12/01/2016

Enclosed are the Coverage Certificates that Explain Your Plan

Dear Member:

Welcome to Humana! Thank you for allowing us to provide your health coverage. We appreciate your business and your trust.

The enclosed National Point-of-Service (POS) Certificate outlines the details of your coverage. Please take a moment to read this letter before reviewing your certificate.

Your National POS Certificate includes two documents – a HMO Evidence of Coverage and a PPO Certificate of Coverage. Your benefits are administered according to the appropriate HMO or PPO regulations. The HMO Evidence of Coverage reflects *your* responsibility, while the PPO Certificate shows *Humana'*s responsibility for each covered service.

When you receive services from in-network providers, the plan covers more of the costs. Also, you don't have to choose a primary care physician (PCP), and you don't need a PCP referral to see other providers or specialists. You have the freedom to choose.

This plan also gives you the flexibility to use *out-of-network* providers, doctors, hospitals and other providers who don't have a contract with Humana. If you see an out-of-network provider, the plan pays less of your costs. But you have the choice – each time you need care.

To help you make informed health care decisions, we encourage you to establish a relationship with a primary or family doctor – someone who knows your complete medical history.

Again, thank you for your membership in the Humana National Point of Service plan. We look forward to serving you for years to come.

Sincerely,

Leonard Kearney
Director

Enclosure: National POS Certificates

PS: Please keep these certificates in a safe place for easy reference.

GHC-20081 05/06

Humana.

Discrimination is Against the Law

Humana Inc. and its subsidiaries comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Humana Inc. and its subsidiaries do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Humana Inc. and its subsidiaries provide:

- Free auxiliary aids and services, such as qualified sign language interpreters, video remote interpretation, and written information in other formats to people with disabilities when such auxiliary aids and services are necessary to ensure an equal opportunity to participate.
- Free language services to people whose primary language is not English when those services are necessary to provide meaningful access, such as translated documents or oral interpretation.

If you need these services, call the number on your ID card or, if you use a TTY, call 711.

If you believe that Humana Inc. and its subsidiaries have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Discrimination Grievances
P.O. Box 14618
Lexington, KY 40512-4618

If you need help filing a grievance, call the number on your ID card or, if you use a TTY, call 711.

You can also file a civil rights complaint with the **U.S. Department of Health and Human Services**, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**

Multi-Language Interpreter Services

English: ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call the number on your ID card (TTY: 711).

Español (Spanish): ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al número que figura en su tarjeta de identificación (TTY: 711).

繁體中文 (Chinese): 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電會員卡上的電話號碼 (TTY：711)。

Tiếng Việt (Vietnamese): CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số điện thoại ghi trên thẻ ID của quý vị (TTY: 711).

한국어 (Korean): 주의 : 한국어를 사용하시는 경우 , 언어 지원 서비스를 무료로 이용하실 수 있습니다 . ID 카드에 적혀 있는 번호로 전화해 주십시오 (TTY: 711).

Tagalog (Tagalog – Filipino): PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tawagan ang numero na nasa iyong ID card (TTY: 711).

Русский (Russian): ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Наберите номер, указанный на вашей карточке-удостоверении (телетайп: 711).

Kreyòl Ayisyen (French Creole): ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele nimewo ki sou kat idantite manm ou (TTY: 711).

Français (French): ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le numéro figurant sur votre carte de membre (ATS : 711).

Polski (Polish): UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Proszę zadzwonić pod numer podany na karcie identyfikacyjnej (TTY: 711).

Português (Portuguese): ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para o número presente em seu cartão de identificação (TTY: 711).

Italiano (Italian): ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero che appare sulla tessera identificativa (TTY: 711).

Deutsch (German): ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Wählen Sie die Nummer, die sich auf Ihrer Versicherungskarte befindet (TTY: 711).

日本語 (Japanese): 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。お手持ちの ID カードに記載されている電話番号までご連絡ください (TTY：711)。

فارسی (Farsi):

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد.
با شماره تلفن روی کارت شناسایی تان تماس بگیرید (TTY: 711).

