of-pocket limit* has been satisfied in a year, the [Level 1] [network provider] benefit percentage for *covered expenses* will be payable at the rate of 100% for the rest of the year, subject to any maximum benefit and all other terms, provisions, limitations and exclusions of the *policy*.] [Benefit specific *copayments* continue to be *your* responsibility.]

[After the [Level [1,2]] individual [non-][network provider] *out-of-pocket limit* has been satisfied in a year, the [Level [1,2]] [non-][network provider] benefit percentage for *covered expenses* for that *covered person* will be payable at the rate of 100% for the rest of the year, subject to any maximum benefit and all other terms, provisions, limitations and exclusions of the *policy*.] [After the family [Level [1,2]] [non-][network provider] *out-of-pocket limit* has been satisfied in a year, the [Level [1,2]] [non-][network provider] benefit percentage for *covered expenses* will be payable at the rate of 100% for the rest of the year, subject to any maximum benefit and all other terms, provisions, limitations and exclusions of the *policy*.] [Benefit specific *copayments* continue to be *your* responsibility.]

[After the [Level 2] individual *non-network provider out-of-pocket limit* has been satisfied in a year, [the [Level 2] *non-network provider* benefit percentage] [both the *network provider* and *non-network provider* benefit percentages] for *covered expenses* for that *covered person* will be payable at the rate of 100% for the rest of the year, subject to any maximum benefit and all other terms, provisions, limitations and exclusions of the *policy*.] [After the family [Level 2] *non-network provider out-of-pocket limit* has been satisfied in a year, [the [Level 2] *non-network provider* benefit percentage] [both the *network provider* and *non-network provider* benefit percentages] for *covered expenses* will be payable at the rate of 100% for the rest of the year, subject to any maximum benefit and all other terms, provisions, limitations and exclusions of the *policy*.] [Benefit specific *copayments* continue to be *your* responsibility.]

[SCHEDULE OF BENEFITS (continued)]

[If you have elected to cover your dependents under this policy, covered expenses for each covered person accumulate towards the family out-of-pocket limit. The entire family out-of-pocket limit must be satisfied before the benefit percentage will be increased for any covered person.]

[Any expense incurred by you for covered expenses that may be applied to any out-of-pocket limit under this provision will be applied equally toward the satisfaction of both network provider and non-network provider out-of-pocket limits.] [Any expense incurred by you for covered expenses that may be applied to the non-network provider out-of-pocket limit will also be applied toward the satisfaction of the network provider out-of-pocket limit.] [Any expense incurred by you for covered expenses provided by a network provider will be applied to the network provider out-of-pocket limit.] [Any expense incurred by you for covered expenses provided by a non-network provider will be applied to the non-network provider out-of-pocket limit.] [Network provider out-of-pocket limit amounts and non-network provider out-of-pocket limit amounts accumulate separately, never to exceed the non-network provider out-of-pocket limit amount.]

[The combined [individual] network provider and non-network provider out-of-pocket limit is: [\$] [including the] [deductible(s)] [and] [copayments].] [The combined [family] network provider and non-network provider out-of-pocket limit is: [\$] [including the] [deductible(s)] [and] [copayments].] [Benefit specific copayments continue to be your responsibility.]

[If you are enrolled in a high deductible health plan (HDHP) in which the out-of-pocket limit is based on the maximum out-of-pocket expense amount allowed by the IRS for an HDHP, the deductible of the policy will be revised without notice at your group's next renewal, based on IRS adjustments.]

[If an out-of-pocket limit is shown to be unlimited, covered expenses will be paid at the levels indicated in the Schedules of Benefits.] [You will be responsible for any out-of-pocket expenses.]

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

[[Deductibles] [and] [copayments] do not apply towards any out-of-pocket limit.] [[Also,][out-of-pocket expenses] [coinsurance] for ^{^^}[home health care][,] [and] [durable medical equipment][,] [and] [diabetes equipment][,] [and] [oxygen][,] [and] [prosthetics][,] [and] [orthotics][,] [and] [covered organ transplants [provided by a transplant provider not approved by us][provided by a non-network provider]][,] [and] [for] [prescription drugs][,] [and] [for] [specialty drugs] [provided by] [obtained from] [a non-network pharmacy] [or] [a non-network provider]][,] [and] [for] [outpatient care and office therapy] [for] [chemical dependency services] [and] [mental health services] [[and][,] [specialty drugs] [[prescription] drugs [provided by a [non-]network provider]] do [not] apply towards any out-of-pocket limit.] [Some services and supplies do not apply towards and/or are not limited by the out-of-pocket limit. The "Schedule of Benefits" sections will identify the services and supplies that do not apply towards the out-of-pocket limit. The "Schedule of Benefits" sections will also identify which services and supplies are not limited by the out-of-pocket limit.]

Out-of-pocket limit

Out-of-pocket limit amount

[[Level 1] Individual [non-][network provider] out-of-pocket limit]	[\$]
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[SCHEDULE OF BENEFITS (continued)]

[[Level 1] Family <i>[non-][network provider out-of-pocket limit]</i>	[\$]
[[Level 2] Individual <i>[non-]network provider out-of-pocket limit]</i>	[\$]
[[Level 2] Family <i>[non-]network provider out-of-pocket limit]</i>	[\$]
[Individual <i>non-network provider out-of-pocket limit]</i>	[\$]
[Family <i>non-network provider out-of-pocket limit]</i>	[\$]
[Combined individual <i>network provider and non-network provider out-of-pocket limit]</i>	[\$]
[Combined family <i>network provider and non-network provider out-of-pocket limit]</i>	[\$]

SCH1-1800 02/12

[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;
- A *covered person* under the age of 19; or
- 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.

Comment [WRJ1]: State mandate
23-86-304

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 02/11

[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 02/11
- [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[, unless for drugs, medicines or medications on the [Women's Healthcare Drug List] with a *prescription* from a *health care practitioner*].]
- [Over-the-counter medical items or supplies that can be provided or prescribed by a *health care practitioner* but are also available without a written order or *prescription*[, except for *preventive services*].]

213250 02/12

- [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] [electronic media].]
- [[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 02/11

- [[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*].]

Comment [WRJ2]: No contraceptive L/E per 23-79-1103

Comment [WRJ3]: Page: 1
Can't use due to HB 1930 mandating coverage of hearing aids.

[LIMITATIONS AND EXCLUSIONS (continued)]

- [Services received in an emergency room, unless required because of *emergency care*.]
- [Weekend non-emergency *hospital admissions*, specifically *admissions* to a *hospital* on a Friday or Saturday at the convenience of the *covered person* or his or her *health care practitioner* when there is no cause for an emergency *admission* and the *covered person* receives no *surgery* or therapeutic treatment until the following Monday.]
- [*Hospital inpatient* services when you are in *observation status*.]
- [[*Infertility services*, 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;]
 - [Sleep therapy;]
 - [Light treatments for Seasonal Affective Disorder (S.A.D.);]
 - [Immunotherapy for food allergy;]
 - [Prolotherapy;]
 - [Cranial banding, unless otherwise determined by us;]
 - [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 02/11

[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;]
 - [Heel wedges, lifts, or shoe inserts;] [and]
 - [Arch supports (foot orthotics) or orthopedic shoes, except for diabetes or hammer toe].]

- [[*Custodial care*] [and] [*maintenance care*].]

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

- [*Sickness* or *bodily injury* caused by the *covered person's*:
 - [Engagement in an illegal occupation][;] [or]
 - [Commission of or an attempt to commit a criminal act].]

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

214900 02/11

- [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, PUVA lights, [and] stethoscopes[, and breast pumps, except *hospital* grade breast pumps used for a *dependent* under one year of age during a *hospital admission*];]
- [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 02/12
- [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

[LIMITATIONS AND EXCLUSIONS (continued)]

- Extended beyond the period necessary for evaluation and diagnosis of learning and behavioral disabilities or for mental retardation.]
- [Marriage counseling.]
- [[Services] [Treatment] 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 02/11
- [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

Comment [WRJ4]: Must cover TMJ per 23-79-150

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

[SPECIALTY DRUG BENEFIT]

This "Specialty Drug Benefit" section describes services that will be considered *covered expenses* for *specialty drugs* under the *policy*.

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

[Any expenses incurred by *you* under provisions of this benefit do not apply toward *your out-of-pocket limit*, if any.]

[For the purposes of coordination of benefits, *specialty drug* coverage under this benefit [section] will be considered a separate plan and will therefore only be coordinated with other *specialty drug* coverage.]

[All terms used in this benefit have the same meaning given to them in this *certificate* and in any "Prescription Drug Benefit Rider" attached to this *certificate*, unless otherwise specifically defined in this benefit.] [All other terms, provisions, limitations and exclusions of the *policy*, [including the *individual lifetime maximum benefit*,] unless otherwise stated, are applicable.]

250000 04/10

Specialty drug cost sharing

[*You* are responsible for any and all *cost share*, when applicable, for *specialty drugs*, according to the "Schedule of benefits – specialty drugs" provision of this section.] [*We* share the cost of *covered expenses* for *specialty drugs* as shown in the "Schedule of benefits – specialty drugs" provision.]

If the health care provider's or dispensing *pharmacy's* charge is less than *your copayment*, *you* will be responsible for the lesser amount.

The amount paid by *us* to the providers listed in the "Schedule of benefits – specialty drugs" provision of this benefit may not reflect the ultimate cost to *us* for the *specialty drug*. *Your cost share* is made on a per *prescription* or refill basis and will not be adjusted if *we* receive any retrospective volume discounts or *prescription* drug rebates.

[The *network provider* benefit allowance is not applicable to *specialty drugs* [from a retail *pharmacy* or *specialty pharmacy*].]

251000 02/11

Definitions

[**Copayment** means the amount to be paid by *you* toward the cost of each separate *prescription* or refill of a covered *prescription* drug [when dispensed by a *pharmacy*].]

[SPECIALTY DRUG BENEFIT (continued)]

[**Cost share** means any [copayment][,] [deductible][,] [drug deductible][,] [and] [amounts exceeding the allowance] [and]/[or] [percentage amount] ^^^that you must pay [per prescription drug or refill] [per [bodily injury] [or] [sickness]] [per year].]

[**Default rate** means the rate or amount equal to the Medicare reimbursement rate for the prescription or refill.]

[**Drug deductible** means a specified amount of [network pharmacy] prescription drug expenses you must incur [per year] before benefits will be paid under this benefit [section]. These expenses do not apply toward any other deductible, if any, stated in the policy.]

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

- Covered pharmacy services; or
- Covered specialty pharmacy services;

as defined by us, to covered persons, including covered prescriptions or refills delivered [to your home] [or] [health care provider].]

[**Network specialty drug [and network [level 4] [group A][,] [B] [and] [C]] drug** out-of-pocket limit means the amount of copayment that you must pay in a year for specialty drugs [and [level 4 drugs] [[group A drugs][,] [group B drugs] [and] [group C drugs]]] from network pharmacies before a benefit percentage will be increased.]

[**Non-network pharmacy** means a pharmacy that has not signed a direct agreement with us or has not been designated by us to provide:

- Covered pharmacy services; or
- Covered specialty pharmacy services;

as defined by us, to covered persons, including covered prescriptions or refills delivered [to your home] [or] [health care provider].]

[**Non-network specialty drug [and non-network [level 4] [group A][,] [B] [and] [C]] drug** out-of-pocket limit means the amount of copayment that you must pay in a year for specialty drugs [and [level 4 drugs] [[group A drugs][,] [group B drugs] [and] [group C drugs]]] from non-network pharmacies before a benefit percentage will be increased.]

Specialty drug means a drug, medicine, medication, or biological used as a specialized therapy developed for chronic, complex sicknesses or bodily injuries. Specialty drugs may:

- Require nursing services or special programs to support patient compliance;
- Require disease-specific treatment programs;
- Have limited distribution requirements; or
- Have special handling, storage or shipping requirements.

[SPECIALTY DRUG BENEFIT (continued)]

[*Specialty drug list* means a list of *specialty drugs* specified by *us*. This list indicates applicable *dispensing limits* and/or any [*preauthorization*]/*prior authorization* or *step therapy* requirements. Visit our Website at www.humana.com or call the customer service telephone number on your identification card to obtain the *specialty drug list*. This list is subject to change without notice.]

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

252000 02/12

Specialty drug benefit

We will pay benefits for *covered expenses* incurred by *you* for *specialty drugs* that are included on our *specialty drug list*. Benefits may be subject to *dispensing limits*[, *preauthorization*][/] [and] *prior authorization* or *step therapy* requirements, if any. Any charge for the administration of a *specialty drug* is not covered under this benefit. *Specialty drugs* received in places of service not listed under the "Schedule of benefits – specialty drugs" provision are not covered under this benefit. Payment for the administration of *specialty drugs* and for places of services not listed under the "Schedule of benefits – specialty drugs" is addressed in the "Schedule of Benefits" section of this *certificate*.

