HUMANA
Guidance when you need it most

Administrative Office:
1100 Employers Boulevard
Green Bay, Wisconsin 54344

Certificate of Insurance
Humana Insurance Company

Policyholder: E W WELLS GROUP LLC

Policy Number: 618704

Effective Date: 08/01/2012

Product Name: TXCA0381 CPYH

In accordance with the terms of the *policy* issued to the *policyholder*, Humana Insurance Company certifies that a *covered person* is insured for the benefits described in this *certificate*. This *certificate* becomes the Certificate of Insurance and replaces any and all certificates and certificate riders previously issued.

Michael B. McCallister
President

THE INSURANCE *POLICY* UNDER WHICH THIS *CERTIFICATE* IS ISSUED IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. *YOU* SHOULD CONSULT *YOUR EMPLOYER* TO DETERMINE WHETHER *YOUR EMPLOYER* IS A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM.

This is not a policy of Long Term Care insurance.

>> This booklet, referred to as a Benefit Plan Document, is provided to describe *your* Humana coverage

200400TX 07/07

1. **IMPORTANT NOTICE**

To obtain information or make a complaint:

2. You may call Humana Insurance Company's toll-free telephone number for information or to make a complaint at:

1-866-4ASSIST

3. You may also write to Humana Insurance Company at:

Green Bay Service Center
(Badger/MTV Medical)
P.O. Box 14618
Lexington, KY 40512-4618

4. You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights or complaints at:

1-800-252-3439

5. You may write the Texas Department of Insurance
P.O. Box 149104
Austin, TX 78714-9104
FAX #: (512) 475-1771
Web: http://www.tdi.state.tx.us
Email: ConsumerProtection@tdi.state.tx.us

6. **PREMIUM OR CLAIM DISPUTES:** Should you have a dispute concerning your premium or about a claim you should contact the agent or the company first. If the dispute is not resolved, you may contact the Texas Department of Insurance.

7. **ATTACH THIS NOTICE TO YOUR POLICY/CERTIFICATE:** This notice is for information only and does not become a part or condition of the attached document.

200500TX 03/07

AVISO IMPORTANTE

Para obtener informacion o para someter una queja:

Usted puede llamar al numero de telefono gratis de Humana Insurance Company's para informacion o para someter una queja al:

1-866-4ASSIST

Usted tambien puede escribir a Humana Insurance Company al:

Green Bay Service Center
(Badger/MTV Medical)
P.O. Box 14618
Lexington, KY 40512-4618

Puede comunicarse con el Departamento de Seguros de Texas para obtener informacion acerca de companias, coberturas, derechos o quejas al:

1-800-252-3439

Puede escribir al Departamento de Seguros de Texas
P.O. Box 149104
Austin, TX 78714-9104
FAX #: (512) 475-1771
Web: http://www.tdi.state.tx.us
Email: ConsumerProtection@tdi.state.tx.us

DISPUTAS SOBRE PRIMAS O RECLAMOS: Si tiene una disputa concerniente a su prima o a un reclamo, debe comunicarse con el agente o la compania primero. Si no se resuelve la disputa, puede entonces comunicarse con el departamento (TDI).

UNA ESTE AVISO A SU POLIZA/CERTIFICADO:
Este aviso es solo para proposito de informacion y no se convierte en parte o condicion del documento adjunto.

TABLE OF CONTENTS

TABLE OF CONTENTS (continued)

201000TX 02/11

PATIENT PROTECTION AND AFFORDABLE CARE ACT AMENDMENT

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

All terms used in this amendment have the same meaning given to them in the benefit plan document unless otherwise defined in this amendment, 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 amendment 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.

PATIENT PROTECTION AND AFFORDABLE CARE ACT AMENDMENT (continued)

Rescission -

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

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 -

The following preventive care services to detect or prevent sickness are covered without cost sharing when provided by a network provider:

- Evidence-based items or services that have an A or B rating in the current recommendations of the United States Preventive Services Task Force (USPSTF);

- Immunizations recommended by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDCP);

- With respect to a covered person who is an infant, child or adolescent dependent child, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration (HRSA);

- With respect to a covered person who is a woman, additional evidence-informed preventive care and screenings not described in the first bullet point as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

PATIENT PROTECTION AND AFFORDABLE CARE ACT AMENDMENT (continued)

Examples of preventive care services required by the Affordable Care Act are routine immunizations, mammograms and well-child visits.

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 contact us at www.humana.com or call the customer service telephone number on your identification card for the recommended services that apply to your plan. You may be responsible for any preventive care services received, that are not specifically required by the Affordable Care Act, unless otherwise prohibited by state law. As required by state law, preventive care services provided by a non-network provider are covered subject to cost sharing amounts shown on the Schedule of Benefits.

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 -

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.

PATIENT PROTECTION AND AFFORDABLE CARE ACT AMENDMENT (continued)

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.

Humana Insurance Company

Michael B. McCallister
President

IMPORTANT INFORMATION ABOUT COVERAGE UNDER THE TEXAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

(For insurers declared insolvent or impaired on or after September 1, 2011)

Texas law establishes a system to protect Texas policyholders if their life or health insurance company fails. The Texas Life and Health Insurance Guaranty Association (the "Association") administers this protection system. Only the policyholders of insurance companies that are members of the Association are eligible for this protection which is subject to the terms, limitations, and conditions of the Association law. (The law is found in the *Texas Insurance Code*, Chapter 463.)

It is possible that the Association may not protect all or part of your policy because of statutory limitations.

Eligibility for Protection by the Association

When a member insurance company is found to be insolvent and placed under an order of liquidation by a court or designated as impaired by the Texas Commissioner of Insurance, the Association provides coverage to policyholders who are:

- Residents of Texas **(regardless of where the policyholder lived when the policy was issued)**
- Residents of other states, ONLY if the following conditions are met:

  - The policyholder has a policy with a company domiciled in Texas;
  - The policyholder's state of residence has a similar guaranty association; and
  - The policyholder is *not eligible* for coverage by the guaranty association of the policyholder's state of residence.

Limits of Protection by the Association

Accident, Accident and Health, or Health Insurance:

- For each individual covered under one or more policies: up to a total of $500,000 for basic hospital, medical-surgical, and major medical insurance, $300,000 for disability or long term care insurance, or $200,000 for other types of health insurance.

Life Insurance:

- Net cash surrender value or net cash withdrawal value up to a total of $100,000 under one or more policies on a single life; or
- Death benefits up to a total of $300,000 under one or more policies on a single life; or
- Total benefits up to a total of $5,000,000 to any owner of multiple non-group life policies.

Individual Annuities:

- Present value of benefits up to a total of $250,000 under one or more contracts on any one life.

Group Annuities:

- Present value of allocated benefits up to a total of $250,000 on any one life; or
- Present value of unallocated benefits up to a total of $5,000,000 for one contractholder regardless of the number of contracts.

Aggregate Limit:

- $300,000 on any one life with the exception of the $500,000 health insurance limit, the $5,000,000 multiple owner life insurance limit, and the $5,000,000 unallocated group annuity limit.

These limits are applied for each insolvent insurance company.

Insurance companies and agents are prohibited by law from using the existence of the Association for the purpose of sales, solicitation, or inducement to purchase any form of insurance. When you are selecting an insurance company, you should not rely on Association coverage. For additional questions on Association protection or general information about an insurance company, please use the following contact information.

Texas Life and Health
Insurance Guaranty Association
515 Congress Avenue, Suite 1875
Austin, Texas 78701
800-982-6362 or www.txlifega.org

Texas Department of Insurance
P.O. Box 149104
Austin, Texas 78714-9104
800-252-3439 or www.tdi.state.tx.us

UNDERSTANDING YOUR COVERAGE

As *you* read through this *certificate*, *you* will notice that certain words and phrases are printed in italics. An italicized word may have a different meaning in the context of this *certificate* than it does in general usage. Please check the "Glossary" section for the definitions of italicized words, so *you* can understand their meaning as it relates to *your* insurance coverage.

How to use your certificate

This *certificate* provides *you* with detailed information regarding *your* coverage. It explains what is covered and what is not covered. It also identifies *your* duties and how much *you* must pay when obtaining services. Although *your* coverage is broad in scope, it is important to remember that *your* coverage has limitations. Be sure to read *your* certificate carefully before using *your* benefits.

Please note the provisions and conditions of this *certificate* apply to *you* and to each of *your* covered *dependents*.
202000 01/06

Covered and non-covered expenses

Benefits are payable only if services are considered to be a *covered expense* and are subject to the specific conditions, limitations and applicable maximums of the *certificate.* The benefit payable for *covered expenses* will not exceed the *maximum allowable fee(s)*.

A *covered expense* is deemed to be incurred on the date a covered service is performed or a covered supply is furnished.

If *you* incur non-*covered expenses*, whether from a *network provider* or *non-network provider*, *you* are responsible for making the full payment to the health care provider. The fact that a *health care practitioner* has performed or prescribed a medically appropriate procedure, treatment, or supply, or the fact that it may be the only available treatment for a *bodily injury* or *sickness*, does not mean that the procedure, treatment or supply is covered under the *policy*.

Please refer to the "Schedule of Benefits", the "Covered Expenses" and the "Limitations and Exclusions" sections of this *certificate* for more information about *covered expenses* and non-*covered expenses*. Also, be sure to check *your certificate* for any attached amendments or supplemental benefit riders that may modify *your* benefits.
202100 01/06

Your choice of providers affects your benefits

In most cases, if *you* receive services from a *network provider*, *we* will pay a higher percentage of benefits and *you* will incur lower out-of-pocket costs. *You* are responsible for any applicable *deductible*, *coinsurance* and/or *copayment*.

If *you* receive services from a *non-network provider*, *we* will pay benefits at a lower percentage and *you* will pay a larger share of the costs. Since *non-network providers* have not agreed to accept discounted or negotiated fees, they may bill *you* for charges in excess of the *maximum allowable fee*. *You* are responsible for charges in excess of the *maximum allowable fee* in addition to any applicable *deductible*, *coinsurance* and/or *copayment*. Any amount *you* pay to the provider in excess of *your coinsurance* or *copayment* will not apply to *your out-of-pocket limit* or *deductible*.

NOTICE: "ALTHOUGH HEALTH CARE SERVICES MAY BE OR HAVE BEEN PROVIDED TO *YOU* AT A HEALTH CARE FACILITY THAT IS A MEMBER OF *OUR* PROVIDER NETWORK, OTHER PROFESSIONAL SERVICES MAY BE OR HAVE BEEN PROVIDED AT OR THROUGH THE FACILITY BY PHYSICIANS AND OTHER *HEALTH CARE PRACTITIONERS* WHO ARE NOT MEMBERS OF *OUR* NETWORK. *YOU* MAY BE RESPONSIBLE FOR PAYMENT OF ALL OR PART OF THE FEES FOR THOSE PROFESSIONAL SERVICES THAT ARE NOT PAID OR COVERED BY *US*."

Please refer to the "Schedule of Benefits" sections in this *certificate* for a description of *network provider* and *non-network provider* benefits available to *you*.
202300TX 01/09

How to find a network provider

An online directory of *network providers* will be made available to *you* and accessible via the Internet on *our* Website at www.humana.com at the time of *your* enrollment. This directory is subject to change. Due to the possibility of *network providers* changing status, please check the online directory of *network providers* prior to obtaining services. If *you* do not have access to the online directory, y*ou* may telephone *our* customer service center prior to services being rendered or to request a directory.
202400 04/04

Continuity of care

If a *covered person* is receiving treatment from a *network provider* and the provider's agreement to provide *medically necessary* services terminates, for reasons other than medical competence or professional behavior, the *covered person* may be entitled to continue treatment with the terminating provider if, at the time of the provider's termination, the *covered person* is:

- Disabled;
- Being treated for a *life threatening* or complex *sickness*; or
- Past the twenty-fourth week of pregnancy.

The treating provider must contact *us* requesting continuity of treatment. If *we* agree to the continued treatment, *medically necessary* services provided to the *covered person* by the terminating provider will continue to be payable at the *network provider* benefit percentage. The maximum duration of continued treatment under this provision may not exceed:

- 90 days from the date of termination of the provider's agreement;
- Nine months in the case of a *covered person* being diagnosed with a terminal sickness; or
- Through the delivery of a child, including immediate post-partum care and follow-up visit within the first six weeks of delivery in the case of a *covered person* past the twenty-fourth week of pregnancy.

202450TX 04/04

How your policy works

Some policies may require *you* to pay a *deductible(s)* before *we* begin to share the cost of most medical services while others offer a benefit allowance before the *deductible(s)* applies.

If a *deductible* is required to be met before benefits are payable under the *policy*, when it is satisfied, *we* share the cost of *covered expenses* at the benefit percentage shown in the "Schedule of Benefits" sections, until *you* have reached any applicable *out-of-pocket limit*. After *you* have met the *out-of-pocket limit*, if any, *we* will pay *covered expenses* at 100% for the rest of the *year*, subject to the *maximum allowable fee(s)*, any maximum benefits and all other terms, provisions, limitations and exclusions of the *policy*. *You* will continue to pay benefit specific *copayments*.

Deductibles, *coinsurance* amounts, *copayments* and maximum amounts, if any, for each benefit are shown in the "Schedule of Benefits" sections. *We* calculate *deductibles* and *coinsurance* amounts by applying the dollar amount or percentage to the net charges. "Net charges" are defined as gross billed charges less any discounts or fee negotiations that may have been arranged with providers. "Gross billed charges" means the amount the provider charges without giving consideration to any discounts or other negotiated fees. The bill submitted by the provider will determine which benefit provision is applicable for payment of *covered expenses*.

202500 04/04

Preauthorization

All benefits payable under the *policy* must be for services and supplies that are *medically necessary* or for *preventive services* as stated in this *certificate*. *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, *electronic mail*, or in writing to obtain 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*.
202600 05/05

Our relationship with providers

Network providers and *non-network providers* are not *our* agents, employees or partners. *Network providers* are independent contractors. *We* do not endorse or control the clinical judgment or treatment recommendation made by *network providers* or *non-network providers.*

Nothing contained in the *policy* or any agreement or reimbursement document shall, nor is it intended to, interfere with communication between *you* and health care providers regarding *your* medical condition or treatment options. When requesting authorizations and ordering services, *health care practitioners* and other providers are acting on *your* behalf. All decisions related to patient care are the responsibility of the patient and the treating *health care practitioner*, regardless of any coverage determination(s) *we* have made or will make. *We* are not responsible for any misstatements made by any provider with regard to the scope of *covered expenses* and/or non-*covered expenses* under *your certificate*. If *you* have any questions concerning *your* coverage, please call *our* customer service center.
202700 05/05

Our financial arrangements with providers

We have agreements with *hospitals, health care practitioners* (including, but not limited to, physicians and other health care professionals), and other health care providers in the provider network(s) that may contain different payment arrangements.

- Many *health care practitioners* and health care providers are paid on a discounted fee-for-services basis, meaning that they are paid a mutually agreed upon amount for each *covered expense* rendered to *covered persons*. Most *hospitals* are paid on a specific Diagnosis Related Group (DRG) basis or flat fee per day basis for services provided to *covered persons* while *hospital confined*. *Outpatient* services rendered by *hospitals* and other facilities generally are reimbursed on a flat fee per service or procedure or a discount off charge basis.

202800TX

Privacy and confidentiality statement

We understand the importance of keeping *your* personal and health information (PHI) private. PHI includes both medical information and individually identifiable information, such as *your* name, address, telephone number or Social Security number. *We* are required by applicable federal and state law to maintain the privacy of *your* PHI.

Under both law and *our* policies, *we* have a responsibility to protect the privacy of *your* PHI. *We*:

- Protect *your* privacy by limiting who may see *your* PHI;
- Limit how *we* may use or disclose *your* PHI;
- Inform *you* of *your* legal duties with respect to *your* PHI;
- Explain *our* privacy policies; and
- Strictly adhere to the policies currently in effect.

We reserve the right to change *our* privacy practices at any time, as allowed by applicable law, rules and regulations. *We* reserve the right to make changes in *our* privacy practices for all PHI that *we* maintain, including information *we* created or received before *we* made the changes. When *we* make a significant change in *our* privacy practices, *we* will send notice to *our* health plan subscribers. For more information about *our* privacy practices, please contact *us*.

As a *covered person*, *we* may use and disclose *your* PHI, without *your* consent/authorization in the following ways:

- **Treatment -** *we* may disclose *your* PHI to a *health care practitioner*, a *hospital* or other entity which asks for it in order for *you* to receive medical treatment; and
- **Payment -** *we* may use and disclose *your* PHI to pay claims for *covered expenses* provided to *you* by *health care practitioners*, *hospitals* or other entities.

We may also use and disclose *your* PHI to conduct other health care operations activities.

In addition, *we* may provide PHI to *your employer* as defined by applicable state law. Please be aware that prior to releasing these claims reports to *your employer*, your *employer* must abide by a number of restrictions described in the Health Insurance Portability and Accountability Act of 1996 (HIPAA). These include, but are not limited, *your employer* not using or disclosing the information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan; and *your employer* restricting the access to and use of the information to only those individuals who have a "need to know" for plan administrative functions.

It has always been *our* goal to ensure the protection and integrity of *your* PHI. Therefore, *we* will notify *you* of any potential situations where *your* identification would be used for reasons other than treatment, payment and health plan operations.
203000TX

A note about this certificate – "benefit plan document"

This *certificate* is part of the insurance *policy* and describes the benefits, provisions and limitations of the *policy*. Nothing in this *certificate* waives or alters any of the terms or conditions of the *policy*. The final interpretation of any specific provision in this *certificate* is governed by the terms of the *policy*. In the event of conflict between the *policy* and this *certificate*, the provisions of the *policy* will prevail. The benefits outlined in this *certificate* are effective only if *you* are eligible for insurance, become insured and remain insured in accordance with the terms of the *policy*.
203100

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, annual *deductible(s)* and maximum *out-of-pocket limit(s)*, unless otherwise stated, are applicable.
SCH1-1100TX 02/11

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
Individual lifetime maximum benefit	Unlimited

SCH1-1300TX 04/10

SCHEDULE OF BENEFITS (continued)

Preauthorization requirements and penalty

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, *electronic mail*, 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, the benefit payable for any *covered expenses* incurred for the services, will be reduced to 50%, after any applicable *deductibles* or *copayments*. 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.
SCH1-1500TX 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 *network provider* and *non-network provider deductibles*. The *deductible* amount(s) for each *covered person* and each covered family are as follows, and must be satisfied each *year*, either individually or combined as a covered family. Once the family *deductible* is met, any remaining *deductible* for a *covered person* in the family will be waived for that *year*. *Copayments* do not apply toward the annual *deductible*.

SCHEDULE OF BENEFITS (continued)

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*.

Deductible	**Deductible amount**
Individual *network provider deductible*	$3,000
Family *network provider deductible*	$6,000
Individual *non-network provider deductible*	$9,000
Family *non-network provider deductible*	$18,000

SCH1-1600TX 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 individual and family *non-network provider out-of-pocket limits*.

SCHEDULE OF BENEFITS (continued)

After the individual *non-network provider out-of-pocket limit* has been satisfied in a *year*, the *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 *non-network provider out-of-pocket limit* has been satisfied in a *year*, the *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.

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*.

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 for covered *organ transplants* provided by a *non-network provider,* and *specialty drugs* do not apply towards any *out-of-pocket limit*.

Out-of-pocket limit	**Out-of-pocket limit amount**
Individual *non-network provider out-of- pocket limit*	$9,000
Family *non-network provider out-of-pocket limit*	$18,000

SCH1-1800TX 02/11

SCHEDULE OF BENEFITS (continued)

Preventive services

Preventive services

Network provider	100% benefit payable
Non-network provider	70% benefit payable after *non-network provider deductible*

Immunizations for covered persons to age 18

Immunizations required by state law for covered *dependents* 6 years of age or younger are not subject to the *deductible* and are covered in full when provided by a *health care practitioner.*

Network provider	100% benefit payable
Non-network provider	70% benefit payable after *non-network provider deductible*

Immunizations for covered persons 18 years of age or over

Network provider	100% benefit payable
Non-network provider	70% benefit payable after *non-network provider deductible*

Hearing impairment screening (birth to 30 days old)

Hearing impairment screening, as required by law, for a *dependent* child from birth through 30 days old is not subject to the *deductible* requirement, if any.

Same as any other *sickness* based upon location of services and the type of provider.

Noninvasive screening for atherosclerosis and abnormal artery structure

Includes computed tomography (CT) scan or ultrasonography as required by state law every five (5) years.

Level 1 *network health care practitioner*	100% benefit payable
Level 2 *network health care practitioner*	100% benefit payable
Non-network health care practitioner	70% benefit payable after *non-network provider deductible*

Routine prostate cancer detection exam including a specific antigen (PSA) test

Level 1 *network health care practitioner*	100% benefit payable
Level 2 *network health care practitioner*	100% benefit payable
Non-network health care practitioner	70% benefit payable after *non-network provider deductible*

Health care practitioner office visit services

Health care practitioner office visit

Excludes diagnostic laboratory and radiology services, *advanced imaging* and *outpatient surgery*.

Level 1 *network health care practitioner*	100% benefit payable after $30 *copayment* per visit
Level 2 *network health care practitioner*	100% benefit payable after $55 *copayment* per visit
Non-network health care practitioner	70% benefit payable after *non-network provider deductible*

Diagnostic follow-up care related to hearing impairment screening required by law for a *dependent* child from birth through 24 months old is not subject to the *deductible requirement*, if any.

Level 1 *network health care practitioner*	100% benefit payable
Level 2 *network health care practitioner*	100% benefit payable
Non-network health care practitioner	70% benefit payable

Diagnostic laboratory and radiology services when performed in the office and billed by the health care practitioner

Excludes *advanced imaging*.

Level 1 *network health care practitioner*	100% benefit payable
Level 2 *network health care practitioner*	100% benefit payable
Non-network health care practitioner	70% benefit payable after *non-network provider deductible*

Advanced imaging when performed in a health care practitioner's office

Level 1 *network health care practitioner*	100% benefit payable after *network provider deductible*
Level 2 *network health care practitioner*	100% benefit payable after *network provider deductible*
Non-network health care practitioner	70% benefit payable after *non-network provider deductible*

SCHEDULE OF BENEFITS (continued)

Allergy serum when received in the health care practitioner's office

Level 1 *network health care practitioner*	100% benefit payable
Level 2 *network health care practitioner*	100% benefit payable
Non-network health care practitioner	70% benefit payable after *non-network provider deductible*

Allergy injections when received in a health care practitioner's office

Level 1 *network health care practitioner*	100% benefit payable after $5 *copayment* per visit
Level 2 *network health care practitioner*	100% benefit payable after $5 *copayment* per visit
Non-network health care practitioner	70% benefit payable after *non-network provider deductible*

Injections other than allergy when received in a health care practitioner's office

Level 1 *network health care practitioner*	100% benefit payable after $5 *copayment* per visit
Level 2 *network health care practitioner*	100% benefit payable after $5 *copayment* per visit
Non-network health care practitioner	70% benefit payable after *non-network provider deductible*

Surgery performed in the office and billed by the health care practitioner

Level 1 *network health care practitioner*	100% benefit payable after *network provider deductible*
Level 2 *network health care practitioner*	100% benefit payable after *network provider deductible*
Non-network health care practitioner	70% benefit payable after *non-network provider deductible*

Hospital services

Hospital inpatient services

Network hospital	100% benefit payable after *network provider deductible*
Non-network hospital	70% benefit payable after *non-network provider deductible*

Health care practitioner inpatient services when provided in a hospital

Level 1 *network health care practitioner*	100% benefit payable after *network provider deductible*
Level 2 *network health care practitioner*	100% benefit payable after *network provider deductible*
Non-network health care practitioner	70% benefit payable after *non-network provider deductible*

SCHEDULE OF BENEFITS (continued)

Hospital outpatient surgical services

Must be performed in a *hospital's outpatient* department.

Network hospital	100% benefit payable after *network provider deductible*
Non-network hospital	70% benefit payable after *non-network provider deductible*

Health care practitioner outpatient services when provided in a hospital

Includes *outpatient surgery*.

Level 1 *network health care practitioner*	100% benefit payable after *network provider deductible*
Level 2 *network health care practitioner*	100% benefit payable after *network provider deductible*
Non-network health care practitioner	70% benefit payable after *non-network provider deductible*

Hospital outpatient non-surgical services

Must be performed in a *hospital's outpatient* department. Excludes *advanced imaging*.

Network hospital	100% benefit payable after *network provider deductible*
Non-network hospital	70% benefit payable after *non-network provider deductible*

Hospital outpatient advanced imaging

Must be performed in a *hospital's outpatient* department.

Network hospital	100% benefit payable after *network provider deductible*
Non-network hospital	70% benefit payable after *non-network provider deductible*

Pregnancy and newborn benefit

Same as any other *sickness* based upon location of services and the type of provider.

Emergency services

Covered expenses incurred by *you* for *emergency care* services provided by *non-network providers* will be covered at the *network provider* benefit level.

Hospital emergency room services

Excludes *advanced imaging*.

Network hospital	100% benefit payable after $250 *copayment* per visit. *Copayment* waived if admitted.
Non-network hospital	100% benefit payable after $250 *copayment* per visit. *Copayment* waived if admitted.

Hospital emergency room advanced imaging

Network hospital	100% benefit payable after *network provider deductible*
Non-network hospital	100% benefit payable after *network provider deductible*

Hospital emergency room health care practitioner services

Network health care practitioner	100% benefit payable
Non-network health care practitioner	100% benefit payable

Ambulance

Network provider	100% benefit payable after *network provider deductible*
Non-network provider	100% benefit payable after *network provider deductible*

Ambulatory surgical center services

Ambulatory surgical center for outpatient surgery

Network provider	100% benefit payable after *network provider deductible*
Non-network provider	70% benefit payable after *non-network provider deductible*

Health care practitioner outpatient services provided in an ambulatory surgical center

Includes *outpatient surgery*.

Level 1 *network health care practitioner*	100% benefit payable after *network provider deductible*
Level 2 *network health care practitioner*	100% benefit payable after *network provider deductible*
Non-network health care practitioner	70% benefit payable after *non-network provider deductible*

Autism spectrum disorders

Autism spectrum disorders, as required by law, for a *dependent* child from the date of diagnosis to age 10. When a *dependent* child who is being treated for an *autism spectrum disorder* attains age 10 and continues to need treatment, benefits are payable for *covered expenses* as recommended in the treatment plan by the *health care practitioner*.

Coverage may be subject to annual *deductibles*, *copayments* and *coinsurance* required for other coverage under the health benefit plan.

Durable medical equipment

Network provider	100% benefit payable after *network provider deductible*
Non-network provider	70% benefit payable after *non-network provider deductible*

Free-standing facility services

Free-standing facility non-surgical services

Excludes *advanced imaging*.

Network provider	100% benefit payable
Non-network provider	70% benefit payable after *non-network provider deductible*

Free-standing facility advanced imaging

Network provider	100% benefit payable after *network provider deductible*
Non-network provider	70% benefit payable after *non-network provider deductible*

Health care practitioner non-surgical services provided in a free-standing facility

Level 1 *network health care practitioner*	100% benefit payable after *network provider deductible*
Level 2 *network health care practitioner*	100% benefit payable after *network provider deductible*
Non-network health care practitioner	70% benefit payable after *non-network provider deductible*

Home health care

Limited to a maximum of 100 visits per *year*.

