Humana National Preferred Silver 4250/6250 with Children's Dental

A PPO plan

Virginia

This plan is available for purchase in the following counties: Accomack, Alexandria City, Albemarle, Alleghany, Amelia, Arlington, Augusta, Bath, Bedford, Bland, Botetourt, Bristol, Brunswick, Buchanan, Buckingham, Caroline, Carroll, Charles City, Charlotte, Charlottesville City, Cheasapeake City, Chesterfield, Colonial Heights City, Craig, Culpeper, Cumberland, Dickenson, Dinwiddie, Essex, Fairfax, Fairfax City, Falls Church City, Fauquier, Floyd, Fluvanna, Franklin, Franklin City, Fredericksburg City, Galax City, Giles, Gloucester, Goochland, Grayson, Greene, Greensville, Hampton City, Hanover, Henrico, Henry, Highland, Hopewell City, Isle of Wright, James City, King and Queen, King George, King William, Lancaster, Lexington City, Loudoun, Louisa, Lunenburg, Madison, Martinsville City, Mathews, Mecklenburg, Middlesex, Montgomery, Nelson, New Kent, Newport News City, Norfolk City, Northampton, Northumberland, Norton City, Nottoway, Orange, Page, Patrick, Petersburg City, Poquoson City, Portsmouth City, Powhatan, Prince Edward, Prince George, Prince William, Pulaski, Radford, Rappahannock, Richmond, Richmond City, Roanoke, Roanoke City, Rockbridge, Russell, Salem, Scott, Smyth, Southampton, Spotsylvania, Stafford, Staunton City, Suffolk City, Surry, Sussex, Tazewell, Virginia Beach City, Washington, Waynesboro City, Westmoreland, Williamsburg City, Wise, Wythe, and York

About this plan

The Humana National Preferred Silver 4250/6250 Plan with Children's Dental is an easy-to-understand Preferred Provider Organization (PPO) health insurance plan that provides preventive services, essential health benefits and more. You have a broad network of healthcare providers to choose from, and you have the freedom to receive care from any in- or out-of-network doctor, specialist or hospital without a referral – even when you travel. However, your out-of-pocket costs are lower when you choose an in-network provider.

- The Humana National Preferred Silver 4250/6250 Plan with Children's Dental, a PPO plan, is a Qualified Health Plan insured by Humana Insurance Company.
- This plan provides all preventive services as well as all essential health benefits, including maternity and childbirth and pediatric dental.

Selecting your healthcare providers – When you enroll in the Humana National Preferred Silver 4250/6250 Plan with Children's Dental, you can receive care from any doctor, specialist or hospital you choose, but you will save more money by choosing an in-network provider.

- To find doctors, specialists and hospitals that are included in your network's select group, visit **Humana.com.** Humana's easy-to-use Physician Finder Plus will help you locate a healthcare professional.
  - If you live in the following counties: Accomack, Alexandria City, Albemarle, Alleghany, Amelia, Arlington, Augusta, Bath, Bedford, Bland, Botetourt, Bristol, Brunswick, Buchanan, Buckingham, Caroline, Carroll, Charles City, Charlotte, Charlottesville City, Cheasapeake City, Chesterfield, Colonial Heights City, Craig, Culpeper, Cumberland, Dickenson, Dinwiddie, Essex, Fairfax, Fairfax City, Falls Church City, Fauquier, Floyd, Fluvanna, Franklin, Franklin City, Fredericksburg City, Galax City, Giles, Gloucester, Goochland, Grayson, Greene, Greensville, Hampton City, Hanover, Henrico, Henry, Highland, Hopewell City, Isle of Wright, James City, King and Queen, King George, King William, Lancaster, Lexington City,

*Products will not be able to be quoted nor sold in counties with insufficient network coverage

Humana®

About this plan

Loudoun, Louisa, Lunenburg, Madison, Martinsville City, Mathews, Mecklenburg, Middlesex, Montgomery, Nelson, New Kent, Newport News City, Norfolk City, Northampton, Northumberland, Norton City, Nottoway, Orange, Page, Patrick, Petersburg City, Poquoson City, Portsmouth City, Powhatan, Prince Edward, Prince George, Prince William, Pulaski, Radford, Rappahannock, Richmond, Richmond City, Roanoke, Roanoke City, Rockbridge, Russell, Salem, Scott, Smyth, Southampton, Spotsylvania, Stafford, Staunton City, Suffolk City, Surry, Sussex, Tazewell, Virginia Beach City, Washington, Waynesboro City, Westmoreland, Williamsburg City, Wise, Wythe, or York, your network is called Humana/ChoiceCare Network PPO