Prior authorization and *step therapy* may be required for *specialty drugs* obtained from a *specialty pharmacy* or a *retail pharmacy*. [*Preauthorization* and *step therapy* may be required for *specialty drugs* received from any other provider.] Please contact *us* or our designee prior to the purchase of any *specialty drug*.

253000 02/11

Covered expenses

The following are *covered expenses* for *specialty drugs*:

- *Prescription* drugs, medicines, medications, *self-administered injectable drugs* or biologicals that under federal or state law may be dispensed only by *prescription* from a *health care practitioner* and are included on our *specialty drug list*.
- Hypodermic needles, syringes or other method of delivery necessary for administration of the *specialty drug*, if included with the charge for the *specialty drug*. (These may be available at no cost to *you*.)

Notwithstanding any other provisions of the *policy*, we may decline coverage or, if applicable, exclude from the *specialty drug list* any and all *prescriptions* until the conclusion of a review period not to exceed six months following FDA approval for the use and release of the *prescriptions* into the market.

254000 04/10

Schedule of benefits – specialty drugs

[SPECIALTY DRUG BENEFIT (continued)]

[You are responsible for the following:] [Benefits will be payable as follows:]

[Drug deductible]

[The *drug deductible* is a specified dollar amount that you must pay for *prescriptions* per year before [*specialty drugs*,] [*group A drugs*,] [[*level*] [*group*] [2] [*B*] *drugs*],] [and] [[*level*] [*group*] [3] [*C*] *drugs*] and [[*level*] [*group*] [4] [*D*] *drugs*] will be paid under the *policy*. *Copayments*, [*specialty drugs*,] [and] [*level 1 drugs*] [and *non-network pharmacy prescriptions*] do not apply toward the annual *drug deductible*.]

[[Drug deductible]

[Drug deductible amount]

[<i>Specialty drugs</i> ,] [<i>Group A drugs</i>],] [[<i>Level</i>] [<i>Group</i>] [2] [<i>B</i>] <i>drugs</i>],] [[<i>Level</i>] [<i>Group</i>] [3] [<i>C</i>] <i>drugs</i>] [and] [[<i>Level</i>] [<i>Group</i>] [4] [<i>D</i>] <i>drugs</i>]	[\$0-\$1,000]
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]

[Network specialty drug [and network [level 4] [group A],] [B] [and] [C]] drug out-of-pocket limit [and non-network specialty drug [and non-network [level 4] [group A],] [B] [and] [C]] drug out-of-pocket limit]

Any expenses incurred by you, under the provisions of this [benefit] [section] do not apply toward your *out-of-pocket limit*, if any. However, there is a *network specialty drug [and network [level 4] [group A],] [B] [and] [C]] drug out-of-pocket limit* [and a *non-network specialty drug [and non-network [level 4] [group A],] [B] [and] [C]] drug out-of-pocket limit*]. The *network specialty drug [and network [level 4] [group A],] [B] [and] [C]] drug out-of-pocket limit* is applicable to *network pharmacies* and *specialty pharmacies* [and is a combined limit between this "Specialty Drug Benefit" and the "Prescription Drug Benefit Rider" attached to this *certificate*]. [The *non-network specialty drug [and non-network [level 4] [group A],] [B] [and] [C]] drug out-of-pocket limit* is applicable to *non-network pharmacies* and *specialty pharmacies* [and is a combined limit between this "Specialty Drug Benefit" and the "Prescription Drug Benefit Rider" attached to this *certificate*].] [*Deductibles* do not apply towards your *network specialty drug [and network [level 4] [group A],] [B] [and] [C]] drug out-of-pocket limit* [or your *non-network specialty drug [and non-network [level 4] [group A],] [B] [and] [C]] drug out-of-pocket limit*].]

After the *network specialty drug [and network [level 4] [group A],] [B] [and] [C]] drug out-of-pocket limit* has been satisfied in a year, the *network pharmacy benefit percentage* for *specialty drugs* [and [*level 4 drugs*] [[*group A drugs*],] [*group B drugs*] [and] [*group C drugs*]]] for that covered person will be payable at the rate of 100% for the rest of the year, subject to any maximum benefit and all other terms, provisions, limitations and exclusions of the *policy*.

[After the *non-network specialty drug [and non-network [level 4] [group A],] [B] [and] [C]] drug out-of-pocket limit* has been satisfied in a year, the *non-network pharmacy benefit percentage* for *specialty drugs* [and [*level 4 drugs*] [[*group A drugs*],] [*group B drugs*] [and] [*group C drugs*]]] for that covered

[SPECIALTY DRUG BENEFIT (continued)]

<p>[Non-network pharmacy[*[*]]]</p>	<p>[[10-100%] [\$0-\$100] <i>copayment</i> per <i>specialty drug prescription</i> or refill.] [Not covered]</p> <p>[[10-100%] [\$0-\$100] benefit payable per <i>prescription</i> or refill [after <i>the prescription drug deductible</i>.]</p> <p>[The <i>non-network pharmacy copayment</i> does <u>not</u> accumulate toward any <i>out-of-pocket limit</i>.]</p>
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[*][Following the initial fill [and [one-six] refill[s]] of a covered *specialty drug* from a *pharmacy*, all subsequent refills must be obtained through a *network pharmacy* designated by us as [a preferred provider] [an approved provider] [for] [of] *specialty drugs*.]

[[*[*]]When a *non-network pharmacy* is used, you must pay for the *prescription* or refill at the time it is dispensed. You must file a claim for reimbursement with us, as described in your *certificate*. [[In addition to the *copayments* shown above,] [Y][y]ou will [also] be responsible for [30% - 60%] of the [default rate] [, after the applicable *copayment*] [as shown above].] [We will reimburse you [30%-60%] of the *default rate* [as shown above].] [You [are] [will] also [be] responsible for 100% of the difference between the *default rate* and the *non-network pharmacy's* charge.] [Any *non-network pharmacy* expenses incurred by you do not apply toward your *out-of-pocket limit*[, if any].] [The charge received from a *non-network pharmacy* for a *prescription* or refill may be higher than the *default rate*.]

255000 02/12

**Office visit, home health care,
free-standing facility and urgent care**

Up to 30-day supply

<p><i>Network provider</i></p>	<p>[[10-100%] [\$0-\$100] <i>copayment</i> per visit [after <i>network provider deductible</i>] [after <i>prescription drug deductible</i>.]</p> <p>[[10-100%] [\$0-\$100] benefit payable after [10-100%] [\$0-\$100] <i>copayment</i> per <i>prescription</i> or refill [and <i>prescription drug deductible</i>] [and <i>network provider deductible</i>.]</p>
<p>[Non-network provider]</p>	<p>[[10-100%] [\$0-\$100] <i>copayment</i> per visit [after <i>non-network provider deductible</i>.]</p> <p>[[10-100%] [\$0-\$100] benefit payable after [10-100%] [\$0-\$100] <i>copayment</i> per <i>prescription</i> or refill [and <i>non-network provider deductible</i>.]</p>

[SPECIALTY DRUG BENEFIT (continued)]

	[The <i>non-network</i> ^{^^} <i>provider</i> copayment does <u>not</u> accumulate toward any <i>out-of-pocket limit</i> .]
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256000 02/12

[Non-network retail pharmacy and non-network specialty pharmacy]

[[*[*]]When a *non-network pharmacy* is used, *you* must pay for the *prescription* or refill at the time it is dispensed. *You* must file a claim for reimbursement with *us*, as described in *your certificate*. [[In addition to the *copayments* shown above,] *[Y][y]ou* will [also] be responsible for [30% - 60%] of the [*default rate*] [, after the applicable *copayment*] [as shown above].] [*We* will reimburse *you* [30%-60%] of the *default rate* [as shown above].] [*You* [are] [will] also [be] responsible for 100% of the difference between the *default rate* and the *non-network pharmacy's* charge.] [Any *non-network pharmacy* expenses incurred by *you* do not apply toward *your out-of-pocket limit*[, if any].] [The charge received from a *non-network pharmacy* for a *prescription* or refill may be higher than the *default rate*.]]

257000 02/12

Limitations and exclusions

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

258000 02/11

- *Specialty drugs* which are not included on *our specialty drug list*.
- [*Specialty drug* refills obtained from a *pharmacy* which is not designated by *us* as [a preferred provider] [an approved provider] of *specialty drugs*.]
- Any amount exceeding the *default rate*.
- *Specialty drugs* for which coverage is not approved by *us*.
- Growth hormones (medications, drugs or hormones to stimulate growth) for idiopathic short stature.
- Growth hormones (medications, drugs or hormones to stimulate growth), unless there is a laboratory confirmed diagnosis of growth hormone deficiency, or as otherwise determined by *us*.
- Any portion of a *specialty drug* that exceeds a 30-day supply, unless otherwise determined by *us*.

259000 02/12

PRESCRIPTION DRUG BENEFIT [RIDER][AMENDMENT]

[This [rider][amendment] is made part of the *policy* to which it is attached. [The effective date of this change is [the latter of the effective date of the *certificate*] [or] [the date this benefit is added to the *policy*].]

[Notwithstanding any other provisions of the *policy*, expenses covered under this "Prescription Drug Benefit [Rider]" are not covered under any other provision of the *policy*.] [Any amount in excess of the maximum amount provided under this benefit [rider], if any, is not covered under any other provision in the *policy*.]

[Any expenses incurred by *you* under provisions of this [rider] [benefit] [do not] [will] apply toward *your out-of-pocket limit* [, if any].]

[For the purposes of coordination of benefits, *prescription* drug coverage under this benefit [rider] will be considered a separate plan and will therefore only be coordinated with other prescription drug coverage.]

[All terms used in this benefit [rider][amendment] have the same meaning given to them in the *certificate*, unless otherwise specifically defined in this benefit [rider][amendment].] [All other terms, provisions, limitations and exclusions of the *policy*, [including the *individual lifetime maximum benefit*,] unless otherwise stated, are applicable.]

1800000 04/10

Prescription drug cost sharing

[*You* are responsible for any and all [*cost share*] [payments of the following], when applicable, according to the "Schedule of benefits-prescription drugs" provision of this benefit [rider][:].]

[

- [The [*brand-name medication*] [*generic medication*] *drug deductible* [, if any]; and]
- The *copayment*[*].]

[*] [If the dispensing *pharmacy's* charge is less than the [*copayment*][*allowance*], [*you*] [*we*] will be responsible for the lesser amount.] [Any unused *allowance* amount on the initial *prescription* fill will not be applied to any additional fills for the same drug within a 30-day period.]

[The amount paid by *us* to the dispensing *pharmacy* may not reflect the ultimate cost to *us* for the drug. *Your* [*copayments*] [*cost share*] [are] [is] made on a per *prescription* or refill basis and will not be adjusted if *we* receive any retrospective volume discounts or *prescription* drug rebates.]

1800100 04/10

Definitions

The following terms are used in this benefit [rider][amendment]:

[**Allowance** means the initial amount to be paid by *us* toward a *prescription* or refill of a covered *prescription* drug when dispensed by a *pharmacy*.]

PRESCRIPTION DRUG BENEFIT [RIDER][AMENDMENT] (continued)

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

[Copayment] means the amount to be paid by *you* toward the cost of each separate *prescription* or refill of a covered *prescription* drug when dispensed by a *pharmacy*.]

[Cost share] means any *[copayment]* [,] *[deductible]* [,] *[drug deductible]* [,] **[and]** *[amounts exceeding the allowance]* [and]/[or] *[percentage amount]* that *you* must pay per *prescription* drug or refill.]

[Default rate] means the rate or amount equal to the *Medicare* reimbursement rate for the *prescription* or refill.]

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

[Drug deductible] means a specified amount of *[network pharmacy]* *prescription* drug expenses *you* must incur *[per year]* before benefits will be paid under this benefit [rider]. These expenses do not apply toward any other *deductible*, if any, stated in the *policy*.]

[Drug list] means a list of *prescription* drugs, medicines, medications, and supplies specified by *us*. [The *drug list* identifies drugs [as [level] [group] [1] [A] [,] [level] [group] [2] [B] [,] [or] [level] [group] [3] [C] [,] [or] [level] [group] [4] [D] [,] [or] [level] [group] [5] [E]] and indicates applicable *dispensing limits* [and/or any *[prior authorization]* [or] *[step therapy]* requirements].] **[There is also a [Women's Healthcare Drug List]].** Visit *our* Website at www.humana.com or call the customer service telephone number on *your* identification card to obtain the *drug list*[s]. [The *drug list*[s] [is] [are] subject to change without notice.] ^^^[Drugs may move between [levels] [groups] [and] [may be subject to specific time constraints].] [There may be times when [a [level] [group] contains no drugs at all] [or] [a drug may be subject to multiple [levels] [groups]].]

[Generic medication] means a drug, medicine or medication that is manufactured, distributed, and available from a pharmaceutical manufacturer and identified by the chemical name, or any drug product that has been designated as generic by an industry-recognized source used by *us*.]

[Legend drug] means any medicinal substance, the label of which, under the Federal Food, Drug and Cosmetic Act, is required to bear the legend: "Caution: Federal Law Prohibits dispensing without prescription".]