Network provider	100% benefit payable after *network provider deductible*
Non-network provider	70% benefit payable after *non-network provider deductible*

Hospice

Network provider	100% benefit payable after *network provider deductible*
Non-network provider	70% benefit payable after *non-network provider deductible*

Physical medicine and rehabilitative services

Physical therapy, occupational therapy and spinal manipulations/adjustments are limited to a combined maximum of 30 visits per *year*. After 10 visits are incurred, no coverage is available for services received from a *non-network provider* for the remainder of the *year*.

Network provider	100% benefit payable after $55 *copayment* per visit
Non-network provider	70% benefit payable after *non-network provider deductible*

Speech therapy, audiology and cognitive rehabilitations services.

Network provider	100% benefit payable after $55 *copayment* per visit
Non-network provider	70% benefit payable after *non-network provider deductible*

Other therapy

Network provider	100% benefit payable after *network provider deductible*
Non-network provider	70% benefit payable after *non-network provider deductible*

Jaw joint benefit

Same as any other *sickness* based upon location of service and type of provider.

Skilled nursing facility

Limited to a maximum of 60 days per *year*.

Network provider	100% benefit payable after *network provider deductible*
Non-network provider	70% benefit payable after *non-network provider deductible*

Urgent care services

Network provider	100% benefit payable after $55 *copayment* per visit
Non-network provider	70% benefit payable after *non-network provider deductible*

Additional covered expenses

Same as any other *sickness* based upon location of services and the type of provider.
SCH2TX 02/11

SCHEDULE OF BENEFITS - BEHAVIORAL HEALTH

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

- The level of benefits generally paid for the *mental health services* and *chemical dependency* services under the *policy*;
- The amounts of *copayments* and/or *coinsurance you* are required to pay; and
- The services that require *you* to meet a *deductible* before benefits are paid.

The benefits outlined in this "Schedule of Benefits – Behavioral Health" 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 – Behavioral Health" and "Limitations and Exclusions" sections of this *certificate*. Please refer to this *certificate* and any applicable riders for additional coverage and/or limitations.

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

Mental health services

Acute inpatient services

All *acute inpatient services* for *mental health services* and *chemical dependency* services are limited to a combined maximum of 10 days per *year*.

Acute inpatient services

Network provider	100% benefit payable after *network provider deductible*
Non-network provider	70% benefit payable after *non-network provider deductible*

Health care practitioner services - inpatient

Network health care practitioner	100% benefit payable after *network provider deductible*
Non-network health care practitioner	70% benefit payable after *non-network provider deductible*

SCHEDULE OF BENEFITS - BEHAVIORAL HEALTH (continued)

SCHEDULE OF BENEFITS - BEHAVIORAL HEALTH (continued)

Outpatient therapy and office therapy

Outpatient therapy and office therapy sessions for *mental health services* and *chemical dependency* services are limited to a combined maximum of 15 visits per *year*.

Network provider	100% benefit payable after $55 *copayment* per visit
Non-network provider	70% benefit payable after *non-network provider deductible*

SCH-BH-MH-TX 02/11

Chemical dependency

Benefits for *chemical dependency* are payable to the same extent as coverage for any other *sickness* under the *policy*, subject to the same limitations, *deductibles*, *coinsurance* or *copayments*, if any.

Chemical dependency services are limited to a lifetime maximum of three separate *series of treatments* for each *covered person*. All *acute inpatient services*, *partial hospitalization*, and *outpatient* therapy, including *outpatient* services provided as part of an *intensive outpatient program*, and office therapy individual and group sessions for *chemical dependency* services are limited to a combined maximum of three separate *series of treatments*. Two days of *partial hospitalization* or treatment in a *chemical dependency treatment center*, *crisis stabilization unit*, *psychiatric day treatment facility*, or *residential treatment center for children and adolescents* is equal to one day of *inpatient services*.
SCH-BH-CD-TX 05/10

SCHEDULE OF BENEFITS - TRANSPLANT SERVICES

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

- The level of benefits generally paid for the transplant services covered under the *policy*;
- The amounts of *copayments* and/or *coinsurance you* are required to pay; and
- The services that require *you* to meet a *deductible* before benefits are paid.

The benefits outlined in this "Schedule of Benefits – Transplant Services" 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 – Transplant Services" and "Limitations and Exclusions" sections of this *certificate*. Please refer to this *certificate* and 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.*

Transplant non-network benefit limit

The total amount of benefits payable by *us* for covered *organ transplant* services received from *non-network providers* will not exceed the transplant *non-network provider* benefit limit of $35,000 per covered *organ transplant.*

Organ transplant benefit

Medical services

- *Hospital* services

  Hospital benefits as shown in the "Schedule of Benefits" section under the "Hospital Services" provision of the *certificate* will be payable as follows:

Network hospital designated by *us* as an approved transplant facility	Same as any other *sickness* based on location of services and type of provider
Non-network hospital	Same as any other *sickness* based on location of services and type of provider to the transplant *non-network provider* benefit limit. *You* are also responsible for all expenses exceeding the *non-network provider* benefit limit.

SCHEDULE OF BENEFITS - TRANSPLANT SERVICES (continued)

- *Health care practitioner* services

  Health care practitioner benefits as shown in the "Schedule of Benefits" section under the "Health Care Practitioner Services" provision of the *certificate* will be payable as follows:

Network health care practitioner designated by *us* as an approved transplant *health care practitioner*	Same as any other *sickness* based on location of services and type of provider
Non-network health care practitioner	Same as any other *sickness* based on location of services and type of provider to the transplant *non-network provider* benefit limit. *You* are also responsible for all expenses exceeding the *non-network provider* benefit limit.

Direct, non-medical costs

Limited to a combined maximum of $10,000 per covered *organ transplant*.

- Transportation

Network hospital designated by *us* as an approved transplant facility	100% benefit payable
Non-network hospital	70% benefit payable

- Temporary lodging

Network hospital designated by *us* as an approved transplant facility	100% benefit payable
Non-network hospital	70% benefit payable

SCH-OT 10/06

COVERED EXPENSES

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

- *Deductible*;
- *Copayment*;
- *Coinsurance* percentage; and
- Maximum benefit.

Refer to the "Limitations and Exclusions" section listed in this *certificate*. All terms and provisions of the *policy*, including the *preauthorization* requirements specified in this *certificate*, are applicable to *covered expenses*.
204000 02/11

Preventive services

Covered expenses include the *preventive services* recommended by the U.S. Department of Health and Human Services (HHS) for *your* plan *year*.

For the recommended *preventive services* that apply to *your* plan *year*, refer to the HHS website at www.HHS.gov or call the customer service telephone number on *your* identification card.
204200TX 02/11

Health care practitioner office services

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

Health care practitioner office visit

Covered expenses include:

- Office visits for the diagnosis and treatment of a *sickness* or *bodily injury*.
- Office visits for prenatal care.
- Office visits for *diabetes self-management training.*
- Diagnostic laboratory and radiology.
- Diagnostic follow-up care related to the hearing impairment screening for a *dependent* child from birth through 24 months old.
- Allergy testing.
- Allergy serum.
- Allergy injections.
- Injections other than allergy.
- *Surgery*, including anesthesia.
- Second surgical opinions.

204400TX 02/11

Hospital services

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

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

Hospital inpatient services

Covered expenses include:

- Daily semi-private, ward, intensive care or coronary care *room and board* charges for each day of *confinement*. Benefits for a private or single-bed room are limited to the *maximum allowable fee* charged for a semi-private room in the *hospital* while a registered bed patient.

- Services and supplies, other than *room and board*, provided by a *hospital* to a registered bed patient.

Health care practitioner inpatient services when provided in a hospital

Services which are payable as a *hospital* charge are not payable as a *health care practitioner* charge. If *you* receive services from a *non-network provider*, *you* may be responsible for any charges in excess of the *maximum allowable fee* and charges in excess of any percentages listed in this provision.

Covered expenses include:

- Medical services furnished by an attending *health care practitioner* to *you* while *you* are *hospital confined*.

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

  - 50% of *maximum allowable fee* for the secondary procedure; and
  - 25% of *maximum allowable fee* for the third and subsequent procedures.

  If two surgeons work together as primary surgeons performing distinct parts of a single reportable procedure, *we* will pay each surgeon 62.5% of the *maximum allowable fee* for the procedure.

- Services of a surgical assistant and/or assistant surgeon when *medically necessary*. Surgical assistants and/or assistant surgeon will be paid at 20% of the *covered expense* for *surgery*.

- Services of a physician assistant (P.A.), registered nurse (R.N.) or a certified operating room technician when *medically necessary*. Physician assistants, registered nurses and certified operating room technicians will be paid at 10% of the *covered expense* for the *surgery*.

- Anesthesia administered by a *health care practitioner* or certified registered anesthetist attendant to a *surgery*.

- Consultation charges requested by the attending *health care practitioner* during a *hospital confinement*. The benefit is limited to one consultation by any one consultant per specialty during a *hospital confinement*.

- Services of a pathologist.

- Services of a radiologist.

- Services performed on an emergency basis in a *hospital* if the *sickness* or *bodily injury* being treated results in a *hospital confinement*.

Hospital outpatient services

Covered expenses include *outpatient* services and supplies, as outlined in the following provisions, provided in a *hospital's outpatient* department.

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

Hospital outpatient surgical services

Covered expenses include services provided in a *hospital's outpatient* department in connection with *outpatient surgery*.

Health care practitioner outpatient services when provided in a hospital

Services which are payable as a *hospital* charge are not payable as a *health care practitioner* charge. If *you* receive services from a *non-network provider*, *you* may be responsible for any charges in excess of the *maximum allowable fee* and charges in excess of any percentages listed in this provision.

Covered expenses include:

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

  - 50% of *maximum allowable fee* for the secondary procedure; and
  - 25% of *maximum allowable fee* for the third and subsequent procedures.

  If two surgeons work together as primary surgeons performing distinct parts of a single reportable procedure, *we* will pay each surgeon 62.5% of the *maximum allowable fee* for the procedure.

- Services of a surgical assistant and/or assistant surgeon when *medically necessary*. Surgical assistants and/or assistant surgeon will be paid at 20% of the *covered expense* for *surgery*.

- Services of a physician assistant (P.A.), registered nurse (R.N.) or a certified operating room technician when *medically necessary*. Physician assistants, registered nurses and certified operating room technicians will be paid at 10% of the *covered expense* for the *surgery*.

- Anesthesia administered by a *health care practitioner* or certified registered anesthetist attendant for a *surgery*.

- Services of a pathologist.

- Services of a radiologist.

Hospital outpatient non-surgical services

Covered expenses include services provided in a *hospital's outpatient* department in connection with non-surgical services.

Covered expenses for *hospital* non-surgical services do not include *advanced imaging*.

Hospital outpatient advanced imaging

We will pay benefits for *covered expenses* incurred by *you* for *outpatient advanced imaging* in a *hospital's outpatient* department.
205450 02/11

Pregnancy and newborn benefit

We will pay benefits for *covered expenses* incurred by a *covered person* for a pregnancy.

Covered expenses include:

- A minimum stay of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated cesarean section. If an earlier discharge is consistent with the most current protocols and guidelines of the American College of Obstetricians and Gynecologists or the American Academy of Pediatrics and is consented to by the mother and the attending *health care practitioner*, a post-discharge office visit to the *health care practitioner* or a home health care visit within the first 48 hours after discharge is also covered, subject to the terms of this *certificate*.

- For a newborn, *hospital confinement* during the first 48 hours or 96 hours following birth, as applicable and listed above for:

  - *Hospital* charges for *routine nursery care*;
  - The *health care practitioner's* charges for circumcision of the newborn child; and
  - The *health care practitioner's* charges for routine examination of the newborn before release from the *hospital*.

- If the covered newborn must remain in the *hospital* past the mother's *confinement*, services and supplies received for:

  - A *bodily injury* or *sickness*;
  - Care and treatment for premature birth; and
  - Medically diagnosed birth defects and abnormalities.

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

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

The newborn will not be required to satisfy a separate *deductible* and/or *copayment* for *hospital* facility charges for the *confinement* period immediately following birth. A *deductible* and/or *copayment*, if applicable, will be required for any subsequent *hospital admission*.
205500TX 02/11

Emergency services

*W*e will pay benefits for *covered expenses* incurred by *you* for *emergency care*, including the treatment and stabilization of an emergency medical condition.

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

Covered expenses also include *health care practitioner* services for *emergency care*, including the treatment and stabilization of an emergency medical condition, provided in a *hospital* emergency facility, free-standing emergency medical care facility. These services are subject to the terms, conditions, limitations, and exclusions of the *policy*.
205700TX 12/09

Ambulance

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

Ambulance service for *emergency care* provided by a *non-network provider* will be covered at the *network provider* benefit percentage. *Non-network providers* have not agreed to accept discounted or negotiated fees, and may bill *you* for charges in excess of the *maximum allowable fee*. *You* may be required to pay any amount not paid by *us*.
205750 02/11

Ambulatory surgical center

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

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

Services which are payable as an *ambulatory surgical center* charge are not payable as a *health care practitioner* charge. If *you* receive services from a *non-network provider*, *you* may be responsible for any charges in excess of the *maximum allowable fee* and charges in excess of any percentages listed in this provision.

Covered expenses include:

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

  - 50% of *maximum allowable fee* for the secondary procedure; and
  - 25% of *maximum allowable fee* for the third and subsequent procedures.

  If two surgeons work together as primary surgeons performing distinct parts of a single reportable procedure, *we* will pay each surgeon 62.5% of the *maximum allowable fee* for the procedure.

- Services of a surgical assistant and/or assistant surgeon when *medically necessary*. Surgical assistants and/or assistant surgeon will be paid at 20% of the *covered expense* for *surgery*.

- Services of a physician assistant (P.A.), registered nurse (R.N.) or a certified operating room technician when *medically necessary*. Physician assistants, registered nurses and certified operating room technicians will be paid at 10% of the *covered expense* for the *surgery*.

- Anesthesia administered by a *health care practitioner* or certified registered anesthetist attendant to a *surgery*.

- Services of a pathologist.

- Services of a radiologist.

205800 02/11

Autism spectrum disorders

We will pay benefits for *covered expenses* incurred by covered *dependents* from the date of diagnosis up to age 10 for *autism spectrum disorder* (ASD) services provided by a *health care practitioner.* When a *dependent* child who is being treated for an *autism spectrum disorder* attains age 10 and continues to need treatment, benefits are payable for *covered expenses* as recommended in the treatment plan by the *health care practitioner*.

Covered expenses include:

- Evaluation and assessment services;
- Applied behavior analysis
- Behavior training and behavior management;
- Speech therapy;
- Occupational therapy;
- Physical therapy; or
- Medications or nutritional supplements used to address symptoms of ASD.

206025TX 02/11

Durable medical equipment

We will pay benefits for *covered expenses* incurred by *you* for *durable medical equipment* and *diabetes equipment*.

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

We will pay for repairs and necessary maintenance of insulin pumps not otherwise covered by the manufacturer and rental fees for pumps during the repair and necessary maintenance, neither shall exceed the purchase price of a similar replacement pump.

Repair and maintenance of purchased *durable medical equipment* and *diabetes equipment,* excluding insulin pumps is a *covered expense* if:

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

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

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

205900TX 04/10

Free-standing facility services

Free-standing non-surgical services

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

Covered expenses for *outpatient* non-surgical services do not include *advanced imaging*.

Health care practitioner services provided in a free-standing facility

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

Free-standing advanced imaging

We will pay benefits for *covered expenses* incurred by *you* for *outpatient advanced imaging* in a *free-standing facility*.
206250 07/07

Home health care

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

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

Home health care *covered expenses* include:

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

Home health care *covered expenses* do not include:

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

206300TX 03/09

Hospice

We will pay benefits for *covered expenses* incurred by *you* for a *hospice care program.* A *health care practitioner* must certify that the *covered person* is terminally ill with a life expectancy of 18 months or less.

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

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

- *Room and board* at a hospice, when it is for management of acute pain or for an acute phase of chronic symptom management;
- Part-time nursing care provided by or supervised by a registered nurse (R.N.) for up to eight hours in any one day;
- Counseling for the terminally ill *covered person* and his/her immediate covered family members by a licensed:
  - Clinical social worker; or
  - Pastoral counselor.
- Medical social services provided to the terminally ill *covered person* or his/her immediate covered family members under the direction of a *health care practitioner*, including:
  - Assessment of social, emotional and medical needs, and the home and family situation; and
  - Identification of the community resources available.

- Psychological and dietary counseling;
- Physical therapy;
- Part-time home health aid services for up to eight hours in any one day, and
- Medical supplies, drugs, and medicines prescribed by a *health care practitioner* for *palliative care*.

Hospice care *covered expenses* do not include:

- A *confinement* not required for acute pain control or other treatment for an acute phase of chronic symptom management;
- Services by volunteers or persons who do not regularly charge for their services;
- Services by a licensed pastoral counselor to a member of his or her congregation. These are services in the course of the duties to which he or she is called as a pastor or minister; and
- Bereavement counseling services for family members not covered under this *policy*.

206400TX 02/11

Jaw joint benefit

We will pay benefits for *covered expenses* incurred by *you* during a plan of treatment for any jaw joint problem, including temporomandibular joint disorder, craniomaxillary disorder, craniomandibular disorder, head and neck neuromuscular disorder or other conditions of the joint linking the jaw bone and the skull, subject to the maximum benefit shown on the "Schedule of Benefits", if any.

The following are *covered expenses*:

- A single examination including a history, physical examination, muscle testing, range of motion measurements, and psychological evaluation, as necessary;

- Diagnostic x-rays;

- Physical therapy of necessary frequency and duration, limited to a multiple modality benefit when more than one therapeutic treatment is rendered on the same date of service;

- Therapeutic injections;

- Appliance therapy utilizing an appliance which does not permanently alter tooth position, jaw position or bite. Benefits for reversible appliance therapy will be based on the *maximum allowable fee* for use of a single appliance, regardless of the number of appliances used in treatment. The benefit for the appliance therapy will include an allowance for all jaw relation and position diagnostic services, office visits, adjustments, training, repair, and replacement of the appliance; and

- Surgical procedures.

Covered expenses do not include charges for:

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

206500TX 05/05

Physical medicine and rehabilitative services benefit

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

- Physical therapy services;
- Occupational therapy services;
- Spinal manipulations/adjustments performed in a *health care practitioner's* office, or on an *inpatient* or *outpatient* basis or in a *rehabilitation facility*;
- Speech therapy or speech pathology services;
- Audiology services;
- Cognitive rehabilitation services;
- Respiratory or pulmonary therapy services; and
- Cardiac rehabilitation services.

The "Schedule of Benefits" shows the maximum number of visits for physical medicine and/or rehabilitative services, if any.
206600TX 04/10

Skilled nursing facility

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

The "Schedule of Benefits" shows the maximum length of time for which *we* will pay benefits for charges made by a *skilled nursing facility*, if any.
206800 05/05

Urgent care services

We will pay benefits for *covered expenses* incurred by *you* for charges made by an *urgent care center* for *urgent care* services. *Covered expense* also includes *health care practitioner* services for *urgent care* provided at and billed by an *urgent care center*.
206900

Additional covered expenses

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

- Blood and blood plasma which is not replaced by donation; administration of the blood and blood products including blood extracts or derivatives.

- Oxygen and rental of equipment for its administration.

- Prosthetic devices, supplies, and professional services related to the fitting and use of the devices, including but not limited to limbs and eyes. Coverage will be provided for prosthetic devices necessary to restore the minimal basic function of a lost limb or eye. *Covered expense* does include replacement and repair of a prosthetic device unless repair or replacement is due to misuse or loss.

- Cochlear implants, when approved by *us*, for a *covered person*:

  - 18 years of age or older with bilateral severe to profound sensorineural deafness; or
  - 12 months through 17 years of age with profound bilateral sensorineural deafness.

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

  - The existing device malfunctions and cannot be repaired;
  - Replacement is due to a change in the *covered person's* condition that makes the present device non-functional; or
  - The replacement or upgrade is not for cosmetic purposes.

- Custom made or custom fit orthotics made of rigid or semi-rigid material. This includes the professional services related to the fitting. Orthotics used to support, align, prevent, or correct deformities. *Covered expense* includes repair and replacement of an orthotic.

  Covered expense does not include:

  - Repair or replacement orthotics when due to misuse or loss;
  - Dental braces; or
  - Oral or dental splints and appliances, unless custom made for the treatment of documented obstructive sleep apnea.

- The following special supplies, dispensed up to a 30-day supply, when prescribed by *your* attending *health care practitioner*:

  - Surgical dressings;
  - Catheters;
  - Colostomy bags, rings and belts; and
  - Flotation pads.

- The initial pair of eyeglasses or contacts needed due to cataract *surgery* or an *accident* if the eyeglasses or contacts were not needed prior to the *accident*.

- Dental treatment only if:

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

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

  Also covered are charges made by a *health care practitioner* or *health care treatment facility* for anesthesia, facility and *health care practitioner* services related to a dental procedure performed on an *inpatient* or *outpatient* basis if it is determined by *your health care practitioner* or dentist providing the dental care that *you* are unable to undergo dental treatment in an office setting or under local anesthesia due to a documented physical, mental, or medical reason.

- Certain oral surgical operations as follows:

  - Excisions of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth when such conditions require pathological examinations;
  - Surgical procedures required to correct accidental injuries of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
  - Reduction of fractures and dislocation of the jaw;
  - External incision and drainage of cellulitis;
  - Incision of accessory sinuses, salivary glands or ducts;
  - Frenectomy (the cutting of the tissue in the midline of the tongue); and
  - Orthognathic *surgery* for a congenital anomaly, *bodily injury* or *sickness* causing a *functional impairment*.

- Elective vasectomy or tubal ligation.

- For a *covered person* in connection with a mastectomy, service for:

  - Reconstructive *surgery* of the breast on which the mastectomy has been performed;
  - *Surgery* and reconstruction on the non-diseased breast to achieve symmetrical appearance; and
  - Prostheses and treatment of physical complications for all stages of mastectomy, including lymphedemas.

- *Inpatient* services for the treatment of breast cancer will be covered for a minimum of:

  - 48 hours following a mastectomy; or
  - 24 hours following a lymph node dissection.

  You and *your* attending *health care practitioner* may determine a shorter length of stay is appropriate.

- Routine patient costs incurred in connection with a phase I, II, III, or IV clinical trial if conducted in relation to the prevention, detection, or treatment of a *life threatening* disease or condition and is approved by:

  - The U.S. Department of Health and Human Services – Centers for Disease Control and Prevention (CDC);
  - The National Institutes of Health (NIH);
  - The U.S. Food and Drug Administration (FDA);
  - The U.S. Department of Defense (DOD);
  - The U.S. Department of Veterans Affairs (VA);
  - An institutional review board of an institution in Texas that has an agreement with the Office for Human Research Protections of the U.S. Department of Health and Human Services.

  Routine costs include the cost of *medically necessary* services related to the care method that is under evaluation in a clinical trial and as required by state law.

  Routine patient costs do not include:

  - The cost of an investigational new drug or device that is not approved for any indication by the U.S. FDA, including a drug or device that is the subject of the clinical trial;
  - The cost of the service that is not a health care service, regardless of whether it is required in connection with the participation in a clinical trial;
  - The cost of a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;
  - A cost associated with managing a clinical trial; or
  - The cost of a service that is specifically excluded from coverage.

  No coverage is provided for services that are customarily paid for by the research institution.

- Enteral formulas, nutritional supplements and low protein modified foods for use at home by a *covered person* that are prescribed or ordered by a *health care practitioner* and are for the treatment of an inherited metabolic disease, e.g. phenylketonuria (PKU).

- Amino-acid based elemental formulas, regardless of the formula delivery method, that are prescribed or ordered by a *health care practitioner* to treat a *covered person* diagnosed with:

  - Immunoglobulin E and non-immunoglobulin E mediated allergies to multiple food proteins;
  - Severe food protein-induced enterocolitis syndrome;
  - Eosinophilic disorders, as evidence by the results of a biopsy; and
  - Impaired absorption of nutrients caused by disorders affecting the absorptive surface, functional length, and motility of the gastrointestinal tract.

  Covered expense includes services associated with the administration of the amino-acid based formula. The amino-acid based elemental formula is a covered expense under this *certificate*, unless otherwise covered in the Prescription Drug Benefit Rider, if any, attached to the *policy*.

- Contraceptive implant systems and devices approved by the United States Food and Drug Administration.

- An outpatient contraceptive service which includes a consultation, examination, procedure, or medical service provided on an outpatient basis and is related to the use of a contraceptive drug or device intended to prevent pregnancy.

- *Telehealth service*.

- *Telemedicine medical service.*

- *Diabetes self-management training.*

- *Medically necessary* care and treatment of loss or impairment of speech or hearing, including the purchase, fitting or advice on the care of hearing aids or implantable hearing devices.

- Rehabilitative and habilitative therapies provided to a *dependent* child which are determined to be necessary to and in accordance with an individualized family service plan. An individualized family service plan means a plan issued by the interagency Council on Early Childhood Intervention under Chapter 73, Human Resources Code. Rehabilitative and habilitative therapies will be covered in the amount, duration, scope and service setting established in the *dependent* child's individualized family service plan.

  For the purposes of this benefit, rehabilitative and habilitative therapies include:

  - Occupational therapy evaluations and services;
  - Physical therapy evaluations and services;
  - Speech therapy evaluations and services; and
  - Dietary or nutritional evaluations.

- Nutritional counseling for the treatment of obesity, which includes *morbid obesity*, limited to 4 visits per *year*.

207000TX 02/11

COVERED EXPENSES - BEHAVIORAL HEALTH

The "Covered Expenses – Behavioral Health" section describes the services that will be considered *covered expenses* for *mental health services* and *chemical dependency* services under the *policy*. Benefits for *mental health services* and *chemical dependency* services will be paid on a *maximum allowable fee* basis and as shown in the "Schedule of Benefits – Behavioral Health" subject to:

- The *deductible*, if applicable;
- Any *copayment*, if applicable;
- Any *coinsurance* percentage; and
- Any maximum benefit.

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

This "Covered Expenses-Behavioral Health" section does not include services for *serious mental illness.*
208000TX 02/11

Acute inpatient services and partial hospitalization services

We will pay benefits for *covered expenses* incurred by *you* for *inpatient* services and *partial hospitalization* care for *mental health services* and *chemical dependency* services provided in a *hospital, health care treatment facility, chemical dependency treatment center*, *crisis stabilization unit, psychiatric day treatment facility,* or *residential treatment center for children and adolescents*.

The "Schedule of Benefits – Behavioral Health" reflects benefit limitations for *inpatient* care and *partial hospitalization* care for *mental health services* and *chemical dependency* services, if any.
208100TX 02/11

Acute inpatient health care practitioner and partial hospitalization services

We will pay benefits for *covered expenses* incurred by *you* for *mental health services* and *chemical dependency* services provided by a *health care practitioner* in a *hospital, health care treatment facility, chemical dependency treatment center, crisis stabilization unit, psychiatric day treatment facility,* or *residential treatment center for children and adolescents.*
208300TX 02/11

Outpatient therapy and office therapy services

We will pay benefits for *covered expense* incurred by *you* for *mental health services* and *chemical dependency* services while not *confined* in a *hospital*, *health care treatment facility*, *chemical dependency treatment center*, *crisis stabilization unit*, *psychiatric day treatment facility*, or *residential treatment center for children and adolescents* for *outpatient* services, including *outpatient* services provided as part of an *intensive outpatient program.*

The "Schedule of Benefits – Behavioral Health" reflects the benefit limitations for *outpatient* care including *outpatient* services provided as part of an *intensive outpatient program*, for *mental health services* and *chemical dependency* services, if any.
208500TX 02/11

COVERED EXPENSES - TRANSPLANT SERVICES

The "Covered Expenses – Transplant Services" section describes the services that will be considered *covered expenses* for transplant services under the *policy*. Benefits for transplant services will be paid on a *maximum allowable fee* basis and as shown in the "Schedule of Benefits – Transplant Services" subject to any applicable:

- *Deductible*;
- *Copayment*;
- *Coinsurance* percentage; and
- Maximum benefit.