Who can apply for this plan – Any individual or family can apply for this plan. There are only three requirements: You must live in the U.S., you must be U.S. citizens or nationals (or lawfully present), and you cannot be currently incarcerated. (http://www.healthcare.gov/marketplace/about/eligibility)

Date the plan starts – Depending on when you enroll, your start date can be as early as the first of the following month after you apply. The initial open enrollment period begins October 1, 2013 and extends through March 31, 2014. Coverage can begin as early as January 1, 2014.

Humana National Preferred Silver 4250/6250 Plan with Children's Dental

How this plan works

	In-network	Out-of-network
The combined medical, children's vision care and children's dental care deductible – The amount of covered expenses you'll pay out of your pocket before this plan begins to pay for covered services	Individual: $4,250 Family: $8,500	Individual: $8,500 Family: $17,000
The prescription drug deductible – The amount you'll pay out of your pocket before this plan begins to pay for prescription drugs	Individual: $1,500 Family: $3,000	Individual: $4,500 Family: $9,000
The out-of-pocket maximum – The maximum amount you're required to pay toward the covered cost of your healthcare; includes deductibles, coinsurance and copays; does not include premium	Individual: $6,250 Family: $12,500	Individual: $25,000 Family: $50,000
Important to know: › If your family is covered, your individual deductible and out-of-pocket accumulate to the individual and the family maximum. An individual covered family member will receive coinsurance benefits once they have met their individual deductible. The rest of the covered family members will receive coinsurance benefits once they have satisfied their individual deductible, or when the entire family deductible has been satisfied › Once you reach your out-of-pocket maximum, then this plan will pay 100% of all covered expenses. › Copays do not accumulate toward the deductible, but they do accumulate to the out-of-pocket maximum › Deductibles and out-of-pocket maximum start over each new calendar year		
Coinsurance – The percentage of covered healthcare costs you have to pay	You pay 20% of covered expenses after you pay your deductible	You pay 40% of covered expenses after you pay your deductible
Lifetime maximum – The total amount this plan will pay for covered expenses in your lifetime	Unlimited	

Humana National Preferred Silver 4250/6250 Plan with Children's Dental

How this plan works

The details below provide a general idea of covered benefits for this plan, yet don't explain everything. To be covered, expenses must be medically necessary and listed as covered in the policy. The policy is a document that outlines the benefits, provisions, and limitations of the plan. Please refer to the policy for this plan to learn more about the actual terms and conditions of the plan. This plan also has limitations and services that are not covered. You should know about these. See page 9 for details.

	In-network	Out-of-network
Preventive care › Child preventive services (birth thru age 6), including well office visits, immunizations, including flu and pneumonia, lab tests, preventive hearing and vision screening	This plan pays 100%	This plan pays 100%
› Includes well office visits, lab tests, X-rays, child immunizations (age 7 to 18), flu and pneumonia immunizations, Pap tests, mammograms, prostrate screening, endoscopic services and more	This plan pays 100%	You pay 40% after you pay your deductible
Diagnostic office visits › Concentra, a national healthcare company and subsidiary of Humana Inc., is in-network for this plan; to find a Concentra location near you, visit **Concentra.com**	This plan pays 100% after you pay a copay: • $25 for a primary care physician at a Concentra location • $35 for a primary care physician at a non-Concentra location • $60 for a specialist • $60 for an Urgent Care visit at a Concentra location • $100 for an Urgent Care visit at a non-Concentra location	You pay 40% after you pay your deductible
Diagnostic lab and X-rays – Includes allergy testing	This plan pays 100% of the first $500 per person per calendar year; then you pay 20% after you pay your deductible Excludes advanced imaging, pulmonary function studies, cardiac catheterization, EKG, ECG and EEG - You pay 20% for these services after you pay your deductible	You pay 40% after you pay your deductible
Emergency room	You pay 20% after you pay your deductible	
Ambulance	You pay 20% after you pay your deductible	
Hospital Stay › Inpatient • Facility fee (e.g. hospital room) • Physician/surgeon fees › Outpatient • Facility fee (e.g. ambulatory surgery center) • Physician/surgeon fees	You pay 20% after you pay your deductible	You pay 40% after you pay your deductible
Maternity › Prenatal and postnatal care › Delivery and other inpatient services	Benefit level is based upon the place of treatment (Inpatient, Outpatient, Clinic location)	