[Level] [Group] [1] [A] drugs means a category of *[generic medication]* *prescription* drugs, medicines or medications within the *drug list* that are designated by *us* as [level] [group] [1] [A].]

[Level] [Group] [2] [B] drugs means a category of *[generic medication]* *[brand-name medication]* *prescription* drugs, medicines or medications within the *drug list* that are designated by *us* as [level] [group] [2] [B].]

[Level] [Group] [3] [C] drugs means a category of *[brand-name medication]* *prescription* drugs, medicines or medications within the *drug list* that are designated by *us* as [level] [group] [3] [C].]

PRESCRIPTION DRUG BENEFIT [RIDER][AMENDMENT] (continued)

[[*Level*] [*Group*] [4] [*D*] *drugs* means a category of [*brand-name medication*] *prescription* drugs, medicines or medications within the *drug list* that are designated by *us* as [level] [group] [4] [D].]

[[*Level*] [*Group*] [5] [*E*] *drugs* means a category of [*brand-name medication*] *prescription* drugs, medicines or medications within the *drug list* that are designated by *us* as [level] [group] [5] [E].]
1801600 02/12

[*Maximum allowable benefit* means a specific amount of *prescription* drug expenses payable by *us* for each *covered person* under this [rider] [amendment].]

[*Mail order pharmacy* means a *pharmacy* that provides covered *mail order pharmacy* services, as defined by *us*, and delivers covered *prescriptions* or refills through the mail to *covered persons*.]

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

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

as defined by *us*, to *covered persons*, including covered *prescriptions* or refills delivered [through the mail] [to [your] [home] [or] [health care provider]].]

[*Network specialty drug [and network [level 4] [group A],[B] [and] [C]] drug out-of-pocket limit* means the amount of *copayment* that *you* must pay in a *year* for *specialty drugs* [and [*level 4 drugs*] [*group A drugs*],[] [*group B drugs*] [and] [*group C drugs*]]] from *network pharmacies* before a benefit percentage will be increased.]

[*Non-network pharmacy* means a *pharmacy* that has not signed a direct agreement with *us* or has not been designated by *us* to provide:

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

as defined by *us*, to *covered persons*, including covered *prescriptions* or refills delivered [through the mail] [to [your home] [or] [health care provider]].]

[*Non-network specialty drug [and non-network [level 4] [group A],[B] [and] [C]] drug out-of-pocket limit* means the amount of *copayment* that *you* must pay in a *year* for *specialty drugs* [and [*level 4 drugs*] [*group A drugs*],[] [*group B drugs*] [and] [*group C drugs*]]] from *non-network pharmacies* before a benefit percentage will be increased.]

[*Orphan drug* means a drug or biological used for the diagnosis, treatment, or prevention of rare diseases or conditions, which:

PRESCRIPTION DRUG BENEFIT [RIDER][AMENDMENT] (continued)

- Affects less than 200,000 persons in the United States; or
- Affects more than 200,000 persons in the United States. However, there is no reasonable expectation that the cost of developing the drug or biological and making it available in the United States will be recovered from the sales of that drug or biological in the United States.]

[Personal [pharmacy] account means an account established by *us* that may be used to offset *your* out-of-pocket cost for [covered *prescription* drugs] [qualified expenses].]

[Pharmacist means a person, who is licensed to prepare, compound and dispense medication, and who is practicing within the scope of his or her license.]

[Pharmacy means a licensed establishment where *prescription* medications are dispensed by a *pharmacist*.]

[Prescription means a direct order for the preparation and use of a drug, medicine or medication. The *prescription* must be given by a *health care practitioner* to a *pharmacist* for *your* benefit and used for the treatment of a *sickness* or *bodily injury* which is covered [under this plan] [or for drugs, medicines or medications on the [Women's Healthcare Drug List]]. The drug, medicine or medication must be obtainable only by *prescription* [or must be obtained by *prescription* for drugs, medicines or medications on the [Women's Healthcare Drug List]]. The *prescription* may be given to the *pharmacist* verbally [, *electronically*] [or] [in writing] by the *health care practitioner*. The *prescription* must include at least:

- *Your* name;
- The type and quantity of the drug, medicine or medication prescribed, and the directions for its use;
- The date the *prescription* was prescribed; and
- The name and address of the prescribing *health care practitioner*.]

[Prior authorization means the required prior approval from *us* for the coverage of *prescription* drugs, medicines and medications, including the dosage, quantity and duration, as appropriate for *your* diagnosis, age and sex. Certain *prescription* drugs, medicines or medications may require *prior authorization*. [Visit our Website at www.humana.com or call the customer service telephone number on *your* identification card to obtain a list of *prescription* drugs, medicines and medications that require *prior authorization*.]

[Specialty drug means a drug, medicine, medication, or biological used as a specialized therapy developed for chronic, complex *sicknesses* or *bodily injuries*. *Specialty drugs* may:

- Require nursing services or special programs to support patient compliance;
- Require disease-specific treatment programs;
- Have limited distribution requirements; or
- Have special handling, storage or shipping requirements.]

[Specialty drug list means a list of *specialty drugs* specified by *us*. This list indicates applicable *dispensing limits* [and/or any [*preauthorization* [/]] [,] [or] [*prior authorization*] [or] [*step therapy*] requirements]. Visit our Website at www.humana.com or call the customer service telephone number on *your* identification card to obtain the *specialty drug list*. This list is subject to change without notice.]

PRESCRIPTION DRUG BENEFIT [RIDER][AMENDMENT] (continued)

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

[*Step therapy* means a type of *prior authorization*. [We may require *you* to follow certain steps prior to *our* coverage of some high-cost drugs, medicines or medications.] [We may require *you* to try a similar drug, medicine or medication that has been determined to be safe, effective and less costly for most people with *your* condition.] [Alternatives may include over-the-counter drugs, *generic medications* and *brand-name medications*.]]

[*Year* means [a 365-day period that begins initially on the *policy's* effective date and each 365-day period thereafter beginning on the anniversary date of the *policy*, unless otherwise agreed to by the *policyholder* and *us*.] [the period of time which begins on any January 1st and ends on the following December 31st.] [When *you* first become covered by the *policy*, the first *year* begins for *you* on the *effective date* of your insurance [and ends on the following December 31st].]

1802690 02/12

Coverage description

We will cover [*generic medication*] *prescription* drugs that are received by *you* while *you* are covered under this "Prescription Drug Benefit [Rider]".^^^ Benefits may be subject to *dispensing limits*[,] [*prior authorization*] [and] [or] [*step therapy*] [requirements], if any.

Covered *prescription* drugs are:

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

PRESCRIPTION DRUG BENEFIT [RIDER][AMENDMENT] (continued)

[Notwithstanding any other provisions of the *policy*, we may decline coverage or, if applicable, exclude [from the *drug list*] any and all *prescriptions* [, including new indications for an existing *prescription*,] until the conclusion of a review period not to exceed [six – twelve] months following FDA approval for the use and release of the *prescriptions* [, including new indications for an existing *prescription*,] into the market.]

1802700 02/12

Schedule of benefits - prescription drugs[***[*]]

[You are responsible for [the following]:] [Benefits will be payable as follows:]

[Drug deductible]

[[$\$0 - \1000] [*brand-name medication*] *drug deductible* for *prescription* drugs per *covered person* [per *year*.] [This *drug deductible* applies to [level] [group] [1] [A] [drugs] [,] [and] [level] [group] [2] [B] [drugs] [,] [and] [level] [group] [3] [C] [drugs] [,] [and] [level] [group] [4] [D] [drugs] [,] [and] [level] [group] [5] [E] [*brand-name medication*] *drugs*.] [*Drug deductible* amounts accumulate separately for [level] [group] [1] [A] [drugs] [,] [level] [group] [2] [B] [drugs] [,] [level] [group] [3] [C] [drugs] [and] [level] [group] [4] [D] [drugs] [,] [and] [level] [group] [5] [E] *drugs*.]

[The *drug deductible* is a specified dollar amount that you must pay for *prescriptions* per *year* before [*specialty drugs*,] [group A *drugs*][,] [[level] [group] [2] [B] *drugs*][,] [[level] [group] [3] [C] *drugs*] and [[level] [group] [4] [D] *drugs*] will be paid under the *policy*. *Copayments*, [*specialty drugs*,] [and] [level 1 *drugs*] [and *non-network pharmacy prescriptions*] do not apply toward the [annual] *drug deductible*.]

[[Drug deductible]

[Drug deductible amount]

[<i>Specialty drugs</i> ,] [Group A <i>drugs</i>][,] [[Level] [Group] [2] [B] <i>drugs</i>][,] [[Level] [Group] [3] [C] <i>drugs</i>] [and] [[Level] [Group] [4] [D] <i>drugs</i>]	[\$^^^0-\$1,000]
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[Network specialty drug[and network [level 4] [group [A][,] [B] [and] [C]] drug] out-of-pocket limit[and non-network specialty drug [and non-network [level 4] [group [A][,] [B] [and] [C]] drug] out-of-pocket limit]]

[Any expenses incurred by you, under the provisions of this [benefit] [rider] do not apply toward your *out-of-pocket limit*, if any. However, there is a *network specialty drug* [and *network* [level 4] [group [A][,] [B] [and] [C]] *drug*] *out-of-pocket limit* [and a *non-network specialty drug* [and *non-network* [level 4] [group [A][,] [B] [and] [C]] *drug*] *out-of-pocket limit*]. The *network specialty drug* [and *network* [level 4] [group [A][,] [B] [and] [C]] *drug*] *out-of-pocket limit* is applicable to *network pharmacies* and *specialty pharmacies* [and is a combined limit between this "Prescription Drug Benefit Rider" and the "Specialty Drug Benefit" section of [this] [the] *certificate*]. [The *non-network specialty drug* [and *non-network*

PRESCRIPTION DRUG BENEFIT [RIDER][AMENDMENT]
(continued)

<p>[[Level 2] [Group B] drugs] [**] [,] [and] [[Level 3] [Group C] drugs] [**] [,] [and] [[Level 4] [Group D] drugs] [**] [,] [and] [[Level 5] [Group E] drugs] [**]</p>	<p>[with a] [\$1-\$200] [minimum copayment] [; and] [a] [\$1-\$400] [maximum copayment]</p> <p>[\$1-\$400] [allowance]</p> <p>[Amounts exceeding [\$1-\$1,000] [allowance] [up to a maximum copayment of] [\$1-\$1,000]]</p> <p>[Coverage [for] [Level 1 drugs] [,] [and] [Level 2 drugs] [,] [and] [Level 3 drugs] [,] [and] [Level 4 drugs] [,] [and] [Level 5 drugs] is limited to a maximum allowable benefit of [\$1 - \$20,000] in a year [for a covered person][.]]</p> <p>[per prescription or refill][.]</p> <p>[Network pharmacy: [1-100%] [benefit payable] [\$1-\$200] [copayment] [after network provider deductible] [per prescription or refill][.]] [Non-network pharmacy: [1-100%] [benefit payable] [\$1-\$400] [copayment] [after non-network provider deductible] [per prescription or refill][.]]</p>
<p>[[Level 1] [Group A] drugs] [**] [,] [and] [[Level 2] [Group B] drugs] [**] [,] [and] [[Level 3] [Group C] drugs] [**] [,] [and] [[Level 4] [Group D] drugs] [**] [,] [and] [[Level 5] [Group E] drugs] [**]</p>	<p>[Not Covered] [No Benefit] [Covered in full]</p> <p>[\$1-\$200] [1-100%] [copayment] [cost share] [with a] [\$1-\$200] [minimum copayment] [; and] [a] [\$1-\$400] [maximum copayment]</p> <p>[\$1-\$400] [allowance]</p> <p>[Amounts exceeding [\$1-\$1,000] [allowance] [up to a maximum copayment of] [\$1-\$1,000]]</p> <p>[Coverage [for] [Level 1 drugs] [,] [and] [Level 2 drugs] [,] [and] [Level 3 drugs] [,] [and] [Level 4 drugs] [,] [and] [Level 5 drugs] is limited to a maximum allowable benefit of [\$1 - \$20,000] in a year [for a covered person][.]]</p> <p>[per prescription or refill][.]</p> <p>[Network pharmacy: [1-100%] [benefit payable] [\$1-\$200] [copayment] [after network provider deductible] [per prescription or refill][.]] [Non-network pharmacy: [1-100%] [benefit</p>

