

HumanaOne

Individual Health Insurance

Individual Health Plan
College Graduate Health Plan
Pre-Employment Health Plan

Summary of Benefits

Arizona



ARIZONA

		Plan pays for services at PARTICIPATING providers	Plan pays for services at NONPARTICIPATING providers
Preventive Care	<ul style="list-style-type: none"> Routine physical exam (1), (2) Routine immunizations (to age 18) (1), (2) Routine Pap smears (1), (2), (3) PSA (1), (2), (3) 	80%	Not covered
	<ul style="list-style-type: none"> Mammogram (3) 	80%	60% after deductible
	<ul style="list-style-type: none"> Routine lab, pathology and X-ray (1) 	80% after deductible	Not covered
Physician Services	<ul style="list-style-type: none"> Office visits (includes diagnostic lab and X-ray) Allergy testing, injections and serum Inpatient and outpatient services (4) 	80% after deductible	60% after deductible
Hospital Services	<ul style="list-style-type: none"> Inpatient care Outpatient surgery – facility (4) Diagnostic tests, lab and X-rays (nonsurgical) 	80% after deductible	60% after deductible
	<ul style="list-style-type: none"> Emergency room (including physician visits) 	80% after \$75 copayment per visit and deductible (copayment waived if admitted)	60% after \$75 copayment per visit and deductible (copayment waived if admitted)
Prescription Drugs (10)	<ul style="list-style-type: none"> Prescription drug deductible (8) 	\$500 prescription drug deductible per individual	\$500 prescription drug deductible per individual
	<ul style="list-style-type: none"> Benefit for each prescription or refill (up to 30-day supply) <ul style="list-style-type: none"> – Level One 	100% after: \$10 copayment after prescription drug deductible	70% after: \$10 copayment after prescription drug deductible
	<ul style="list-style-type: none"> – Level Two 	\$30 copayment after prescription drug deductible	\$30 copayment after prescription drug deductible
	<ul style="list-style-type: none"> – Level Three 	\$50 copayment after prescription drug deductible	\$50 copayment after prescription drug deductible
	<ul style="list-style-type: none"> – Level Four 	25% copayment after prescription drug deductible up to \$2,500 maximum out-of-pocket per calendar year	25% copayment after prescription drug deductible up to \$2,500 maximum out-of-pocket per calendar year
	<ul style="list-style-type: none"> Mail order (90-day supply) 	100% after three times the retail copayment	100% after three times the retail copayment
Other Medical Services	<ul style="list-style-type: none"> Skilled nursing facility (up to 30 days per calendar year) (5) Home health care (5) Durable medical equipment (5) Hospice (5), (6) Physical and speech therapy, chiropractic services (up to combined maximum of 20 visits per calendar year) 	80% after deductible	60% after deductible
	<ul style="list-style-type: none"> Ambulance (up to \$15,000 maximum per calendar year) 	80% after deductible	80% after deductible
	<ul style="list-style-type: none"> Transplant services (organ) (5) 	80% after deductible (when services are at a National Transplant Network provider)	60% after deductible (subject to separate out-of-pocket maximum of \$35,000 per calendar year)
	<ul style="list-style-type: none"> Outpatient mental health maximum reduces inpatient mental health maximum Inpatient (up to \$2,500 maximum per calendar year) Outpatient therapy (up to \$500 maximum per calendar year) 	50% after deductible	50% after deductible
Maximum Out-of-Pocket Expense (7), (8)	<ul style="list-style-type: none"> Individual (must be satisfied by each covered person) 	\$2,000	\$8,000

ARIZONA

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Annual Deductible (7), (8)	<ul style="list-style-type: none"> Annual amount (does not apply to maximum out-of-pocket expense) 	Single Deductible	Family Deductible (9)	Single Deductible	Family Deductible (9)
		\$ 500	\$ 1,500	\$1,000	\$ 3,000
		1,000	3,000	2,000	6,000
		2,500	5,000	5,000	10,000
		5,000	10,000	10,000	20,000
Lifetime Maximum		\$5,000,000 per covered person			
Optional Benefits (not available for HumanaOne College Graduate and Pre-employment Health Plans) (11)	<ul style="list-style-type: none"> Prescription coverage no deductible Maternity (benefits payable after 270 day waiting period) (8) Office visit copayment option (includes office diagnostic tests, lab and X-rays, up to \$100 per calendar year) (12) 	Under this option, no deductible is required to be met before plan benefits are payable.			
		60% after \$500 maternity deductible		40% after \$1,000 maternity deductible	
		100% after \$25 copayment for primary care physician and \$40 copayment for specialist, limited to four combined visits (primary care physician/specialist) per calendar year. After four visits are met, plan pays 80% after deductible.		60% after deductible	

To be covered, services must be medically necessary and specified as covered. Please see your Policy for more information on medical necessity and other specific plan benefits.