How this plan works

	In-network	Out-of-network
Transplants	You pay 20% when services are received from a Humana National Transplant Network provider after you pay your deductible	You pay 40% after you pay your deductible; plan pays up to $35,000 per transplant
Mental health (Mental illness and chemical and alcohol dependency) › Includes inpatient and outpatient services	Benefit level is based upon the place of treatment (Inpatient, Outpatient, Clinic location)	
Other medical services › Skilled nursing facility – up to 100 days per calendar year › Physical, and occupational therapy - combined, up to 30 visits per calendar year › Speech therapy - up to 30 visits per calendar year › Cognitive, audiology, cardiac, and respiratory therapy - visit limits do not apply › Spinal manipulations, adjustments, and modalities - up to 30 visits per calendar year › Home healthcare services - up to 100 visits per calendar year › Hospice Care › Private duty nursing in the home care setting - up to 1 visit per calendar year	You pay 20% after you pay your deductible	You pay 40% after you pay your deductible
Prescription drugs **Important to know:** › If you use an out-of-network pharmacy, you'll need to pay the full cost up front and then ask Humana to pay you back by submitting a claim › You pay a copay for each covered prescription fill or refill up to a 30-day supply › Find details about Humana's preferred mail-order service at **RightSourceRx.com** • Mail Order (up to 90 day supply): 2 times the retail copay › To find out what drugs are included in your plan, visit **Humana.com –** once there, an easy-to-use Rx Tool will help you learn more about this plan's prescription drug benefits; the prescription drug plan name is **Rx4 - EHB**	**1.** Your covered drug expenses are first applied to your deductible (unless a Level 1 drug – with these drugs you only have to pay your copay, no deductible) **2.** Once you've met your deductible, then you pay a copay: • $15 copay for Level 1: Covered low-cost generic and brand name drugs (These drugs are covered before meeting your deductible) • $35 copay for Level 2: Covered higher cost generic and brand name drugs • $50 for Level 3: Covered high cost, mostly brand name drugs • 50% for Level 4: Covered high-technology drugs – certain brand name drugs and self-administered injectable medications (Covered specialty drugs are 40% when purchased from a preferred network specialty drug pharmacy like **RightSourceRx.com)**	You pay 30% after you pay your copay and deductible; however, after the plan has paid its required portion, you are responsible for 100% of any additional charges

How this plan works

	In-network	Out-of-network
Children's vision care › Exam with dilation as necessary (limit 1 per year) › Eyeglass lenses (limit 1 per year) • Single • Bifocal • Trifocal • Lens options – standard polycarbonate and/or standard scratch coating › Contact lenses (limit 1 per year) • Choose from a selection of covered contact lenses • Medically necessary contacts › Frames • Choose from a selection of covered frames › Low vision • Supplemental testing (limit 1 every 2 years) • Vision aids (limit 1 every 3 years) - excludes video magnification aids (1 every 5 years) **Important to know:** › If you prefer contact lenses, this plan provides for a contact lens benefit in lieu of glass lenses; contact lens benefit is a one-time use per benefit frequency › If you buy a frame outside of the selection, this plan provides for a benefit up to the amount that would have been paid had you chosen a frame from the selection › Children, up to age 19, are covered under this plan › The above services are not all inclusive; see the plan policy for more details	You pay 50% after you pay your deductible	You pay 50% after you pay your deductible

How this plan works

	In-network	Out-of-network
Children's dental care	You pay 50% after you pay your deductible	You pay 50% after you pay your deductible

Diagnostic and preventive services

- Routine oral exams, periodontal exams, cleanings (limit 2 each per year)
- Bitewing X-rays (limit 2 sets per year, excludes full mouth and panoramic)
- Topical fluoride treatment (limit 2 per year)
- Sealant

Minor restorative services and surgical

- Prefabricated crowns (limit 1 per 5 years, primary teeth only)
- Fillings
- Simple oral surgery
  - Extractions

Major restorative services

- Resin onlays, inlays and crowns (limit 1 per tooth per 5 years, permanent teeth only)
- Root extraction

Important to know:

- Please see your medical schedule of benefits for complex oral surgery and medically necessary orthodontia benefit details
- There are more than 170,000 dentist locations in the Humana Dental PPO network; to find dentists in your area, visit **Humana.com**
- Children, up to age 19, are covered under this plan