**PRESCRIPTION DRUG BENEFIT [RIDER][AMENDMENT]
(continued)**

	<p>payable] [\$1-\$400] [copayment] [after non-network provider deductible] [per prescription or refill][.]</p>
<p>[[Level 2] [Group B] drugs] [**] [,] [and] [[Level 3] [Group C] drugs] [**] [,] [and] [[Level 4] [Group D] drugs] [**] [,] [and] [[Level 5] [Group E] drugs] [**]</p>	<p>[Not Covered] [No Benefit] [Covered in full]</p> <p>[\$1-\$400] [1-100%] [copayment] [cost share] [with a] [\$1-\$400] [minimum copayment] [; and] [a] [\$1-\$800] [maximum copayment]</p> <p>[\$1-\$800] [allowance]</p> <p>[Amounts exceeding [\$1-\$3,000] [allowance] [up to a maximum copayment of] [\$1-\$3,000]]</p> <p>[Coverage [for] [Level 2 drugs] [,] [and] [Level 3 drugs] [,] [and] [Level 4 drugs] [,] [and] [Level 5 drugs] is limited to a maximum allowable benefit of [\$1 - \$40,000] in a year [for a covered person][.]]</p> <p>[per prescription or refill][.]</p> <p>[Network pharmacy: [1-100%] [benefit payable] [\$1-\$400] [copayment] [after network provider deductible] [per prescription or refill][.]] [Non-network pharmacy: [1-100%] [benefit payable] [\$1-\$800] [copayment] [after non-network provider deductible] [per prescription or refill][.]]</p>
<p>[[Level 3] [Group C] drugs] [**] [,] [and] [[Level 4] [Group D] drugs] [**] [,] [and] [[Level 5] [Group E] drugs] [**]</p>	<p>[Not Covered] [No Benefit] [Covered in full]</p> <p>[\$1-\$800] [1-100%] [copayment] [cost share] [with a] [\$1-\$800] [minimum copayment] [; and] [a] [\$1-\$800] [maximum copayment]</p> <p>[\$1-\$1,600] [allowance]</p> <p>[Amounts exceeding [\$1-\$9,000] [allowance] [up to a maximum copayment of] [\$1-\$9,000]]</p> <p>[Coverage [for] [Level 2 drugs] [,] [and] [Level 3 drugs] [,] [and] [Level 4 drugs] [,] [and] [Level 5 drugs] is limited to a maximum allowable benefit of [\$1 - \$60,000] in a year [for a covered person][.]]</p> <p>[per prescription or refill][.]</p>

**PRESCRIPTION DRUG BENEFIT [RIDER][AMENDMENT]
(continued)**

	<p>[<i>Network pharmacy</i>: [1-100%] [benefit payable] [\$1-\$800] [<i>copayment</i>] [after <i>network provider deductible</i>] [per <i>prescription</i> or refill]] [<i>Non-network pharmacy</i>: [1-100%] [benefit payable] [\$1-\$1,600] [<i>copayment</i>] [after <i>non-network provider deductible</i>] [per <i>prescription</i> or refill][.]]</p>
<p>[[<i>Level 4</i>] [<i>Group D</i>] <i>drugs</i>] [**] [,] [and] [[<i>Level 5</i>] [<i>Group E</i>] <i>drugs</i>] [**]</p>	<p>[Not Covered] [No Benefit] [Covered in full]</p> <p>[\$1-\$1,600] [1-100%] [<i>copayment</i>] [<i>cost share</i>] [with a] [\$1-\$1,600] [<i>minimum copayment</i>] [; and] [a] [\$1-\$3,200] [<i>maximum copayment</i>]</p> <p>[\$1-\$3,200] [<i>allowance</i>]</p> <p>[Amounts exceeding [\$1-\$27,000] [<i>allowance</i>] [up to a maximum <i>copayment</i> of] [\$1-\$27,000]]</p> <p>[Coverage [for] [<i>Level 2 drugs</i>] [,] [and] [<i>Level 3 drugs</i>] [,] [and] [<i>Level 4 drugs</i>] [,] [and] [<i>Level 5 drugs</i>] is limited to a <i>maximum allowable benefit</i> of [\$1 - \$80,000] in a <i>year</i> [for a <i>covered person</i>][.]]</p> <p>[per <i>prescription</i> or refill][.]</p> <p>[<i>Network pharmacy</i>: [1-100%] [benefit payable] [\$1-\$1,600] [<i>copayment</i>] [after <i>network provider deductible</i>] [per <i>prescription</i> or refill][.]] [<i>Non-network pharmacy</i>: [1-100%] [benefit payable] [\$1-\$3,200] [<i>copayment</i>] [after <i>non-network provider deductible</i>] [per <i>prescription</i> or refill][.]]</p>
<p>[[<i>Level 5</i>] [<i>Group E</i>] <i>drugs</i>] [**]</p>	<p>[Not Covered] [No Benefit] [Covered in full]</p> <p>[\$1-\$3,200] [1-100%] [<i>copayment</i>] [<i>cost share</i>] [with a] [\$1-\$3,200] [<i>minimum copayment</i>] [; and] [a] [\$1-\$6,400] [<i>maximum copayment</i>]</p> <p>[\$1-\$6,400] [<i>allowance</i>]</p> <p>[Amounts exceeding [\$1-\$81,000] [<i>allowance</i>] [up to a maximum <i>copayment</i> of] [\$1-\$81,000]]</p>

**PRESCRIPTION DRUG BENEFIT [RIDER][AMENDMENT]
(continued)**

	<p>[Coverage [for] [<i>Level 2 drugs</i>] [,] [and] [<i>Level 3 drugs</i>] [,] [and] [<i>Level 4 drugs</i>] [,] [and] [<i>Level 5 drugs</i>] is limited to a <i>maximum allowable benefit</i> of [\$1 - \$80,000] in a year [for a <i>covered person</i>][.]]</p> <p>[per <i>prescription</i> or refill][.]</p> <p>[<i>Network pharmacy</i>: [1-100%] [benefit payable] [\$1-\$3,200] [<i>copayment</i>] [after <i>network provider deductible</i>] [per <i>prescription</i> or refill][.]]</p> <p>[<i>Non-network pharmacy</i>: [1-100%] [benefit payable] [\$1-\$6,400] [<i>copayment</i>] [after <i>non-network provider deductible</i>] [per <i>prescription</i> or refill][.]]</p>
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[Some retail *pharmacies* [and *specialty pharmacies*] participate in our program, which allows you to receive a [10–180]-day supply of a *prescription* or refill. [[After the *deductible* is met,] [Y][y]our cost is[:]

- [[*Level 1 drugs*] [,] [and] [*Level 2 drugs*] [,] [and] [*Level 3 drugs*] [,] [and] [*Level 4 drugs*] [,] [and] [*Level 5 drugs*]: [1-3] times the *copayment* above][; or]
- [[*Level 1 drugs*] [,] [and] [*Level 2 drugs*] [,] [and] [*Level 3 drugs*] [,] [and] [*Level 4 drugs*] [,] [and] [*Level 5 drugs*]: [The applicable *cost share* above, subject to [1-3] times the applicable, if any, minimum and maximum *copayments* above.] [The applicable benefit amount above.]]

[based on the applicable benefit amount above][.] [amounts exceeding] [[1-3] times] [the applicable] [*copayment*] [*allowance*] [up to [1-3] times the applicable maximum *copayments* as outlined above, after the *drug deductible*] [as outlined above] [, after [any] [applicable] [the] *drug deductible* is met] [amount as calculated for the *copayment* above] [0–100%] [benefit payable after [the] applicable *network provider deductible* [or *non-network provider deductible*]][.] [*Self-administered injectable drugs* [and *specialty drugs*] are limited to a [1–120]-day supply from a retail *pharmacy* [or *specialty pharmacy*], unless otherwise determined by us.]]

[[**Mail order pharmacy**]

[Up to [10-180]-day supply]

[Excludes *specialty drugs* [and *self-administered injectable drugs*].]

<p>[Benefit]</p> <p>[[<i>Level 1</i>] [<i>Group A drugs</i>] [**] [,] [and] [<i>Level 2</i>] [<i>Group B drugs</i>] [**] [,] [and] [<i>Level 3</i>] [<i>Group C drugs</i>] [**] [,] [and]</p>	<p>[Not Covered] [No Benefit] [Covered in full]</p> <p>[[1-3] times the applicable <i>copayment</i>[, as outlined above under Retail pharmacy [/ specialty pharmacy]] per <i>prescription</i> or refill[.]</p>
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PRESCRIPTION DRUG BENEFIT [RIDER][AMENDMENT]
(continued)

<p>[[Level 4] [Group D] drugs] [**] [,] [and] [[Level 5] [Group E] drugs] [**]</p>	<p>[[1-100%] <i>cost share</i> with a:</p> <ul style="list-style-type: none"> • [[[\$1-\$1,000] minimum <i>copayment</i>][; and] • [[[\$1-\$5,000] maximum <i>copayment</i>] per <i>prescription</i> or <i>refill</i>[.] <p>[[1-100%] [<i>copayment</i>] [<i>cost share</i>] per <i>prescription</i> or <i>refill</i>[.]</p> <p>[<i>Network pharmacy</i>: [1-100%] benefit payable after <i>network provider deductible</i> per <i>prescription</i> or <i>refill</i>[.]</p> <p>[<i>Non-network pharmacy</i>: [1-100%] benefit payable after <i>non-network provider deductible</i> per <i>prescription</i> or <i>refill</i>[.]</p> <p>[<i>Network pharmacy</i>: [1-3] times the applicable <i>copayment</i>, as outlined above under Retail pharmacy [/ specialty pharmacy] per <i>prescription</i> or <i>refill</i> after <i>network provider deductible</i>[.]</p> <p>[<i>Non-network pharmacy</i>: [1-3] times the applicable <i>copayment</i>, as outlined above under Retail pharmacy [/ specialty pharmacy] per <i>prescription</i> or <i>refill</i> after <i>non-network provider deductible</i>[.]</p> <p>[Amounts exceeding [1-3] times the applicable <i>allowance</i>, as outlined above under Retail pharmacy [/ specialty pharmacy] [per <i>prescription</i> or <i>refill</i>,] [up to a maximum <i>copayment</i> of [\$1-\$5,000] per <i>prescription</i> or <i>refill</i>] [subject to one <i>allowance</i> for up to a [1-180]-day <i>supply</i>][.]</p>
<p>[[Level 1] [Group A] drugs] [**] [,] [and] [[Level 2] [Group B] drugs] [**] [,] [and] [[Level 3] [Group C] drugs] [**] [,] [and] [[Level 4] [Group D] drugs] [**] [,] [and] [[Level 5] [Group E] drugs] [**]</p>	<p>[Not Covered] [No Benefit] [Covered in full]</p> <p>[[1-3] times the applicable <i>copayment</i>[, as outlined above under Retail pharmacy [/ specialty pharmacy]] per <i>prescription</i> or <i>refill</i>[.]</p> <p>[[1-100%] <i>cost share</i> with a:</p> <ul style="list-style-type: none"> • [[[\$1-\$1,000] minimum <i>copayment</i>][; and] • [[[\$1-\$5,000] maximum <i>copayment</i>] per <i>prescription</i> or <i>refill</i>[.]

**PRESCRIPTION DRUG BENEFIT [RIDER][AMENDMENT]
(continued)**

	<p>[[1-100%] <i>copayment</i>] [<i>cost share</i>] per <i>prescription</i> or <i>refill</i>[.]</p> <p>[<i>Network pharmacy</i>: [1-100%] benefit payable after <i>network provider deductible</i> per <i>prescription</i> or <i>refill</i>[.]</p> <p>[<i>Non-network pharmacy</i>: [1-100%] benefit payable after <i>non-network provider deductible</i> per <i>prescription</i> or <i>refill</i>[.]</p> <p>[<i>Network pharmacy</i>: [1-3] times the applicable <i>copayment</i>, as outlined above under Retail pharmacy [/ specialty pharmacy] per <i>prescription</i> or <i>refill</i> after <i>network provider deductible</i>[.]</p> <p>[<i>Non-network pharmacy</i>: [1-3] times the applicable <i>copayment</i>, as outlined above under Retail pharmacy [/ specialty pharmacy] per <i>prescription</i> or <i>refill</i> after <i>non-network provider deductible</i>[.]</p> <p>[Amounts exceeding [1-3] times the applicable <i>allowance</i>, as outlined above under Retail pharmacy [/ specialty pharmacy] [per <i>prescription</i> or <i>refill</i>,] [up to a maximum <i>copayment</i> of [\$1-\$5,000] per <i>prescription</i> or <i>refill</i>] [subject to one <i>allowance</i> for up to a [1-180]-day supply][.]</p>
<p>[[<i>Level 2</i>] [<i>Group B</i>] <i>drugs</i>] [**] [,] [and] [[<i>Level 3</i>] [<i>Group C</i>] <i>drugs</i>] [**] [,] [and] [[<i>Level 4</i>] [<i>Group D</i>] <i>drugs</i>] [**] [,] [and] [[<i>Level 5</i>] [<i>Group E</i>] <i>drugs</i>] [**]</p>	<p>[Not Covered] [No Benefit] [Covered in full]</p> <p>[[1-3] times the applicable <i>copayment</i>[, as outlined above under Retail pharmacy [/ specialty pharmacy]] per <i>prescription</i> or <i>refill</i>[.]</p> <p>[[1-100%] <i>cost share</i> with a:</p> <ul style="list-style-type: none"> • [[[\$1-\$1,000] minimum <i>copayment</i>][; and] • [[[\$1-\$5,000] maximum <i>copayment</i>] <p>per <i>prescription</i> or <i>refill</i>[.]</p> <p>[[1-100%] <i>copayment</i>] [<i>cost share</i>] per <i>prescription</i> or <i>refill</i>[.]</p> <p>[<i>Network pharmacy</i>: [1-100%] benefit payable after <i>network provider deductible</i> per <i>prescription</i> or <i>refill</i>[.]</p> <p>[<i>Non-network pharmacy</i>: [1-100%] benefit</p>