- (1) Benefits payable after 90-day waiting period for preventive care and 12-month waiting period for mental health.
- (2) Up to a combined maximum of \$240 per person per calendar year.
- (3) Age and/or frequency limits apply.
- (4) Outpatient benefits payable after 90-day waiting period for nonemergency removal of tonsils and/or adenoids, and 180-day waiting period for nonemergency surgical treatment for bunions, varicose veins, hemorrhoids or hernia (does not include strangulated or incarcerated hernia).
- (5) Prior authorization required in order to be eligible for these benefits.
- (6) Bereavement limited to 15 visits per family per lifetime, Medical Social Services limited to \$100 per family per lifetime.
- (7) When you obtain care from nonparticipating providers:
 - 50 percent of your payment toward the deductible is credited to the deductible for participating providers.
 - 50 percent of your out-of-pocket costs are credited to the out-of-pocket maximum for participating providers.
 Once you meet your deductible and out-of-pocket expense limits, the plan pays 100 percent for covered services. Participating provider covered expenses are not credited to the nonparticipating provider deductible or out-of-pocket maximum.
- (8) Copayments do not apply to deductible or out-of-pocket maximum. The out-of-pocket maximum does not apply to transplant services from nonparticipating providers, prescription drugs, mental health services or maternity services if optional maternity benefit is selected.
- (9) Two or three family members must meet their individual deductibles, depending on the deductible amount selected.
- (10) If a nonparticipating pharmacy is used you must pay 100 percent of the actual charges and file a claim with Humana for reimbursement.
- (11) These benefits are optional and can be added to your plan for an additional cost.
- (12) This benefit does not cover MRI, CAT, EEG, EKG, ECG, cardiac catheterization or pulmonary function studies. Primary care physicians include family practitioner, general practitioner, pediatrician or internist; Specialist includes any other participating physician. Please contact Customer Service for details.

For information regarding the state mandated high and low plans, please call (800) 833-6916.

Payments - Plan benefits are paid based on the maximum allowable fee, as defined in your policy. Participating providers agree to accept the maximum allowable fee, as listed in negotiated payment schedules, as payment in full.

For services rendered by nonparticipating providers, the member is responsible for charges exceeding the maximum allowable fee as explained in your policy.

Participating primary care and specialist physicians and other providers in Humana's networks are not the agents, employees or partners of Humana or any of its affiliates or subsidiaries. They are independent contractors. Humana is not a provider of medical services. Humana does not endorse or control the clinical judgement or treatment recommendations made by the physicians or other providers listed in network directories or otherwise selected by you.

Disease Management

Humana's member-focused programs span a health continuum, from preventive care and education to supportive case management for individuals with certain diseases or chronic conditions. Our goal is to facilitate access to care and decision-making for all members, empowering them with knowledge and the appropriate tools to meet their needs regardless of health status.

HumanaBeginnings®

HumanaBeginnings is a prenatal education and case management program designed to encourage healthy practices during pregnancy, and as a result, reduce the incidence of infants born prematurely or at a low birth weight. Registered nurses assess pregnant members and provide education and follow-up evaluations for all eligible participants.

Personal Nurse®

Personal Nurse provides guidance to resources and tools to help members manage their condition and understand their health care options. The service is available to members who we believe may benefit most from additional support.

Value-Added Services

Humana.com

Humana's award-winning Web site, www.humana.com, makes insurance information more convenient and accessible. Humana.com offers access to the information you need, 24 hours a day, seven days a week. It offers valuable features like:

- **Physician Finder Plus.** Select Humana/ChoiceCare Network and check to see if your physician or hospital is included. You can perform a search by name, specialty or location, and even obtain directions to the doctor's office.
- **Prescription Drug Services and Information.** Enter a drug name and search for drug alternatives that could save you money and identify possible dangerous drug interactions.
- **Pharmacy Locator.** Find in-network pharmacies anywhere in the U.S.
- **Health and Wellness Center.** Take advantage of our online assessments, interactive tools and member newsletter. This center is also the place to learn about Humana's health management programs.