Refer to the "Exclusions" provision in this section and the "Limitations and Exclusions" section listed in this *certificate* for transplant services not covered by the *policy*. All terms and provisions of the *policy*, including *preauthorization* requirements specified in this *certificate*, are applicable to *covered expenses*.
210000 10/06

Organ transplant benefit

We will pay benefits for *covered expenses* incurred by *you* for an *organ transplant*. The *organ transplant* must be approved in advance by *us*, and is subject to the terms, conditions and limitations described below and contained in the *policy*. Please contact *our* Transplant Management Department or *our* designee when in need of these services.

For an *organ transplant* to be considered fully approved, *preauthorization* from *us* is required in advance of the *organ transplant*. *You* or *your health care practitioner* must notify *us* in advance of *your* need for an initial evaluation for the *organ transplant* in order for *us* to determine if the *organ transplant* will be covered. For approval of the *organ transplant* itself, *we* must be given a reasonable opportunity to review the clinical results of the evaluation before rendering a determination.

Once coverage for the *organ transplant* is approved, *we* will advise *your health care practitioner*. Benefits are subject to *preauthorization* requirements and penalties. Coverage for post-discharge services and treatment of complications after transplantation are limited to the *organ transplant treatment period.*

Corneal transplants and porcine heart valve implants, which are tissues rather than organs, are considered part of regular plan benefits and are subject to other applicable provisions of the *policy*.
210100TX 10/06

Covered expenses

Covered expense for an *organ transplant* includes pre-transplant services, transplant inclusive of any chemotherapy and associated services, post-discharge services, and treatment of complications after transplantation of the following organs or procedures only:

- Heart;
- Lung(s);
- Liver;
- Kidney;
- *Bone marrow;*
- Intestine;
- Pancreas;
- Auto islet cell;
- Any combination of the above listed organs; and
- Any organ not listed above required by state or federal law.

The following are *covered expenses* for approved *organ transplants* and all related complications:

- *Hospital* and *health care practitioner* services.
- Organ acquisition and donor costs, including pre-transplant services, the acquisition procedure, and any complications resulting from the acquisition.
- Direct, non-medical costs for:

    - The *covered person* receiving the *organ transplant*, if he or she lives more than 100 miles from the transplant facility; and
    - One designated caregiver or support person (two, if the *covered person* receiving the organ transplant is under 18 years of age), if they live more than 100 miles from the transplant facility.

    Direct, non-medical costs include:

    - Transportation to and from the *hospital* where the *organ transplant* is performed; and
    - Temporary lodging at a prearranged location when requested by the *hospital* and approved by *us*.

All direct, non-medical costs for the *covered person* receiving the *organ transplant* and the designated caregiver(s) or support person(s) are limited to a combined maximum coverage per *organ transplant* as specified in the "Schedule of Benefits – Transplant Services" section in this *certificate*.
210200TX 10/06

Exclusions

No benefit is payable for or in connection with an *organ transplant* if:

- It is *experimental*, or *investigational*, or *for research purposes*.
- The expense relates to storage of cord blood and stem cells, unless it is an integral part of an *organ transplant* approved by *us*.
- *We* do not approve coverage for the *organ transplant*, based on *our* established criteria.
- Expenses are eligible to be paid under any private or public research fund, government program except *Medicaid*, or another funding program, whether or not such funding was applied for or received.
- The expense relates to the transplantation of any non-human organ or tissue, unless otherwise stated in the *policy*.
- The expense relates to the donation or acquisition of an organ for a recipient who is not covered by *us*.
- The expense relates to an *organ transplant* performed outside of the United States and any care resulting from that *organ transplant*.
- A denied transplant is performed; this includes the pre-transplant evaluation, the transplant procedure, follow-up care, immunosuppressive drugs, and expenses related to complications of such transplant.
- *You* have not met pre-transplant criteria as established by *us*.

210300 07/07

LIMITATIONS AND EXCLUSIONS

Pre-existing condition limitation

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

The exclusion does not apply to:

- Pregnancy;
- Genetic information in the absence of a diagnosis of the condition related to the information; or
- A *covered person* under the age of 19.

The *pre-existing condition* limitation shall not be applied to *you* if *you* were continuously covered for an aggregate period of 12 months under *creditable coverage.*

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*. *You* are also eligible for portability of *creditable coverage* if *you* had *creditable coverage* in effect at any time during the 12 months prior to *your enrollment date* under this *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.
211100TX 02/11

LIMITATIONS AND EXCLUSIONS (continued)

Other limitations and exclusions

Unless specifically stated otherwise, no benefits will be provided for, or on account of, the following items:
211200 05/05

- Treatments, services, supplies or *surgeries* that are not *medically necessary*, except *preventive services*.

- 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 02/11

- 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 in a *year* except as required by law for *emergency care* services.

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

LIMITATIONS AND EXCLUSIONS (continued)

- 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.

212600TX 07/07

- 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* except for clinical trials.

- 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) and amino-acid based elemental formulas as stated in this *certificate*.

- Over-the-counter, non-prescription medications.

- 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.*

213250TX 02/11

- 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 or *electronic* media.

- Prescription drugs and *self-administered injectable drugs*, unless administered to *you*:

    - While an *inpatient* in a *hospital*, *skilled nursing facility*, *health care treatment facility*, *chemical dependency treatment center, crisis stabilization unit, psychiatric day treatment facility*, or *residential treatment center for children and adolescents;*

    - 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*.

213700TX 02/11

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*; or reversal of elective sterilization.

214100TX 07/07

- Sex change services, regardless of any diagnosis of gender role or psychosexual orientation problems.

- 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.
  - Resulting from congenital disease or anomaly of a covered *dependent* child which resulted in a *functional impairment.*
  - Resulting from craniofacial abnormalities of a covered *dependent* child to improve the function of or attempt to create a normal appearance.

  Expenses incurred for reconstructive *surgery* performed due to the presence of a psychological condition are <u>not</u> covered, unless the condition(s) described above are also met.

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

214400TX 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 hammertoe.

- *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).

214900TX 02/11

- Expenses for any membership fees or program fees paid by *you*, including but not limited to, health clubs, health spas, 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 weight loss *surgery*.

LIMITATIONS AND EXCLUSIONS (continued)

- Expenses for services that are primarily and customarily used for environmental control or enhancement (whether or not prescribed by a *health care practitioner*) and certain medical devices including, but not limited to:

  - Common household items including air conditioners, air purifiers, water purifiers, vacuum cleaners, waterbeds, hypoallergenic mattresses or pillows or exercise equipment;

  - Motorized transportation equipment (e.g. scooters), escalators, elevators, ramps or modifications or additions to living/working quarters or transportation vehicles;

  - Personal hygiene equipment including bath/shower chairs, transfer equipment or supplies or bed side commodes;

  - Personal comfort items including cervical pillows, gravity lumbar reduction chairs, swimming pools, whirlpools, spas or saunas;

  - Medical equipment including blood pressure monitoring devices, PUVA lights, 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.

- 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.

215300TX 02/11

- Communications or travel time.

LIMITATIONS AND EXCLUSIONS (continued)

- Bariatric *surgery*, any services or complications related to bariatric *surgery*, and other weight loss products or services.

- 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.*

215800 02/11

- 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.

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

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

- Vision examinations or testing for the purposes of prescribing corrective lenses; orthoptic training (eye exercises); radial keratotomy, refractive keratoplasty or any other *surgery* or procedure to correct myopia, hyperopia or stigmatic error; or, the purchase or fitting of eyeglasses or contact lenses (except as the result of an *accident* or following cataract *surgery* as stated in this *certificate*).

216300TX 04/09

- Services and supplies which are:

  - Rendered in connection with mental illnesses not classified in the International Classification of Diseases of the U.S. Department of Health and Human Services; or
  - Extended beyond the period necessary for evaluation and diagnosis of learning and behavioral disabilities or for mental retardation.

- Marriage counseling.

- *Court-ordered behavioral health* services.

- Expenses incurred by *you* for the treatment of *serious mental illness*.

- 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.

216650TX 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.*

216880 07/07

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

216900 04/04

ELIGIBILITY AND EFFECTIVE DATES

Eligibility date

Employee eligibility date

The *employee* is eligible for coverage on the date:

- The eligibility requirements are satisfied as stated in the Employer Group Application, or as otherwise agreed to by the *policyholder* and *us*; and
- The *employee* is in an *active status.*

217000 04/09

Dependent eligibility date

Each *dependent* is eligible for coverage on:

- The date the *employee* is eligible for coverage, if he or she has *dependents* who may be covered on that date;
- The date of the *employee's* marriage for any *dependents* (spouse or child) acquired on that date;
- The date of birth of the *employee's* natural-born child;
- The date the child for whom the *employee* is a party in a suit in which adoption of the child is sought by the *employee*; or
- The date specified in a Qualified Medical Child Support Order (QMCSO) or a National Medical Support Notice (NMSN) for a child, or a valid court or administrative order for a spouse, which requires the *employee* to provide coverage for a child or spouse as specified in such orders.

The *employee* may cover his or her *dependents* only if the *employee* is also covered.

A covered *dependent* child who becomes an *employee* eligible for group coverage under the *policy* through employment is no longer eligible as a *dependent* for coverage under the *policy* and must request enrollment as an eligible *employee*.

217100TX 04/09

Enrollment

Employees and *dependents* eligible for coverage under the *policy* may enroll for coverage as specified in the enrollment provisions outlined below.

217150 04/09

ELIGIBILITY AND EFFECTIVE DATES (continued)

Employee enrollment

The *employee* must enroll, as agreed to by the *policyholder* and *us*, within 31 days of the *employee's eligibility date*, or within the time period specified in the "Special enrollment" provision.

The *employee* is a *late applicant* if enrollment is requested more than 31 days after the *employee's eligibility date*, after the *employer's open enrollment period*, or later than the time period specified in the "Special enrollment" provision. A *late applicant* must wait to enroll for coverage during the *open enrollment period*, unless the *late applicant* becomes eligible for special enrollment as specified in the "Special enrollment" provision.

Depending on the total number of *employees* covered by the *employer's policy*, *we* may require any *employee* to provide evidence of health status whenever enrolling as permitted by laws, rules, or regulations. *We* will not use *health status-related factors* to decline coverage to an eligible *employee* and *we* will administer this provision in a non-discriminatory manner.
217200TX 04/09

Dependent enrollment

If electing *dependent* coverage, the *employee* must enroll eligible *dependents*, as agreed to by the *policyholder* and *us*, within 31 days of the *dependent's eligibility date* or within the time period specified in the "Special enrollment" provision.

The *dependent* is a *late applicant* if enrollment is requested more than 31 days after the *dependent's eligibility date*, after the *employer's open enrollment period*, or later than the time period specified in the "Special enrollment" provision. A *late applicant* must wait to enroll for coverage during the *open enrollment period*, unless the *late applicant* becomes eligible for special enrollment as specified in the "Special enrollment" provision.

Depending on the total number of *employees* covered by the *employer's policy*, *we* may require any *dependent* to provide evidence of health status whenever enrolling as permitted by laws, rules, or regulations. *We* will not use *health status-related factors* to decline coverage to an eligible *dependent* and *we* will administer this provision in a non-discriminatory manner.
217300TX 04/09

Newborn dependent enrollment

A newborn *dependent* of the *employee* will be covered automatically from the date of birth to 31 days of age.

An *employee* who already has *dependent* child coverage in force prior to the newborn's date of birth must notify *us* within 31 days after the date of birth to enroll the newborn for coverage.

An *employee* who does not have *dependent* child coverage must elect *dependent* coverage and enroll the newborn *dependent*, as agreed to by the *policyholder* and *us*, within 31 days after the newborn's date of birth and pay the required premium to maintain the coverage in force.

ELIGIBILITY AND EFFECTIVE DATES (continued)

A newborn *dependent* is a *late applicant* if enrollment is requested more than 31 days after the date of birth. A *late applicant* must wait to enroll for coverage during the *open enrollment period*, unless the *late applicant* becomes eligible for special enrollment as specified in the "Special enrollment" provision.
217400TX 04/09

Special enrollment

Special enrollment is available if the following apply:

- *You* have a change in family status due to:

  - Marriage;
  - Divorce;
  - A Qualified Medical Child Support Order (QMCSO);
  - A National Medical Support Notice (NMSN);
  - The birth of a natural born child; or
  - The adoption of a child or placement of a child with the *employee* for the purpose of adoption or because *you* become a party in a suit for the adoption of a child; or
  - A child of an employee has lost coverage under Title XIX of the Social Security Act, or under Chapter 62, Health and Safety Code; and
  - You enroll within 31 days after the *special enrollment date*; or

- You are an *employee* or *dependent* eligible for coverage under the *policy*, and:

  - You previously declined enrollment stating you were covered under another group health plan or other *health insurance coverage*; and
  - Loss of eligibility of such other coverage occurs, regardless of whether you are eligible for, or elect COBRA; and
  - You enroll within 31 days after the *special enrollment date*.

  Loss of eligibility of other coverage includes, but is not limited to:

  - Termination of employment or eligibility;
  - Reduction in number of hours of employment;
  - Divorce or death of a spouse;
  - Loss of dependent eligibility, such as attainment of the limiting age;
  - Termination of your employer's contribution for the coverage;
  - Loss of individual HMO coverage because you no longer reside, live or work in the service area;
  - Loss of group HMO coverage because you no longer reside, live or work in the service area, and no other benefit package is available;
  - An incurred claim meeting or exceeding a lifetime limit on all benefits; or
  - The plan no longer offers benefits to a class of similarly situated individuals; or

- You had COBRA continuation coverage under another plan at the time of eligibility, and:

  - Such coverage has since been exhausted; and
  - You stated at the time of the initial enrollment that coverage under COBRA was your reason for declining enrollment; and
  - You enroll within 31 days after the *special enrollment date*; or

- You were covered under an alternate plan provided by the *employer* that terminates, and:
  - You are replacing coverage with this *policy*; and
  - You enroll within 31 days after the *special enrollment date*; or
- You are an *employee* or *dependent* eligible for coverage under the policy that is not a high deductible health plan (HDHP), and:
  - Your *Medicaid* coverage or your Children's Health Insurance Program (CHIP) coverage terminated as a result of loss of eligibility; and
  - You enroll within 60 days after the *special enrollment date*; or
- You are an *employee* or *dependent* eligible for coverage under the *policy* that is not a high deductible health plan (HDHP), and:
  - You become eligible for a premium assistance subsidy under *Medicaid* or CHIP; and
  - You enroll within 60 days after the *special enrollment date*.

The *employee* or *dependent* is a *late applicant* if enrollment is requested later than the time period specified above. A *late applicant* must wait to enroll for coverage during the *open enrollment period*.
217500TX 04/09

Dependent special enrollment

The *dependent* special enrollment is the time period specified in the "Special enrollment" provision.

If *dependent* coverage is available under the *employer's policy* or added to the *policy*, an *employee* who is a *covered person* can enroll eligible *dependents* during the special enrollment. An *employee*, who is otherwise eligible for coverage and had waived coverage under the *policy* when eligible, can enroll himself/herself and eligible *dependents* during the special enrollment.

The *employee* or *dependent* is a *late applicant* if enrollment is requested later than the time period specified above. A *late applicant* must wait to enroll for coverage during the *open enrollment period*.
217600 04/09

Open enrollment

Eligible *employees* or *dependents*, that do not enroll for coverage under the *policy* following their *eligibility date* or *special enrollment date*, have an opportunity to enroll for coverage during the *open enrollment period*. The *open enrollment period* is also the opportunity for *late applicants* to enroll for coverage.

Eligible *employees* or *dependents*, including *late applicants*, must request enrollment during the *open enrollment period*. If enrollment is requested after the *open enrollment period*, the *employee* or *dependent* must wait to enroll for coverage during the next *open enrollment period*, unless they become eligible for special enrollment as specified in the "Special enrollment" provision.
217620 04/09

ELIGIBILITY AND EFFECTIVE DATES (continued)

Effective date

The provisions below specify the *effective date* of coverage for *employees* or *dependents* if enrollment is requested within 31 days of their *eligibility date* or within the time period specified in the "Special Enrollment" provision. If enrollment is requested during an *open enrollment period*, the *effective date* of coverage is specified in the "Open enrollment effective date" provision.
217650 04/09

Employee effective date

The *employee's effective date* provision is stated in the Employer Group Application. The *employee's effective date* of coverage may be the date immediately following completion of the *waiting period*, or the first of the month following completion of the *waiting period*, if enrollment is requested within 31 days of the *employee's eligibility date*. The *special enrollment date* is the *effective date* of coverage for an *employee* that requests enrollment within the time period specified in the "Special enrollment" provision. The *employee effective dates* specified in this provision apply to an *employee* who is not a *late applicant*.
217700 04/09

Employee delayed effective date

If the *employee* is not in *active status* on the *eligibility date*, coverage will be effective the day after the *employee* returns to *active status*. The *employer* must notify *us* in writing or by *electronic mail* of the *employee's* return to *active status*.
217800

Dependent effective date

The *dependent's effective date* is the date the *dependent* is eligible for coverage if enrollment is requested within 31 days of the *dependent's eligibility date.* The *special enrollment date* is the *effective date* of coverage for the *dependent* that requests enrollment within the time period specified in the "Special enrollment" provision. The *dependent effective dates* specified in this provision apply to a *dependent* who is not a *late applicant*.

In no event will the *dependent's effective date* of coverage be prior to the *employee's effective date* of coverage.
219800 04/09

Newborn dependent effective date

The *effective date* of coverage for a newborn *dependent* is the date of birth if enrollment is requested within 31 days of the newborn's date of birth and the newborn is not a *late applicant*.

Note: Premium is due for any period of newborn *dependent* coverage whether or not the newborn *dependent* is subsequently enrolled, unless specifically not allowed by applicable law.
219900 04/09

Open enrollment effective date

The *effective date* of coverage for an *employee* or *dependent*, including a *late applicant*, who requests enrollment during an *open enrollment period,* is the first day of the *policy year* as agreed to by the *policyholder* and *us*.
219950 04/09

Benefit changes

Benefit changes will become effective on the date specified by *us*.
220000

Retired employee coverage

Retired employee eligibility date

Retired *employees* are eligible if the *policyholder* requested such coverage on the Employer Group Application and the request is approved by *us*. An *employee* who retires while insured under this *policy* is considered eligible for retired *employee* medical coverage on the date of retirement if the eligibility requirements stated in the Employer Group Application are satisfied.
220100TX

Retired employee enrollment

The *employer* must notify *us* of the *employee's* retirement within 31 days of the date of retirement. If *we* are notified more than 31 days after the date of retirement, the retired *employee* is a *late applicant.* A *late applicant* must wait to enroll for coverage during the *open enrollment period*, unless the *late applicant* becomes eligible for special enrollment as specified in the "Special enrollment" provision.
220200 04/09

Retired employee effective date

The *effective date* of coverage for an eligible retired *employee* is the date of retirement for an *employee* who retires after the date *we* approve the *employer's* request for a retiree classification, provided *we* are notified within 31 days of the retirement. If *we* are notified more than 31 days after the date of retirement, the *effective date* of coverage for the *late applicant* is the date *we* specify.
220300 04/09

Retired employee benefit changes

Additional or increased insurance or a decrease in insurance will become effective on the approved date of change.
220400

REPLACEMENT OF COVERAGE

Applicability

The "Replacement of Coverage" section applies when an *employer's* previous group health plan not offered by *us* or *our* affiliates (Prior Plan) is terminated and replaced by coverage under the *policy* and:

- *You* are eligible to become insured for medical coverage on the *effective date* of the *policy*; and
- *You* were covered under the *employer's* Prior Plan on the day before the *effective date* of the *policy*.

Benefits available for *covered expense* under the *policy* will be reduced by any benefits payable by the Prior Plan during an extension period.
221000

Deductible credit

Medical expense incurred while *you* were covered under the Prior Plan may be used to satisfy *your network provider*
deductible amount under the *policy* if:

- The expense incurred was applied to the deductible amount under the Prior Plan; and
- The expense incurred qualifies as a *covered expense* under the *policy*; and
- The expense incurred would have served to partially or fully satisfy the *deductible* amount under the *policy* for the *year* in which *your* coverage becomes effective.

This provision does not apply to *coinsurance* satisfied under the Prior Plan.
221200 06/06

Waiting period credit

If the *employee* had not completed the initial *waiting period* under the *policyholder's* Prior Plan on the day that it ended, any period of time that the *employee* satisfied will be applied to the appropriate *waiting period* under the *policy*, if any. The *employee* will then be eligible for coverage under the *policy* when the balance of the *waiting period* has been satisfied.
221300

Out-of-pocket limit

Any amount applied to the Prior Plan's *out-of-pocket limit* or stop-loss limit will not be credited toward the satisfaction of any *out-of-pocket limit* of the *policy*.
221400

REPLACEMENT OF COVERAGE (continued)

Pre-existing conditions

If a *sickness* or *bodily injury* is a *pre-existing condition* as stated in the "Pre-Existing Condition Limitation" provision of this *certificate* but would not have been a *pre-existing condition* under the Prior Plan had it remained in force, it will not be a *pre-existing condition* under the *policy*. If a *sickness* or *bodily injury* is a *pre-existing condition* under both the Prior Plan and the *policy*, any benefits payable are applicable only to medical expenses which were incurred after the date such *sickness* or *bodily injury* would no longer have been a *pre-existing condition* under the Prior Plan had it remained in force.

The amount payable for such *sickness* or *bodily injury* will be the lesser of:

- The benefits payable under the *policy* regardless of any *pre-existing condition* limitation; or
- The benefits that would have been payable under the Prior Plan had it remained in force reduced by any amount actually paid by the Prior Plan for such *sickness* or *bodily injury*.

However, this does not apply to any *sickness* or *bodily injury* for which *you* are entitled to receive benefits during any extension period provided by the Prior Plan.
221500

TERMINATION PROVISIONS

Termination of insurance

The date of termination, as described in this "Termination Provisions" section, may be the actual date specified or the end of that month, as selected by *your employer* on the Employer Group Application (EGA).

You must notify *us* as soon as possible if *you* or *your dependent* no longer meets the eligibility requirements of the *policy*. Notice should be provided to *us* within 31 days of the change.

When *we* receive notification of a change in eligibility status in advance of the effective date of the change, insurance will terminate on the actual date specified by the *employer* and/or *employee* or at the end of that month, as selected by *your employer* on the EGA.
222000TX 02/11

When *we* receive notification of a change in eligibility status more than 31 days after the date of the change, retroactive premium credit will not be permitted. An *employer* is liable for premiums from the time the *covered person* is no longer eligible for coverage under the *policy* until the end of the month in which *we* are notified by the *employer* that a *covered person* is no longer eligible for coverage under the *policy*. This individual will remain a *covered person* under the *policy* until the end of that period.

Otherwise, insurance terminates on the earliest of the following:

- The date the *group policy* terminates;
- The end of the period for which required premium was due to *us* and not received by *us*;
- The date the *employee* terminated employment with the *employer*;
- The date the *employee* is no longer qualified as an *employee*;
- The date *you* fail to be eligible under the *policy* as stated in the EGA;
- The date *you* entered full-time military, naval or air service;
- The date the *employee* retired, except if the EGA provides coverage for retired *employees* and the retiree meets the participation criteria of the large employer;
- The date of an *employee* request for termination of insurance for the *employee* or *dependents*;
- For a *dependent*, the date the *employee's* insurance terminates;
- For a *dependent*, the date the *employee* ceases to be eligible for *dependent* insurance;
- The date *your dependent* no longer qualifies as a *dependent*;
- For any benefit, the date the benefit is deleted from the *policy*; or
- The date fraud or an intentional misrepresentation of a material fact has been committed by *you*.

222100TX 02/11

Any dissatisfaction may be expressed to *us* through the established complaint and appeal process set out in the "Complaints and Appeal Procedures" section of this *certificate*.
222200TX

TERMINATION PROVISIONS (continued)

Termination for cause

We will terminate *your* coverage for cause under the following circumstances:

- If *you* allow an unauthorized person to use *your* identification card or if *you* use the identification card of another *covered person*. Under these circumstances, the person who receives the services provided by use of the identification card will be responsible for paying *us* the *maximum allowable fee* for those services.

- If *you* or the *policyholder* perpetrate fraud and/or intentional misrepresentation on claims, identification cards or other identification in order to obtain services or a higher level of benefits. This includes, but is not limited to, the fabrication and/or alteration of a claim, identification card or other identification.

222300 02/11

EXTENSION OF BENEFITS

Extension of health insurance for total disability

We extend limited health insurance benefits if:

- The *policy* terminates while *you* are *totally disabled* due to a *bodily injury* or *sickness* that occurs while the *policy* is in effect; and
- *Your* coverage is not replaced by other group coverage providing substantially equivalent or greater benefits than those provided for the disabling conditions by the *policy*; or
- *You* cannot demonstrate *creditable coverage* to the replacing carrier.

223000

Benefits are payable only for those expenses incurred for the same *sickness* or *bodily injury* which caused *you* to be *totally disabled*. Insurance for the disabling condition continues, but not beyond the earliest of the following dates:

- The date *your health care practitioner* certifies *you* are no longer *totally disabled*; or
- The date any maximum benefit or *your individual lifetime maximum benefit* is reached; or
- The last day of the 90 consecutive day period following the date the *policy* terminated.

No insurance is extended to a child born as a result of a *covered person's* pregnancy.
223100TX

CONTINUATION

Continuation options in the event of termination

If health insurance terminates:

- It may be continued as described in the "State continuation of health insurance" provision;
- It may be continued as described in the "Continuation of coverage for dependents" provision, if applicable; or
- It may be continued under the continuation provisions as provided by the Consolidated Omnibus Budget Reconciliation Act (COBRA), if applicable.

A complete description of the "State continuation of health insurance" and "Continuation of coverage for dependents" provisions follow.
224000TX 02/11

State continuation of health insurance

A *covered person* whose coverage terminates shall have the right to continuation under the *policy* as follows.

An *employee* may elect to continue coverage for himself or herself.

If the *employee* was insured for *dependent* coverage when his or her health insurance terminated, an *employee* may choose to continue health insurance for any *dependent* who was insured by the *policy*. The same terms with regard to the availability of continued health insurance described below will apply to *dependents*.

In order to be eligible for this option:

- The *employee* must have been continuously covered under the *policy* for at least three consecutive months prior to termination; and
- The *covered person's* coverage must be terminated for any other reason other than involuntary termination for cause.

There is no right to continuation if:

- The termination of coverage occurred because the *employee* failed to pay the required premium contribution;
- The discontinued *group* coverage was replaced by similar group coverage within 31 days of the discontinuance;
- The *covered person* is or could be covered by *Medicare;*
- The *covered person* has similar benefits under another group or individual plan whether insured or self-insured;
- The *covered person* is eligible for similar benefits under another group plan whether insured or self-insured; or
- Similar benefits are provided for or available to the *covered person* under any state or federal law.

CONTINUATION (continued)

Written application for election of continuation must be made within 60 days after the date coverage terminates or within 60 days after the *covered person* has been given any required notice, whichever is later. No evidence of insurability is required to obtain continuation.

If this state continuation option is selected, the premium rate will be 102% of the *group* premium. The first premium payment must be paid to the *policyholder* within 45 days after the date of the election for continuation of coverage. Subsequent premium payments will be payable to the *policyholder* on a monthly basis. Premium payments are timely if made on or before the 30th day after the date on which the payment is due.