PRESCRIPTION DRUG BENEFIT [RIDER][AMENDMENT]
(continued)

	<p>payable after <i>non-network provider deductible</i> per <i>prescription</i> or refill[.]</p> <p>[<i>Network pharmacy</i>: [1-3] times the applicable <i>copayment</i>, as outlined above under Retail pharmacy [/ specialty pharmacy] per <i>prescription</i> or refill after <i>network provider deductible</i>[.]</p> <p>[<i>Non-network pharmacy</i>: [1-3] times the applicable <i>copayment</i>, as outlined above under Retail pharmacy [/ specialty pharmacy] per <i>prescription</i> or refill after <i>non-network provider deductible</i>[.]</p> <p>[Amounts exceeding [1-3] times the applicable <i>allowance</i>, as outlined above under Retail pharmacy [/ specialty pharmacy] [per <i>prescription</i> or refill,] [up to a maximum <i>copayment</i> of [\$1-\$5,000] per <i>prescription</i> or refill] [subject to one <i>allowance</i> for up to a [1-180]-day supply][.]</p>
<p>[[<i>Level 3</i>] [<i>Group C</i>] <i>drugs</i>] [**] [,] [and] [[<i>Level 4</i>] [<i>Group D</i>] <i>drugs</i>] [**] [,] [and] [[<i>Level 5</i>] [<i>Group E</i>] <i>drugs</i>] [**]</p>	<p>[Not Covered] [No Benefit] [Covered in full]</p> <p>[[1-3] times the applicable <i>copayment</i>[, as outlined above under Retail pharmacy [/ specialty pharmacy]] per <i>prescription</i> or refill[.]</p> <p>[[1-100%] <i>cost share</i> with a:</p> <ul style="list-style-type: none"> • [[[\$1-\$1,000] minimum <i>copayment</i>][; and] • [[[\$1-\$5,000] maximum <i>copayment</i>] <p>per <i>prescription</i> or refill[.]</p> <p>[[1-100%] [<i>copayment</i>] [<i>cost share</i>] per <i>prescription</i> or refill[.]</p> <p>[<i>Network pharmacy</i>: [1-100%] benefit payable after <i>network provider deductible</i> per <i>prescription</i> or refill[.]</p> <p>[<i>Non-network pharmacy</i>: [1-100%] benefit payable after <i>non-network provider deductible</i> per <i>prescription</i> or refill[.]</p> <p>[<i>Network pharmacy</i>: [1-3] times the applicable <i>copayment</i>, as outlined above under Retail pharmacy [/ specialty pharmacy] per <i>prescription</i> or refill after <i>network provider deductible</i>[.]</p>

**PRESCRIPTION DRUG BENEFIT [RIDER][AMENDMENT]
(continued)**

	<p>[<i>Non-network pharmacy</i>: [1-3] times the applicable <i>copayment</i>, as outlined above under Retail pharmacy [/ specialty pharmacy] per <i>prescription</i> or refill after <i>non-network provider deductible</i>[.]</p> <p>[Amounts exceeding [1-3] times the applicable <i>allowance</i>, as outlined above under Retail pharmacy [/ specialty pharmacy] [per <i>prescription</i> or refill,] [up to a maximum <i>copayment</i> of [\$1-\$5,000] per <i>prescription</i> or refill] [subject to one <i>allowance</i> for up to a [1-180]-day supply][.]</p>
<p>[[<i>Level 4</i>] [<i>Group D</i>] <i>drugs</i>] [**] [,] [and] [[<i>Level 5</i>] [<i>Group E</i>] <i>drugs</i>] [**]</p>	<p>[Not Covered] [No Benefit] [Covered in full]</p> <p>[[1-3] times the applicable <i>copayment</i>[, as outlined above under Retail pharmacy [/ specialty pharmacy]] per <i>prescription</i> or refill[.]</p> <p>[[1-100%] <i>cost share</i> with a:</p> <ul style="list-style-type: none"> • [[[\$1-\$1,000] minimum <i>copayment</i>][; and] • [[[\$1-\$5,000] maximum <i>copayment</i>] per <i>prescription</i> or refill[.] <p>[[1-100%] [<i>copayment</i>] [<i>cost share</i>] per <i>prescription</i> or refill[.]</p> <p>[<i>Network pharmacy</i>: [1-100%] benefit payable after <i>network provider deductible</i> per <i>prescription</i> or refill[.]</p> <p>[<i>Non-network pharmacy</i>: [1-100%] benefit payable after <i>non-network provider deductible</i> per <i>prescription</i> or refill[.]</p> <p>[<i>Network pharmacy</i>: [1-3] times the applicable <i>copayment</i>, as outlined above under Retail pharmacy [/ specialty pharmacy] per <i>prescription</i> or refill after <i>network provider deductible</i>[.]</p> <p>[<i>Non-network pharmacy</i>: [1-3] times the applicable <i>copayment</i>, as outlined above under Retail pharmacy [/ specialty pharmacy] per <i>prescription</i> or refill after <i>non-network provider deductible</i>[.]</p> <p>[Amounts exceeding [1-3] times the applicable</p>

**PRESCRIPTION DRUG BENEFIT [RIDER][AMENDMENT]
(continued)**

	<p><i>allowance</i>, as outlined above under Retail pharmacy [/ specialty pharmacy] [per <i>prescription</i> or refill,] [up to a maximum <i>copayment</i> of [\$1-\$5,000] per <i>prescription</i> or refill] [subject to one <i>allowance</i> for up to a [1-180]-day supply][.]</p>
<p>[[Level 5] [Group E] drugs] [**]</p>	<p>[Not Covered] [No Benefit] [Covered in full]</p> <p>[[1-3] times the applicable <i>copayment</i>[, as outlined above under Retail pharmacy [/ specialty pharmacy]] per <i>prescription</i> or refill[.]</p> <p>[[1-100%] <i>cost share</i> with a:</p> <ul style="list-style-type: none"> • [[\$1-\$1,000] minimum <i>copayment</i>][; and] • [[\$1-\$5,000] maximum <i>copayment</i>] per <i>prescription</i> or refill[.] <p>[[1-100%] [<i>copayment</i>] [<i>cost share</i>] per <i>prescription</i> or refill[.]</p> <p>[<i>Network pharmacy</i>: [1-100%] benefit payable after <i>network provider deductible</i> per <i>prescription</i> or refill[.]</p> <p>[<i>Non-network pharmacy</i>: [1-100%] benefit payable after <i>non-network provider deductible</i> per <i>prescription</i> or refill[.]</p> <p>[<i>Network pharmacy</i>: [1-3] times the applicable <i>copayment</i>, as outlined above under Retail pharmacy [/ specialty pharmacy] per <i>prescription</i> or refill after <i>network provider deductible</i>[.]</p> <p>[<i>Non-network pharmacy</i>: [1-3] times the applicable <i>copayment</i>, as outlined above under Retail pharmacy [/ specialty pharmacy] per <i>prescription</i> or refill after <i>non-network provider deductible</i>[.]</p> <p>[Amounts exceeding [1-3] times the applicable <i>allowance</i>, as outlined above under Retail pharmacy [/ specialty pharmacy] [per <i>prescription</i> or refill,] [up to a maximum <i>copayment</i> of [\$1-\$5,000] per <i>prescription</i> or refill] [subject to one <i>allowance</i> for up to a [1-180]-day supply][.]</p>

PRESCRIPTION DRUG BENEFIT [RIDER][AMENDMENT] (continued)

]

*****Prescription drugs, medicines or medications for behavioral health**

- *Network pharmacy:* [[3-100%] benefit payable] [Covered in full] per *prescription* or refill after *network provider deductible*;
- *Non-network pharmacy:* [3-100%] benefit payable per *prescription* or refill after *non-network provider deductible*

*****[*]Drugs, medicines or medications on the [Women's Healthcare Drug List] from a network pharmacy are covered in full.]**

[Drugs not appearing on the *drug list* will be covered after [one - three (1-3)] times the *copayment*.]

[[***] After *copayments* [for [level] [group] [I] [A] [drugs] [,] [and] [level] [group] [2] [B] [drugs] [,] [and] [level] [group] [3] [C] [drugs] [,] [and] [level] [group] [4] [D] [drugs] [,] [and] [level] [group] [5] [E] [drugs]] equal [\$100 - \$40,000] in a year [for a *covered person*], no further *copayments* must be made [for that *covered person*] [for [level] [group] [I] [A] [drugs] [,] [and] [level] [group] [2] [B] [drugs] [,] [and] [level] [group] [3] [C] [drugs] [,] [and] [level] [group] [4] [D] [drugs] [,] [and] [level] [group] [5] [E] [drugs]] [for the remainder of that year].]

[[**] Coverage [for [level] [group] [I] [A] [drugs] [,] [and] [level] [group] [2] [B] [drugs] [,] [and] [level] [group] [3] [C] [drugs] [,] [and] [level] [group] [4] [D] [drugs] [,] [and] [level] [group] [5] [E] [drugs]] is limited to a *maximum allowable benefit* of [\$100 - \$40,000] in a year [for a *covered person*].]

[For [level] [group] [I] [A] [drugs] [,] [and] [level] [group] [2] [B] [drugs] [,] [and] [level] [group] [3] [C] [drugs] [,] [and] [level] [group] [4] [D] [drugs] [,] [and] [level] [group] [5] [E] [drugs] indicating “[No Benefit] [Not Covered]”, you may still receive a discount off the retail cost based on negotiated arrangements with *network pharmacies*.]

[If you [or the *prescribing health care practitioner*] request a *brand-name medication* when a *generic medication* is available, your *cost share* is greater. You are responsible for the applicable [generic medication] *copayment* and 100% of the difference between the amount we would have paid the dispensing *pharmacy* for the *brand-name medication* and the amount we would have paid the dispensing *pharmacy* for the *generic medication*; unless, the *prescribing health care practitioner* determines that the *brand-name medication* is *medically necessary*. Then you are only responsible for the [applicable] [copayment of a *brand-name medication* [on the *drug list*]] [or the *copayment* for a medication not on the *drug list*].]

[[Non-network [retail] pharmacy [[and] non-network mail order pharmacy]]

[When a *non-network pharmacy* is used][, you must pay for the *prescription* or refill at the time it is dispensed] [and then file a claim for reimbursement with us][, as described in your *certificate*]. [You must file a claim for reimbursement with us, as described in your *certificate*.] [[In addition to the *copayments* shown above,] [Y][y]ou will [also] be responsible for [30% - 60%] of the [default rate] [actual charge]

PRESCRIPTION DRUG BENEFIT [RIDER][AMENDMENT] (continued)

[made by the dispensing *pharmacy*][, after the applicable *copayment*.] [We will reimburse you [30%-60%] of the *default rate*.] [You are also responsible for 100% of the difference between the *default rate* and the *non-network pharmacy's* charge.] [This does not apply to [*specialty drug*,] [*level*] [*group*] [1] [A] [*drugs*] [,] [and] [*level*] [*group*] [2] [B] [*drugs*] [,] [and] [*level*] [*group*] [3] [C] [*drugs*] [,] [and] [*level*] [*group*] [4] [D] [*drugs*] [,] [and] [*level*] [*group*] [5] [E] [*drugs*].] [Any *non-network pharmacy* expenses incurred by you do not apply toward your *out-of-pocket limit*, if any.] [The charge received from a *non-network pharmacy* for a *prescription* or refill may be higher than the *default rate*.] [In most cases, you will pay more if you obtain *prescriptions* from a *non-network pharmacy*.]

[Mandatory mail

Following the initial fill [and one refill] of a covered *prescription* drug or therapeutic equivalent medication prescribed by one or more *health care practitioners* and dispensed by one or more retail *pharmacies*, all subsequent refills must be obtained through a *mail order pharmacy*.]

[For [up to] a [[10-180]-day] supply of a medication received from a *mail order pharmacy*, you must pay [the amount in excess of] [[1-3]time(s)] the applicable [*copayment*] [*allowance*][, subject to one [*copayment*] [*allowance*] for up to a 30-day supply].]

1803400 02/12

Personal [pharmacy] account benefit

If the dispensing *pharmacy's* charge is less than the *allowance*, we will pay the lesser amount. The difference will then be placed into the *employee's personal [pharmacy] account*. The funds available in this account shall be used to offset any out-of-pocket expenses for [covered *prescription* drugs] [qualified expenses] incurred by you. [These funds are available only when covered *prescription* drugs are received at a *network pharmacy*.] Upon termination of coverage, all access to the funds by you will cease and any unused amounts returned to us. [If you continue to be covered under a *prescription* drug benefit which includes a *personal [pharmacy] account*, the funds accumulated will carryover to the following year.]