Add extra benefits to your plan

The following dental benefits are available to you at an extra cost

Dental

Protect your healthy smile with affordable, easy-to-use optional dental benefits from one of the nation's largest dental insurers. For a low monthly premium, you can use a provider located in more than 170,000 dentist locations. Just choose the type of coverage that meets your needs:

- **Loyalty Plus** rewards members for loyalty by increasing benefits from years one to three, with increasing coverage on services like routine exams, root canals and crowns, a one-time deductible for as long as you are on the plan, and no copayments or waiting periods. You can go to the dentist you prefer with the comfort of knowing this plan pays the same percentage of the cost no matter which dentist you visit.
- **Traditional Plus** includes coverage for preventive, basic, and major services. You can go to network or non-network dentists, but you'll pay less when you choose dentists in the network.
- **Preventive Plus** covers the most common preventive and basic services. Discounts are available for major services and basic services the plan doesn't cover.
- **Preventive Plus Package for Veterans** is exclusively for U.S. Veterans. It provides dental coverage at 100% for many in-network dental preventive procedures, low deductibles, no copayments, and offers many extras such as discount on vision, hearing, prescriptions and clinic care services.
- **Dental Savings Plan Plus** is not insurance, but a discount plan that could save you 15-40% on many services, including dental, vision, Rx, hearing or alternative medicine.

Make your Humana plan fit your needs even better. Extra benefits are an easy and affordable way to get the coverage you need.

For more information, go to Humana.com or contact your sales agent.

Network agreements

Network providers agree to accept an agreed-upon amount as payment in full. Your policy explains your share of the cost of services rendered by network providers. It may include a deductible, a set amount (copayment), and a percent of the cost (coinsurance).

When you go to a network provider:

- The amount you pay is based on the agreed-upon amount.
- The provider can't "balance bill" you for charges greater than that amount.

When you go to an out-of-network provider:

- The amount you pay for is based on Humana's maximum allowable fee.
- The provider can balance bill you for charges greater than the maximum allowable fee. These charges don't apply to your out-of-pocket limit or deductible.

Limitations and Exclusions (things that are not covered)

This is an outline of the limitations and exclusions for the HumanaOne individual health plan listed above. It is designed for convenient reference. Consult the policy for a complete list of limitations and exclusions. Your policy is guaranteed renewable as long as premiums are paid. Other termination provisions apply as listed in the policy.