Continuation may not terminate until the earliest of:

- The date the maximum state continuation period provided by law ends, which is:
    - Nine months after the date state continuation election is made for any *covered person* not eligible for continuation under Consolidated Omnibus Budget Reconciliation Act (COBRA); or
    - Six additional months of state continuation following any period of continuation provided under COBRA for a *covered person* eligible for continuation coverage under COBRA.
- The date timely premium payments are not made on *your* behalf;
- The date the *group* coverage terminates in its entirety;
- The date on which the *covered person* is or could be covered under *Medicare*;
- The date on which the *covered person* is covered for similar benefits under another group or Individual policy;
- The date on which the *covered person* is eligible for similar benefits under another group plan; or
- The date on which similar benefits are provided for or available to the *covered person* under any state or federal law.

The *policyholder* is responsible for sending *us* the premium payments for those individuals who choose to continue their health insurance. If the *policyholder* fails to make proper payment of the premiums to *us*, *we* are relieved of all liability for any health insurance that was continued and the liability will rest with the *policyholder*.
224100TX 02/11

State continuation of coverage for certain dependents

Continuation of coverage is available for *dependents* who are no longer eligible for the health insurance provided by the *policy* as a result of:

- The death of the covered *employee;*
- The retirement of the covered *employee*; or
- The severance of the family relationship.

Each *dependent* may choose to continue these benefits for up to three years after the date the coverage would have normally terminated. *We* must receive proper notice of the choice to continue coverage, but *we* will not require evidence of insurability.

CONTINUATION (continued)

Proper notice of the choice to continue coverage is given as follows:

- The covered *employee* or *dependent* must give the *policyholder* written notice within 30 days of any severance of the family relationship that might activate this continuation option; and

- The *policyholder* must give written notice to each affected *dependent* of the continuation option immediately upon receipt of notice of severance of the family relationship or upon receipt of notice of the *employee's* death or retirement; and

- The *dependent* must give written notice to the *policyholder* of his or her desire to exercise the continuation option within 60 days from the date of severance of the family relationship or the date of the *employee's* death or retirement.

The *policyholder* must notify *us* of the choice to continue coverage upon receipt of it.

Premiums must be paid each month in advance for coverage to continue. The *policyholder* is responsible for sending *us* the premium payments for those individuals who choose to continue their coverage.

The option to continue coverage is <u>not</u> available if:

- The *policy* terminates;
- A *dependent* becomes eligible for similar group coverage either on an insured or self-insured basis;
- The *dependent* was not covered by the *policy* and the Prior Plan replaced by the *policy* for at least one year prior to the date coverage terminates, except in the case of an infant under one year of age; or
- The *dependent* elects to continue his or her coverage under the terms and conditions described in the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

Continued coverage terminates on the earliest of the following dates:

- The last day of the three-year period following the date the *dependent* was no longer eligible for coverage;
- The date the *dependent* becomes eligible for similar group benefits, either on an insured or self-insured basis;
- The date timely premium payments are not made on *your* behalf; or
- The date the *policy* terminates.

The *policyholder* is responsible for sending *us* the premium payments for those individuals who choose to continue their health insurance. If the *policyholder* fails to make proper payment of the premiums to *us*, *we* are relieved of all liability for any health insurance that was continued and the liability will rest with the *policyholder*.
224200TX 02/11

Texas Health Insurance Pool

You and/or *your dependents* may be eligible for coverage under the Texas Health Insurance Pool. Information regarding this coverage may be obtained via the Internet at www.txhealthpool.org; by calling 1-888-398-3927/TDD 1-800-735-2989 or writing to the following address:

Texas Health Insurance Pool
P.O. Box 6089
Abilene, Texas 79608-6089

224300TX 11/09

COORDINATION OF BENEFITS

This coordination of benefits (COB) provision applies when a person has health care coverage under more than one *plan*. The order of benefit determination rules below determine which *plan* will pay as the *primary plan*. The *primary plan* pays first without regard to the possibility another *plan* may cover some expenses. A *secondary plan* pays after the *primary plan* and may reduce the benefits it pays so that payments from all *plans* do not exceed 100% of the total *allowable expense*.
226000

Definitions

The following definitions are used exclusively in this provision.

Plan means any of the following that provide benefits or services for medical or dental care or treatment. However, if separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered part of the same *plan* and there is no COB among those separate contracts.

Plan includes:

- Group insurance, closed panel or other forms of group or group-type coverage (whether insured or uninsured);
- Hospital indemnity benefits in excess of $200 per day;
- Medical care components of group long-term care contracts, such as skilled nursing care;
- Medical benefits under group or individual automobile contracts, including "No Fault" and Medical Payments coverages; and
- *Medicare* or other governmental benefits, as permitted by law.

Plan does not include:

- Individual or family insurance;
- Closed panel or other individual coverage (except for group-type coverage);
- Hospital indemnity benefits of $200 or less per day;
- School accident type coverage;
- Benefits for non-medical care components of group long-term care contracts;
- Medicare supplement policies;
- A state plan under *Medicaid*; and
- Coverage under other governmental plans, unless permitted by law.

Each contract for coverage is a separate *plan*. If a *plan* has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate *plan*.

Notwithstanding any statement to the contrary, for the purposes of COB, prescription drug coverage under a Prescription Drug Benefit Rider, if applicable, will be considered a separate *plan* and will therefore only be coordinated with other prescription drug coverage.

COORDINATION OF BENEFITS (continued)

Primary/secondary means the order of benefit determination stating whether this *plan* is *primary* or *secondary* covering the person when compared to another *plan* also covering the person.

When this *plan* is *primary*, its benefits are determined before those of any other *plan* and without considering any other *plan's* benefits. When this *plan* is *secondary*, its benefits are determined after those of another *plan* and may be reduced because of the *primary plan's* benefits.

Allowable expense means a health care service or expense, including deductibles and copayments, that is covered at least in part by any of the *plans* covering the person. When a *plan* provides benefits in the form of services (e.g. an *HMO*), the reasonable cash value of each service will be considered an *allowable expense* and a benefit paid. An expense or service that is not covered by any of the *plans* is not an *allowable expense*. The following are examples of expenses or services that are not *allowable expenses*:

- If a *covered person* is confined in a private *hospital* room, the difference between the cost of a semi-private room in the *hospital* and the private room, (unless the patient's stay in a private *hospital* room is *medically necessary* in terms of generally accepted medical practice, or one of the *plans* routinely provides coverage for *hospital* private rooms) is not an *allowable expense*.

- If a person is covered by two or more *plans* that compute their benefits payments on the basis of usual and customary fees, any amount in excess of the highest usual and customary fees for a specific benefit is not an *allowable expense*.

- If a person is covered by two or more *plans* that provide benefits or services on the basis of negotiated fees, any amount in excess of the highest of the fees is not an *allowable expense*.

- If a person covered by one *plan* that calculates its benefits or services on the basis of usual and customary fees and another *plan* that provides its benefits or services on the basis of negotiated fees, the *primary plan's* payment arrangement shall be the *allowable expense* for all *plans*.

- The amount a benefit is reduced by the *primary plan* because a *covered person* does not comply with the *plan* provisions. Examples of these provisions are second surgical opinions, precertification of *admissions* and preferred provider arrangements.

Claim determination period means a calendar year. However, it does not include any part of a year during which a person has no coverage under this *plan*, or before the date this COB provision or a similar provision takes effect.

Closed panel plan is a *plan* that provides health benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the *plan*, and that limits or excludes benefits for services provided by other providers, except in the cases of emergency or referral by a panel member.

Custodial parent means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.
226100 06/06

Order of determination rules

General

When two or more *plans* pay benefits, the rules for determining the order of payment are as follows:

- The *primary plan* pays or provides its benefits as if the *secondary plan* or *plans* did not exist.

- A *plan* that does not contain a COB provision that is consistent with applicable promulgated regulation is always *primary*. There is one exception: coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the *plan* provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base *plan* hospital and surgical benefits, and insurance type coverages that are written in connection with a *closed panel plan* to provide out-of-network benefits.

- A *plan* may consider the benefits paid or provided by another *plan* in determining its benefits only when it is *secondary* to that other *plan*.

226200

Rules

The first of the following rules that describes which *plan* pays its benefits before another *plan* is the rule to use.

- **Non-dependent or *dependent***. The *plan* that covers the person other than as a *dependent*, for example as an *employee*, member, subscriber or retiree is *primary* and the *plan* that covers the person as a *dependent* is *secondary*. However, if the person is a *Medicare* beneficiary and, as a result of federal law, *Medicare* is *secondary* to the *plan* covering the person as a *dependent*; and *primary* to the *plan* covering the person as other than a *dependent* (e.g. retired *employee*); then the order of benefits between the two *plans* is reversed so that the *plan* covering the person as an *employee*, member, subscriber or retiree is *secondary* and the other *plan* is *primary*.

- **Child covered under more than one *plan***. The order of benefits when a child is covered by more than one *plan* is:

  - The *primary plan* is the *plan* of the parent whose birthday is the earlier in the year if:

    - The parents are married;
    - The parents are not separated (whether or not they have been married); or
    - A court decree awards joint custody with out specifying that one part has the responsibility to provide health care coverage.

  - If both the parents have the same birthday, the *plan* that covered either of the parents longer is *primary*.

- If the specific terms of a court decree state that one parent is responsible for the child's health care expenses or health care coverage and the *plan* of that parent has actual knowledge of those terms, that *plan* is *primary*. This rule applies to *claim determination periods* or plan years commencing after the *plan* is given notice of the court decree.

- If the parents are not married, or are separated (whether or not they ever have been married) or are divorced, the order of benefits is:

  - The *plan* of the *custodial parent*;
  - The *plan* of the spouse of the *custodial parent*;
  - The *plan* of the non-*custodial parent*; and then
  - The *plan* of the spouse of the non-*custodial parent*.

- **Active or inactive *employee***. The *plan* that covers a person as an *employee* who is neither laid off nor retired, is *primary*. The same would hold true if a person is a *dependent* of a person covered as a retiree and an *employee*. If the other *plan* does not have this rule, and if, as a result, the *plans* do not agree on the order of benefits, this rule is ignored.

- **Continuation coverage**. If a person whose coverage is provided under a right of continuation provided by federal or state law also is covered under another *plan*, the *plan* covering the person as an *employee*, member, subscriber or retiree (or as that person's *dependent*) is *primary*, and the continuation coverage is *secondary*. If the other *plan* does not have this rule, and if, as a result, the *plans* do not agree on the order of benefits, this rule is ignored.

- **Longer or shorter length of coverage**. The *plan* that covered the person as an *employee*, member, subscriber or retiree longer is *primary*.

If the preceding rules do not determine the *primary plan*, the *allowable expenses* shall be shared equally between the *plans* meeting the definition of *plan* under this provision. In addition, this *plan* will not pay more that it would have had it been *primary*.
226300

Effects on the benefits of this plan

When this *plan* is *secondary*, benefits may be reduced to the difference between the *allowable expense* (determined by the *primary plan*) and the benefits paid by any *primary plan* during the *claim determination period*. Payment from all *plans* will not exceed 100% of the total *allowable expense*.

The difference between the benefit payments that this *plan* would have paid had it been the *primary plan*, and the benefit payments that it actually paid or provided shall be recorded as a benefit reserve for the *covered person* and used by this *plan* to pay an *allowable expense*, not otherwise paid during the *claim determination period*. As each claim is submitted, this *plan* will:

- Determine its obligation to pay or provide benefits under its contract;
- Determine whether a benefit reserve has been recorded for the *covered person*; and
- Determine whether there are any unpaid *allowable expenses* during the *claim determination period.*

If there is a benefit reserve, the *secondary plan* will use the *covered person's* benefit reserve to pay up to 100% of total *allowable expenses* incurred during the *claim determination period*. At the end of the *claim determination period*, the benefit reserve returns to zero. A new benefit reserve must be created for each new *claim determination period*.

If a *covered person* is enrolled in two or more *closed panel plans* and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one *closed panel plan*, COB shall not apply between that *plan* and the other *closed panel plan.*
226400 06/06

Right to receive and release needed information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this *plan* and other *plans*. *We* may get the facts *we* need from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under this *plan* and other *plans* covering the person claiming benefits. *We* need not tell, or get the consent of, any person to do this. Each person claiming benefits under this *plan* must give *us* any facts *we* need to apply those rules and determine benefits payable.
226500

Facility of payment

A payment made under another *plan* may include an amount that should have been paid under this *plan*. If it does, *we* may pay that amount to the organization that made the payment. That amount will then be treated as though it were a benefit paid under this *plan*. *We* will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means a reasonable cash value of the benefits provided in the form of services.
226600

Right of recovery

If the amount of the payments made by *us* is more than *we* should have paid under this COB provision, *we* may recover the excess from one or more of the persons *we* have paid or for whom we have paid; or any other person or organization that may be responsible for the benefits or services provided for the *covered person*. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.
226700

COORDINATION OF BENEFITS FOR MEDICARE ELIGIBLES

Definitions

Medicare Part A means the *Medicare* program that provides hospital insurance benefits.

Medicare Part B means the *Medicare* program that provides medical insurance benefits.

Medicare Part D means the *Medicare* program that provides prescription drug benefits.
227000 06/06

General coordination of benefits with Medicare

If *you* are covered under both *Medicare* and this *certificate*, federal law mandates that *Medicare* is the secondary plan in most situations. But when permitted by law, this plan is the secondary plan. In all cases, coordination of benefits with *Medicare* will conform to federal statutes and regulations. If *you* are enrolled in *Medicare*, *your* benefits under this *certificate* will be coordinated to the extent benefits are payable under *Medicare*, as allowed by federal statutes and regulations.
227100TX 06/06

CLAIMS

Notice of claim

Network providers will submit claims to *us* on *your* behalf. If *you* utilize a *non-network provider* for *covered expenses*, *you* must submit a notice of claim to *us*. Notice of claim must be given to *us* in writing or by *electronic mail* as required by *your* plan, or as soon as is reasonably possible thereafter. Notice must be sent to *us* at *our* mailing address shown on *your* identification documentation or at *our* Website at www.humana.com.
228000

Claims must be complete. At a minimum a claim must contain:

- Name of the *covered person* who incurred the *covered expenses*;
- Name and address of the provider;
- Diagnosis;
- Procedure or nature of the treatment;
- Place of service;
- Date of service; and
- Billed amount.

The forms necessary for filing proof of loss are available via the internet at *our* Website. When requested by *you*, *we* will send *you* the forms for filing proof of loss. If the requested forms are not sent to *you* within 15 days, *you* will have met the proof of loss requirements by sending *us* a written or *electronic* statement of the nature and extent of the loss containing the above elements within the time limit stated in the "Proof of Loss" provision.
228100

Proof of loss

You must give written or *electronic* proof of loss within 90 days after the date of loss. *Your* claims will not be reduced or denied if it was not reasonably possible to give such proof. In any event, written or *electronic* notice must be given within one year after the date proof of loss is otherwise required, except if *you* were legally incapacitated.
228200

Right to require medical examinations

We have the right to require a medical examination on any *covered person* as often as *we* may reasonably require. If *we* require a medical examination, it will be performed at *our* expense. *We* also have a right to request an autopsy in the case of death, if state law so allows.
228300 05/05

To whom benefits are payable

If *you* receive services from a *network provider*, *we* will pay the provider directly for all *covered expenses*. *You* will not have to submit a claim for payment.

All benefits are payable to the *covered person* for services rendered by a *non-network provider*. However, with *our* consent, a *covered person* may direct *us* to pay all or any part of the medical benefits to the health care provider on whose charge the claim is based. If *we* pay *you* directly, *you* are then responsible for any and all payments to the *non-network provider*(s).

If any *covered person* to whom benefits are payable is a minor or, in *our* opinion, not able to give a valid receipt for any payment due him or her, such payment will be made to his or her parent or legal guardian. However, if no request for payment has been made by the parent or legal guardian, *we* may, at *our* option, make payment to the person or institution appearing to have assumed his or her custody and support.
228400TX

For a minor child who otherwise qualifies as a *dependent* of the *employee*, benefits may be paid on behalf of the child to a person who is not the *employee* if an order issued by a court of competent jurisdiction in this or any other state names such person managing conservator of the child.

To be entitled to receive benefits, a managing conservator of a child must submit to *us*, with the claim application, written notice that such person is the managing conservator of the child on whose behalf the claim is made, and submit a certified copy of a court order establishing the person as managing conservator or other evidence designated by rule of the Texas Department of Insurance that the person qualifies to be paid the benefits. Such requirements shall not apply in the cases of any unpaid medical bill for which a valid assignment of benefits have been exercised or to claims submitted by the *employee* where the *employee* has paid any portion of a medical bill that would be covered under the terms of the *policy*.
228440TX

If *you* receive medical assistance from the Texas Department of Human Services while *you* are a *covered person* under the *policy*, *we* will reimburse the department for the actual cost of medical expenses the department pays through medical assistance, if such assistance was paid for a *covered person* for which benefits are payable under the *policy*, and if *we* receive timely notice from the department of payment of such assistance. Any reimbursement to the department made by *us* will discharge *us* to the extent of the reimbursement. This provision applies only to the extent *we* have not already made payment of *your* claim to *you* or to the provider.

If the Texas Department of Human Services is paying financial and medical assistance for a child and *you* are a parent covered by the *policy* and have possession or access to the child, or *you* are not entitled to access or possession of the child but are required by the court to pay child support, all benefits paid on behalf of the child or children under the *policy* must be paid to the Texas Department of Human Services.

We must receive written notice, affixed to the claim when first submitted, that benefits must be paid directly to the Texas Department of Human Services.
228460TX

CLAIMS (continued)

Time of payment of claims

Payments due under the *policy* will be paid no more than 30 days after receipt of written or *electronic* proof of loss.
228500

Right to request overpayments

We reserve the right to recover any payments made by *us* that were:

- Made in error; or
- Made to *you* and/or any party on *your* behalf, where *we* determine that such payment made is greater than the amount payable under the *policy*; or
- Made to *you* and/or any party on *your* behalf, based on fraudulent or misrepresented information; or
- Made to *you* and/or any party on *your* behalf for charges that were discounted, waived or rebated.

We reserve the right to adjust any amount applied in error to the *deductible* or *out-of-pocket limit*.
228700

Right to collect needed information

You must cooperate with *us* and when asked, assist *us* by:

- Authorizing the release of medical information including the names of all providers from whom *you* received medical attention;

- Obtaining medical information and/or records from any provider as requested by *us*;

- Providing information regarding the circumstances of *your sickness*, *bodily injury* or *accident*;

- Providing information about other insurance coverage and benefits, including information related to any *bodily injury* or *sickness* for which another party may be liable to pay compensation or benefits; and

- Providing information *we* request to administer the *policy*.

If *you* fail to cooperate or provide the necessary information, *we* may recover payments made by *us* and deny any pending or subsequent claims for which the information is requested.
228800 05/05

Exhaustion of time limits

If *we* fail to complete a claim determination or appeal within the time limits set forth in the *policy*, the claim shall be deemed to have been denied and *you* may proceed to the next level in the review process outlined under the "Complaint and Appeal Procedures" section of this *certificate* or as required by law.
228900

Recovery rights

You as well as *your dependents* agree to the following, as a condition of receiving benefits under the *policy*.
229000

Duty to cooperate in good faith

You are obligated to cooperate with *us* and *our* agents in order to protect *our* recovery rights. Cooperation includes promptly notifying *us* that *you* may have a claim, providing *us* relevant information, and signing and delivering such documents as *we* or *our* agents reasonably request to secure *our* recovery rights. *You* agree to obtain *our* consent before releasing any party from liability for payment of medical expenses. *You* agree to provide *us* with a copy of any summons, complaint or any other process serviced in any lawsuit in which *you* seek to recover compensation for *your* injury and its treatment.

You will do whatever is necessary to enable *us* to enforce *our* recovery rights and will do nothing after loss to prejudice *our* recovery rights.

You agree that *you* will not attempt to avoid *our* recovery rights by designating all (or any disproportionate part) of any recovery as exclusively for pain and suffering.

In the event that *you* fail to cooperate with *us*, *we* shall be entitled to recover from *you* any payments made by *us*.
229100

Duplication of benefits/other insurance

We will not provide duplicate coverage for benefits under the *policy* when a person is covered by *us* and has, or is entitled to, benefits as a result of their injuries from any other coverage including, but not limited to, first party uninsured or underinsured motorist coverage, any no-fault insurance, medical payment coverage (auto, homeowners or otherwise), Workers' Compensation settlement or awards, other group coverage (including student plans), direct recoveries from liable parties, premises medical pay or any other insurer providing coverage that would apply to pay *your* medical expenses, except another "plan", as defined in the "Coordination of Benefits" section (e.g. group health coverage), in which case priority will be determined as described in the "Coordination of Benefits" section.

Where there is such coverage, *we* will not duplicate other coverage available to *you* and shall be considered secondary, except where specifically prohibited. Where double coverage exists, *we* shall have the right to be repaid from whomever has received the overpayment from *us* to the extent of the duplicate coverage.

We will not duplicate coverage under the *policy* whether or not *you* have made a claim under the other applicable coverage.

When applicable, *you* are required to provide *us* with authorization to obtain information about the other coverage available, and to cooperate in the recovery of overpayments from the other coverage, including executing any assignment of rights necessary to obtain payment directly from the other coverage available.
229200 05/05

Workers' compensation

If benefits are paid by *us* and *we* determine that the benefits were for treatment of *bodily injury* or *sickness* that arose from or was sustained in the course of, any occupation or employment for compensation, profit or gain, *we* have the right to recover as described below. *We* will exercise *our* right to recover against *you*.

The recovery rights will be applied even though:

- The Workers' Compensation benefits are in dispute or are made by means of settlement or compromise;
- No final determination is made that *bodily injury* or *sickness* was sustained in the course of, or resulted from, *your* employment;
- The amount of Workers' Compensation due to medical or health care is not agreed upon or defined by *you* or the Workers' Compensation carrier, or
- Medical or health care benefits are specifically excluded from the Workers' Compensation settlement or compromise.

You hereby agree that, in consideration for the coverage provided by the *policy*, *you* will notify *us* of any Workers' Compensation claim *you* make, and that *you* agree to reimburse *us* as described above.
229300

Right of subrogation

As a condition to receiving benefits from *us*, *you* agree to transfer to *us* any rights *you* may have to make a claim, take legal action or recover any expenses paid under the *policy*. *We* will be subrogated to *your* rights to recover from any funds paid or payable as a result of a personal injury claim or any reimbursement of expenses by:

- Any legally liable person or their carrier;
- Any uninsured motorist or underinsured motorist coverage;

- Medical payments/expense coverage under any automobile, homeowners, premises or similar coverages;
- No-fault or other similar coverage.

We may enforce *our* subrogation rights by asserting a claim to any coverage to which *you* may be entitled.

If *we* are precluded from exercising *our* rights of subrogation, *we* may exercise *our* right of reimbursement.
229400

Right of reimbursement

If benefits are paid under the *policy* and *you* recover from any legally responsible person, their insurer, or any uninsured motorist, underinsured motorist, medical payment/expense, no-fault, or other similar coverage, *we* have the right to recover from *you* an amount equal to the amount *we* paid.

You shall notify *us*, in writing or by *electronic mail*, within 31 days of any settlement, compromise or judgment. Any *covered person* who waives, abrogates or impairs *our* right of reimbursement or fails to comply with these obligations, relieves *us* from any obligation to pay past or future benefits or expenses until all outstanding lien(s) are resolved.

If, after the inception of coverage with *us*, *you* recover payment from and release any legally responsible person, their insurer, or any uninsured motorist, underinsured motorist, medical payment/expense, no-fault, or other similar insurer from liability for future medical expenses relating to a *sickness* or *bodily injury*, *we* shall have a continuing right to reimbursement from *you* to the extent of the benefits *we* provided with respect to that *sickness* or *bodily injury*. This right, however, shall apply only to the extent of such payment and only to the extent not limited or precluded by law in the state whose laws govern the *policy*, including any made whole or similar rule.

The obligation to reimburse *us* in full exists, regardless of whether the settlement, compromise, or judgment designates the recovery as including or excluding medical expenses.
229500

Assignment of recovery rights

The *policy* contains an exclusion for *sickness* or *bodily injury* for which there is medical payment/expenses coverage provided under any automobile, homeowner's, premises or other similar coverage.

If *your* claim against the other insurer is denied or partially paid, *we* will process *your* claim according to the terms and conditions of the *policy*. If payment is made by *us* on *your* behalf, *you* agree to assign to *us* the right *you* have against the other insurer for medical expenses *we* pay.

If benefits are paid under the *policy* and *you* recover under any automobile, homeowner's, premises or similar coverage, *we* have the right to recover from *you* an amount equal to the amount *we* paid.
229600

Cost of legal representation

The costs of *our* legal representation in matters related to *our* recovery rights shall be borne solely by *us*. The costs of legal representation incurred by *you* shall be borne solely by *you*, unless *we* were given timely notice of the claim and an opportunity to protect *our* own interests and *we* failed or declined to do so.
229700

COMPLAINT AND APPEAL PROCEDURES

If *you* are dissatisfied with *our* determination of *your* claim, *you* may appeal the decision. *You* should appeal in writing to the address given on the denial letter *you* received. Such appeals will be handled on a timely basis and appropriate records will be kept on all appeals.

All requests for review should be submitted in writing or on *our* web site at www.HUMANA.com. *We* have procedures for reviewing appeals and may conduct informal hearings about the appeal. If a hearing is to be held, *you* will be notified in advance. Resolution of the appeal will be completed within a reasonable amount of time. *Our* findings and recommendations will be final.

The appeal process does not preclude *you* from pursuing other appropriate remedies, including injunctive relief, a declaratory judgment, or relief available under law.
230000TX 05/05

Legal actions and limitations

No action at law or in equity shall be brought to recover on the *policy* prior to the expiration of sixty days after written proof of loss has been furnished in accordance with the requirements of the *policy*. No such action shall be brought after the expiration of three years after the latter of:

- The date on which *we* first denied the service or claim; paid less than *you* believe appropriate; or failed to timely pay the claim; or
- 180 days after a final determination of a timely filed appeal.

230200TX 06/06

DISCLOSURE PROVISIONS

Shared savings program

As a member of a Preferred Provider Organization Plan, *you* are free to obtain services from providers participating in the Preferred Provider Organization network (*network providers*), or providers not participating in the Preferred Provider Organization network (*non-network providers*). If *you* choose a *network provider*, *your* out-of-pocket expenses are normally lower than if *you* choose a *non-network provider*.

We have a Shared Savings Program that may allow *you* to share in discounts *we* have obtained from *non-network providers*.

Although *our* goal is to obtain discounts whenever possible, *we* cannot guarantee that services rendered by *non-network providers* will be discounted. The *non-network provider* discounts in the Shared Savings Program may not be as favorable as *network provider* discounts.

In most cases, to maximize *your* benefit design and minimize *your* out-of-pocket expense, please access *network providers* associated with *your* plan.

If *you* choose to obtain services from a *non-network provider*, it is not necessary for *you* to inquire about a provider's status in advance. When processing *your* claim, *we* will automatically determine if that provider is participating in the Shared Savings Program and calculate *your deductible* and *coinsurance* on the discounted amount. *Your* Explanation of Benefits statement will reflect any savings with a remark code used to reference the Shared Savings Program.

However, if *you* would like to inquire in advance to determine if a *non-network provider* participates in the Shared Savings Program, please contact *our* customer service department at the telephone number shown on *your* identification card. Please note provider arrangements in the Shared Savings Program are subject to change without notice. *We* cannot guarantee that the provider from whom *you* received treatment is still participating in the Shared Savings Program at the time treatment is received. Discounts are dependent upon availability and cannot be guaranteed.