1803500 4/04

Limitations and exclusions

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

1803600 03/09

- [*Legend drugs*, which are not deemed *medically necessary* by us.]
- [Any amount exceeding the *default rate*.]
- [*Brand-name medications*.]

PRESCRIPTION DRUG BENEFIT [RIDER][AMENDMENT] (continued)

- [More than two fills for the same drug or therapeutic equivalent medication prescribed by one or more *health care practitioners* and dispensed by one or more retail *pharmacies*.]
 - [Any drug prescribed for intended use other than for:
 - Indications approved by the FDA; or
 - Off-label indications recognized through peer-reviewed medical literature.]
 - [Any drug prescribed for a *sickness* or *bodily injury* not covered under the *policy*.]
 - [Any drug, medicine or medication that is either:
 - Labeled "Caution-limited by federal law to investigational use"; or
 - *Experimental* or *investigational* or *for research purposes*,even though a charge is made to *you*.]
- 1804200 04/10
- [Allergen extracts.]
 - [Therapeutic devices or appliances, including, but not limited to:
 - Hypodermic needles and syringes [(except needles and syringes for [use with insulin and] [*self-administered injectable drugs*, whose coverage is approved by *us*]);]
 - Support garments;
 - Test reagents;
 - Mechanical pumps for delivery of medications; and
 - Other non-medical substances.]
 - [Dietary supplements, except enteral formulas and nutritional supplements for the treatment of phenylketonuria (PKU) or other inherited metabolic disease. [Refer to the "Covered Expenses" section of [the] [this] *certificate* for coverage of low protein modified foods.]]
 - [Nutritional products.]
 - [Fluoride supplements.]
 - [Minerals.]
 - [Growth hormones (medications, drugs or hormones to stimulate growth) for idiopathic short stature.]
 - [Growth hormones (medications, drugs or hormones to stimulate growth) [, unless there is a laboratory confirmed diagnosis of growth hormone deficiency] [, or as otherwise determined by *us*].]
 - [Herbs and vitamins, except prenatal (including greater than one milligram of folic acid) [and pediatric multi-vitamins with fluoride].]

1805000 03/09

PRESCRIPTION DRUG BENEFIT [RIDER][AMENDMENT]
(continued)

- [Anabolic steroids.]
 - [Anorectic or any drug used for the purpose of weight control.]
 - [Any drug used for cosmetic purposes[, including, but not limited to:
 - Dermatologicals or hair growth stimulants; or
 - Pigmenting or de-pigmenting agents].]
 - [Any drug or medicine that is:
 - Lawfully obtainable without a *prescription* (over-the-counter drugs), except insulin; or
 - Available in prescription strength without a *prescription*.]
 - [Compounded drugs in any dosage form[, except when prescribed for pediatric use for children up to 19 years of age] [, or as otherwise determined by *us*].]
 - [Progesterone crystals or powder in any compounded dosage form [, unless otherwise determined by *us*].]
 - [Contraceptives, other than oral, whether medication or device[, regardless of the purpose for which they are prescribed].]
 - [Abortifacients (drugs used to induce abortions).]
 - [*Infertility services* including medications.]
 - [Any drug prescribed for impotence and/or sexual dysfunction.]
- 1806000 02/11
- [Any drug, medicine or medication that is consumed or injected at the place where the *prescription* is given, or dispensed by the *health care practitioner*.]
 - [The administration of covered medication(s).]
 - [*Prescriptions* that are to be taken by or administered to *you*, in whole or in part, while *you* are a patient in a facility where drugs are ordinarily provided by the facility on an *inpatient* basis. [*Inpatient* facilities include, but are not limited to:
 - *Hospital*;
 - *Skilled nursing facility*; or
 - *Hospice facility*.]]
 - [Injectable drugs, including, but not limited to:
 - Immunizing agents [, unless otherwise determined by *us*];

PRESCRIPTION DRUG BENEFIT [RIDER][AMENDMENT] (continued)

- Biological sera;
 - Blood;
 - Blood plasma; or
 - *Self-administered injectable drugs* [or *specialty drugs*] for which coverage is not approved by *us*.]

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

 - [Any portion of a *prescription* or refill that exceeds a [10 – 180]-day supply when received from a *mail order pharmacy* or a retail *pharmacy* that participates in *our* program, which allows *you* to receive a [10-180]-day supply of a *prescription* or refill.]

 - [Any portion of a *prescription* or refill that exceeds a [1 – 120]-day supply when received from a retail *pharmacy* that does not participate in *our* program, which allows *you* to receive a [10-180]-day supply of a *prescription* or refill.]

 - [Any portion of a [*specialty drug* or] *self-administered injectable drug* that exceeds a [1 – 120]-day supply, unless otherwise determined by *us*.]

 - [Any portion of a *prescription* or refill that:
 - Exceeds *our* drug specific *dispensing limit*;
 - Is dispensed to a *covered person*, whose age is outside the drug specific age limits defined by *us*;
[or]
 - [Is refilled early, as defined by *us*; or]
 - Exceeds the duration-specific *dispensing limit*.]

 - [Any drug for which *prior authorization* [or *step therapy*] is required, as determined by *us*, and not obtained.]
- 1806800 02/11
- [Any drug for which a charge is customarily not made.]

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

 - [Any costs related to the mailing, sending or delivery of *prescription* drugs.]

 - [Any intentional misuse of this benefit, including *prescriptions* purchased for consumption by someone other than *you*.]

 - [Any *prescription* or refill for drugs, medicines or medications that are lost, stolen, spilled, spoiled, or damaged.]

PRESCRIPTION DRUG BENEFIT [RIDER][AMENDMENT]
(continued)

1807300 03/09

- [Any drug, medication, or supply to eliminate or reduce a dependency on, or addiction to, tobacco and tobacco products.]
- [Drug delivery implants.]
- [Treatment for onychomycosis (nail fungus).]
- [[More than one *prescription* or refill 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] [or] [a] [specialty pharmacy] [or] [a] [retail pharmacy] that participates in *our* program, which allows *you* to receive a [1-180]-day supply of a *prescription* or refill]. For drugs received from a [mail order pharmacy] [or] [a] [specialty pharmacy] [or] [a] [retail pharmacy] that participates in *our* program, which allows *you* to receive a [1-180]-day supply of a *prescription* or refill], more than one *prescription* or refill within a 20-day period for a [1-30] day supply; or a [60-90]-day period for a [61-180]-day supply.] [More than one *prescription* or refill 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* or refill, unless the drug or therapeutic equivalent medication is purchased through a [mail order pharmacy] [,] [or] [a] [specialty pharmacy] [,] [or] [a] [retail pharmacy] that participates in *our* program, which allows *you* to receive a [1-180]-day supply of a *prescription* or refill], 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*).]
- [More than one *prescription* or refill for the same drug or therapeutic equivalent medication prescribed by one or more *health care practitioners* and dispensed by one or more *pharmacies* unless *you* have used, or should have used:
 - A [20-25]-day supply of the previous 30-day *prescription* or refill; or
 - A [70-80]-day supply of the previous 90-day retail *prescription* purchased through a retail *pharmacy* that participates in *our* program; or
 - A [50-80]-day supply of the previous 90-day *mail order pharmacy prescription*.

(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 amount *you* paid for a *prescription* that has been filled, regardless of whether the *prescription* is revoked or changed due to adverse reaction or change in dosage or *prescription*.]

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

1807955 02/11

PRESCRIPTION DRUG BENEFIT [RIDER][AMENDMENT]
(continued)

[Humana Insurance Company]

[

[Signature of Officer]
[Typed Name of Officer]
[Title of Officer]]

1808000

VARIABLE OPTIONS

Policy Series: CC2003-P et al. for the State of Arkansas

In compliance with Bulletin 9-85, the difference in coinsurance rates between in-network covered services and out-of-network covered services for this product shall not exceed 25 percentage points.

Comment [WRJ1]: State mandate Bulletin 9-85.

SCHEDULE OF BENEFITS - SCHEDULE 2

Option 1:

[[%] [benefit payable] [after] [a] [{"Level 1"} {"Level 2"} {"non-"}network provider deductible] [and] [{"\$"} copayment per {visit} {service} {day} {charge} {(waived if admitted)}] [{"up"} to a maximum {benefit} of {#} visits] {per covered person} {per} {#} {visit} {service}{test} {screening} {immunization} {day} {charge} {year}] [or { % } of the fee, whichever is {lesser} {greater}] [, then] [{" % }] [to the {out-of-pocket limit} [{"(\$)} maximum per {day} {visit}]] [and] [after] [{"Level 1"} {"Level 2"} {"non-"}network provider deductible] [after {plan} deductible] [Deductible does not apply.] [The {copayment} {coinsurance} does not accumulate toward and is not subject to any out-of-pocket limit] [.] [Same as any other sickness [based upon location of services and the type of provider].] [Not covered.] [No benefit.]]

A. Indemnity:

[Provider]	
[Benefits] [provider]	

B. PPO:

[Provider]	
[Level 1] [Option A] network [health care practitioner] [provider]	
[Level 1] [Option B] network [health care practitioner] [provider]	
[Level 2] [Option A] [non-]network [health care practitioner] [provider]	
[Level 2] [Option B] [non-]network [health care practitioner] [provider]	
[Non-network [health care practitioner]]	

VARIABLE OPTIONS (continued)

[provider]	
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Option 2:

[[%] [benefit payable] [after] [a] [[Level 1] {Level 2} {non-}network provider deductible] [and] [{\$} copayment per {visit} {service} {day} {confinement} {admission} {procedure} {test} {occurrence}] [for {the first} {#} {day(s)} {visit(s)} {of confinement} {per admission}] [[up] to a maximum {benefit} of {# days} {# visits} {per covered person} {per} {visit} {service} {day} {year} {confinement} {admission}] [, then] [[%] {benefit payable}] [after] [{\$} copayment per {visit} {service} {day} {confinement} {admission} {procedure} {test} {occurrence}] [to the {out-of-pocket limit} {{\$} maximum per {day} {visit} {for the rest of the year}}] [and] [after] [[Level 1] {Level 2} {non-}network provider deductible] [after {plan} deductible] [The {copayment} {coinsurance} does not apply to any out-of-pocket limit] [.] [Copayment waived if admitted.] [Same as any other sickness [based upon location of services and the type of provider].] [Not covered.] [No benefit.]

A. Indemnity:

[Provider]	
[Benefits] [Hospital]	

B. PPO:

[Provider]	
[Level 1] network hospital	
[[Level 2] [non-]network hospital]	
[Non-network hospital]	

Option 3:

[[%] [benefit payable] [after] [a] [[Level 1] {Level 2} {non-}network provider deductible] [and] [{\$} copayment per {visit} {service} {day} {charge} {trip} {procedure} {test} {occurrence} {admission} {confinement} {(waived if admitted)}] [for {the first} {#} day(s) {of confinement} {per admission}] [up] to a maximum {benefit} of {# days} {# visits} {per covered person} {per} {#} {visit} {service} {day} {charge} {year} {confinement} {admission}] [or { %} of the fee, whichever is {lesser} {greater}] [, then] [[%] [to {the} {a} {out-of-pocket limit} {{\$}} maximum per {day} {visit}}] [and] [after]

VARIABLE OPTIONS (continued)

[[Level 1] {Level 2} {non-}network provider deductible] [after {plan} deductible] [Deductible does not apply.] [The {copayment} {coinsurance} does not accumulate toward and is not subject to any *out-of-pocket limit*] [.] [Same as any other *sickness* [based upon location of services and the type of provider].] [Not covered.] [No benefit.] [Copayment waived if admitted.]

A. Indemnity:

[Provider]	
[Benefits] [Provider]	

B. PPO:

[Provider]	
[Level 1] <i>network provider</i>	
[[Level 2] {non-}network provider]	
[Non-network provider]	

Option 4:

[[%] [benefit payable] [after] [a] [[Level 1] {Level 2} {non-}network provider deductible] [and] [{\$} copayment per {visit} {service} {day} {charge} {confinement} {admission} {procedure} {test} {occurrence} {trip} {(waived if admitted)}] [for the first {#} days of {of confinement} {per admission}] [[up] to a maximum {benefit} of {\$} {# days}{# visits} {per covered person} {per} {#} {visit} {service}{test} {screening} {immunization} {day} {charge} {confinement} {admission} {year}] [or {%} of the fee, whichever is {lesser} {greater}] [, then] [{%}] {benefit payable} [to {the} {a} {out-of-pocket limit}] {(\$)} {maximum per year} [and] [after] [[Level 1] {Level 2} {non-}network provider deductible] [after {plan} deductible] [Deductible does not apply.] [The {copayment} {coinsurance} does not accumulate toward and is not subject to any *out-of-pocket limit*] [.] [Copayment waived if admitted.] [Same as any other *sickness* [based upon location of services and the type of provider].] [Not covered.] [No benefit.]