Prescription Drug Coverage

Humana's pharmacy benefit includes both generic and brand-name drugs. It even includes coverage for many of the more progressive, high-technology drugs.

Humana Inc. is one of the nation's largest publicly traded health benefits companies, with approximately 6.4 million medical members located primarily in 18 states and Puerto Rico. Humana offers coordinated health insurance coverage and related services through traditional and Internet-based plans to individuals, employer groups, and government-sponsored plans.

This document and accompanying materials contain a general summary of benefits, exclusions and limitations. Please refer to the policy for 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 govern.



Limitations and Exclusions

Pre-Existing Conditions

If a covered person received medical attention for any disease, illness, sickness, malady or condition which was diagnosed or treated by a provider, or produced symptoms which would have caused an ordinarily prudent person to seek medical diagnosis or treatment, within six (6) months prior to the covered person's effective date, such condition will be subject to the "Pre-existing condition exclusion" section that is described in this provision.

The pre-existing condition exclusion will not exceed 12 months from the date benefits for a covered person take effect.

A diagnosis is not required for a condition to be a pre-existing condition. Genetic information, in itself, is not considered a condition.

For the following dependents, the pre-existing condition exclusion will not apply, if they are added to coverage within 31 days of the:

- Birth of a newborn child; or
- Legal adoption of a child, including a child placed with you for the purpose of adoption.

Pre-existing condition exclusion

We will not pay benefits for services rendered for pre-existing conditions, unless those conditions were fully disclosed on the application for this policy and benefits relating to those conditions are not specifically excluded.

Any conditions not disclosed on the application may result in rescission or modification of benefits. Rescission means that coverage is void from the effective date.

Medical Limitations & Exclusions

This policy does not provide benefits for:

- Services not medically necessary for diagnosis and treatment of a bodily injury or sickness;
- Any service which is experimental, investigational, or for research purposes, except for patient costs directly associated with a cancer clinical trial that is performed at a study site in Arizona will be covered if otherwise covered under the policy as required by state law;
- Services:
 - Not furnished by a health care practitioner or health care treatment facility;
 - Not authorized or prescribed by a health care practitioner;
 - For which no charge is made, or for which the covered person would not be required to pay if they did not have this insurance, unless charges are received from and reimbursable to the United States government or any of its agencies as required by law;
 - Furnished by or payable under any plan or law through a government or any political subdivision, unless prohibited by law;
 - 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;
 - Which are not rendered or not substantiated in the medical records;
 - That are not listed as a covered expense;

- Provided by a person who ordinarily resides in the covered person's home or who is a family member;
- That are performed in association with a service that is not covered under this policy;
- That are billed separately as professional services, when the procedure requires only a technical component (CPT code) that gives a numerical or self-explanatory result and does not require professional intervention or interpretation; or
- That are billed incorrectly or billed separately, but are an integral part of another billed service, as determined by us;
- Charges in excess of the maximum allowable fee for the service;
- Pre-existing conditions to the extent specified in this policy;
- Any expense incurred before the covered person's effective date under this policy or after the date the covered person's coverage under this policy terminates;
- Any expense incurred exceeding any policy benefit maximum;
- Cosmetic surgery or any complication therefrom, unless for reconstructive surgery:
 - Resulting from:
 - A bodily injury, infection or other disease of the involved part, when functional impairment is present; or
 - Congenital disease or anomaly of a covered dependent child; or
 - For a covered person, who is receiving benefits in connection with a mastectomy for:
 - Reconstructive surgery of the breast on which the mastectomy has been performed; and
 - Surgery and reconstruction of the other breast to achieve symmetrical appearance;

A functional impairment is defined as a direct measurable reduction of physical performance of an organ or body part. The presence of a psychological condition will not entitle a covered person to coverage for cosmetic surgery, plastic or reconstructive surgery, unless it is for the conditions or surgery described above;