We reserve the right to modify, amend or discontinue the Shared Savings Program at any time.
231100

MISCELLANEOUS PROVISIONS

Entire contract

The entire contract is made up of the *policy*, the application of the *policyholder*, incorporated by reference herein, and the applications or enrollment forms, if any, of the *covered persons*. All statements made by the *policyholder* or by a *covered person* are considered to be representations, not warranties. This means that the statements are made in good faith. No statement will void the *policy*, reduce the benefits it provides or be used in defense to a claim unless it is contained in a written or *electronic* application or enrollment form and a copy is furnished to the person making such statement or his or her beneficiary.
232000 03/10

Additional policyholder responsibilities

In addition to responsibilities outlined in the *policy*, the *policyholder* is responsible for:

- Collection of premium; and
- Providing access to:
  - Benefit plan documents;
  - Renewal notices and policy modification information;
  - Product discontinuance notices; and
  - Information regarding continuation rights.

No *policyholder* has the power to change or waive any provision of the *policy*.
232100 06/06

Certificates of insurance

A *certificate* setting forth a statement of insurance protection to which the *employee* and the *employee's* covered *dependents* are entitled will be available via internet access, or in writing when requested. The *policyholder* is responsible for providing *employees* access to the *certificate*.
232200 04/04

This *certificate* is part of the *policy* that controls *our* obligations regarding coverage. No document that is viewed as being not consistent with the *policy* shall take precedence over it. This is true, also, when this *certificate* is incorporated by reference into a summary description of plan benefits prepared and distributed by the administrator of a group health plan subject to ERISA. This *certificate* is not subject to the ERISA style and content conventions that apply to summary plan descriptions. So if the terms of a summary plan description appear to differ with the terms of this *certificate* respecting coverage, the terms of this *certificate* will control.
232300 04/04

MISCELLANEOUS PROVISIONS (continued)

Incontestability

After two years from the *effective date* of the *policy*, no misstatement made by the *policyholder*, except a fraudulent misstatement made in the application may be used to void the *policy*.

After *you* are insured without interruption for two years, *we* cannot contest the validity of *your* coverage except for:

- Nonpayment of premium; or
- Any fraudulent misrepresentation made by *you*.

At any time, *we* may assert defenses based upon provisions in the *policy* which relate to *your* eligibility for coverage under the *policy*.

No statement made by *you* can be contested unless it is in a written or *electronic* form signed by *you*. A copy of the form must be given to *you* or *your* beneficiary.

An independent incontestability period begins for each type of change in coverage or when a new application or enrollment form of the *covered person* is completed.
232400 03/10

Fraud

Health insurance fraud is a criminal offense that can be prosecuted. Any person(s) who willingly and knowingly engages in an activity intended to defraud *us* by filing a claim or form that contains a false or deceptive statement may be guilty of insurance fraud.

If *you* commit fraud against *us* or *your employer* commits fraud pertaining to *you* against *us*, as determined by *us*, *your* coverage ends automatically, without notice, as of the date fraud is committed or as of the date otherwise determined by *us*.
232500

Clerical error, misstatement of age or gender

If it is determined that information about the age or gender of *you* or *your dependents* was omitted or misstated in error, the amount of insurance for which *you* are properly eligible will be in effect. An equitable premium adjustment will be made. This provision applies equally to *you* and to *us*.
232600

MISCELLANEOUS PROVISIONS (continued)

Modification of policy

The *policy* may be modified at any time by agreement between *us* and the *policyholder* without the consent of any *covered person* or any beneficiary. No modification will be valid unless approved by *our* President, Secretary or Vice-President. The approval must be endorsed on or attached to the *policy*. No agent has authority to modify the *policy*, waive any of the *policy* provisions, extend the time of premium payment, or bind *us* by making any promise or representation.

The *policy* may be modified by *us* at anytime without prior consent of, or notice to, the *policyholder* when the changes are:

- Allowed by state or federal law or regulation;
- Directed by the state agency that regulates insurance;
- Benefit increases that do not impact premium; or
- Corrections of clerical errors or clarifications that do not reduce benefits.

Modifications due to reasons other than those listed above, may be made by *us*, upon renewal of the *policy*, in accordance with state and federal law. The *policyholder* will be notified in writing or *electronically* at least 60 days prior to the effective date of such changes.

If this *certificate* offers a standard benefit level and an enhanced benefit level as specified in the "Schedule of Benefits" section, movement between these benefit levels is not a modification of *policy*.
232700TX 03/10

Premium contributions

Your employer must pay the required premiums to *us* as they become due. *Your employer* may require *you* to contribute toward the cost of *your* insurance. Failure of *your employer* to pay any required premium to *us* when due may result in the termination of *your* insurance.
232800

Premium rate change

We reserve the right to change any premium rates in accordance with applicable law upon notice to the *employer*. *We* will provide notice to the *employer* of any such premium changes. Questions regarding changes to premium rates should be addressed to the *employer*.
232900

Assignment

The *policy* and its benefits may not be assigned by the *policyholder*.
233200

Conformity with statutes

Any provision of the *policy* which is not in conformity with applicable state law(s) or other applicable law(s) shall not be rendered invalid, but shall be construed and applied as if it were in full compliance with the applicable state law(s) and other applicable law(s).
233300

GLOSSARY

Terms printed in italic type in this *certificate* have the meaning indicated below. Defined terms are printed in italic type wherever found in this *certificate*.
234000

A

Accident means a sudden event that results in a *bodily injury* or *dental injury* and is exact as to time and place of occurrence.

Active status means the *employee* is performing all of his or her customary duties whether performed at the *employer's* business establishment, some other location which is usual for the *employee's* particular duties or another location when required to travel on the job:

- On a regular full-time basis for the number of hours per week shown on the Employer Group Application or as specified in the *participation criteria* established by a *large employer*; and
- For 48 weeks a year; and
- Is maintaining a bona fide *employer-employee* relationship with the *policyholder* of the *group policy* on a regular basis.

Each day of a regular vacation and any regular non-working holiday is deemed *active status*, if the *employee* was in *active status* on his or her last regular working day prior to the vacation or holiday. An *employee* is deemed to be in *active status* if an absence from work is due to a *sickness* or *bodily injury*, provided the *employee* otherwise meets the definition of an *eligible employee* for a *small employer* or meets the *participation criteria* of a *large employer*.

Acute inpatient services means care given in a *hospital* or *health care treatment facility* which:

- Maintains permanent full-time facilities for *room and board* of resident patients;
- Provides emergency, diagnostic and therapeutic services with a capability to provide life-saving medical and psychiatric interventions;
- Has physician services, appropriately licensed behavioral health practitioners and skilled nursing services available 24-hours a day;
- Provides direct daily involvement of the physician; and
- Is licensed and legally operated in the jurisdiction where located.

Acute inpatient services are utilized when there is an immediate risk to engage in actions which would result in death or harm to self or others or there is a deteriorating condition in which an alternative treatment setting is not appropriate.

Admission means entry into a facility as a registered bed patient according to the rules and regulations of that facility. An *admission* ends when *you* are discharged, or released, from the facility and are no longer registered as a bed patient.

Advanced imaging, for the purpose of this definition, includes Magnetic Resonance Imaging (MRI), Magnetic Resonance Angiography (MRA), Positron Emission Tomography (PET), Single Photon Emission Computed Tomography (SPECT), and Computed Tomography (CT) imaging.

Alternative medicine, for the purposes of this definition, includes, but is not limited to: acupressure, aromatherapy, ayurveda, biofeedback, faith healing, guided mental imagery, herbal medicine, holistic medicine, homeopathy, hypnosis, macrobiotics, massage therapy, naturopathy, ozone therapy, reflexotherapy, relaxation response, rolfing, shiatsue and yoga.

Ambulance means a professionally operated vehicle, provided by a licensed ambulance service, equipped for the transportation of a sick or injured person to or from the nearest medical facility qualified to treat the person's *sickness* or *bodily injury*. Use of the *ambulance* must be *medically necessary* and/or ordered by a *health care practitioner*.

Ambulatory surgical center means an institution which meets all of the following requirements:

- It must be staffed by physicians and a medical staff which includes registered nurses.
- It must have permanent facilities and equipment for the primary purpose of performing *surgery*.
- It must provide continuous physicians' services on an *outpatient* basis.
- It must admit and discharge patients from the facility within a 24-hour period.
- It must be licensed in accordance with the laws of the jurisdiction where it is located. It must be operated as an *ambulatory surgical center* as defined by those laws.
- It must not be used for the primary purpose of terminating pregnancies, or as an office or clinic for the private practice of any physician or dentist.

Autism spectrum disorder means a neurobiological disorder that includes autism, Asperger's syndrome, or Pervasive Developmental Disorder – not otherwise specified.
234800TX 02/11

B

Behavioral health means *mental health services* and *chemical dependency* services.

Bodily injury means bodily damage other than a *sickness*, including all related conditions and recurrent symptoms. However, bodily damage resulting from infection or muscle strain due to athletic or physical activity is considered a *sickness* and not a *bodily injury*.

Bone marrow means the transplant of human blood precursor cells which are administered to a patient following high-dose, ablative or myelosuppresive chemotherapy. Such cells may be derived from bone marrow, circulating blood, or a combination of bone marrow and circulating blood obtained from the patient in an autologous transplant or from a matched related or unrelated donor or cord blood. If chemotherapy is an integral part of the treatment involving an *organ transplant* of *bone marrow*, the term *bone marrow* includes the harvesting, the transplantation and the chemotherapy components.
235100 07/07

C

Certificate means this benefit plan document which outlines the benefits, provisions and limitations of the *policy*.

Chemical dependency means the abuse of, or psychological or physical dependence on, or addiction to, alcohol or a *controlled substance*.

Chemical dependency treatment center means a facility that provides a program for the treatment of *chemical dependency* pursuant to a written treatment plan approved and monitored by a physician. The facility must also be:

- Affiliated with a *hospital* under a contractual agreement with an established system for patient referral; or
- Accredited as such a facility by the Joint Commission on Accreditation of Healthcare Organizations; or
- Licensed as a chemical dependency treatment program by the Texas Commission on Alcohol and Drug Abuse; or
- Licensed, certified or approved as a chemical dependency treatment program or center by any other state agency having legal authority to so license, certify, or approve.

Coinsurance means the amount expressed as a percentage of the *covered expense* that *you* must pay. The percentage of the *covered expense* that *we* pay is shown in the "Schedule of Benefits" sections.

Complications of pregnancy means:

- Conditions, requiring *hospital confinement* (when the pregnancy is not terminated) with diagnoses which are distinct from pregnancy but adversely affected by pregnancy. Such conditions include, but are not limited to:

    - Acute nephritis;
    - Nephrosis;
    - Cardiac decompensation;
    - Hyperemesis gravidarum;
    - Puerperal infection;
    - Pre-eclampsia (toxemia);
    - Eclampsia;
    - Abruptio placenta;
    - Placenta previa;
    - Missed abortion (miscarriage) or threatened abortion;
    - Endometritis;
    - Hydatiform mole;
    - Chorionic carcinoma;
    - Pre-term labor; and
    - Medical and surgical conditions of comparable severity;

- A nonelective cesarean section; or
- Terminated Ectopic pregnancy; or
- Spontaneous termination of pregnancy which occurs during a period of gestation in which a viable birth is not possible.

Complication of pregnancy does not mean:

- False labor;
- Occasional spotting;
- Physician prescribed rest during the period of pregnancy;
- Morning sickness;
- Conditions associated with the management of a difficult pregnancy but which do not constitute distinct complications of pregnancy; or
- An elective cesarean section.

Confinement or ***confined*** means *you* are admitted as a registered bed patient as the result of a *health care practitioner's* recommendation. It does not mean detainment in *observation status*.

Controlled substance means a *toxic inhalant* or a substance designated as a controlled substance in Chapter 481, Health and Safety code.

Copayment means the specified dollar amount that *you* must pay to a provider for certain *covered expenses* regardless of any amounts that may be paid by *us* as shown in the "Schedule of Benefits" sections.

Cosmetic surgery means *surgery* performed to reshape normal structures of the body in order to improve or change *your* appearance or self-esteem.

Court-ordered means involuntary placement in *behavioral health* treatment as a result of a judicial directive.

Covered expense means *medically necessary* services or routine *preventive services* which are:

- Ordered by a *health care practitioner*;
- For the benefits described herein, subject to any maximum benefit and all other terms, provisions limitations and exclusions of the *policy*; and
- Incurred when *you* are insured for that benefit under the *policy* on the date that the service is rendered.

Covered person means the *employee* and/or the *employee's dependents* who are enrolled for benefits provided under the *policy*.

Craniofacial abnormality means abnormal structure caused by congenital defects, development deformities, trauma, tumors, infections, or disease.

GLOSSARY (continued)

Creditable coverage means a *covered person's* prior coverage under any of the following:

- A self-funded or self-insured employee welfare benefit plan providing health benefits in accordance with the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.);
- A group health plan, including church and governmental plans;
- Group or individual *Health insurance coverage*;
- *Medicare* (Part A or B) or *Medicaid*;
- The health plan for active military personnel, including TRICARE;
- The Indian Health Services or other tribal organization program;
- A state health benefits risk pool;
- The Federal Employees Health Benefits Program;
- A non-federal, public health plan;
- A health benefit plan under section 5(e) of the Peace Corps Act;
- State Children's Health Insurance Program; or
- Foreign health care.

Creditable coverage does not include any of the following:

- Accident only coverage, disability income insurance, or any combination thereof;
- Supplemental coverage to liability insurance;
- Liability insurance, including general liability insurance and automobile liability insurance;
- Workers' compensation or similar insurance;
- Automobile medical payment insurance;
- Credit-only insurance;
- Coverage for on site medical clinics;

- Benefits if offered separately:

    - Limited scope dental and vision;
    - Long-term care, nursing home care, home health care, community based care, or any combination thereof; and
    - Other similar, limited benefits;

- Benefits if offered as independent, non-coordinated benefits:

    - Specified disease or illness coverage; and
    - Hospital indemnity or other fixed indemnity insurance;

- Benefits offered as a separate policy:

    - *Medicare* supplement insurance;
    - Supplemental coverage to the health plan for active military personnel, including TRICARE; and
    - Similar supplemental coverage provided to group health plan coverage;

- A health Flexible Spending Account (FSA), if it meets the Internal Revenue Service definition of a health FSA, and:

  - *You* have other coverage available under a group health plan; and

  - *Your* maximum benefit payable under the FSA does not exceed two times *your* salary election. If *your* maximum benefit payable under the FSA is greater than two times *your* salary election, it must not exceed more than $500 plus *your* salary election.

Crisis stabilization unit means a 24-hour residential program usually short term in nature and that provides intensive supervision and highly structured activities to persons who are demonstrating an acute demonstrable psychiatric crisis of moderate to severe proportions.

Custodial care means services given to *you* if:

- *You* need services including, but not limited to, assistance with dressing, bathing, preparation and feeding of special diets, walking, supervision of medication which is ordinarily self administered, getting in and out of bed, maintaining continence; or

- The services *you* require are primarily to maintain, and not likely to improve, *your* condition; or

- The services involve the use of skills which can be taught to a layperson and do not require the technical skills of a *nurse*.

Services may still be considered *custodial care* by *us* even if:

- *You* are under the care of a *health care practitioner*;
- The *health care practitioner* prescribed services are to support or maintain *your* condition; or
- Services are being provided by a *nurse*.

236100TX 02/11

D

Deductible means the amount of *covered expenses* that *you*, either individually or combined as a covered family, must pay per *year* before *we* pay benefits for certain specified services.

Some plans may have a *network provider* benefit allowance prior to the applicability of the *deductible*. Please refer to the "Schedule of Benefits" section for more information.

Dental injury means an injury to a *sound natural tooth* caused by a sudden and external force that could not be predicted in advance and could not be avoided. It does not include biting or chewing injuries.

GLOSSARY (continued)

Dependent means a covered *employee's*:

- Legally recognized spouse;

- Natural born child, step-child, legally adopted child, child for whom the *employee* is a party in a suit in which adoption of the child is sought by the *employee*, or grandchild, if the grandchild is dependent on the *employee* for Federal Income Tax purposes at the time of application;

- Child of any age who is medically certified as disabled. Medically certified as disabled means being incapable of self-sustaining employment by reason of mental retardation or physical handicap and being chiefly dependent upon the employee for support and maintenance; or

- Child whose age is less than the limiting age and for whom the *employee* has received a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN) to provide coverage, if the *employee* is eligible for family coverage until:

    - Such QMCSO or NMSN is no longer in effect; or
    - The child is enrolled for comparable health coverage, which is effective no later than the termination of the child's coverage under the *policy*.

Under no circumstances shall *dependent* mean a great grandchild or foster child including where the great grandchild or foster child meets all of the qualifications of a dependent as determined by the Internal Revenue Service.

The limiting age means the birthday the *dependent* child attains age 26. Each *dependent* child is covered to the limiting age regardless if the child is:

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

A covered *dependent* child who attains the limiting age <u>while insured</u> under the *policy* remains eligible if the covered *dependent* child is:

- Permanently mentally or physically handicapped; and
- Incapable of self-sustaining employment; and
- Unmarried.

In order for the covered *dependent* child to remain eligible as specified above, *we* must receive notification within 31 days of the covered *dependent* child attaining the limiting age.

A handicapped *dependent* child, as defined in the bulleted items above, who attained the limiting age while insured under the *employer's* previous group medical plan (Prior Plan) is eligible for coverage under the *policy*. Please refer to the "Replacement of Coverage" section of this *certificate*.

You must furnish satisfactory proof to *us* upon *our* request that the conditions, as defined in the bulleted items above, continuously exist on and after the date the limiting age is reached. After two years from the date the first proof was furnished, *we* may not request such proof more often than annually. If satisfactory proof is not submitted to *us*, the child's coverage will not continue beyond the last date of eligibility.

Diabetes equipment means blood glucose monitors, including noninvasive glucose monitors and monitors designed to be used by or adapted for legally blind individuals; insulin pumps and associated accessories; insulin infusion devices; and podiatric appliances, including up to two pairs of therapeutic footwear per *year*, for the prevention of complications associated with diabetes.

Diabetes self-management training means the training provided to a *covered person* after the initial diagnosis of diabetes for care and management of the condition including nutritional counseling and use of *diabetes equipment* and supplies. It also includes training when changes are required to the self-management regime and when new techniques and treatments are developed.

Diabetes supplies means test strips for blood glucose monitors; visual reading and urine test strips and tablets; lancets and lancet devices; insulin and insulin analogs; injection aids, including devices used to assist with insulin injection and needleless systems; insulin syringes; durable and disposable devices to assist in the injection of insulin; other required disposable supplies; prescriptive and nonprescriptive oral agents for controlling blood sugar levels; glucagon emergency kits; alcohol swabs; infusion sets; insulin cartridges; batteries; skin preparation items; adhesive supplies; and biohazard disposable containers.

Durable medical equipment means equipment that meets all of the following criteria:

- It is prescribed by a *health care practitioner*;
- It can withstand repeated use;
- It is primarily and customarily used for a medical purpose rather than being primarily for comfort or convenience;
- It is generally not useful to *you* in the absence of *sickness* or *bodily injury*;
- It is appropriate for home use or use at other locations as necessary for daily living;
- It is related to and meets the basic functional needs of *your* physical disorder;
- It is not typically furnished by a *hospital* or s*killed nursing facility*;
- It is *medically necessary* and necessitated by *your bodily injury* or *sickness*; and
- It is provided in the most cost effective manner required by *your* condition, including, at *our* discretion, rental or purchase.

236800TX 02/11

E

Effective date means the date *your* coverage begins under the *policy*.

Electronic or electronically means relating to technology having electrical, digital, magnetic, wireless, optical, electromagnetic, or similar capabilities.

Electronic mail means a computerized system that allows a user of a network computer system and/or computer system to send and receive messages and documents among other users on the network and/or with a computer system.

Electronic signature means an electronic sound, symbol, or process attached to or logically associated with a record and executed or adopted by a person with the intent to sign the record.

Eligibility date means the date the *employee* or *dependent* is eligible to participate in the plan.

Eligible employee means an *employee* who works on a full-time basis and who usually works at least 30 hours a week. The term also includes a sole proprietor, partnership, partner, corporate officer or an independent contractor if the *employer* includes the sole proprietor, partner, corporate officer or an independent contractor as an *employee* under the *group* insurance plan of the *policyholder*, regardless of the number of hours the sole proprietor, partner, corporate officer or independent contractor works weekly, but only if the plan includes at least two other eligible employees who work on a full-time basis and who usually work at least 30 hours a week. The term does not include:

- An employee who works on a part-time, temporary, seasonal or substitute basis; or
- An employee who is covered under:
    - Another health plan;
    - A self-funded ERISA plan;
    - Medicaid if the employee elects not to be covered;
    - Another federal program, including TRICARE or Medicare, if the employee elects not to be covered; or
    - A plan established in another country if the employee elects not to be covered.

Emergency care means services provided in a *hospital* emergency facility, free-standing emergency medical care facility or a comparable emergency facility to evaluate and stabilize medical conditions of a recent onset and severity for a *bodily injury* or *sickness* manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of that individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; or
- Serious impairment of bodily functions; or
- Serious dysfunction of any bodily organ or part; or
- Serious disfigurement; or
- In the case of a pregnant woman, serious jeopardy to the health of the fetus.

Emergency care does not mean services for the convenience of the *covered person* or the provider of treatment or services.

Employee means any individual employed by the *employer*.

If specified on the Employer Group Application and approved by *us*, *employee* includes retirees of the *employer*. A retired *employee* is not required to be in *active status* to be eligible for coverage under this *policy*.

Employer means the sponsor of this *group* insurance plan, or any subsidiary or affiliate described in the Employer Group Application.

Enrollment date means:

- If *you* are not a *late applicant*, *your enrollment date* is the earlier of the following:
  - The first day *your* coverage is effective under the *policy*; or
  - The first day of the *waiting period* for enrollment, if any *waiting period* is applicable.
- *Your enrollment date* is the first day *your* coverage is effective under the *policy*, if:
  - *You* are a *late applicant*; or
  - *You* enroll during the employer established *open enrollment period*; or
  - *You* are enrolled on a *special enrollment date*.

The term *enrollment date* in this *certificate* is used for the determination and application of the *pre-existing condition* limitation and/or *creditable coverage*.

Experimental or ***investigational*** or ***for research purposes*** means a drug, biological product, device, treatment or procedure that meets any one of the following criteria, as determined by *us*:

- Cannot be lawfully marketed without the final approval of the United States Food and Drug Administration (FDA) and which lacks such final FDA approval for the use or proposed use, unless (a) found to be accepted for that use in the most recently published edition of the United States Pharmacopeia-Drug Information for Healthcare Professional (USP-DI) or in the most recently published edition of the American Hospital Formulary Service (AHFS) Drug Information, or (b) identified as safe, widely used and generally accepted as effective for that use as reported in nationally recognized peer reviewed medical literature published in the English language as of the date of service; or (c) is mandated by state law;
- Is a device required to receive Premarket Approval (PMA) or 510K approval by the FDA but has not received a PMA or 510K approval;
- Is not identified as safe, widely used and generally accepted as effective for the proposed use as reported in nationally recognized peer reviewed medical literature published in the English language as of the date of service;

- Is the subject of a National Cancer Institute (NCI) Phase I, II or III trial or a treatment protocol comparable to a NCI Phase I, II or III trial, or any trial not recognized by NCI regardless of phase; or

- Is identified as not covered by the Centers for Medicare and Medicaid Services (CMS) Medicare Coverage Issues Manual, a CMS Operational Policy Letter or a CMS National Coverage Decision, except as required by state or federal law.

238000TX 12/09

F

Family member means *you* or *your* spouse, or *your* or *your* spouse's child, brother, sister, or parent.

Free-standing facility means any licensed public or private establishment other than a *hospital* which has permanent facilities equipped and operated to provide laboratory and diagnostic laboratory, *outpatient* radiology, *advanced imaging*, chemotherapy, inhalation therapy, radiation therapy, lithotripsy, physical, cardiac, speech and occupational therapy, or renal dialysis services. An appropriately licensed birthing center is also considered a *free-standing facility*.

Full-time, for an *employee*, means a work week of the number of hours shown on the Employer Group Application.

Functional impairment means a direct and measurable reduction in physical performance of an organ or body part.

238300TX 03/09

G

Group means the persons for whom this insurance coverage has been arranged to be provided.

238400

H

Health care practitioner means a practitioner professionally licensed by the appropriate state agency to diagnose or treat a *sickness* or *bodily injury* and who provides services within the scope of that license.

Health care treatment facility means a facility, institution or clinic, duly licensed by the appropriate state agency to provide medical services or *behavioral health* services, and is primarily established and operating within the scope of its license. *Health care treatment facility* does not include a *chemical dependency treatment center, crisis stabilization unit, psychiatric day treatment facility* or *residential treatment center for children and adolescents.*

Health insurance coverage means medical coverage under any hospital or medical service policy or certificate, hospital or medical service plan contract or Health Maintenance Organization (HMO) contract offered by a health insurance issuer. "Health insurance issuer" means an insurance company, insurance service, or insurance organization (including an HMO) that is required to be licensed to engage in the business of insurance in a state and that is subject to the state law that regulates insurance.

Health status-related factor means any of the following:

- Health status or medical history;
- Medical condition, either physical or mental;
- Claims experience;
- Receipt of health care;
- Genetic information;
- Disability; or
- Evidence of insurability, including conditions arising out of acts of domestic violence.

Home health care agency means a *home health care agency* licensed by the Texas Department of Health.

Home health care plan means a plan of care and treatment for *you* to be provided in *your* home. To qualify, the *home health care plan* must be established and approved by a *health care practitioner*. The services to be provided by the plan must require the skills of a *nurse*, or another *health care practitioner* and must not be for *custodial care*.

Hospice care program means a coordinated, interdisciplinary program provided by a hospice designed to meet the special physical, psychological, spiritual and social needs of a terminally ill *covered person* and his or her immediate covered family members, by providing *palliative care* and supportive medical, nursing and other services through at-home or *inpatient* care. A hospice must be licensed by the laws of the jurisdiction where it is located and must be run as a hospice as defined by those laws. It must provide a program of treatment for at least two unrelated individuals who have been medically diagnosed as having no reasonable prospect for cure for their *sickness* and, as estimated by their physicians, are expected to live 18 months or less as a result of that *sickness*.

Hospital means an institution that meets all of the following requirements:

- It must provide, for a fee, medical care and treatment of sick or injured patients on an *inpatient* basis;
- It must provide or operate, either on its premises or in facilities available to the *hospital* on a pre-arranged basis, medical, diagnostic and surgical facilities;
- Care and treatment must be given by and supervised by physicians. Nursing services must be provided on a 24-hour basis and must be given by or supervised by registered *nurses*;
- It must be licensed by the laws of the jurisdiction where it is located. It must be operated as a *hospital* as defined by those laws;
- It must not be primarily a:

  - Convalescent, rest or nursing home; or
  - Facility providing custodial, educational or rehabilitative care; or
  - *Chemical dependency treatment center*; or
  - *Crisis stabilization unit*; or
  - *Psychiatric day treatment facility*; or
  - *Residential treatment center for children and adolescents.*

The *hospital* must be accredited by one of the following:

- The Joint Commission on the Accreditation of Hospitals;
- The American Osteopathic Hospital Association; or
- The Commission on the Accreditation of Rehabilitative Facilities.