A. Indemnity:

[Provider]	
[Benefits] [Provider]	

VARIABLE OPTIONS (continued)

B. PPO:

[Provider]	
[Level 1] <i>network provider</i>	
[[Level 2] <i>[non-]network provider</i>]	
[<i>Non-network provider</i>]	

Preventive services maximum visits per year		0 - unlimited	
Preventive services	Percentage: 0% - 100%		Copayment: \$0 - \$2,000 (encompasses visit, service and day amounts)
[[Each] Preventive services office visit[s]] [for covered persons [under [0- 19] years of age]] [to age [0 - 19]] [through the age of [0 - 19]]	Percentage: 0% - 100%		Copayment: \$0 - \$2,000 (encompasses visit, service and day amounts)
[[Each] Preventive services office visit[s]] [for covered persons [over [0 - 19] years of age]] [[0-19] years of age or over]	Percentage: 0% - 100%		Copayment: \$0 - \$2,000 (encompasses visit, service and day amounts)
[[Annual] gynecological office visit[s]] [for covered persons [under [0- 19] years of age]] [to age [0 - 19]] [through the age of [0 - 19]]	Percentage: 0% - 100%		Copayment: \$0 - \$2,000 (encompasses visit, service and day amounts)

VARIABLE OPTIONS (continued)

[[Annual] gynecological office visit[s]] [for covered persons [over [0 - 19] years of age]] [[0-19] years of age or over]	Percentage: 0% - 100%		Copayment: \$0 - \$2,000 (encompasses visit, service and day amounts)
[Preventive screenings] [and] [immunizations][:] [for covered persons [under [0- 19] years of age]] [to age [0 - 19]] [through the age of [0 - 19]]	Percentage: 0% - 100%		Copayment: \$0 - \$2,000 (encompasses visit, service and day amounts)
Routine childhood immunizations	100%		
[Preventive screenings] [and] [immunizations][:] [for covered persons over [0 - 19] years of age]	Percentage: 0% - 100%		Copayment: \$0 - \$2,000 (encompasses visit, service and day amounts)
[Each] [Routine] [preventive] [radiology] [,] [laboratory] [and] [pathology] [and/or endoscopic] [service[s]] [test[s]]	Percentage: 0% - 100%		Copayment: \$0 - \$2,000 (encompasses visit, service and day amounts)
[Routine] [preventive] endoscopic services	Percentage: 0% - 100%		Copayment: \$0 - \$2,000 (encompasses visit, service and day amounts)
[Routine] [preventive] mammogram	Percentage: 0% - 100%		Copayment: \$0 - \$2,000 (encompasses visit, service and day amounts)
[Routine] [preventive] pap smear	Percentage: 0% - 100%		Copayment: \$0 - \$2,000 (encompasses visit, service and day amounts)
[Routine] [preventive] prostate specific antigen (PSA) test	Percentage: 0% - 100%	Maximum Benefit: \$0 - \$1000	Copayment: \$0 - \$2,000 (encompasses visit, service and day amounts)

VARIABLE OPTIONS (continued)

Colorectal cancer screening	Percentage: 0% - 100%		Copayment: \$0 - \$2,000 (encompasses visit, service and day amounts)
Other preventive cancer screenings	Percentage: 0% - 100%	Maximum Benefit: \$0 - \$1000	Copayment: \$0 - \$2,000 (encompasses visit, service and day amounts)
Immunizations	Percentage: 0% - 100%		Copayment: \$0 - \$2,000 (encompasses visit, service and day amounts)
Immunizations against influenza (flu shot) and pneumonia:	Percentage: 0% - 100%		Copayment: \$0 - \$2,000 (encompasses visit, service and day amounts)

Health care practitioner home/office visit services:	Percentage: 0% - 100%	Copayment: \$0 - \$2,000 (encompasses visit, service and day amounts)
Health care practitioner prenatal home/office visit services:	Percentage: 0% - 100%	Copayment: \$0 - \$2,000 (encompasses visit, service and day amounts)
Health care practitioner home visit services billed by the health care practitioner:	Percentage: 0% - 100%	Copayment: \$0 - \$2,000 (encompasses visit, service and day amounts)
[Each] [diagnostic] [laboratory][,] [and] [radiology] [and] [pathology] [test[s]] [service[s]] [when performed in the office and billed by the health care practitioner]	Percentage: 0% - 100%	Copayment: \$0 - \$2,000 (encompasses visit, service and day amounts)
Advanced imaging when performed in a health care practitioner's office	Percentage: 0% - 100%	Copayment: \$0 - \$2,000 (encompasses visit, service and day amounts)
Nuclear medicine [when performed in a health care practitioner's office]	Percentage: 0% - 100%	Copayment: \$0 - \$2,000 (encompasses visit, service and day amounts)
[Each] [plain film] radiology [service[s]] [when performed in a health care practitioner's office]	Percentage: 0% - 100%	Copayment: \$0 - \$2,000 (encompasses visit, service and day amounts)

VARIABLE OPTIONS (continued)

Allergy testing [when received in the health care practitioner's office]:	Percentage: 0% - 100%	Copayment: \$0 - \$2,000 (encompasses visit, service and day amounts)
Allergy serum [when received in the health care practitioner's office]:	Percentage: 0% - 100%	Copayment: \$0 - \$2,000 (encompasses visit, service and day amounts)
Allergy injection [when received in the health care practitioner's office]:	Percentage: 0% - 100%	Copayment: \$0 - \$2,000 (encompasses visit, service and day amounts)
Injections other than allergy [when received in a health care practitioner's office.]:	Percentage: 0% - 100%	Copayment: \$0 - \$2,000 (encompasses visit, service and day amounts)
Chemotherapy, radiation therapy and dialysis [when received in the health care practitioner's office]:	Percentage: 0% - 100%	Copayment: \$0 - \$2,000 (encompasses visit, service and day amounts)
Each surgery [performed in the office and billed by the health care practitioner] [Surgeon] [Fee[s]]:	Percentage: 0% - 100%	Copayment: \$0 - \$2,000 (encompasses visit, service and day amounts)

Hospital inpatient services	Percentage: 0% - 100%	Copayment: \$0 - \$20,000 (encompasses visit, confinement, admission, service and day amounts)
Hospital inpatient services semi-private room:	Percentage: 0% - 100%	Copayment: \$0 - \$20,000 (encompasses visit, confinement, admission, service and day amounts)
Hospital inpatient care – intensive care unit:	Percentage: 0% - 100%	Copayment: \$0 - \$50,000 (encompasses visit, confinement, admission, service and day amounts)
Hospital inpatient care – operating room:	Percentage: 0% - 100%	Copayment: \$0 - \$20,000 (encompasses visit, confinement, admission, service and day amounts)
Hospital inpatient care – ancillary services:	Percentage: 0% - 100%	Copayment: \$0 - \$20,000 (encompasses visit, confinement, admission, service and day amounts)

VARIABLE OPTIONS (continued)

Hospital inpatient maximum number of days per year:	0 – 365	
Number of days the hospital copayment is applicable:	0 – unlimited	
Maximum number of days per hospital confinement:	0 – unlimited	
Hospital inpatient daily maximum benefit	\$1000 - unlimited	
Health care practitioner inpatient services [when] provided in a hospital:	Percentage: 0% - 100%	Copayment: \$0 - \$20,000 (encompasses visit, confinement, admission, service and day amounts)
[Each] [anesthesiology] [services] [anesthesiologist] [fees] for inpatient surgery provided in a hospital:	Percentage: 0% - 100%	Copayment: \$0 - \$2,000 (encompasses visit, service and day amounts)
[Hospital] outpatient services	Percentage: 0% - 100%	Copayment: \$0 - \$5,000 (encompasses visit, service and day amounts)
[Hospital] outpatient surgical services:	Percentage: 0% - 100%	Copayment: \$0 - \$5,000 (encompasses visit, service and day amounts)
[Hospital] outpatient services – operating room for outpatient surgery:	Percentage: 0% - 100%	Copayment: \$0 - \$5,000 (encompasses visit, service and day amounts)
[Hospital] outpatient ancillary services [for outpatient surgery]:	Percentage: 0% - 100%	Copayment: \$0 - \$5,000 (encompasses visit, service and day amounts)
Health care practitioner outpatient services [when provided in a hospital]:	Percentage: 0% - 100%	Copayment: \$0 - \$5,000 (encompasses visit, service and day amounts)
[Each] [anesthesiology] [services] [anesthesiologist] [fees] for outpatient surgery provided in a hospital:	Percentage: 0% - 100%	Copayment: \$0 - \$2,000 (encompasses visit, service and day amounts)
[Hospital] outpatient non-surgical services:	Percentage: 0% - 100%	Copayment: \$0 - \$5,000 (encompasses visit, service and day amounts)

VARIABLE OPTIONS (continued)

[Each] [diagnostic][,] [and] [radiology][,] [and] [laboratory] [and] [pathology] [test[s]] [service[s]] [when provided in a hospital's outpatient department [or in a free standing facility]:	Percentage: 0% - 100%	Copayment: \$0 - \$5,000 (encompasses visit, service and day amounts)
[Hospital] [outpatient] advanced imaging:	Percentage: 0% - 100%	Copayment: \$0 - \$3,000 (encompasses visit, service and day amounts)
[Hospital] [outpatient] [plain film] radiology:	Percentage: 0% - 100%	Copayment: \$0 - \$1,500 (encompasses visit, service and day amounts)
[Hospital] [outpatient] nuclear medicine:	Percentage: 0% - 100%	Copayment: \$0 - \$1,500 (encompasses visit, service and day amounts)

Hospital emergency room services:	Percentage: 0% - 100%	Copayment: \$0 - \$^^1,000 (encompasses visit, service and day amounts)
[Hospital emergency room] [[Advanced imaging] [when performed in [a] [an] [hospital] emergency room]]	Percentage: 0% - 100%	Copayment: \$0 - \$^^1,000 (encompasses visit, service and day amounts)
Hospital emergency room ancillary services:	Percentage: 0% - 100%	Copayment: \$0 - \$^^1,000 (encompasses visit, service and day amounts)
Hospital emergency room health care practitioner services:	Percentage: 0% - 100%	Copayment: \$0 - \$^^1,000 (encompasses visit, service and day amounts)

Ambulance:	Percentage: 0% - 100%	Copayment: \$0 - \$1,500 (encompasses visit, service and day amounts)
Ambulatory surgical center services:	Percentage: 0% - 100%	Copayment: \$0 - \$5,000 (encompasses visit, service and day amounts)
Ambulatory surgical center [operating room for outpatient surgery] [for outpatient surgery:]	Percentage: 0% - 100%	Copayment: \$0 - \$5,000 (encompasses visit, service and day amounts)

VARIABLE OPTIONS (continued)

Ambulatory surgical center ancillary services [for outpatient surgery]:	Percentage: 0% - 100%	Copayment: \$0 - \$5,000 (encompasses visit, service and day amounts)
Health care practitioner outpatient services[provided in an ambulatory surgical center]:	Percentage: 0% - 100%	Copayment: \$0 - \$5,000 (encompasses visit, service and day amounts)
[Each] [anesthesiology] [services] [anesthesiologist] [fee[s]] for outpatient surgery provided in an ambulatory surgical center:	Percentage: 0% - 100%	Copayment: \$0 - \$2,000 (encompasses visit, service and day amounts)
Durable medical equipment [and] [diabetes equipment]:	Percentage: 0% - 100%	Copayment: \$0 - \$5,000 (encompasses visit, service and day amounts)
Diabetes equipment	Percentage: 0% - 100%	Copayment: \$0 - \$2,000 (encompasses visit, service and day amounts)
Oxygen	Percentage: 0% - 100%	Copayment: \$0 - \$2,000 (encompasses visit, service and day amounts)
[Prosthetic] [devices] [and] [supplies]:	Percentage: 0% - 100%	Copayment: \$0 - \$2,000 (encompasses visit, service and day amounts)
[Prosthetic] [devices] [and] [supplies] maximum benefit:	\$0 to unlimited	
[Hearing Aids]	Percentage: 0% - 100%	Copayment: \$0
[Hearing Aids] maximum benefit:	\$1,400 to unlimited	
Free-standing facility outpatient non-surgical services:	Percentage: 0% - 100%	Copayment: \$0 - \$2,000 (encompasses visit, service and day amounts)
Free-standing facility ancillary services for [outpatient] [non-surgical] services:	Percentage: 0% - 100%	Copayment: \$0 - \$2,000 (encompasses visit, service and day amounts)
[Each] [diagnostic][,] [and] [radiology][,] [and] [laboratory] [and] [pathology] [test[s]] [services] [when provided in a free-standing facility]:	Percentage: 0% - 100%	Copayment: \$0 - \$2,000 (encompasses visit, service and day amounts)

Comment [WRJ2]: State mandate – 23-79-1302

VARIABLE OPTIONS (continued)