- Custodial care and maintenance care;
- Any drug, medicine, or device which does not have the United States Food and Drug Administration formal market approval through a New Drug Application, Premarket Approval, or 510K (an exception may be allowed for orphan drugs when approved by us);
- Contraceptives, including implant systems and devices, regardless of the purpose(s) for which prescribed. See the "Supplemental benefit prescription drugs" for coverage of oral contraceptives;
- Medications, drugs or hormones to stimulate growth, unless there is a laboratory confirmed diagnosis of growth hormone deficiency;
- Prescription drugs, except drugs, medicines, or medications that are:
 - Provided to, or administered to, a covered person:
 - While confined as a bed patient in a hospital or skilled nursing facility;
 - By a health care practitioner during an office visit; or
 - By a home health care agency;

(See the "Supplemental benefit prescription drugs" for prescription drug benefits.)

- Vitamins, dietaries, and any other nonprescription supplements;
- Infertility services;
- Treatment of normal pregnancy and well baby expenses, unless provided in this policy;

- Elective medical or surgical abortion, reversal of elective sterilization, or any service associated with gender reassignment or sexual dysfunction or inadequacy or to enhance sexual performance or desire;
- Eye refractive disorders, eyeglass frames and lenses or contact lenses, radial keratotomy, laser or lasik and any other surgery to correct myopia, hyperopia or stigmatic error, vision therapy, or orthoptic treatment (eye exercises), unless specifically described in this policy;
- Routine physical examination for occupation, employment, school, travel, the purchase of insurance, or premarital tests/examinations;
- Routine hearing or eye exams;
- Dental services, appliances or supplies for treatment of the teeth, gums, jaws or alveolar processes, including but not limited to, any oral or periodontal 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 indicated in this policy;
- Any loss contributed to, or caused, by:
 - War or any act of war, whether declared or not; or
 - Any act of armed conflict, or any conflict involving armed forces of any authority;
- The treatment of mental disorders, chemical or alcohol dependence unless shown in the "Supplemental benefit mental health" provision;
- Private duty nursing;
- Loss due to commission or attempt to commit a civil or criminal battery or felony;
- Services rendered by a standby physician or assistant surgeon, unless medically necessary;
- 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;
- Treatment of obesity, unless qualified as morbid obesity (clinically severe obesity);
- Treatment of nicotine habit or addiction, including, but not limited to, nicotine patches, hypnosis, smoking cessation classes or tapes;
- Educational or vocational therapy, services and schools, including, but not limited to, videos and books;
- Foot care services, unless otherwise indicated in this policy, including:
 - Care and treatment of:
 - Weak, strained, flat, unstable or unbalanced feet;
 - Superficial lesions of the feet, such as corns, calluses or hyperkeratoses;
 - Tarsalgia, metatarsalgia or bunion, except surgery which involves exposure of bones, tendons or ligaments; and
 - Toenails, except removal of nail matrix; and
 - Arch supports, heel wedges, lifts, the fitting or provision of foot orthotics or orthopedic shoes, except as an integral part of a brace;
 - Communications or travel time;
 - Lodging accommodations or transportation, except as specified in this policy;
 - 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 physician) including, but not limited to:
 - Common household items such as air conditioners, air purifiers, vacuum cleaners, waterbeds, hypoallergenic mattresses or exercise equipment;
 - Scooters or motorized transportation equipment, escalators, elevators, ramps, or modifications or additions to living/working quarters or transportation vehicles;
 - Personal hygiene equipment such as bath/shower chairs, or bed side commodes;
 - Personal comfort items such as cervical pillows, gravity lumbar reduction chairs, swimming pools, whirlpools, or spas;
 - Professional medical equipment such as blood pressure kits, breast pumps, PUVA lights, and stethoscopes;
 - Personal computers and related equipment or other similar items or equipment; or
 - Communication devices, except after surgical removal of the larynx or a diagnosis of permanent lack of function of the larynx;
- Light treatments for Seasonal Affective Disorder (S.A.D.);
- Charges for health clubs or health spas, aerobic and strength conditioning, work-hardening programs, and all related material and products for these programs;
- Hearing aids, hair prosthesis, hair transplants or implants, and wigs;
- Sleep therapy or services rendered in a premenstrual syndrome clinic or holistic medicine clinic;
- Any charges, including health care practitioner charges, which are incurred if a covered person is admitted to a hospital on a Friday or Saturday unless:
 - The hospital admission is due to emergency care; or
 - Treatment or surgery is performed on that same day;
- Hospital inpatient services when a covered person is in observation status;
- Alternative medicine;
- Marital counseling;
- Transplant services, except as specified in this policy;
- Routine immunizations, unless otherwise specified in this policy;
- Immunizations, including those required for foreign travel for covered persons of any age, unless otherwise specified in this policy;
- 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;
- Treatment of any bodily injury or sickness that is arising from, or sustained in the course of, any occupation or employment for compensation, profit or gain 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 or similar law and lawfully chose not to be;
- Services for any condition excluded by rider under this policy;
- Genetic testing, counseling or services;
- 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 a mental disorder;
- Treatment as a result of attempted suicide or intentionally self-inflicted injury, whether sane or insane;
- Charges for which there is automobile or liability insurance providing medical payments; or
- Services associated with a Phase I trial for the treatment, palliation or prevention of cancer when the service is received outside the state of Arizona.