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

1. Services for care and treatment of non-covered procedures;
2. Services incurred before the effective date or after the termination date;
3. Services not medically necessary for diagnosis and treatment of a bodily injury or sickness, except for the specified routine preventive services;
4. Charges for prophylactic services including, but not limited to, prophylactic mastectomy or any other services performed to prevent a disease process from becoming evident in the organ tissue at a later date;
5. Services which are experimental, investigational or for research purposes, or related to such, whether incurred prior to, in connection with, or subsequent to the service which is experimental, investigational or for research purposes, other than medically necessary services received in an approved clinical trial, as determined by us. The fact that a service is the only available treatment for a condition may not make it eligible for coverage if we deem it to be experimental, investigational or for research purposes;
6. Complications directly related to a service that is not a covered expense under the policy because it was determined by us to be experimental, investigational or for research purposes or not medically necessary. Directly related means that the service occurred as a direct result of the experimental, investigational or for research purposes, other than medically necessary services received in an approved clinical trial, or not medically necessary service and would not have taken place in the absence of the experimental, investigational or for research purposes or not medically necessary service;
7. Charges in excess of the maximum allowable fee for the service;
8. Services exceeding the amount of benefits available for a particular service;
9. Services for treatment of complications of non-covered procedures or services;
10. Services relating to a sickness or bodily injury incurred as a result of the covered person:
    a. Being intoxicated, as defined by applicable state law in the state in which the loss occurred; or
    b. Being under the influence of narcotics unless administered or prescribed by a healthcare practitioner;
11. Services relating to a sickness or bodily injury as a result of:
    a. Intentionally self-inflicted bodily harm or attempted suicide whether sane or insane;
    b. War or an act of war, whether declared or not;
    c. Taking part in a riot;
    d. Engaging in an illegal occupation; or
    e. Any act of armed conflict, or any conflict involving armed forces or any authority;
12. Services:
    a. For charges which are not authorized, furnished or prescribed by a healthcare practitioner or healthcare treatment facility;
    b. For which no charge is made, or for which the covered person would not be required to pay if he/she did not have insurance, unless charges are received from and reimbursable to the United States government or any of its agencies as required by law;
    c. Furnished by or payable under any plan or law through a government or any political subdivision except Medicaid who is the payor of last resort, unless prohibited by law;
    d. Furnished while a covered person is confined in a hospital or institution owned or operated by the United States government or any of its agencies for any service-connected sickness or bodily injury;
    e. For charges received from a healthcare practitioner over the rate we would pay for the least costly provider;
    f. Which are not rendered or not substantiated in the medical records;
    g. Provided by an immediate family member;
    h. Rendered by a standby healthcare practitioner, surgical assistant, assistant surgeon, physician assistant, nurse or certified operating room technician unless medically necessary; or
    i. Performed in association with a non-covered service;
13. Any charges, including healthcare practitioner charges, which are incurred if a covered person is admitted to a hospital on a Friday or Saturday unless:
    a. The hospital admission is due to emergency care; and
    b. Treatment or surgery is performed on that same day;
14. Hospital inpatient services when the covered person is in observation status but not admitted as an inpatient;
15. Cosmetic services, or any complication therefrom except when such service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part;
16. Custodial care and maintenance care other than as provided under habilitative/rehabilitative services;
17. Ambulance services for routine transportation to, from or between medical facilities and/or a healthcare practitioner's office;
18. Elective medical or surgical procedures except elective sterilization procedures unless determined to be medically necessary, including tubal ligation and vasectomy;
19. Elective medical or surgical abortion unless:
    a. The pregnancy would endanger the life of the mother;
    b. The pregnancy is a result of rape or incest; or
    c. The fetus has been diagnosed with a lethal or otherwise significant abnormality;
20. Elective caesarean section delivery;
21. Reversal of sterilization;
22. Infertility services;
23. Sexual dysfunction;
24. Sex change services, regardless of any diagnosis of gender role or psychosexual orientation problems;
25. Vision examinations or testing for the purposes of prescribing corrective lenses; radial keratotomy; refractive keratoplasty; or any other surgery or procedure to correct myopia, hyperopia or stigmatic error; orthoptic treatment (eye exercises); or the purchase or fitting of eyeglasses or contact lenses, unless specified in the policy;
26. Dental services, appliances or supplies for treatment of the teeth, gums, jaws or alveolar processes including, but not limited to, excision of partially or completely unerupted impacted teeth, any oral or periodontal surgery and preoperative and post operative care, implants and related procedures, orthodontic procedures, and any dental services related to a bodily injury or sickness except as expressly provided in the policy;
27. Pre-surgical/procedural testing duplicated during a hospital confinement;
28. Any treatment for obesity, unless qualified as morbid obesity regardless of any potential benefits for co-morbid conditions, including but not limited to:
    a. Surgical procedures for obesity; or
    b. Complications related to any services rendered for weight reduction;
29. Surgical procedures for the removal of excess skin and/or fat in conjunction with or resulting from weight loss or a weight loss surgery;
30. Treatment of nicotine habit or addiction, including but not limited to, nicotine patches, hypnosis, smoking cessation classes, tapes, or electronic media except as eligible for coverage under preventive services;
31. Educational or vocational training or therapy, services, and schools including but not limited to videos and books;
32. Foot care services (other than medically necessary for diabetes, vascular disease or due to capsular or bone surgery) including but not limited to:
    a. Shock wave therapy of the feet;

b. Treatment of weak, strained, flat, unstable or unbalanced feet;
c. Hygienic care, and the treatment of superficial lesions of the feet, such as corns, calluses or hyperkeratosis;
d. Tarsalgia, metatarsalgia or bunion treatment, except surgery which involves exposure of bones, tendons or ligaments;
e. Cutting of toenails, except removal of nail matrix; and
f. Arch supports, heel wedges, lifts, shoe inserts, the fitting or provision of foot orthotics or orthopedic shoes, unless medically necessary because of diabetes or hammertoe;