Health care practitioner [outpatient] [non-surgical services] [provided in a free-standing facility]:	Percentage: 0% - 100%	Copayment: \$0 - \$2,000 (encompasses visit, service and day amounts)
Free-standing facility [outpatient] advanced imaging:	Percentage: 0% - 100%	Copayment: \$0 - \$2,000 (encompasses visit, service and day amounts)
Free-standing facility [outpatient] [plain film] radiology:	Percentage: 0% - 100%	Copayment: \$0 - \$2,000 (encompasses visit, service and day amounts)
Free-standing facility [outpatient] nuclear medicine:	Percentage: 0% - 100%	Copayment: \$0 - \$2,000 (encompasses visit, service and day amounts)
Home health care:	Percentage: 0% - 100%	Copayment: \$0 - \$1,500 (encompasses visit, service and day amounts)
Home health care maximum visits per year:	0 to unlimited	
Hospice:	Percentage: 0% - 100%	Copayment: \$0 - \$5,000 (encompasses visit, confinement, admission, service and day amounts)
Hospice maximum benefit	\$0 to unlimited	
Hospice maximum days per year	0 to unlimited	
Hospice inpatient:	Percentage: 0% - 100%	Copayment: \$0 - \$5,000 (encompasses visit, confinement, admission, service and day amounts)
Hospice inpatient maximum benefit	\$0 to unlimited	
Hospice inpatient maximum days per year	0 to unlimited	
Hospice outpatient:	Percentage: 0% - 100%	Copayment: \$0 - \$5,000 (encompasses visit, service and day amounts)

VARIABLE OPTIONS (continued)

Hospice outpatient maximum benefit:	\$0 – unlimited	
Hospice outpatient maximum days per year:	0 to unlimited	
Bereavement counseling	Percentage: 0% - 100%	Copayment: \$0 - \$5,000 (encompasses visit, service and day amounts)
In-vitro fertilization	Percentage: 0% - 100%	Copayment: \$0 - \$5,000 (encompasses visit, service and day amounts)
In-vitro fertilization maximum benefit:	\$15,000 - unlimited	
Jaw joint benefit	Percentage: 0% - 100%	Copayment: \$0 - \$2,000 (encompasses visit, service and day amounts)
Jaw joint maximum benefit per year:	\$0 – unlimited	
Physical medicine and rehabilitative services:	Percentage: 0% - 100%	Copayment: \$0 - \$2,000 (encompasses visit, service and day amounts)
[Physical [therapy]] [and],[,] [occupational] [therapy] [and],[,] [speech therapy],[,] [and] [audiology],[,] [and] [cognitive rehabilitation services] [,][and] [spinal manipulations],[,][/] adjustments [and modalities]] [combined] maximum visits per year:	0 – unlimited	

Comment [WRJ3]: State mandate 23-85-137 (d)

VARIABLE OPTIONS (continued)

[Physical [therapy] [and],[,] [occupational] [therapy] [and],[,] [speech therapy],[,] [and] [audiology],[,] [and] [cognitive rehabilitation services] [,][and spinal manipulations[,] [/] adjustments [and modalities]] [non-][network provider] maximum visits per year:	0 – unlimited	
Physical therapy [combined] maximum visits per year:	0 – unlimited	
Occupational therapy [combined] maximum visits per year:	0 – unlimited	
Speech therapy [and],[,] [speech pathology services] [and] [,][audiology] [and cognitive rehabilitation services] [combined] maximum visits per year:	0 – unlimited	
Spinal manipulations[,] [/] adjustments [and modalities] maximum number visits per year:	0 – unlimited	
Physical medicine and rehabilitative services [combined] maximum number of visits per year:	0 – unlimited	
Physical medicine-spinal manipulations, adjustments and modalities therapy:	Percentage: 50% - 100%	Copayment: \$0 - \$2,000 (encompasses visit, service and day amounts)
Physical medicine – speech or cognitive therapy:	Percentage: 0% - 100%	Copayment: \$0 - \$2,000 (encompasses visit, service and day amounts)
Physical medicine speech or cognitive therapy maximum visits per year:	0 to unlimited	
Respiratory or pulmonary therapy services	Percentage: 0% - 100%	Copayment: \$0 - \$2,000 (encompasses visit, service and day amounts)

VARIABLE OPTIONS (continued)

Respiratory or pulmonary therapy services maximum visits per year	0 to unlimited	
Cardiac rehabilitation services	Percentage: 0% - 100%	Copayment: \$0 - \$2,000 (encompasses visit, service and day amounts)
Cardiac rehabilitation services maximum visits per year	0 to unlimited	
Physical medicine - other therapy	Percentage: 0% - 100%	Copayment: \$0 - \$2,000 (encompasses visit, service and day amounts)
Physical medicine - other therapy maximum visits per year:	0 to unlimited	
Pre-surgical/procedural testing:	Percentage: 0% - 100%	Copayment: \$0 - \$1,500 (encompasses visit, service and day amounts)
Skilled nursing facility:	Percentage: 0% - 100%	Copayment: \$0 - \$1,000 (encompasses visit, confinement, admission, service and day amounts)
Skilled nursing facility maximum days per year:	0 to unlimited	
Urgent care facility services:	Percentage: 0% - 100%	Copayment: \$0 - \$500 (encompasses visit, service and day amounts)
Urgent care facility health care practitioner services:	Percentage: 0% - 100%	Copayment: \$0 - \$500 (encompasses visit, service and day amounts)
Private duty nursing [while hospital confined]	Percentage: 0% - 100%	Copayment: \$0 - \$100 (encompasses visit, service and day amounts)
Private duty nursing maximum days per year:	0 to unlimited	
Private duty nursing maximum benefit:	\$0 to unlimited	
Additional [medical services] [covered expenses]:	Percentage: 0% - 100%	Copayment: \$0 - \$100 (encompasses visit, service and day amounts)

VARIABLE OPTIONS (continued)

SERFF Tracking Number: HUMA-127179661 State: Arkansas
 Filing Company: Humana Insurance Company State Tracking Number:
 Company Tracking Number: AR-12-001
 TOI: H16G Group Health - Major Medical Sub-TOI: H16G.001A Any Size Group - PPO
 Product Name: CC2003 et al
 Project Name/Number: 2012 Refresh /CC757 CC760 CC775

Supporting Document Schedules

	Item Status:	Status Date:
<p>Satisfied - Item: Flesch Certification</p> <p>Comments: see attached</p> <p>Attachments: AR-12-001 Certificate of Compliance-Bulletin 9-85.pdf AR-12-001 Certification of Compliance-Rule & Regulation 19.pdf</p>	Approved-Closed	02/16/2012
<p>Satisfied - Item: Application</p> <p>Comments: Applications were approved 12/20/11 SERFF number HUMA-127855749</p>	Approved-Closed	02/16/2012
<p>Satisfied - Item: PPACA Uniform Compliance Summary</p> <p>Comments: see attached</p> <p>Attachments: PGN HCR Rider Grp GF 6-10 (a).pdf PGN HCR Rider Grp non-GF 6-10 (a).pdf</p>	Approved-Closed	02/16/2012
<p>Satisfied - Item: Statement of Variability</p> <p>Comments: see attached</p> <p>Attachment: AR Matrix Filing Variability Statement.pdf</p>	Approved-Closed	02/16/2012

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-12-001

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

02/15/2012

(Date)

Individual responsible for this filing:

Wendy Jeffries
Contract Analyst
Product Compliance

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

February 15, 2012
Date

Individual responsible for this filing:

Wendy Jeffries
Contract Analyst
Product Compliance

PATIENT PROTECTION AND AFFORDABLE CARE ACT RIDER

This rider is made part the benefit plan document to which it is attached.

All terms used in this rider have the same meaning given to them in the benefit plan document unless otherwise defined in this rider, by the Patient Protection and Affordable Care Act of 2010 (the Affordable Care Act), also known as federal health care reform, or by future federal regulations. Except as modified below, all conditions and limitations of the benefit plan document apply. State laws continue to apply except to the extent that the state law prevents application of federal health care reform.

The following will apply to your current plan as of your plan renewal date on or after 9/23/2010.

Definitions

Essential health benefits mean the items and services in the following categories defined by the United States Health and Human Services (HHS) as set forth by the Affordable Care Act and future federal regulations:

- Ambulatory patient services;
- Emergency services;
- Hospitalization;
- Maternity and newborn care;
- Mental and substance use disorder, including behavioral health treatment;
- Prescription drugs;
- Rehabilitative and habilitative services and devices;
- Laboratory services;
- Preventive and wellness services and chronic disease management;
- Pediatric services, including oral and vision care.

Lifetime maximum -

The lifetime maximum does not apply to essential health benefits.

Annual limits -

Annual dollar limits for essential health benefits are removed.

Rescission -

We will rescind coverage only due to fraud or an intentional misrepresentation of a material fact.

Dependent coverage -

**PATIENT PROTECTION AND AFFORDABLE CARE ACT
RIDER (continued)**

If your health plan includes coverage for dependent children, your child is covered to age 26 regardless if the child is:

- Married;
- A tax dependent;
- A student;
- Employed; or
- Residing with or receives financial support from you.

Pre-existing conditions -

The pre-existing condition limitation does not apply to a covered person who is under the age of 19.

Humana Insurance Company

[Signature of Officer]
[Typed Name of Officer]
[Title of Officer]

PATIENT PROTECTION AND AFFORDABLE CARE ACT RIDER

This rider is made part of the benefit plan document to which it is attached.

All terms used in this rider have the same meaning given to them in the benefit plan document unless otherwise defined in this rider, by the Patient Protection and Affordable Care Act of 2010 (the Affordable Care Act), also known as federal health care reform, or by future federal regulations. Except as modified below, all conditions and limitations of the benefit plan document apply. State laws continue to apply except to the extent that the state law prevents application of federal health care reform.

If your plan is effective prior to 09/23/2010, these requirements will apply to your current plan as of your plan renewal date on or after 09/23/2010. If your plan is effective 09/23/2010 or after, this rider is applicable to your current plan as of your plan's effective date.

Definitions

Essential health benefits mean the items and services in the following categories defined by the United States Health and Human Services (HHS) as set forth by the Affordable Care Act and future federal regulations:

- Ambulatory patient services;
- Emergency services;
- Hospitalization;
- Maternity and newborn care;
- Mental and substance use disorder, including behavioral health treatment;
- Prescription drugs;
- Rehabilitative and habilitative services and devices;
- Laboratory services;
- Preventive and wellness services and chronic disease management;
- Pediatric services, including oral and vision care.

Lifetime maximum -

The lifetime maximum does not apply to essential health benefits.

Annual limits -

Annual dollar limits for essential health benefits are removed.

Rescission -

We will rescind coverage only due to fraud or an intentional misrepresentation of a material fact.

PATIENT PROTECTION AND AFFORDABLE CARE ACT RIDER (continued)

Dependent coverage -

If your health plan includes coverage for dependent children, your child is covered to age 26 regardless if the child is:

- Married;
- A tax dependent;
- A student;
- Employed;
- Eligible for other coverage through employment; or
- Residing with or receives financial support from you.

Pre-existing conditions -

The pre-existing condition limitation does not apply to a covered person who is under the age of 19.

Preventive care -

Preventive care services to detect or prevent sickness that have an A or B rating in the current recommendations of the U.S. Preventive Services Task Force (USPSTF) are covered without cost sharing when provided by a network provider. The recommendations by the USPSTF for breast cancer screening, mammography and prevention issued prior to any recommendations issued in or around November 2009 will be considered current when applying this benefit. HHS will specify the recommendations for preventive services that apply for your plan year. You may be responsible for any preventive care services received, that are not specifically required by the Affordable Care Act.

Internal appeals and external review -

You have the right to an internal appeal and the right to request an external review of an adverse claim determination. If you have questions, you can call the Customer Care number on the back of your Humana ID card. We are available to help you Monday through Friday, 8 a.m. to 6 p.m.

Primary care physicians -

If your health plan requires you to select a primary care physician, a participating physician specializing in pediatrics is permitted to be selected as the primary care physician for a covered dependent child.

Gynecological and obstetrical services -

PATIENT PROTECTION AND AFFORDABLE CARE ACT RIDER (continued)

If a primary care physician referral is required by your health plan, a female covered person is permitted to receive services for obstetrical or gynecological care from a participating health care professional specializing in obstetrics or gynecology without a referral from her primary care physician. Services received from, or ordered by a participating health care professional for obstetrical or gynecological services, are considered authorization from the primary care physician.

Emergency care -

Coverage will be provided for an emergency medical condition in a hospital's emergency department:

- Without prior authorization;
- With the same restrictions on coverage for non-network providers as those applied for network providers;
- With the same cost-sharing requirements for non-network providers as those applied to network providers. In addition to the cost sharing requirements, you may be responsible for the difference between the allowed amount under your plan and what is billed by a non-network provider, as permitted by the Affordable Care Act;
- Without regard to any other terms or conditions of the policy other than exclusion; coordination of benefits, affiliation or waiting periods, or cost-sharing requirements.

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[Title of Officer]

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.