239200TX 02/11

I

Individual lifetime maximum benefit means the maximum amount of benefits payable by *us* for all *covered expenses* incurred by *you*. Once the *individual lifetime maximum benefit* is reached, benefits are not payable and will not be reinstated.

Infertility services means any diagnostic evaluation, treatment, supply, medication, or service provided to achieve pregnancy or to achieve or maintain ovulation. This includes, but is not limited to:

- Artificial insemination;
- Gamete Intrafallopian Transfer (GIFT);
- Zygote Intrafallopian Transfer (ZIFT);
- Tubal ovum transfer;
- Embryo freezing or transfer;
- Sperm storage or banking;
- Ovum storage or banking;
- Embryo or zygote banking;
- Diagnostic and/or therapeutic laparoscopy;
- Hysterosalpingography;
- Ultrasonography;
- Endometrial biopsy; and
- Any other assisted reproductive techniques or cloning methods.

Inpatient means *you* are *confined* as a registered bed patient.

Intensive outpatient program means *outpatient* services providing:

- Group therapeutic sessions greater than one hour a day, three days a week;
- *Behavioral health* therapeutic focus;
- Group sessions centered on cognitive behavioral constructs, social/occupational/educational skills development and family interaction;
- Additional emphasis on recovery strategies, monitoring of participation in 12-step programs and random drug screenings for the treatment of *chemical dependency*; and
- Physician availability for medical and medication management.

Intensive outpatient program does not include services that are for:

- *Custodial care*; or
- Day care.

239600TX 02/11

J

K

L

Large employer means an *employer* who employed an average of at least 51 *eligible employees* on business days during the preceding calendar year and who employs at least two *employees* on the first day of the *year*, unless otherwise provided under state law. For purposes of this definition, a partnership is the *employer* of a partner.

Late applicant means an *employee* or *dependent* who requests enrollment for coverage under the *policy* more than 31 days after his/her *eligibility date*, later than the time period specified in the "Special enrollment" provision, or after the *open enrollment period*.

Life Threatening means a disease or condition for which the likelihood of death is probable unless the course of the disease or condition is interrupted.
239700TX 02/11

M

Maintenance care means services and supplies furnished mainly to:

- Maintain, rather than improve, a level of physical or mental function; or
- Provide a protected environment free from exposure that can worsen the *covered person's* physical or mental condition.

Maximum allowable fee for a *covered expense* is the lesser of:

- The fee charged by the provider for the services;
- The fee that has been negotiated with the provider whether directly or through one or more intermediaries or shared savings contracts for the services;
- The fee established by *us* by comparing rates from one or more regional or national databases or schedules for the same or similar services from a geographical area determined by *us*;
- The fee based upon rates negotiated as payment in full by *us* or other payors with one or more *network providers* in a geographic area determined by *us* for the same or similar services;
- The fee equal to the facility'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 (CMS) annually; or

- The fee based on a percentage determined by *us* of the fee *Medicare* allows for the same or similar services provided in the same geographic area.

Any *network provider* or a provider who has negotiated the fee will accept *maximum allowable fee* as payment in full, excluding any applicable *copayment*, *deductible* or *coinsurance* amounts. The bill *you* receive for services from *non-network providers* may be significantly higher than the *maximum allowable fee*. In addition to *deductibles*, *copayments* and *coinsurance*, *you* are responsible for the difference between the *maximum allowable fee* and the amount the provider bills *you* for the services. Any amount *you* pay to the provider in excess of the *maximum allowable fee* will not apply to *your out-of-pocket limit* or *deductible*.

Medicaid means a state program of medical care for needy persons, as established under Title 19 of the Social Security Act of 1965, as amended.

Medically necessary means health care services that a *health care practitioner* exercising prudent clinical judgment would provide to his or her patient for the purpose of preventing, evaluating, diagnosing or treating a *sickness* or *bodily injury* or its symptoms. Such health care service must be:

- In accordance with nationally recognized standards of medical practice;
- Clinically appropriate in terms of type, frequency, extent, site, and duration, and considered effective for the patient's *sickness* or *bodily injury*;
- Not primarily for the convenience of the patient, physician or other health care provider; and
- Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the patient's *sickness* or *bodily injury.*

For the purpose of *medically necessary*, generally accepted standards of medical practice means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations, the views of physicians practicing in relevant clinical areas and any other relevant factors.

Medicare means a program of medical insurance for the aged and disabled, as established under Title 18 of the Social Security Act of 1965, as amended.

Mental health services means those diagnoses and treatments related to the care of a *covered person* who exhibits a mental, nervous or emotional condition classified in the Diagnostic and Statistical Manual of Mental Disorders, except for pervasive development disorder.

Morbid obesity (clinically severe obesity) means a body mass index (BMI) as determined by a *health care practitioner* as of the date of service of:

- 40 kilograms or greater per meter squared (kg/m^2); or;
- 35 kilograms or greater per meter squared (kg/m^2) with an associated comorbid condition such as hypertension, type II diabetes, life-threatening cardiopulmonary conditions; or joint disease that is treatable, if not for the obesity.

240300TX 02/11

N

Network health care practitioner means a *health care practitioner* who has signed a direct agreement with *us* as an independent contractor or who has been designated by *us* as an independent contractor to provide services to all *covered persons*. *Network health care practitioner* designation by *us* may be limited to specified services.

Network hospital means a *hospital* which has signed a direct agreement with *us* as an independent contractor or has been designated by *us* as an independent contractor to provide services to all *covered persons*. *Network hospital* designation by *us* may be limited to specified services.

Network provider means a *hospital*, *health care treatment facility*, physician, or any other health services provider who has signed an agreement with *us* as an independent contractor or who has been designated by *us* as an independent contractor to provide services to all *covered persons*. *Network provider* designation by *us* may be limited to specified services.

Neurobiological disorder means an illness of the nervous system caused by genetic, metabolic, or other biological factors.

Non-network health care practitioner means a *health care practitioner* who has not been designated as a *network health care practitioner* by *us*.

Non-network hospital means a *hospital* which has not been designated as a *network hospital* by *us*.

Non-network provider means a *hospital*, *health care treatment facility*, physician, or any other health services provider who has not been designated as a *network provider* by *us*.

Nurse means a registered nurse (R.N.), a licensed practical nurse (L.P.N.), or a licensed vocational nurse (L.V.N.).

241000 07/07

O

Observation status means a stay in a *hospital* or *health care treatment facility* for less than 24 hours if:

- *You* have not been admitted as a resident *inpatient*;
- *You* are physically detained in an emergency room, treatment room, observation room or other such area; or
- *You* are being observed to determine whether *confinement* will be required.

Open enrollment period means no less than a 31 day period of time, occurring annually for the *group,* during which the *employee* has an opportunity to enroll themselves and their eligible *dependents* for coverage under the *policy.*

Oral surgery means procedures to correct diseases, injuries and defects of the jaw and mouth structures. These procedures include, but are not limited to, the following:

- Surgical removal of full bony impactions;
- Mandibular or maxillary implant;
- Maxillary or mandibular frenectomy;
- Alveolectomy and alveoplasty;
- Orthognathic *surgery*;
- *Surgery* for treatment of temporomandibular joint syndrome/dysfunction; and
- Periodontal *surgery*, including gingivectomies.

Organ transplant means only the services, care, and treatment received for or in connection with the pre-approved transplant of the organs identified in the "Covered Expenses - Transplant Services" section, which are determined by *us* to be *medically necessary* services and which are not *experimental,* or *investigational*, or *for research purposes*. Transplantation of multiple organs, when performed simultaneously, is considered one *organ transplant*.

Organ transplant treatment period means 365 days from the date of discharge from the *hospital* following an *organ transplant* received while *you* were covered by *us*.

Out-of-pocket limit means the amount of *covered expenses* that must be paid by a *covered person*, either individually or combined as a covered family, per *year* before a benefit percentage will be increased.

Outpatient means *you* are not *confined* as a registered bed patient.

Outpatient surgery means *surgery* performed in a *health care practitioner's* office, *ambulatory surgical center*, or the *outpatient* department of a *hospital*.
241600TX 02/11

P

Palliative care means care given to a *covered person* to relieve, ease, or alleviate, but not to cure, a *bodily injury* or *sickness*.

Partial hospitalization means services provided by a *hospital, health care treatment facility, chemical dependency treatment center, crisis stabilization unit, psychiatric day treatment facility* or *residential treatment center for children and adolescents* in which patients do not reside for a full 24-hour period:

- For a comprehensive and intensive interdisciplinary psychiatric treatment for minimum of 5 hours a day, 5 days per week;

- That provides for social, psychological and rehabilitative training programs with a focus on reintegration back into the community and admits children and adolescents who must have a treatment program designed to meet the special needs of that age range; and

- That has physicians and appropriately licensed behavioral health practitioners readily available for the emergent and urgent needs of the patients.

The *partial hospitalization* program must be accredited by the Joint Commission of the Accreditation of Hospitals or in compliance with an equivalent standard.

Licensed drug abuse rehabilitation programs and alcohol rehabilitation programs accredited by the Joint Commission on the Accreditation of Health Care Organizations or approved by the appropriate state agency are also considered *partial hospitalization* services.

Partial hospitalization does not include services that are for:

- *Chemical dependency treatment center;* or
- *Custodial care*; or
- Day care.

Participation criteria means any criteria or rules established by a *large employer* to determine the *employees* who are eligible for enrollment, including continued enrollment, under the *policy*. Such criteria or rules may not be based on *health status related factors*. *Participation criteria* is subject to change by the *large employer*.

Periodontics means the branch of dentistry concerned with the study, prevention, and treatment of diseases of the tissues and bones supporting the teeth.

Phenylketonuria means an inherited condition that may cause severe mental retardation if not treated.

Policy means the document describing the benefits *we* provide as agreed to by *us* and the *policyholder*.

Policyholder means the legal entity identified as the *policyholder* on the face page of the *policy* who establishes, sponsors and endorses an employee benefit plan for insurance coverage.

Pre-surgical/procedural testing means:

- Laboratory tests or radiological examinations done on an *outpatient* basis in a *hospital* or other facility accepted by the *hospital* before *hospital confinement* or *outpatient surgery* or procedure;
- The tests must be accepted by the *hospital* or *health care practitioner* in place of like tests made during *confinement*; and
- The tests must be for the same *bodily injury* or *sickness* causing *you* to be *hospital confined* or to have the *outpatient surgery* or procedure.

Preauthorization means approval by *us*, or *our* designee, of a service prior to it being provided. Certain services require medical review by *us* in order to determine eligibility for coverage.

Preauthorization is granted when such a review determines that a given service is a *covered expense* according to the terms and provisions of the *policy*.

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

Preventive services means services in the following recommendations appropriate for *you* during *your* plan *year*:

- Services with an A or B rating in the current recommendations of the U. S. Preventive Services Task Force (USPSTF). The recommendations by the USPSTF for breast cancer screenings, mammography and preventions issued prior to November 2009 will be considered current.

- Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC).

- Preventive care for infants, children and adolescents provided in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA).

- Preventive care for women provided in the comprehensive guidelines supported by HRSA.

For the recommended *preventive services* that apply to *your* plan *year*, refer to the U.S. Department of Health and Human Services (HHS) website at www.HHS.gov or call the customer service telephone number on *your* identification card.

Psychiatric day treatment facility means an accredited mental health facility which:

- Provides treatment for individuals suffering from acute *mental health services* in a structured psychiatric program utilizing individualized treatment plans with specific attainable goals and objectives appropriate both to the patient and treatment modality of the program; and

- Is clinically supervised by a certified psychiatrist.

242500TX 02/11

Q

Qualified individual means:

- A postmenopausal woman who is not receiving estrogen replacement therapy; or
- An individual with:

  - Vertebral abnormalities;
  - Primary hyperparathyroidism; or
  - A history of bone fractures; or

- An individual who is:

  - Receiving long-term glucocorticoid therapy; or
  - Being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy.

242575TX

R

Rehabilitation facility means any licensed public or private establishment which has permanent facilities that are equipped and operated primarily to render physical and occupational therapies, diagnostic services and other therapeutic services.

Residential treatment center for children and adolescents means an institution which:

- Provides residential care and treatment for emotionally disturbed individuals; and

- Is accredited as a residential treatment center by the Council on Accreditation, the Joint Commission on Accreditation of Healthcare Organizations, or the American Association of Psychiatric Services for Children.

Room and board means all charges made by a *hospital* or other *health care treatment facility* on its own behalf for room and meals and all general services and activities needed for the care of registered bed patients.

Routine nursery care means the charges made by a *hospital* or licensed birthing center for the use of the nursery. It includes normal services and supplies given to well newborn children following birth. *Health care practitioner* visits are not considered *routine nursery care.* Treatment of a *bodily injury*, *sickness,* birth abnormality, congenital defect following birth and care resulting from prematurity is <u>not</u> considered *routine nursery care.*
242900TX 07/09

S

Self-administered injectable drugs means an FDA approved medication which a person may administer to himself or herself by means of intramuscular, intravenous, or subcutaneous injection, excluding insulin, and prescribed for use by *you.*

Series of treatments means a planned, structured, and organized program to promote chemical free status which may include different facilities or modalities and is complete when the *covered person* is discharged on medical advice from *inpatient* detoxification, *inpatient* rehabilitation/treatment, *partial hospitalization*, an *intensive outpatient program* or a series of these levels of treatments without lapse in treatment or when a *covered person* fails to materially comply with the treatment program for a period of 30 days.

Serious mental illness means the following psychiatric illnesses as defined by the American Psychiatric Association in the Diagnostic and Statistical Manual (DSM):

- Schizophrenia;
- Paranoid and other psychotic disorders;
- Bipolar disorders (hypomanic, manic, depressive and mixed);
- Major depressive disorders (single episodes or recurrent);
- Schizo-affective disorders (bipolar or depressive);
- Obsessive-compulsive disorders; and
- Depression in childhood and adolescence.

Sickness means a disturbance in function or structure of the body which causes physical signs or physical symptoms and which, if left untreated, will result in a deterioration of the health state of the structure or system(s) of the body. The term also includes: (a) pregnancy; (b) any medical *complications of pregnancy*; and (c) *behavioral health*.

Skilled nursing facility means a licensed institution (other than a *hospital*, as defined) which meets all of the following requirements:

- It must provide permanent and full-time bed care facilities for resident patients;
- It must maintain, on the premises and under arrangements, all facilities necessary for medical care and treatment;
- It must provide such services under the supervision of physicians at all times;
- It must provide 24-hours-a-day nursing services by or under the supervision of a registered *nurse*; and
- It must maintain a daily record for each patient.

A *skilled nursing facility* is not, except by incident, a rest home, a home for the care of the aged, or engaged in the care and treatment of *chemical dependency*.

Small employer means an *employer* who employed an average of two but not more than 50 *eligible employees* on business days during the preceding calendar year and who employs at least two *employees* on the first day of the *year*, unless otherwise provided under state law. All entities that are affiliated or that are eligible to file a combined tax return are considered one *employer*.

Sound natural tooth means a tooth that:

- Is organic and formed by the natural development of the body (not manufactured, capped, crowned or bonded);
- Has not been extensively restored;
- Has not become extensively decayed or involved in periodontal disease; and
- Is not more susceptible to injury than a whole natural tooth, (for example a tooth that has not been previously broken, chipped, filled, cracked or fractured).

Special enrollment date means the date of:

- Change in family status after the *eligibility date*;
- Loss of other coverage under another group health plan or other *health insurance coverage*;
- COBRA exhaustion;
- Loss of coverage under *your* employer's alternate plan;
- Termination of your *Medicaid* coverage or your Children's Health Insurance Program (CHIP) coverage as a result of loss of eligibility; or
- Eligibility for a premium assistance subsidy under *Medicaid* or CHIP.

To be eligible for special enrollment, you must meet the requirements specified in the "Special enrollment" provision within the "Eligibility and Effective Dates" section of this *certificate*.

Surgery means services categorized as Surgery in the Current Procedural Terminology (CPT) Manuals published by the American Medical Association. The term *surgery* includes, but is not limited to: excision or incision of the skin or mucosal tissues or insertion for exploratory purposes into a natural body opening; insertion of instruments into any body opening, natural or otherwise, done for diagnostic or other therapeutic purposes; and treatment of fractures.
243800TX 02/11

T

Telehealth service means a health service, other than a telemedicine medical service, delivered by a health care practitioner who does not perform a telemedicine medical service that requires the use of advanced telecommunications technology, other than by telephone or facsimile, including:

- Compressed digital interactive video, audio, or data transmission;
- Clinical data transmission using computer imaging by way of still-image capture and store and forward; and
- Other technology that facilitates access to health care services or medical specialty expertise.

Telemedicine medical service means a health care service initiated by a *health care practitioner* for the purpose of patient assessment, diagnosis or consultation, treatment, or the transfer of medical data that requires the use of advanced telecommunications technology including:

- Compressed digital interactive video, audio, or data transmission;
- Clinical data transmission using computer imaging by way of still-image capture and store and forward; and
- Other technology that facilitates access to health care services or medical specialty expertise.

Total disability or ***totally disabled*** means *your* continuing inability, as a result of a *bodily injury* or *sickness*, to perform all of the substantial and material duties and functions of his or her respective job or occupation and any other gainful occupation in which such *covered person* earns substantially the same wage or profit which he or she earned prior to the disability.

The term also means a *dependent's* inability to engage in the normal activities of a person of like age. If the *dependent* is employed, the *dependent* must be unable to perform his or her job.

Toxic inhalant means a volatile chemical under Chapter 484, Health and Safety Code, or abusable glue or aerosol paint under Section 485.001, Health and Safety Code.
244000TX 07/07

U

Urgent care means those health care services that are appropriately provided for an unforeseen condition of a kind that usually requires attention without delay but that does not pose a threat to life, limb or permanent health of the *covered person*.

Urgent care center means any licensed public or private non-*hospital free-standing facility* which has permanent facilities equipped to provide *urgent care* services on an *outpatient* basis.
244200 07/07

V

W

Waiting period means the period of time, elected by the *policyholder*, which must pass before an *employee* is eligible for coverage under the *policy*.

We, us or ***our*** means the offering company as shown on the cover page of the *policy* and *certificate*.
244400 07/07

X

Y

Year means 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.

You or ***your*** means any *covered person*.

Z

244600 02/11

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" 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.

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*, unless otherwise stated, are applicable.
250000TX 02/11

Specialty drug cost sharing

You are responsible for any and all *cost share*, when applicable, for s*pecialty 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 drug" 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.
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.

Cost share means any *copayment*, *deductible*, *drug deductible*, and/or percentage amount that *you* must pay per *prescription* drug or refill per *year*.

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

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.

Network specialty drug and network level 4 drug out-of-pocket limit means the amount of *copayment* that *you* must pay in a *year* for *specialty drugs* and *level 4 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.

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*/*prior authorization* or *step therapy* requirements. 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 02/11

SPECIALTY DRUG BENEFIT (continued)

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*/*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

You are responsible for the following:

Network specialty drug and network level 4 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 drug out-of-pocket limit*. The *network specialty drug* and *network level 4 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*. *Deductibles* do not apply towards *your network specialty drug and network level 4 drug out-of-pocket limit*.

After the *network specialty drug* and *network level 4 drug out-of-pocket limit* has been satisfied in a *year*, the *network pharmacy* benefit percentage for *specialty drugs* and *level 4 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*.

SPECIALTY DRUG BENEFIT (continued)

If the *cost share* applied to *your* claim is waived by *your pharmacy* or 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*.

Network drug out-of-pocket limit	**Network drug out-of-pocket limit amount**
Network specialty drug and network level 4 drug out-of-pocket limit	$3,500

Retail pharmacy and specialty pharmacy	**Up to 30-day supply**
Pharmacy designated by *us* as a preferred provider of *specialty drugs*	25% *copayment* per *specialty drug prescription* or refill.
Network pharmacy	35% *copayment* per *specialty drug prescription* or refill.
*Non-network pharmacy**	50% *copayment* per *specialty drug prescription* or refill.

*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*. *You* will be responsible for 50% of the *default rate* as shown above. *You* will also be responsible for 100% of the difference between the *default rate* and the *non-network pharmacy's* charge. The charge received from a *non-network pharmacy* for a *prescription* or refill may be higher than the *default rate*.
255000TX 02/11

Office visit, home health care, freestanding facility and urgent care **Up to 30-day supply**

Network provider	$50 *copayment* per visit.
Non-network provider	50% *copayment* per visit after *non-network provider deductible.*

256000 04/10

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.*
- 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 04/10

DOMESTIC PARTNER BENEFIT RIDER

This rider 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*.

All terms used in this rider have the same meaning given to them in the *certificate* unless otherwise specifically defined in this rider.

This rider modifies the *policy* as follows:
1200000 02/11

- By adding the definition of *domestic partner* to the "Glossary" section of the *certificate* as follows:

  Domestic partner means an individual of the same or opposite gender who resides with the covered *employee* in a long-term relationship of indefinite duration; and, there is an exclusive mutual commitment in which the partners agree to be jointly responsible for each other's common welfare and share financial obligations. *We* will allow coverage for only one *domestic partner* of the covered *employee* at any one time. The *employee* and *domestic partner* must each be at a minimum 18 years of age, competent to contract, and may not be related by blood to a degree of closeness which would prohibit legal marriage in the state in which the *employee* and *domestic partner* both legally reside. *We* reserve the right to require an affidavit from the *employee* and *domestic partner* attesting that the domestic partnership has existed for a minimum period of 12 months and, periodically thereafter, to require proof that the *domestic partner* relationship continues to exist.

1200100 02/11

- By deleting the definition of *dependent* in the "Glossary" section of the *certificate* and replacing it with the following:

  Dependent means a covered *employee's*:

  - Legally recognized spouse or *domestic partner*;

  - Natural born child, step-child, legally adopted child, child for whom the *employee* is a party in a suit in which adoption of the child is sought by the *employee*, or grandchild, if the grandchild is dependent on the *employee* for Federal Income Tax purposes at the time of application;

  - Child of any age who is medically certified as disabled. Medically certified as disabled means being incapable of self-sustaining employment by reason of mental retardation or physical handicap and being chiefly dependent upon the employee for support and maintenance;

  - Child whose age is less than the limiting age and for whom the *employee* has received a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN) to provide coverage, if the *employee* is eligible for family coverage until:

  - Such QMCSO or NMSN is no longer in effect; or
  - The child is enrolled for comparable health coverage, which is effective no later than the termination of the child's coverage under the *policy*; or

- *Domestic partner's* natural born child, step-child, legally adopted child, or child for whom the *employee* is a party in a suit in which adoption of the child is sought by the *employee* whose age is less than the limiting age;

- *Domestic partner's* child whose age is less than the limiting age and for whom the *domestic partner* has received a QMCSO or NMSN to provide coverage, if the *employee* is eligible for family coverage until:

  - Such QMCSO or NMSN is no longer in effect; or
  - The *domestic partner's* child is enrolled for comparable health coverage, which is effective no later than the termination of the child's coverage under the *policy*.

- The *domestic partner's* child cannot qualify as a *dependent* prior to the *employee's domestic partner* becoming a qualified *dependent*.

Under no circumstances shall *dependent* mean a great grandchild or foster child ncluding where the great-grandchild or foster child meets all of the qualifications of a dependent as determined by the Internal Revenue Service.

The limiting age means the birthday the *dependent* child attains age 26. Each *dependent* child is covered to the limiting age regardless if the child is:

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

A covered *dependent* child who attains the limiting age while insured under the *policy* remains eligible if the covered *dependent* child is:

- Permanently mentally or physically handicapped; and
- Incapable of self-sustaining employment; and
- Unmarried.

DOMESTIC PARTNER BENEFIT RIDER (continued)

In order for the covered *dependent* child to remain eligible as specified above, *we* must receive notification within 31 days prior to the covered *dependent* child attaining the limiting age.

A handicapped *dependent* child, as defined in the bulleted items above, who attained the limiting age while insured under the *employer's* previous group medical plan (Prior Plan) is eligible for coverage under the *policy*. Please refer to the "Replacement of Coverage" section of this *certificate*.

You must furnish satisfactory proof to *us* upon *our* request that the conditions, as defined in the bulleted items above, continuously exist on and after the date the limiting age is reached. After two years from the date the first proof was furnished, *we* may not request such proof more often than annually. If satisfactory proof is not submitted to *us*, the child's coverage will not continue beyond the last date of eligibility.

1200200TX 02/11

- By deleting the definition of *family member* in the "Glossary" section of the *certificate* and replacing it with the following:

Family member means *you*, *your* legally recognized spouse or *domestic partner*. It also means *your* or *your* legally recognized spouse's or *domestic partner's* child, brother, sister or parent.

1200300 02/11

Humana Insurance Company

Michael B. McCallister
President

1200400

PRESCRIPTION DRUG BENEFIT RIDER

This rider 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 do not 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 have the same meaning given to them in the *certificate*, unless otherwise specifically defined in this benefit rider. All other terms, provisions, limitations and exclusions of the *policy*, unless otherwise stated, are applicable.
1800000 02/11

Disclosure

The most commonly prescribed drugs, medicines, and medications covered by *us* are specified on *our drug list*. The *drug list* identifies categories of drugs, medicines or medications by levels. It also indicates *dispensing limits* and any applicable *prior authorization* or *step therapy* requirements. This information is reviewed on a regular basis by a Pharmacy and Therapeutics committee made up of physicians and *pharmacists*. Placement on the *drug list* does not guarantee *your health care practitioner* will prescribe that *prescription* drug, medicine, or medication for a particular medical condition or mental illness.

You can obtain a copy of *our drug list* by visiting *our* Website at www.humana.com or calling the customer service telephone number on *your* identification card. If a specific drug, medicine or medication is not listed on the *drug list*, *you* may contact *us* orally or in writing with a request to determine whether a specific drug is included on *our drug list*. *We* will respond to *your* request no later than the third business day after the receipt date of the request.

Modification of coverage

Prescription drug coverage is subject to change. Based on state law, advance written notice is required for the following modifications that affect *prescription* drug coverage:

- Removal of a drug from the *drug list*;
- Requirement that *you* receive *prior authorization* for a drug;
- An imposed or altered quantity limit;
- An imposed *step-therapy* restriction;

- Moving a drug to a higher cost-sharing level unless a generic alternative to the drug is available.

These types of changes to *prescription* drug coverage will only be made by *us* at renewal of the *policy*. *We* will provide written notice no later than 60 days prior to the *effective date* of the change.
1800030TX 11/11

Prescription drug cost sharing

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

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

The amount paid by *us* to the dispensing *pharmacy* may not reflect the ultimate cost to *us* for the 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.
1800100 02/11

Definitions

The following terms are used in this benefit rider:

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/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 *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 1, level 2, level 3, or level 4 and indicates applicable *dispensing limits* and/or any *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 *drug list*. The *drug list* is subject to change without notice.

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 1 drugs means a category of *prescription* drugs, medicines or medications within the *drug list* that are designated by *us* as level 1.

Level 2 drugs means a category of *prescription* drugs, medicines or medications within the *drug list* that are designated by *us* as level 2.

Level 3 drugs means a category of *prescription* drugs, medicines or medications within the *drug list* that are designated by *us* as level 3.

Level 4 drugs means a category of *prescription* drugs, medicines or medications within the *drug list* that are designated by *us* as level 4.
1801600 02/11

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 *mail order pharmacy* services,

as defined by *us*, to *covered persons*, including covered *prescriptions* or refills delivered to *your* home.

Network specialty drug and network level 4 drug out-of-pocket limit means the amount of *copayment* that *you* must pay in a *year* for *specialty drugs* and *level 4 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 *mail order pharmacy* services,

as defined by *us*, to *covered persons*, including covered *prescriptions* or refills delivered to *your* home.