Hospice Care Limitations

Covered expenses for hospice care benefits do not include expenses for the following services:

- Private duty nursing when confined in a hospice facility;
- Services relating to a confinement not required for acute pain control or other treatment for an acute phase of chronic symptom management;
- Funeral arrangements;
- Financial or legal counseling, including estate planning or drafting of a will;
- Homemaker or caretaker services, including:
 - Sitter or companion services;
 - Housecleaning; and
 - Household maintenance;
- Services of a social worker other than a licensed clinical social worker;
- Services by volunteers or persons who do not regularly charge for their services;
- Services by a licensed pastoral counselor to a member of his or her congregation. These are services in the course of the duties to which he or she is called as a pastor or minister; or
- Bereavement counseling services.

Transplant Benefit Exclusions

No benefit is payable for, or in connection with a transplant which is not identified in the policy as a covered organ transplant.

We do not pay benefits for, or in connection with, a covered organ transplant if:

- It is experimental, investigational, or for research purposes;
- We are not contacted for authorization prior to referral for evaluation of the covered organ transplant, unless such authorization is waived by us;
- We do not approve coverage for the covered organ transplant, based on our established criteria;
- Expenses are eligible to be paid under any private or public research fund, government program (except Medicaid), or another funding program, whether or not such funding was applied for, or received;
- The expense relates to the transplantation of any non-human organ or tissue, unless otherwise stated in this policy;
- The expense relates to the donation or acquisition of an organ for a recipient who is not a covered person under this policy;
- A denied transplant is performed; this includes the pre-transplant evaluation, the transplant procedure, follow up care, immunosuppressive drugs, and complications of such transplant;
- The covered person, for whom a covered organ transplant is requested, has not met pre-transplant criteria as established by us; or
- Expenses related to the storage of cord blood and stem cells unless the storage is an integral part of a covered organ transplant of bone marrow approved by us.

Coinurance related out-of-pocket expenses paid for transplant services (organ) received from a non-participating transplant provider only accumulate toward and are subject to the coinsurance out-of-pocket limit for non-participating transplant providers.

Prescription Drug Limitations & Exclusions

Expense incurred will not be payable under this benefit for the following non-covered expenses:

- Legend drugs which are not recommended and not deemed necessary by a health care practitioner;
- Any drug prescribed for intended use other than for:
 - Indications approved by the FDA; or
 - Recognized off-label indications through peer-reviewed medical literature;
- Any drug prescribed for a sickness or bodily injury not covered under this policy;
- Any drug, medicine or medication labeled "Caution - Limited by Federal Law to Investigational Use" or any experimental drug, medicine or medication, except for patient costs directly associated with a cancer clinical trial that is performed at a study site in Arizona will be covered if otherwise covered under the policy as required by state law;
- Allergen extracts;
- Therapeutic devices or appliances, including:
 - Hypodermic needles and syringes except needles and syringes for use with insulin, and self-administered injectable drugs approved by us;
 - Support garments;
 - Test reagents;
 - Mechanical pumps for delivery of medications; and
 - Other non-medical substances;
- Dietary supplements;
- Nutritional products;
- Fluoride supplements;
- Minerals;
- Growth hormones (medications, drugs or hormones to stimulate growth), unless there is a laboratory confirmed diagnosis of growth hormone deficiency;
- Herbs and vitamins, except pediatric multi-vitamins with fluoride;
- Anabolic steroids;
- Anorectic or any drug used for the purpose of weight control;
- Any drug used for cosmetic purposes, including but not limited to:
 - Tretinoin, e.g. Retin A, except if the covered person is under the age of 45 or are diagnosed as having adult acne;
 - Dermatologicals or hair growth stimulants; or
 - Pigmenting or de-pigmenting agents, e.g. Solaquin;
- Any drug or medicine that is:
 - Lawfully obtainable without a prescription (over the counter drugs), except insulin; or
 - Available in prescription strength without a prescription;
- Compounded drugs in any dosage form; except when prescribed for pediatric use for children up to 19 years of age;
- Progesterone crystals or powder in any compounded dosage form;
- 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, e.g. Viagra;
- 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 the covered person, in whole or in part, while he or 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:

- Hospital;
- Rest home;
- Sanitarium;
- Skilled nursing facility;
- Convalescent hospital; or
- Hospice facility;
- Injectable drugs, including but not limited to:
 - Immunizing agents;
 - Biological sera;
 - Blood;
 - Blood plasma; or
 - Self administered injectable drugs for which coverage is not approved by us;
- Prescription refills:
 - In excess of the number specified by the health care practitioner; or
 - Dispensed more than one year from the date of the original order;
- Any portion of a prescription or refill that exceeds a 30-day supply (or a 90-day supply for a prescription or refill that is received from a mail order pharmacy);
- Any portion of a prescription or refill that:
 - Exceeds our drug specific dispensing limit, e.g. IMITREX;
 - Is dispensed to a covered person whose age is outside the drug specific age limits defined by us; or
 - Exceeds the duration-specific dispensing limit;
- Any drug for which prior authorization is required, as determined by us, and not obtained;
- Any drug for which a charge is customarily not made;
- Any drug, medicine or medication received by the covered person:
 - Before becoming covered under this benefit; or
 - After the date the covered person's coverage under this benefit 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 the covered person;
- Prescription or refill for drugs, medicines or medications that are lost, stolen, spilled, spoiled or damaged;
- Any service, supply or therapy to eliminate or reduce a dependency on, or addiction to tobacco and tobacco products, including but not limited to Nicotine withdrawal therapies, programs, services or medications;
- Drug delivery implants, e.g. Norplant;
- Treatment for Onychomycosis (nail fungus);
- More than one prescription for the same drug or therapeutic equivalent medication prescribed by one or more health care practitioners and dispensed by one or more pharmacies until at least 75 percent of the previous prescription has been used or should have been used by the covered person, unless the drug

or therapeutic equivalent medication is a maintenance medication, purchased through a mail order pharmacy, in which case 66 percent of the previous prescription must have been used or should have been used by the covered person (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 copayments or coinsurance related out-of-pocket expenses 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; or
- Any drug or device associated with a Phase I clinical trial for the treatment, palliation or prevention of cancer.

Maximum Allowable Fee

Maximum allowable fee referenced in the definition of expense incurred is the lesser of:

- The fee most often charged in the geographical area where the service was performed;
- The fee most often charged by the provider;
- The fee which is recognized as reasonable by a prudent person;
- The fee determined by comparing charges for similar services to a national data base adjusted to the geographical area where the services or procedures were performed;
- At our choice, the fee determined by using a national Relative Value Scale. Relative Value Scale means a methodology that values medical procedures and services relative to each other that includes, but is not limited to, a scale in terms of difficulty, work, risk, as well as the material and outside costs of providing the service, as adjusted to the geographic area where the services or procedures were performed;
- In the case of services rendered by network providers, the fee that we have negotiated with network providers;
- The fee based on rates negotiated by us or other payors with one or more participating providers in the geographic area for the same or similar services;
- The fee based on the provider's costs for providing the same or similar services as reported by such provider in its most recent publicly available Medicare cost report submitted to the Centers for Medicare and Medicaid Services annually; or
- The fee based on a percentage of the fee allows for the same or similar services provided in the same geographic area.

NOTE: The bill you or the covered person receives for services from non-network providers may be significantly higher than the maximum allowable fee. In addition to covered person's coinsurance related out-of-pocket expenses and deductible, you or the covered persons are responsible for the difference between the maximum allowable fee and the amount the provider bills for the services. Any amount you or the covered person pays to the provider in excess of the maximum allowable fee will not apply to the covered person's coinsurance out-of-pocket limit or deductible.