33. Hair prosthesis, hair transplants or implants;
34. Hearing care that is routine, including but not limited to exams and tests, any artificial hearing device, auditory prostheses or other electrical, digital, mechanical or surgical means of enhancing, creating or restoring auditory comprehension;
35. Services rendered in a premenstrual syndrome clinic or holistic medicine clinic;
36. Transplant services except as expressly provided in the policy;
37. Charges for growth hormones (drugs, medications or hormones to stimulate growth), unless medically necessary;
38. Over the counter medical items or supplies that can be provided or prescribed by a healthcare practitioner but are also available without a written order or prescription except for preventive services;
39. Immunizations including those required for foreign travel for covered persons of any age except as expressly provided in the policy;
40. Treatment for any jaw joint problem, including but not limited to, temporomandibular joint disorder, craniomaxillary disorder, craniomandibular disorder, head and neck neuromuscular disorder or other conditions of the joint linking the jaw bone and skull unless required due to a medical condition or injury which prevents normal function of the joint or bone and is medically necessary to attain functional capacity of the affected part;
41. Genetic testing, counseling or services except as expressly provided in the Maternity services and Preventive services provisions of the policy;
42. Covered expense to the extent of any amount received from Workers' Compensation;
43. Expense for employment, school, sports or camp physical examinations or for the purpose of obtaining insurance, premarital tests/ examinations;
44. Services received in an emergency room unless required because of emergency care;
45. Any expense incurred for services received outside of the United States except as required by law for emergency care services;
46. Services received during an inpatient stay when the stay is primarily related to behavioral, social maladjustment, lack of discipline or other antisocial actions which are not specifically the result of mental health;
47. Services and supplies which are:
    a. Rendered in connection with mental illnesses not classified in the International Classification of Diseases of the U.S. Department of Health and Human Services;
    b. Extended beyond the period necessary for evaluation and diagnosis of learning and behavioral disabilities or for mental retardation; and
    c. Specifically excluded is marriage counseling;
48. No benefits will be provided for:
    a. Immunotherapy for recurrent abortion;
    b. Chemonucleolysis;
    c. Biliary lithotripsy;
    d. Home uterine activity monitoring;
    e. Light treatment for Seasonal Affective Disorder (S.A.D.);
    f. Immunotherapy for food allergy;
    g. Prolotherapy;
    h Cranial banding, unless otherwise determined by us;
    i. Hyperhydrosis surgery; and
    j. Sensory integration therapy;
49. Services or supplies provided in connection with a sickness or bodily injury arising out of, or sustained in the course of, any occupation, employment or activity for compensation, profit or gain, whether or not benefits are available under Workers' Compensation except as expressly provided in the policy. This exclusion does not apply to services or supplies received by a covered person qualifying as a sole proprietor, officer or partner under the laws of that state, and such benefits are not covered under any Workers' Compensation plan, provided he or she is not covered under a Workers' Compensation plan, and he or she is not engaged in the following professions or activities: air craft operations, armed forces, pilots;
50. Court-ordered mental health services;
51. Charges for alternative medicine, including medical diagnosis, treatment and therapy. Alternative medicine services includes, but is not limited to:
    a. Acupressure;
    b. Acupuncture;
    c. Aromatherapy;
    d. Ayurveda;
    e. Biofeedback;
    f. Faith healing;
    g. Guided mental imagery;
    h. Herbal medicine;
    i. Holistic medicine;
    j. Homeopathy;
    k. Hypnosis macrobiotic;
    l. Massage therapy;
    m. Naturopathy;
    n. Ozone therapy;
    o. Reflexotherapy;
    p. Relaxation response;
    q. Rolfing;
    r. Shiatsu; and
    s. Yoga;
52. Private duty nursing services except as expressly provided in the policy;
53. Living expenses, travel, transportation, except as expressly provided in the "Ambulance services" provision or "Transplants" provision in the "Your Policy Benefits" section of the policy; and
54. Charges for services that are primarily and customarily used for a non-medical purpose or used for environmental control or enhancement (whether or not prescribed by a healthcare practitioner) including but not limited to:
    a. Common household items such as air conditioners, air purifiers, water purifiers, vacuum cleaners, waterbeds, hypoallergenic mattresses or pillows, or exercise equipment;
    b. Scooters or motorized transportation equipment, escalators, elevators, ramps, modifications or additions to living/working quarters or transportation vehicles;
    c. Personal hygiene equipment including bath/shower chairs, transfer equipment or supplies or bed side commodes;
    d. Personal comfort items including cervical pillows, gravity lumbar reduction chairs, swimming pools, whirlpools or spas or saunas;
    e. Medical equipment including blood pressure monitoring devices, PUVA lights and stethoscopes;
    f. Charges for any membership fees or program fees paid by a covered person, including but not limited to, health clubs, health spas, aerobic and strength conditioning, work-hardening programs and weight loss or similar programs, and any related material or products related to these programs;
    g. Communication system, telephone, television or computer systems and related equipment or similar items or equipment; and
    h. Communication devices except after surgical removal of the larynx or a diagnosis of permanent lack of function of the larynx.