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

- 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.

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. The drug, medicine or medication must be obtainable only by *prescription*. 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 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 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 02/11

Coverage description

We will cover *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 *step therapy* requirements, if any.

Covered *prescription* drugs are:

- 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*.
- Contraceptive drugs and contraceptive drug delivery implants approved by the FDA.
- 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*).
- *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.

Notwithstanding any other provisions of the *policy*, *we* may decline coverage or, if applicable, exclude from the *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. Any *prescription* contraceptive drug or device approved by the United States Food and Drug Administration is not subject to a review period.
1802700TX 11/11

Schedule of benefits - prescription drugs

You are responsible for the following:

Network specialty drug and network level 4 drug out-of-pocket limit

Any expenses incurred by *you*, under the provisions of this rider do not apply toward *your out-of-pocket limit*, if any. However, there is a *network specialty drug and network level 4 drug out-of-pocket limit. The network specialty drug and network level 4 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 the *certificate*. *Deductibles* do not apply towards *your network specialty drug and network level 4 drug out-of-pocket limit*.

After the *network specialty drug* and *network level 4 drug out-of-pocket limit* has been satisfied in a *year*, the *network pharmacy* benefit percentage for *specialty drugs* and *level 4 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*.

PRESCRIPTION DRUG BENEFIT RIDER (continued)

If the *cost share* applied to *your* claim is waived by *your pharmacy* or 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*.

Network drug out-of-pocket limit	**Network drug out-of-pocket limit amount**
Network specialty drug and network level 4 drug out-of-pocket limit	$3,500

Retail pharmacy	**Up to 30-day supply**
Level 1 drugs	$10 *copayment* per *prescription* or refill
Level 2 drugs	$40 *copayment* per *prescription* or refill
Level 3 drugs	$70 *copayment* per *prescription* or refill
Level 4 drugs	25% *copayment* per *prescription* or refill

Some retail *pharmacies* participate in *our* program, which allows *you* to receive a 90-day supply of a *prescription* or refill. *Your* cost is 3 times the applicable *copayment* as outlined above. *Self-administered injectable drugs* are limited to a 30-day supply from a retail *pharmacy*, unless otherwise determined by *us*.

PRESCRIPTION DRUG BENEFIT RIDER (continued)

Mail order pharmacy **Up to 90-day supply**

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

Level 1 drugs, *level 2 drugs*, *level 3 drugs*, and *level 4 drugs*	2.5 times the applicable *copayment*, as outlined above under **Retail pharmacy** per *prescription* or refill

If *you* 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*.

Non-network 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, *you* will be responsible for 30% of the *default rate*. *You* are also responsible for 100% of the difference between the *default rate* and the *non-network pharmacy's* charge. The charge received from a *non-network pharmacy* for a *prescription* or refill may be higher than the *default rate*.
1803400 02/11

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*.

- 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 *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 02/11

- 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*.
- Abortifacients (drugs used to induce abortions).
- *Infertility services* including medications.
- Any drug prescribed for impotence and/or sexual dysfunction.

1806000TX 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*;
  - 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 90-day supply when received from a *mail order pharmacy* or a retail *pharmacy* that participates in *our* program, which allows *you* to receive a 90-day supply of a *prescription* or refill.

- 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 *you* to receive a 90-day supply of a *prescription* or refill.

- Any portion of a *self-administered injectable drug* that exceeds a 30-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*;
  - 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.

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).

- 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

Humana Insurance Company

Michael B. McCallister
President

1808000

SERIOUS MENTAL ILLNESS RIDER

This rider 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*.
5100000TX 04/04

Notwithstanding any exclusions or limitations contained in the *policy*, benefits are payable for expenses incurred by *you* for the treatment of *serious mental illness* to the same extent as coverage for any other *sickness* under the *policy*, subject to the same limitations, *deductibles*, *coinsurance* or *copayments*, if any.
5100100TX 04/04

All terms used in this benefit rider have the same meaning given to them in the *certificate*.
5100200TX 04/04

Preauthorization requirements and penalty

Preauthorization is required for non-emergent *admissions* for the treatment of *serious mental illness*. If any required *preauthorization* of services is not obtained, the benefit payable for any *covered expenses* incurred for the treatment of *serious mental illness* will be reduced by 50%, after any applicable *deductibles* or *copayments*. 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* or *non-network provider* when *preauthorization* is required and not obtained.
5100300TX 04/04

Coverage description

Inpatient services

Serious mental illness inpatient care is limited to a maximum of 45 days per *year*. Two days of *partial hospitalization*, treatment in a *crisis stabilization unit, psychiatric day treatment facility,* or *residential treatment center for children and adolescents* is equal to one day of *inpatient* care. A *health care practitioner* must certify that the treatment being provided in a *crisis stabilization unit, psychiatric day treatment facility, or residential treatment center for children or adolescents* is in lieu of hospitalization.
5100400TX 04/04

Outpatient services

Outpatient visits for medication management are payable to the same extent as coverage for any other *sickness* under the *policy,* but will not apply toward the *year* limit for *serious mental illness.*
5100600TX 04/04

SERIOUS MENTAL ILLNESS RIDER

Humana Insurance Company

Michael B. McCallister
President

5100700TX 04/04

ACQUIRED BRAIN INJURY AMENDMENT

This 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 amendment are not covered under any other provision of the *policy*.

All terms used in this amendment have the same meaning given to them in the *certificate* unless otherwise specifically defined in this amendment.

Definitions

The following terms are used in this amendment:

Acquired brain injury means a neurological insult to the brain, which is not hereditary, congenital, or degenerative. The injury to the brain has occurred after birth and results in a change in neuronal activity, which results in an impairment of physical functioning, sensory processing, cognition, or psychosocial behavior.

Cognitive communication therapy means *services* designed to address modalities of comprehension and expression, including understanding, reading, writing, and verbal expression of information.

Cognitive rehabilitation therapy means *services* designed to address therapeutic cognitive activities, based on an assessment and understanding of the individual's brain-behavioral deficits.

Community reintegration services means *services* that facilitate the continuum of care as an affected individual transitions into the community.

Neurobehavioral testing means an evaluation of the history of neurological and psychiatric difficulty, current symptoms, current mental status, and premorbid history, including the identification of problematic behavior and the relationship between behavior and the variables that control behavior. This may include interviews of the individual, family, or others.

Neurobehavioral treatment means interventions that focus on behavior and the variables that control behavior.

Neurocognitive rehabilitation means *services* designed to assist cognitively impaired individuals to compensate for deficits in cognitive functioning by rebuilding cognitive skills and/or developing compensatory strategies and techniques.

Neurocognitive therapy means *services* designed to address neurological deficits in informational processing and to facilitate the development of higher level cognitive abilities.

Neurofeedback therapy means *services* that utilize operant conditioning learning procedure based on electroencephalography (EEG) parameters, and which are designed to result in improved mental performance and behavior, and stabilized mood.

Neurophysiological testing means an evaluation of the functions of the nervous system.

Neurophysiological treatment means interventions that focus on the functions of the nervous system.

Neuropsychological testing means the administering of a comprehensive battery of tests to evaluate neurocognitive, behavioral, and emotional strengths and weaknesses and their relationship to normal and abnormal central nervous system functioning.

Neuropsychological treatment means interventions designed to improve or minimize deficits in behavioral and cognitive processes.

Post-acute transition services means *services* that facilitate the continuum of care beyond the initial neurological insult through rehabilitation and community reintegration.

Psychophysiological testing means an evaluation of the interrelationships between the nervous system and other bodily organs and behavior.

Psychophysiological treatment means interventions designed to alleviate or decrease abnormal physiological responses of the nervous system due to behavioral or emotional factors.

Remediation means the process(es) of restoring or improving a specific function.

Services means the work of testing, treatment, and providing therapies to an individual with an *acquired brain injury*.

Therapy means the scheduled remedial treatment provided through direct interaction with the individual to improve a pathological condition resulting from an *acquired brain injury*.

Coverage description

We will pay benefits for *covered expenses* incurred by a *covered person* as a result from or related to an *acquired brain injury* provided in a *hospital*, an acute or post-acute *rehabilitation facility* or an *assisted living facility*.

Benefits are payable for the following *medically necessary* services received by a *covered person* as a result from or related to an *acquired brain injury*:

- *Cognitive rehabilitation therapy;*
- *Cognitive communication therapy;*
- *Neurocognitive therapy* and *rehabilitation;*
- *Neurobehavioral testing* or *treatment;*
- *Neurophysiological testing* or *treatment;*
- *Neuropsychological testing* or *treatment;*
- *Psychophysiological testing* or *treatment;*
- *Neurofeedback therapy;*
- *Remediation;*
- *Post-acute transition services*; or
- *Community reintegration services.*

ACQUIRED BRAIN INJURY AMENDMENT (continued)

Covered expense will be paid the same as any other *sickness* based upon location of service and type of provider.

Humana Insurance Company, Inc.

Michael B. McCallister
President

TEXAS CONSUMER HEALTH ASSISTANCE PROGRAM AMENDMENT

This 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 amendment are not covered under any other provision of the *policy*.

All terms used in this amendment have the same meaning given to them in the *certificate* unless otherwise specifically defined in this amendment.

The "Complaint and Appeals Procedures" section of *your certificate* is amended by adding the following:

Texas Consumer Health Assistance Program

If *you* need help with appeals, complaints, or the external review process, contact the Texas Consumer Health Assistance Program (CHAP). Call CHAP at 1-855-839-2427. *You* can also send an e-mail to chap@tdi.state.tx.us or a written request to:

CHAP
Texas Department of Insurance
Mail Code 111-1A
P.O. Box 149091
Austin, Texas 78714-9091

Humana Insurance Company, Inc.

Michael B. McCallister
President

WELLNESS PROGRAMS AMENDMENT

This amendment is made part of the master group contract 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 master group contract.

Notwithstanding any other provisions of the master group contract, expenses covered under this amendment are not covered under any other provision of the master group contract.

The "Disclosure Provisions" section of your certificate is amended as follows:

Wellness programs

The wellness programs are designed and have been shown to improve health and prevent disease for those participating by encouraging healthy behavior and assisting in managing your health. These programs may be accessed by registering at www.humana.com. Participation in these programs may include:

- Completing certain health related activities that can be tracked, such as taking wellness classes, exercising and getting regular medical check ups and screenings;

- Completing a health risk assessment. A personalized health program will be developed for you based on this assessment. This health program may be educational, preventive, fitness related or informational.

- Achieving certain health standards or reaching certain goals developed for you, such as lowering blood pressure or becoming smoke free.

Please call the telephone number listed on your identification card or in the marketing literature for a possible alternative activity if:

- It is unreasonably difficult for you to reach certain goals due to your medical condition; or
- Your health care practitioner advises you not to take part in the activities needed to reach certain goals.

We may require proof in writing from your health care practitioner that your medical condition prevents you from taking part in the available activities.

By participating in these health related activities you will accumulate reward points that may be used toward obtaining rewards. For additional information on how to redeem your points for rewards, please go to our website at www.humana.com. From time to time we may enter into agreements with third parties who provide rewards for participating in certain wellness programs. These rewards may include items such as merchandise, gift cards, travel and merchandise discounts. If our agreements with third parties terminate, your reward points will not be affected. In the event our agreement with a third party terminates, your points will still be redeemable for rewards with another third party.

WELLNESS PROGRAMS AMENDMENT (continued)

The rewards may be taxable income. You may consult a tax advisor for further guidance.

The wellness program may be terminated in accordance with the termination provision of your certificate.

The wellness programs are included in your health plan, however it is your decision to participate in the activities to earn points toward the rewards. You may participate anytime during the year. If your coverage terminates, you will no longer be eligible for the programs. To resolve a complaint or issue, refer to the complaint and appeals provisions of your certificate.

Humana Insurance Company

Michael B. McCallister
President

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INSURED BY
HUMANA INSURANCE COMPANY

NOTICE OF CERTAIN MANDATORY BENEFITS

This notice is to advise you of certain coverage and/or benefits provided by your contract with Humana Insurance Company.

Coverage of Tests for Detection of Human Papillomavirus and Cervical Cancer

Coverage is provided, for each woman enrolled in the plan who is 18 years of age or older, for expenses incurred for an annual medically recognized diagnostic examination for the early detection of cervical cancer. Coverage required under this section includes at a minimum a conventional Pap smear screening or a screening using liquid-based cytology methods, as approved by the United States Food and Drug Administration, alone or in combination with a test approved by the United States Food and Drug Administration for the detection of the human papillomavirus.

If any person covered by this plan has questions concerning the above, please call Humana Insurance Company at: 1-866-4ASSIST, or write us at: Green Bay Service Center (Badger/MTV Medical) P.O. Box 14618 Lexington, KY 40512-4618.

NOTICE OF COVERAGE FOR ACQUIRED BRAIN INJURY

Your health benefit plan coverage for an acquired brain injury includes the following services:

- Cognitive rehabilitation therapy;
- Cognitive communication therapy;
- Neurocognitive therapy and rehabilitation;
- Neurobehavioral testing or treatment;
- Neurophysiological testing or treatment;
- Neuropsychological testing or treatment;
- Psychophysiological testing or treatment;
- Neurofeedback therapy and remediation;
- Post-acute transition services and community reintegration services, including outpatient day treatment services or other post-acute care treatment services;
- Reasonable expenses related to periodic re-evaluation of the care of an individual covered under the plan who has incurred an acquired brain injury, has been unresponsive to treatment, and becomes responsive to treatment at a later date, at which time the cognitive rehabilitation services would be a covered benefit.

The fact that an acquired brain injury does not result in hospitalization or acute care treatment does not affect the right of the insured or the enrollee to receive the preceding treatments or services commensurate with their condition. Post-acute care treatment or services may be obtained in any facility where such services may legally be provided, including acute or post-acute rehabilitation hospitals and assisted living facilities regulated under the Health and Safety Code.

If any person covered by this plan has questions concerning the above, please call customer service at 1-866-4ASSIST (1-866-427-7478) or write us at Humana, Green Bay Service Center, P.O. Box 14618, Lexington, KY 40512-4618.

FEDERAL NOTICES

The following pages contain important information about certain federal laws. There may be differences between the Certificate of Insurance and this Notice packet. There may also be differences between this notice packet and state law. You are eligible for the rights more beneficial to you.

This section includes notices about:

Federal Legislation

- **Women's Health and Cancer Rights Act**
- **Statement of Rights Under the Newborns' and Mothers' Health Protection Act**
- **Medical Child Support Orders**
- **General Notice of COBRA Continuation of Coverage Rights**
- **Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA)**
- **Family and Medical Leave Act (FMLA)**
- **Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)**
- **Your Rights Under ERISA**
- **Patient Protection Act**

Certificate of Creditable Coverage

FEDERAL NOTICES (continued)

Federal legislation

Women's health and cancer rights act of 1998
Required coverage for reconstructive surgery following mastectomies

Under federal law, group health plans and health insurance issuers offering group health insurance providing medical and surgical benefits with respect to mastectomy shall provide, in a case of a participant or beneficiary who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with such mastectomy, coverage for:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce symmetrical appearance; and
- Prostheses and physical complications of all stages of mastectomy, including lymphedemas;

in a manner determined in consultation with the attending physician and the patient. Such coverage may be subject to annual deductibles and coinsurance provisions as may be deemed appropriate and as are consistent with those established for other benefits under the plan.

Statement of rights under the newborns' and mothers' health protection act (NMHPA)

If your plan covers normal pregnancy benefits, the following notice applies to you.

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, group health plans and health insurance issuers may not set the level of benefits or out-of-pocket costs so any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a group health plan or health insurance issuer may not, under federal law, require a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain pre-authorization. For information on pre-authorization, contact your plan administrator.

FEDERAL NOTICES (continued)

Medical child support orders

An individual who is a child of a covered employee shall be enrolled for coverage under the group health plan in accordance with the direction of a Qualified Medical Child Support Order (QMCSO) or a National Medical Support Notice (NMSO).

A QMCSO is a state-court order or judgment, including approval of a settlement agreement that:

- Provides for support of a covered employee's child;
- Provides for health care coverage for that child;
- Is made under state domestic relations law (including a community property law);
- Relates to benefits under the group health plan; and
- Is "qualified," i.e., it meets the technical requirements of ERISA or applicable state law.

QMCSO also means a state court order or judgment enforcing state Medicaid law regarding medical child support required by the Social Security Act §1908 (as added by Omnibus Budget Reconciliation Act of 1993).

An NMSO is a notice issued by an appropriate agency of a state or local government that is similar to a QMCSO requiring coverage under the group health plan for a dependent child of a non-custodial parent who is (or will become) a covered person by a domestic relations order providing for health care coverage.

Procedures for determining the qualified status of medical child support orders are available at no cost upon request from the plan administrator.

General notice of COBRA continuation coverage rights

Introduction

You are receiving this notice because you have recently become covered under a group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

FEDERAL NOTICES (continued)

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event". Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary". You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, the qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if any of the following qualifying events cause you to lose your coverage under the Plan:

- Your hours of employment are reduced; or
- Your employment ends for any reason other than gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if any of the following qualifying events cause you to lose your coverage under the Plan:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if any of the following qualifying events cause them to lose coverage under the Plan:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a "dependent child".

When is COBRA coverage available?

The plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or commencement of a proceeding in bankruptcy with respect to the employer, the employer must notify the Plan Administrator of the qualifying event.

FEDERAL NOTICES (continued)

You must give notice of some qualifying events

For the other qualifying events (<u>divorce</u> or <u>legal separation</u> of the employee and spouse or a <u>dependent child's losing eligibility for coverage</u> as a dependent child) you must notify the Plan Administrator within 60 days after the qualifying event occurs.

How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children. Once the Plan Administrator offers COBRA continuation coverage, the qualified beneficiaries must elect such coverage within 60 days.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction in the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee last until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which the employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to at total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended:

- ***Disability extension of 18-month period of continuation coverage*** - If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator within 60 days of such determination, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage;

FEDERAL NOTICES (continued)

- ***Second qualifying event extension of 18-month period of continuation coverage*** - If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is given to the Plan within 60 days of the event. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting your group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at http://www.dol.gov/ebsa/. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep your plan informed of address changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information:

Humana
Billing/Enrollment Department
101 E Main Street
Louisville, KY 40201
1-800-872-7207

FEDERAL NOTICES (continued)

Important notice for individuals entitled to Medicare tax equity and fiscal responsibility act of 1982 (TEFRA) options

Where an employer employs more than 20 people, the Tax Equity And Fiscal Responsibility Act of 1982 (TEFRA) allows covered employees in active service who are age 65 or older and their covered spouses who are eligible for Medicare to choose one of the following options:

- ***Option 1*** - The benefits of their group health plan will be payable first and the benefits of Medicare will be payable second.
- ***Option 2*** - Medicare benefits only. The employee and his or her dependents, if any, will not be insured by the group health plan.

The employer must provide each covered employee and each covered spouse with the choice to elect one of these options at least one month before the covered employee or the insured spouse becomes age 65. All new covered employees and newly covered spouses age 65 or older must be offered these options. If Option 1 is chosen, its issue is subject to the same requirements as for an employee or dependent that is under age 65.

Under TEFRA regulations, there are two categories of persons eligible for Medicare. The calculation and payment of benefits by the group health plan differs for each category.

- ***Category 1*** Medicare eligibles are:

    - Covered employees in active service who are age 65 or older who choose Option 1;
    - Age 65 or older covered spouses; and
    - Age 65 or older covered spouses of employees in active service who are either under age 65 or age 70 or older;

- ***Category 2*** Medicare eligibles are any other covered persons entitled to Medicare, whether or not they enrolled. This category includes, but is not limited to:

    - Retired employees and their spouses; or
    - Covered dependents of a covered employee, other than his or her spouse.

Calculation and payment of benefits

For covered persons in Category 1, benefits are payable by the policy without regard to any benefits payable by Medicare. Medicare will then determine its benefits.

For covered persons in Category 2, Medicare benefits are payable before any benefits are payable by the policy. The benefits of the policy will then be reduced by the full amount of all Medicare benefits the covered person is entitled to receive, whether or not the eligible individual is actually enrolled for Medicare Benefits.

FEDERAL NOTICES (continued)

Family and Medical Leave Act (FMLA)

If an employee is granted a leave of absence (Leave) by the employer as required by the Federal Family and Medical Leave Act, s/he may continue to be covered under the plan for the duration of the Leave under the same conditions as other employees who are currently employed and covered by the plan. If the employee chooses to terminate coverage during the Leave, or if coverage terminates as a result of nonpayment of any required contribution, coverage may be reinstated on the date the employee returns to work immediately following the end of the Leave. Charges incurred after the date of reinstatement will be paid as if the employee had been continuously covered.

Uniformed services employment and reemployment rights act of 1994 (USERRA)

Continuation of benefits

Effective October 13, 1994, federal law requires health plans offer to continue coverage for employees that are absent due to service in the uniformed services and/or dependents.

Eligibility

An employee is eligible for continuation under USERRA if he or she is absent from employment because of voluntary or involuntary performance of duty in the Armed Forces, Army National Guard, Air National Guard, or commissioned corps of the Public Health Service. Duty includes absence for active duty, active duty for training, initial active duty for training, inactive duty training and for the purpose of an examination to determine fitness for duty.

An employee's dependents that have coverage under the plan immediately prior to the date of the employee's covered absence are eligible to elect continuation under USERRA.

If continuation of Plan coverage is elected under USERRA, the employee or dependent is responsible for payment of the applicable cost of coverage. If the employee is absent for not longer than 31 days, the cost will be the amount the employee would otherwise pay for coverage. For absences exceeding 30 days, the cost may be up to 102% of the cost of coverage under the plan. This includes the employee's share and any portion previously paid by the employer.

Duration of coverage

If elected, continuation coverage under USERRA will continue until the earlier of:

- 24 months beginning the first day of absence from employment due to service in the uniformed services; or

- The day after the employee fails to apply for a return to employment as required by USERRA, after the completion of a period of service.

Under federal law, the period coverage available under USERRA shall run concurrently with the COBRA period available to an employee and/or eligible dependent.

Other information

Employees should contact their employer with any questions regarding coverage normally available during a military leave of absence or continuation coverage and notify the employer of any changes in marital status, or change of address.

Your rights under the Employee Retirement Income Security Act of 1974 (ERISA)

Under ERISA, all plan participants covered by ERISA are entitled to certain rights and protections, as described below. Notwithstanding anything in the group health plan or group insurance policy, following are a covered person's minimum rights under ERISA. ERISA requirements do not apply to plans maintained by governmental agencies or churches.

Information about the plan and benefits

Plan participants may:

- Examine, free of charge, all documents governing the plan. These documents are available in the plan administrator's office;

- Obtain, at a reasonable charge, copies of documents governing the plan, including a copy of any updated summary plan description and a copy of the latest annual report for the plan (Form 5500), if any, by writing to the plan administrator;

- Obtain, at a reasonable charge, a copy of the latest annual report (Form 5500) for the plan, if any, by writing to the plan administrator.

As a plan participant, you will receive a summary of any material changes made in the plan within 210 days after the end of the plan year in which the changes are made unless the change is a material reduction in covered services or benefits, in which case you will receive a summary of the material reduction within 60 days after the date of its adoption.

If the plan is required to file a summary annual financial report, you will receive a copy from the plan administrator.

FEDERAL NOTICES (continued)

Responsibilities of plan fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the plan. These people, called "fiduciaries" of the plan, have a duty to act prudently and in the interest of plan participants and beneficiaries.

No one, including an employer, may discharge or otherwise discriminate against a plan participant in any way to prevent the participant from obtaining a benefit to which the participant is otherwise entitled under the plan or from exercising ERISA rights.

Continue group health plan coverage

Participants may be eligible to continue health care coverage for themselves, their spouse or dependents if there is a loss of coverage under the group health plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review the COBRA notice in this document regarding the rules governing COBRA continuation coverage rights.

Participants should review their group health plan document regarding reduction or elimination of exclusionary periods for preexisting conditions due to creditable coverage from another plan. The group health plan or health insurance issuer should provide a certificate of creditable coverage when coverage ends under the plan, the participant becomes entitled to elect COBRA continuation coverage, COBRA continuation coverage ceases (if COBRA is requested before losing coverage) or, if requested, up to 24 months after losing coverage. Without evidence of creditable coverage, a participant may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after the coverage enrollment date.

Claims determinations

If a claim for a plan benefit is denied or disregarded, in whole or in part, participants have the right to know why this was done, to obtain copies of documents relating to the decision without charge and to appeal any denial within certain time schedules.

Enforce your rights

Under ERISA, there are steps participants may take to enforce the above rights. For instance:

- If a participant requests a copy of plan documents and does not receive them within 30 days, the participant may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until the participant receives the materials, unless the materials were not sent because of reasons beyond the control of the plan administrator;

- If a claim for benefits is denied or disregarded, in whole or in part, the participant may file suit in a state or Federal court;

- If the participant disagrees with the plan's decision, or lack thereof, concerning the qualified status of a domestic relations order or a medical child support order, the participant may file suit in Federal court;

- If plan fiduciaries misuse the plan's money, or if participants are discriminated against for asserting their rights, they may seek assistance from the U.S. Department of Labor, or may file suit in a Federal court.

The court will decide who should pay court costs and legal fees. If the participant is successful, the court may order the person sued to pay costs and fees. If the participant loses, the court may order the participant to pay the costs and fees.

Assistance with questions

- Contact the group health plan human resources department or the plan administrator with questions about the plan;

- For questions about ERISA rights, contact the nearest area office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or:

The Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue N.W.
Washington, D.C. 20210;

- Call the publications hotline of the Employee Benefits Security Administration to obtain publications about ERISA rights.

Patient Protection Act

Humana generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For children, you may designate a pediatrician as the primary care provider. For information on how to select a primary care provider, and for a list of the participating primary care providers, visit our Website at www.humana.com or call the customer service telephone number on your identification card.

FEDERAL NOTICES (continued)

If you plan provides coverage for obstetric or gynecological care, you do not need prior authorization from us or from any other person (including a primary care provider) in order to obtain access to this care from a health care professional in our network who specialize in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, visit our Website at www.humana.com or call the customer service telephone number on your identification card.

Certificate of Creditable Coverage

Upon termination of this group health plan, you will receive a certificate of creditable coverage. You may also call the Customer Service number on the back of your Humana identification card to request a copy.

Appeal and External Review Notice

The following pages contain important information about Humana's claims procedures, internal appeals and external review. There may be differences between the Certificate of Insurance Policy/Certificate and this Notice packet. There may also be differences between this notice packet and state law. You are eligible for the rights more beneficial to you.

Federal standards

The Employee Retirement Income Security Act of 1974 (ERISA) established minimum requirements for claims procedures. The Patient Protection and Affordable Care Act (PPACA) including all regulation enforcing PPACA established additional requirements for claims procedures, internal appeal and *external review* processes. Humana complies with these standards. In addition to the procedures below, you should also refer to your insurance benefit plan documents (e.g., the Certificate of Insurance or Evidence of Coverage).

Definitions

Adverse benefit determination means a denial, reduction, or termination of, or a failure to provide or make a payment (in whole or in part) for a benefit based on:

- A determination of your eligibility to participate in the plan or health insurance coverage;
- A determination that the benefit is not covered;
- The imposition of a preexisting condition exclusion, source-of-injury exclusion, network exclusion, or other limitation on otherwise covered benefits; or
- A determination that a benefit is experimental, investigational, or not medically necessary or appropriate.

Claimant means a covered person (or authorized representative) who files a claim.