Prescription Drug Exclusions

1. Contraceptives, including oral and transdermal, whether medication or device, when prescribed for purpose(s) other than to prevent pregnancy;
2. Growth hormones (medications, drugs or hormones to stimulate growth) for idiopathic short stature or any other condition unless there is a laboratory confirmed diagnosis of growth hormone deficiency, or as otherwise determined by us;
3. Drugs which are not included on the drug lists;
4. Dietary supplements except enteral formulas and nutritional supplements and nutritional products for the treatment of phenylketonuria (PKU), inborn errors of amino acid or organic acid metabolism, metabolic abnormality or severe protein or soy allergies or certain other inherited metabolic disease;
5. Fluoride supplements;
6. Minerals;
7. Herbs and vitamins;
8. Legend drugs which are not deemed medically necessary by us;
9. Any drug prescribed for a sickness or bodily injury not covered under the policy;
10. Any drug prescribed for intended use other than for:
    a. Indications approved by the FDA;
    b. Off-label indications recognized through peer-reviewed medical literature;
11. Any amount exceeding the default rate;
12. Any drug, medicine or medication that is either:
    a. Labeled "Caution-limited by Federal law to investigational use"; or
    b. Experimental, investigational or for research purposes, even though a charge is made to the covered person;
13. Allergen extracts except as provided in a healthcare practitioner's office or facility;
14. The administration of covered medication(s);
15. Therapeutic devices or appliances, including but not limited to:
    a. Hypodermic needles and syringes except needles and syringes for use with insulin, and self-administered injectable drugs whose coverage is approved by us;
    b. Support garments;
    c. Test reagents;
    d. Mechanical pumps for delivery of medication; and
    e. Other non-medical substances;
16. Anabolic steroids;
17. Anorectic or any drug used for the purpose of weight control;
18. Abortifacients (drugs used to induce abortions);
19. Any drug used for cosmetic purposes, including but not limited to:
    a. Tretinoin, e.g. Retin A, except if the covered person is under the age of 45 or is diagnosed as having adult acne;
    b. Dermatologicals or hair growth stimulants; or
    c. Pigmenting or de-pigmenting agents, e.g. Solaquin;
20. Any drug or medicine that is:
    a. Lawfully obtainable without a prescription (over the counter drugs), except insulin; or drugs, medicines or medications on the Women's Healthcare Drug List with a prescription from a healthcare practitioner;
    b. Available in prescription strength without a prescription;
21. 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;
22. Progesterone crystals or powder in any compounded dosage form, unless otherwise determined by us;
23. Infertility services including medications;
24. Any drug prescribed for impotence and/or sexual dysfunction, e.g. Viagra;
25. Any drug, medicine or medication that is consumed or injected at the place where the prescription is given or dispensed by the healthcare practitioner;
26. Drug delivery implants;
27. Treatment for Onychomycosis (nail fungus);
28. Prescriptions that are to be taken by or administered to the covered person, in whole or in part, while he/she is 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:
    a. Hospital;
    b. Skilled nursing facility; or
    c. Hospice facility;
29. Injectable drugs, including but not limited to:
    a. Immunizing agents unless otherwise determined by us;
    b. Biological sera;
    c. Blood;
    d. Blood plasma;
    e. Self-administered injectable drugs or specialty drugs for which coverage is not approved by us; or
    f. Flu and pneumonia vaccines;
30. Prescription refills:
    a. In excess of the number specified by the healthcare practitioner; or
    b. Dispensed more than one year from the date of the original order;
31. Any portion of a prescription or refill that exceeds a 90-day supply when received from either a mail-order pharmacy or from a retail pharmacy that participates in our program which allows a covered person to receive a 90-day supply of a prescription or refill;
32. Any portion of a prescription or refill that exceeds a 30-day supply when received from a retail pharmacy that does not participate in our program which allows a covered person to receive a 90-day supply of a prescription or refill;
33. Any portion of a specialty drug or self-administered injectable drug that exceeds a 30-day supply, unless otherwise determined by us;
34. Any drug for which preauthorization and notification or step therapy is required, as determined by us, and not obtained;
35. Any drug for which a charge is customarily not made;
36. Any portion of a prescription or refill that:
    a. Exceeds our drug specific dispensing limit (i.e. IMITREX);
    b. Is dispensed to a covered person whose age is outside the drug specific age limits defined by us;
    c Is refilled early, as defined by us; or
    d. Exceeds the duration-specific dispensing limit;
37. Any drug, medicine or medication received by the covered person:
    a. Before becoming covered under this benefit or after the Grace period; or
    b. After the date the covered person's coverage under the policy has ended;
38. Any costs related to the mailing, sending or delivery of prescription drugs;
39. Any intentional misuse of this benefit, including prescriptions purchased for consumption by someone other than the covered person;
40. Any prescription or refill for drugs, that are spilled, spoiled or damaged;
41. Any drug, medication, or supply to eliminate or reduce a dependency on or addiction to tobacco and tobacco products except as eligible for coverage under preventive services;
42. Any drug or biological that has received designation as an orphan drug unless approved by us; and
43. Any amount the covered person 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.