Clinical peer reviewer is:

- An expert in the treatment of your medical condition that is the subject of an *external review*;
- Knowledgeable about the recommended healthcare service or treatment through recent or current actual clinical experience treating patients with the same or similar to your medical condition;
- Holds a non-restricted license in a state of the United States and, for physicians, a current certification by a recognized American medical specialty board in the area or areas appropriate to the subject of the *external review*;

- Has no history of disciplinary actions or sanctions, including loss of staff privileges or participation restrictions, that have been taken or are pending by any hospital, governmental agency or unit, or regulatory body that raise a substantial question as to the *clinical peer reviewer's* physical, mental or professional competence or moral character; and

- Does not have a material professional, family or financial conflict of interest with the *claimant*, Humana and any of the following:

    - The healthcare provider, the healthcare provider's medical group or independent practice association recommending the healthcare service or treatment;
    - The facility at which the recommended healthcare service or treatment would be provided; or
    - The developer or manufacturer of the principal drug, device, procedure or other therapy being recommended.

Commissioner means the Commissioner of Insurance.

Concurrent-care decision means a decision by the plan to reduce or terminate benefits otherwise payable for a course of treatment that has been approved by the plan (other than by plan amendment or termination) or a decision with respect to a request by a *claimant* to extend a course of treatment beyond the period of time or number of treatments that has been approved by the plan.

Evidence-based standard means the conscientious, explicit and judicious use of the current best evidence based on the overall systematic review of the research in making decisions about the care of individual patients.

External review means a review of an *adverse benefit determination* including a *final adverse benefit determination* conducted by an *Independent review organization (IRO)*.

Final adverse benefit determination means an *adverse benefit determination* that has been upheld by us at the completion of the internal appeals process or when the internal appeals process has been exhausted.

Group health plan means an employee welfare benefit plan to the extent the plan provides medical care to employees or their dependents directly (self insured) or through insurance (including HMO plans), reimbursement or otherwise.

Health insurance issuer means the offering company listed on the face page of your Certificate of Insurance and referred to in this document as "Humana," "we," "us," or "our".

Independent review organization (IRO) means an entity that conducts independent *external reviews* of *adverse benefit determinations* and *final adverse benefit determinations*. All *IRO's* must be accredited by a nationally recognized private accrediting organization and have no conflicts of interest to influence its independence.

Appeal and External Review Notice (continued)

Medical or scientific evidence means evidence found in the following sources:

- Peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff;

- Peer-reviewed medical literature, including literature relating to therapies reviewed and approved by a qualified institutional review board, biomedical compendia and other medical literature that meet the criteria of the National Institutes of Health's Library of Medicine for indexing in Index Medicus (Medline) and Elsevier Science Ltd. for indexing in Excerpta Medicus (EMBASE);

- Medical journals recognized by the Secretary of Health and Human Services;

- The following standard reference compendia:

    - The American Hospital Formulary Service–Drug Information;
    - Drug Facts and Comparisons;
    - The American Dental Association Accepted Dental Therapeutics; and
    - The United States Pharmacopoeia–Drug Information;

- Findings, studies or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes, including:

    - The federal Agency for Healthcare Research and Quality;
    - The National Institutes of Health;
    - The National Cancer Institute;
    - The National Academy of Sciences;
    - The Centers for Medicare & Medicaid Services;
    - The federal Food and Drug Administration; and
    - Any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health care services; or

- Any other *medical or scientific evidence* that is comparable to the sources listed above.

Preliminary review means a review by Humana of an *external review* request to determination if:

- You are or were covered under the plan at the time a service was recommended, requested, or provided;
- The service is covered under the plan except when we determine the service is:

    - Not covered because it does not meet plan requirements for medical necessity, appropriateness, healthcare setting, level of care or effectiveness; or
    - Experimental or investigational for a particular medical condition and is not explicitly listed as an excluded benefit under the plan.

- In the case of experimental or investigational treatment:
  - Your treating physician has certified one of the following situations is applicable:
    - Standard services have not been effective in improving your condition;
    - Standard services are not medically appropriate for you; or
    - There is no available standard service covered by the plan that is more beneficial to you than the recommended or requested service.
  - The treating physician certifies in writing:
    - The recommended service is likely to be more beneficial to you, in the physician's opinion, than any available standard services; or
    - Scientifically valid studies using accepted protocols demonstrate the service is likely to be more beneficial to you than any available standard services and the physician is a licensed, board certified or board eligible physician qualified to practice in the area of medicine appropriate to treat your condition.
- The internal appeals process has been exhausted as specified under the 'exhaustion of remedies' section;
- You have provided all information required to process an *external review*; including:
  - An *external review* request form provided with the *adverse benefit determination* or *final adverse benefit determination*; and
  - Release forms authorizing us to disclose protected health information that is pertinent to the *external review*.

Post-service claim means any claim for a benefit under a *group health plan* that is not a *pre-service claim*.

Pre-service claim means a request for authorization of a benefit for which the plan conditions receipt of the benefit, in whole or in part, on advance approval.

Urgent-care claim means a claim for covered services to which the application of the time periods for making non-urgent care determinations:

- Could seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function; or
- In the opinion of a physician with knowledge of the covered person's medical condition, would subject the covered person to severe pain that cannot be adequately managed without the service that is the subject of the claim.

Humana will make a determination of whether a claim is an *urgent-care claim*. However, any claim a physician, with knowledge of a covered person's medical condition, determines is an "*urgent-care claim*" will be treated as a "claim involving urgent care".

Appeal and External Review Notice (continued)

Claim procedures

Discretionary authority

With respect to paying claims for benefits or determining eligibility for coverage under a policy issued by Humana, Humana as administrator for claims determinations and as ERISA claims review fiduciary, shall have full and exclusive discretionary authority to:

- Interpret plan provisions;
- Make decisions regarding eligibility for coverage and benefits; and
- Resolve factual questions relating to coverage and benefits.

Submitting a claim

This section describes how a *claimant* files a claim for plan benefits. A claim must be filed in writing and delivered by mail, postage prepaid, by FAX or e-mail. A request for pre-authorization may be filed by telephone. The claim or request for pre-authorization must be submitted to Humana or to Humana's designee at the address indicated in the covered person's benefit plan document or identification card. This is particularly important with respect to mental health coordinators and other providers to whom Humana has delegated responsibility for claims administration. Claims will be not be deemed submitted for purposes of these procedures unless and until received at the correct address.

Claims submissions must be in a format acceptable to Humana and compliant with any legal requirements. Claims not submitted in accordance with the requirements of applicable federal law respecting privacy of protected health information and/or electronic claims standards will not be accepted by Humana.

Claims submissions must be timely. Claims must be filed as soon as reasonably possible after they are incurred, and in no event later than the period of time described in the benefit plan document.

Claims submissions must be complete and delivered to the designated address. At a minimum they must include:

- Name of the covered person who incurred the covered expense;
- Name and address of the provider;
- Diagnosis;
- Procedure or nature of the treatment;
- Place of service;
- Date of service; and
- Billed amount.

Presentation of a prescription to a pharmacy does not constitute a claim for benefits under the plan. If a covered person is required to pay the cost of a covered prescription drug, he or she may submit a written claim for plan benefits to Humana.

A general request for an interpretation of plan provisions will not be considered a claim. Requests of this type, such as a request for an interpretation of the eligibility provisions of the plan, should be directed to the plan administrator.

Failure to provide necessary information

If a *pre-service claim* submission is not made in accordance with the plan's requirements, Humana will notify the *claimant* of the problem and how it may be remedied within five days (or as soon as possible but not more than 24 hours, in the case of an *urgent-care claim*). If a *post-service claim* is not made in accordance with the plan's requirement, it will be returned to the submitter.

Authorized representatives

A covered person may designate an authorized representative to act on his or her behalf in pursuing a benefit claim, an internal appeal or an *external review.* The authorization must be in writing and authorize disclosure of health information. If a document is not sufficient to constitute designation of an authorized representative, as determined by Humana, the plan will not consider a designation to have been made. An assignment of benefits does not constitute designation of an authorized representative.

Any document designating an authorized representative must be submitted to Humana in advance or at the time an authorized representative commences a course of action on behalf of the covered person. Humana may verify the designation with the covered person prior to recognizing authorized representative status.

In any event, a health care provider with knowledge of a covered person's medical condition acting in connection with an *urgent-care claim* will be recognized by the plan as the covered person's authorized representative.

Covered persons should carefully consider whether to designate an authorized representative. Circumstances may arise under which an authorized representative may make decisions independent of the covered person, such as whether and how to appeal a claim denial.

Claims decisions

After a determination on a claim is made, Humana will notify the *claimant* within a reasonable time, as follows:

- ***Pre-service claims*** - Humana will provide notice of a favorable or *adverse benefit determination* within a reasonable time appropriate to the medical circumstances but no later than 15 days after the plan receives the claim.

  This period may be extended by an additional 15 days, if Humana determines the extension is necessary due to matters beyond the control of the plan. Before the end of the initial 15-day period, Humana will notify the *claimant* of the circumstances requiring the extension and the date by which Humana expects to make a decision.

If the reason for the extension is because Humana does not have enough information to decide the claim, the notice of extension will describe the required information, and the *claimant* will have at least 45 days from the date the notice is received to provide the necessary information.

- ***Urgent-care claims*** - Humana will determine whether a particular claim is an *urgent-care claim*. This determination will be based on information furnished by or on behalf of a covered person. Humana will exercise its judgment when making the determination with deference to the judgment of a physician with knowledge of the covered person's condition. Humana may require a *claimant* to clarify the medical urgency and circumstances supporting the *urgent-care claim* for expedited decision-making.

  Notice of a favorable or *adverse benefit determination* will be made by Humana as soon as possible, taking into account the medical urgency particular to the covered person's situation, but not later than 24 hours after receiving the *urgent-care claim*.

  If a claim does not provide sufficient information to determine whether, or to what extent, services are covered under the plan, Humana will notify the *claimant* as soon as possible, but not more than 24 hours after receiving the *urgent-care claim*. The notice will describe the specific information necessary to complete the claim. The *claimant* will have a reasonable amount of time, taking into account the covered person's circumstances, to provide the necessary information – but not less than 48 hours.

  Humana will provide notice of the plan's *urgent-care claim* determination as soon as possible but no more than 48 hours after the earlier of:

  - The plan receives the specified information; or
  - The end of the period afforded the *claimant* to provide the specified additional information.

- ***Concurrent-care decisions*** - Humana will notify a *claimant* of a *concurrent-care decision* involving a reduction or termination of pre-authorized benefits sufficiently in advance of the reduction or termination to allow the *claimant* to appeal and obtain a determination.

  Humana will decide *urgent-care claim*s involving an extension of a course of treatment as soon as possible taking into account medical circumstances. Humana will notify a *claimant* of the benefit determination, whether adverse or not, within 24 hours after the plan receives the claim, provided the claim is submitted to the plan 24 hours prior to the expiration of the prescribed period of time or number of treatments.

- ***Post-service claims*** - Humana will provide notice of a favorable or *adverse benefit determination* within a reasonable time appropriate to the medical circumstances but no later than 30 days after the plan receives the claim.

  This period may be extended an additional 15 days, if Humana determines the extension is necessary due to matters beyond the plan's control. Before the end of the initial 30-day period, Humana will notify the affected *claimant* of the extension, the circumstances requiring the extension and the date by which the plan expects to make a decision.

Appeal and External Review Notice (continued)

If the reason for the extension is because Humana does not have enough information to decide the claim, the notice of extension will describe the required information, and the *claimant* will have at least 45 days from the date the notice is received to provide the specified information. Humana will make a decision on the earlier of the date on which the *claimant* responds or the expiration of the time allowed for submission of the requested information.

Initial denial notices

Notice of a claim denial (including a partial denial) will be provided to *claimants* by mail, postage prepaid, by FAX or by e-mail, as appropriate, within the time frames noted above. With respect to adverse decisions involving *urgent-care claims*, notice may be provided to *claimants* orally within the time frames noted above. If oral notice is given, written notification must be provided no later than three days after oral notification.

A claims denial notice will convey the specific reason for the *adverse benefit determination* and the specific plan provisions upon which the determination is based. The notice will also include a description of any additional information necessary to perfect the claim and an explanation of why such information is necessary. The notice will disclose if any internal plan rule, protocol or similar criterion was relied upon to deny the claim and a copy of the rule, protocol or similar criterion will be provided to *claimants*, free of charge. In addition to the information provided in the notice, a *claimant* has the right to request the diagnosis and treatment codes and descriptions upon which the determination is based.

The notice will describe the plan's review procedures and the time limits applicable to such procedures, including a statement of the *claimant's* right to bring a civil action under ERISA Section 502(a) following an *adverse benefit determination* on review**.**

If an *adverse benefit determination* is based on medical necessity, experimental treatment or similar exclusion or limitation, the notice will provide an explanation of the scientific or clinical basis for the determination, free of charge. The explanation will apply the terms of the plan to the covered person's medical circumstances.

In the case of an adverse decision of an *urgent-care claim*, the notice will provide a description of the plan's expedited review procedures.

For assistance with appeals, complaints or the external review process a *claimant* may write or call:

Consumer Health Assistance Program
Department of Insurance
Mail Code 111-1A
PO Box 149091
Austin, TX 78714
Website: www.texashealthoptions.com
Email: chap@tdi.state.tx.us
Phone: 855-839-2427

Appeal and External Review Notice (continued)

Internal appeals and external review of adverse benefit determinations

Internal appeals

A *claimant* must appeal an *adverse benefit determination* within 180 days after receiving written notice of the denial (or partial denial). An appeal may be made by a *claimant* by means of written application to Humana, in person, or by mail, postage prepaid.

A *claimant*, on appeal, may request an expedited internal appeal of an adverse *urgent-care claim* decision orally or in writing. In such case, all necessary information, including the plan's benefit determination on review, will be transmitted between the plan and the *claimant* by telephone, FAX, or other available similarly expeditious method, to the extent permitted by applicable law.

A *claimant* may request an expedited *external review* at the same time a request is made for an expedited internal appeal of an *adverse benefit determination* for an *urgent-care claim* or when you are receiving an ongoing course of treatment.

Determination of appeals of denied claims will be conducted promptly, will not defer to the initial determination and will not be made by the person who made the initial adverse claim determination or a subordinate of that person. The determination will take into account all comments, documents, records, and other information submitted by the *claimant* relating to the claim.

On appeal, a *claimant* may review relevant documents and may submit issues and comments in writing. A *claimant* on appeal may, upon request, discover the identity of medical or vocational experts whose advice was obtained on behalf of the plan in connection with the *adverse benefit determination* being appealed, as permitted under applicable law.

If the claims denial is based in whole, or in part, upon a medical judgment, including determinations as to whether a particular treatment, drug, or other service is experimental, investigational, or not medically necessary or appropriate, the person deciding the appeal will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The consulting health care professional will not be the same person who decided the initial appeal or a subordinate of that person.

If new or additional evidence is relied upon or if new or additional rational is used during the internal appeal process, Humana will provide the *claimant*, free of charge, the evidence or rational as soon as possible and in advance of the appeals decision in order to provide the *claimant* a reasonable opportunity to respond.

Time periods for decisions on appeal

Appeals of claims denials will be decided and notice of the decision provided as follows:

- ***Urgent-care claims*** - As soon as possible but not later than 72 hours after Humana receives the appeal request;
- ***Pre-service claims*** - Within a reasonable period but not later than 30 days after Humana received the appeal request;

Appeal and External Review Notice (continued)

- ***Post-service claims*** - Within a reasonable period but not later than 60 days after Humana receives the appeal request;
- ***Concurrent-care decisions*** - Within the time periods specified above depending on the type of claim involved.

Appeals denial notices

Notice of a claim denial (including a partial denial) will be provided to *claimants* by mail, postage prepaid, by FAX or by e-mail, as appropriate, within the time periods noted above.

A notice that a claim appeal has been denied will include:

- The specific reason or reasons for the *adverse benefit determination*;
- Reference to the specific plan provision upon which the determination is based;
- If any internal plan rule, protocol or similar criterion was relied upon to deny the claim. A copy of the rule, protocol or similar criterion will be provided to the *claimant*, free of charge;
- A statement of the *claimant's* right to *external review*, a description of the *external review* process, and the forms for submitting an *external review* request, including release forms authorizing Humana to disclose protected health information pertinent to the *external review*;
- A statement about the *claimant's* right to bring an action under §502(a) of ERISA;
- If an *adverse benefit determination* is based on medical necessity, experimental treatment or similar exclusion or limitation, the notice will provide an explanation of the scientific or clinical basis for the determination, free of charge. The explanation will apply the terms of the plan to the covered person's medical circumstances.

In addition to the information provided in the notice, a *claimant* has the right to request the diagnosis and treatment codes and descriptions upon which the determination is based.

For assistance with appeals, complaints or the external review process the *claimant* may write or call:

Consumer Health Assistance Program
Department of Insurance
Mail Code 111-1A
PO Box 149091
Austin, TX 78714
Website: www.texashealthoptions.com
Email: chap@tdi.state.tx.us
Phone: 855-839-2427

Appeal and External Review Notice (continued)

Exhaustion of remedies

Upon completion of the internal appeals process under this section, a *claimant* will have exhausted his or her administrative remedies under the plan. If Humana fails to adhere to all requirement of the internal appeal process, except for failures that are based on a minimal error, the claim shall be deemed to have been denied and the *claimant* may request an *external review*.

After exhaustion of remedies, a *claimant* may pursue any other legal remedies available, which may include bringing civil action under ERISA section 502(a) for judicial review of the plan's determination. Additional information may be available from the local U.S. Department of Labor Office.

External review

Within four months after a *claimant* receives notice of an *adverse benefit determination* or *final adverse benefit determination* the *claimant* may request an *external review* if the determination concerns treatment that is *experimental, investigational* or not *medically necessary*. The request for *external review* must be made in writing to the *commissioner*. The *claimant* may be assessed a $25 filing fee that will be refunded if the *adverse benefit determination* is overturned. This fee may be waived with proof of financial hardship. The annual limit on filing fees for any *claimant* within a single plan year will not exceed $75. Please refer to the section titled 'Expedited external review' if the *adverse benefit determination* involves an *urgent-care claim* or an ongoing course of treatment.

The *claimant* may contact the *commissioner* for assistance at any time at the address and telephone number below:

Department of Insurance
PO Box 149104
Austin, TX 78714-9104
Phone: 512-463-6169 or 800-578-4677

The *claimant* may also call or write the Consumer Assistance Program for assistance with appeals, complaints or the external review process:

Consumer Health Assistance Program
Department of Insurance
Mail Code 111-1A
PO Box 149091
Austin, TX 78714
Website: www.texashealthoptions.com
Email: chap@tdi.state.tx.us
Phone: 855-839-2427

Appeal and External Review Notice (continued)

Within one business day after the receipt of a request for *external review*, the *commissioner* will send a copy of the request to Humana. Within five business days, we will complete a *preliminary review* of the request.

Within one business day after we complete the *preliminary review*, we will notify the *claimant* and the *commissioner* in writing whether:

- The request is complete and is eligible for *external review*;
- The request is not complete and the information or materials needed to make the request complete; or
- The request is not eligible for *external review*, the reasons for ineligibility and the *claimant's* right to appeal to the *commissioner*. If appealed, the *commissioner* may determine that the request is eligible for *external review*.

Within one business day after the *commissioner* receives notice that the request is eligible for *external review*, the *commissioner* will:

- Impartially assign an *IRO* from a list compiled and maintained by the *commissioner* to conduct the *external review*;
- Provide Humana with the name of the *IRO*. Within five business days after the date of receipt of this notice, we will provide the *IRO* with all documents and information we considered in making the *adverse benefit determination* or *final adverse benefit determination*;
- Notify the *claimant* in writing of the following:
  - The eligibility of the request and acceptance for *external review*; and
  - The right to submit additional information in writing to the *IRO* and the time limits to submit the information.

Any information received by the *IRO* will be forwarded to Humana within one business day of receipt. Upon receipt of additional information, we may reconsider the *adverse benefit determination* or *final adverse benefit determination*. If we reverse the *adverse benefit determination* or *final adverse benefit determination*, the *external review* will be terminated and we will provide coverage for the service. We will immediately notify the *claimant*, the *IRO*, and the *commissioner* in writing of our decision.

The *IRO* will review all of the information received including, if available and considered appropriate the following:

- Your medical records;
- The attending healthcare professional's recommendation;
- Consulting reports from appropriate healthcare professionals and other documents submitted by Humana, the *claimant*, and treating provider;
- The terms of the coverage under the plan;

Appeal and External Review Notice (continued)

- The most appropriate practice guidelines, which will include applicable *evidence-based standards* and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards and associations;

- Any applicable clinical review criteria developed and used by Humana; and

- The opinion of the *IRO's clinical peer reviewer* or reviewers after considering the information and documents listed above.

If the *external review* involves experimental or investigational treatment, within one business day after the *IRO* receives notice of assignment to conduct the *external review*, the *IRO* will select one or more *clinical peer reviewers* to conduct the *external review*. The *clinical peer reviewer* will review all of the information and within 20 days after being selected, will provide a written opinion to the *IRO* on whether the service should be covered. The written opinion will include:

- A description of the medical condition;

- A description of the indicators relevant to determining whether there is sufficient evidence to demonstrate that the service is more likely than not to be beneficial to you than any available standard services;

- The adverse risks of the service would not be substantially increased over those of available standard services;

- A description and analysis of any *medical or scientific evidence*, or *evidence-based standard* considered in reaching the opinion;

- Information on whether the reviewer's rationale for the opinion is based on either:

  - The service has been approved by the federal Food and Drug Administration, if applicable, for the condition; or

  - *Medical or scientific evidence* or *evidence-based standards* demonstrate that the expected benefits of the service is more likely than not to be beneficial to you than any available standard health care service and the adverse risks of the service would not be substantially increased over those of available standard services.

The *IRO's* decision to either uphold or reverse the *adverse benefit determination* or *final adverse benefit determination* will be provided in writing to the *claimant*, the *commissioner* and Humana within:

- 20 days after receipt of each *clinical peer reviewer* opinion for an experimental or investigational treatment; or
- 45 days after receipt of the request for an *external review*.

In the case of experimental or investigational treatment, if a majority of *clinical peer reviewers* recommend the service should be covered, the *IRO* will make a decision to reverse the *adverse benefit determination* or *final adverse benefit determination*. If a majority of *clinical peer reviewers* recommend the service should not be covered, the *IRO* will make a decision to uphold the *adverse benefit determination* or *final adverse benefit determination*. If the *clinical peer reviewers* are evenly split, the *IRO* will obtain the opinion of an additional *clinical peer reviewer* in order for the *IRO* to make a decision.

The *IRO's* written notice of the decision will include:

- A general description of the reason for the request for *external review*;
- The date the *IRO* received the assignment from the *commissioner* to conduct the *external review*;
- The date the *external review* was conducted;
- The date of the *IRO's* decision;
- The principal reason for the decision, including applicable *evidence-based standards*, if any, used as a basis for the decision;
- The rationale for the decision;
- References to the evidence or documentation, including the *evidence-based standards*, considered in reaching the decision; and
- In the case of experimental or investigational treatment, the written opinion and rational for the recommendation of each *clinical peer reviewer*.

Immediately upon our receipt of the *IRO's* decision reversing the *adverse benefit determination* or *final adverse determination*, we will approve the service.

Expedited external review

You may request an expedited *external review* from the *commissioner*:

- At the same time you request an expedited internal appeal of an *adverse benefit determination* for an *urgent-care claim* or when you are receiving an ongoing course of treatment; or
- When you receive an *adverse benefit determination* or *final adverse benefit determination* of:

    - An *urgent-care claim*;
    - An admission, availability of care, continued stay or health care service for which you received emergency services, but you have not been discharged from the facility; or
    - An experimental or investigational treatment if the treating physician certifies, in writing, that the recommended service would be significantly less effective if not promptly initiated.

The *commissioner* will immediately send a copy of the request to Humana and upon receipt; we will immediately complete a *preliminary review* of the request. We will immediately notify the *claimant* and the *commissioner* of the *preliminary review* determination. If we determine the request is not eligible, the notice will advise you of your right to appeal to the *commissioner*. If appealed, the *commissioner* may determine that the request is eligible for *external review.*

Appeal and External Review Notice (continued)

Immediately after the commissioner receives notice that the request is eligible for *external review*, the *commissioner* will:

- Impartially assign an *IRO* to conduct the expedited *external review.*
- Provide Humana with the name of the *IRO* and we will immediately provide the *IRO* with all necessary documents and information.

The *IRO* will review all of the information received including, if available and considered appropriate, the following:

- Your medical records;
- The attending healthcare professional's recommendation;
- Consulting reports from appropriate healthcare professionals and other documents submitted by Humana, the *claimant* and treating provider;
- The terms of the coverage under the plan;
- The most appropriate practice guidelines, which will include *evidence-based standards* and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards and associations;
- Any applicable clinical review criteria developed and used by Humana; and
- The opinion of the *IRO's clinical peer reviewer* or reviewers after considering the information and documents listed above.

If the expedited *external review* request involves experimental or investigational treatment, within one business day after the *IRO* receives notice of assignment to conduct the *external review*, the *IRO* will select one or more *clinical peer reviewers* to conduct the *external review.* The *clinical peer reviewer* will:

- Review all of the information noted above including whether:
    - The recommended service has been approved by the federal Food and Drug Administration, if applicable, for the condition; or
    - Medical or scientific evidence or *evidence-based standards* demonstrate that the expected benefits of the recommended service is more likely than not to be beneficial to you than any available standard service and the adverse risks of the recommended service would not be substantially increased over those of available standard services.
- Provide an opinion to the *IRO* as expeditiously as your condition or circumstances require, but in no event more than five calendar days after being selected.

Appeal and External Review Notice (continued)

The *IRO's* decision to either uphold or reverse the *adverse benefit determination* or *final adverse benefit determination* will be provided orally or in writing to the *claimant*, the *commissioner* and Humana within:

- 48 hours after receipt of each *clinical peer reviewer* opinion of an expedited *external review* for an experimental or investigational treatment; or
- 72 hours after the date of receipt of the request for an expedited *external review*.

In the case of experimental or investigational treatment, if a majority of *clinical peer reviewers* recommend the service should be covered, the *IRO* will make a decision to reverse the *adverse benefit determination* or *final adverse benefit determination*. If a majority of *clinical peer reviewers* recommend the service should not be covered, the *IRO* will make a decision to uphold the *adverse benefit determination* or *final adverse benefit determination*. If the *clinical peer reviewers* are evenly split, the *IRO* will obtain the opinion of an additional *clinical peer reviewer* in order for the *IRO* to make a decision.

The *IRO* will send written confirmation within 48 hours of an oral decision and will include:

- A general description of the reason for the request for an expedited *external review*;
- The date the *IRO* received the assignment from the *commissioner* to conduct the expedited *external review*;
- The date the expedited *external review* was conducted;
- The date of the *IRO's* decision;
- The principal reason for the decision, including applicable *evidence-based standards*, if any, used as a basis for the decision;
- The rationale for the decision;
- References to the evidence or documentation, including the *evidence-based standards*, considered in reaching the decision, except in the case of experimental or investigational treatment; and
- In the case of experimental or investigational treatment, the written opinion and rational for the recommendation of each *clinical peer reviewer*.

Immediately upon receipt of the *IRO's* decision reversing the *adverse benefit determination* or *final adverse benefit determination*, we will approve the service.

Legal actions and limitations

No lawsuit may be brought with respect to plan benefits until all remedies under the plan have been exhausted.

No lawsuit with respect to plan benefits may be brought after the expiration of the applicable limitations period stated in the benefit plan document. If no limitation is stated in the benefit plan document, then no such suit may be brought after the expiration of the applicable limitations under applicable law.