Pediatric Dental Care Limitations and Exclusions

1. Any expense arising from the completion of forms;
2. Any expense due to a covered person's failure to keep an appointment;
3. Any expense for a service we consider cosmetic, unless it is due to an accidental dental injury;
4. Expenses incurred for:
   a. Precision or semi-precision attachments;
   b. Overdentures and any endodontic treatment associated with overdentures;
   c. Other customized attachments;
   d. Any services for 3D imaging (cone beam images);
   e. Temporary and interim dental services; or
   f. Additional charges related to materials or equipment used in the delivery of dental care;
5. Charges for services rendered by a family member or person who resides with the covered person;
6. Any service related to:
   a. Altering vertical dimension of teeth or changing the spacing and/or shape of the teeth;
   b. Restoration or maintenance of occlusion;
   c. Splinting teeth, including multiple abutments, or any service to stabilize periodontally weakened teeth;
   d. Replacing tooth structures lost as a result of abrasion, attrition, erosion, or abfraction; or
   e. Bite registration or bite analysis;
7. Infection control, including but not limited to, sterilization techniques;
8. Expenses incurred for services performed by someone other than a dentist, except for scaling and teeth cleaning and the topical application of fluoride, which can be performed by a licensed dental hygienist. The treatment must be rendered under the supervision and guidance of the dentist in accordance with generally accepted dental standards;
9. Any hospital, surgical or treatment facility, or for services of an anesthesiologist or anesthetist;
10. Prescription drugs or pre-medications, whether dispensed or prescribed;
11. Any service that:
    a. Is not eligible for benefits based on the clinical review;
    b. Does not offer a favorable prognosis;
    c. Does not have uniform professional acceptance; or
    d. Is deemed to be experimental or investigational in nature;
12. Orthodontic services, unless specified in the "Pediatric Dental Care Benefit" section;
13. Repair and replacement of orthodontic appliances;
14. Preventive control programs including, but not limited to, oral hygiene instructions, plaque control, take-home items, prescriptions and dietary planning;
15. Replacement of any lost, stolen, damaged, misplaced or duplicate major restoration, prosthesis or appliance; or
16. Any caries susceptibility testing, laboratory tests, saliva samples, anaerobic cultures, sensitivity testing or charges for oral pathology procedures.

Pediatric Vision Care Limitations and Exclusions

1. Orthoptic or vision training and any associated supplemental testing;
2. Two or more multiple pair of glasses, in lieu of bifocals or trifocals;
3. Medical or surgical treatment of the eye, eyes or supporting structure;
4. Any services and/or materials required by an employer as a condition of employment;
5. Safety lenses and frames;
6. Contact lenses, when benefits for frames and lenses are received;
7. Oversized 61 and above lens or lenses;
8. Cosmetic items;
9. Any services or materials not listed in the "Pediatric Vision Care Benefit" section or "Schedule of Benefits";
10. Expenses for missed appointments;
11. Any charge from a providers' office to complete and submit claim forms;
12. Treatment relating to or caused by disease;
13. Non-prescription materials or vision devices;
14. Costs associated with securing materials;
15. Pre- and post-operative services;
16. Orthokeratology;
17. Routine maintenance of materials;
18. Refitting or change in lens design after initial fitting;
19. Artistically painted lenses; or
20. Premium lens options.

This document contains a general summary of covered benefits, exclusions, and limitations. Please refer to the policy for the actual terms and conditions that apply. In the event there are discrepancies with the information given in this document, the terms and conditions of the policy will apply.

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