Diné Bizaad (Navajo): Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, námboo ninaaltsoos yézhí, bee nééh ho'dólzin bikáá'ígíí bee hólne' (TTY: 711).

العربية (Arabic):

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم الهاتف الموجود على بطاقة الهوية الخاصة بك (رقم هاتف الصم والبكم: 711).

Administrative Office:
1221 S. Mopac, Suite 200
Austin, TX 78746
(512) 338-6100

Evidence of Coverage
Humana Health Plan of Texas, Inc.

This Consumer Choice of Benefits Health Maintenance Organization health care plan, either in whole or in part, does not provide state-mandated health benefits normally required in evidence of coverage in Texas. This standard health benefit plan may provide a more affordable health plan for you although, at the same time, it may provide you with fewer health plan benefits than those normally included as state-mandated health benefits in Texas. Please consult with your insurance agent to discover which state-mandated health benefits are excluded in this evidence of coverage.

Group Plan Sponsor: SPECIALTY COMPOSITES

Group Plan Number: 737070

Effective Date: 12/01/2016

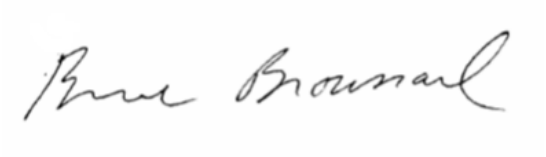
Product Name: TXFF0003 COIN

In accordance with the terms of the *master group contract* issued to the *group plan sponsor*, Humana Health Plan of Texas, Inc. certifies that a *covered person* has coverage for the benefits described in this *Evidence of Coverage*. This becomes the *Evidence of Coverage* and replaces any other *Evidence of Coverage* and riders previously issued.

A companion plan Certificate of Insurance is issued to *you* by Humana Insurance Company and attached to this *Evidence of Coverage*. **A *covered person* is not required to use the benefits outlined in this *Evidence of Coverage* prior to utilizing the benefits outlined in the attached Certificate of Insurance of the companion plan.**

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

THIS EVIDENCE OF COVERAGE IS NOT A MEDICARE SUPPLEMENT (POLICY OR CERTIFICATE). If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from *us*.



Bruce Broussard
President

This booklet, referred to as an Evidence of Coverage is provided to describe *your* Humana coverage.

1. **IMPORTANT NOTICE**
To obtain information or make a complaint:

2. You may call Humana Health Plan of Texas Inc.'s toll-free telephone number for information or to make a complaint at:

1-866-4ASSIST

3. You may also write Humana Health Plan of Texas Inc. 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) 490-1007
Web: www.tdi.texas.gov
Email: ConsumerProtection@tdi.texas.gov

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/EVIDENCE OF COVERAGE:**
This notice is for information only and does not become a part or condition of the attached document.

AVISO IMPORTANTE
Para obtener información o para presentar una queja:

Usted puede llamar al número de teléfono gratuito de Humana Health Plan of Texas Inc.'s para obtener información o para presentar una queja al:

1-866-4ASSIST

Usted también puede escribir a Humana Health Plan of Texas Inc. al:

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

Usted puede comunicarse con el Departamento de Seguros de Texas para obtener información sobre compañías, coberturas, derechos, o quejas al:

1-800-252-3439

Usted puede escribir al Departamento de Seguros de Texas:
P.O. Box 149104
Austin, TX 78714-9104
FAX: (512) 490-1007
Sitio Web: www.tdi.texas.gov
Email: ConsumerProtection@tdi.texas.gov

DISPUTAS POR PRIMAS DE SEGUROS O RECLAMACIONES:
Si tiene una disputa relacionada con a su prima de seguro o con una reclamación, usted debe comunicarse con la compañía primero. Si la disputa no es resuelta, usted puede s comunicarse con el Departamento de Seguros de Texas.

ADJUNTE ESTE AVISO A SU PÓLIZA/EVIDENCIA DE COBERTURA:
Este aviso es solamente para propósitos informativos y no se convierte en parte o en condición del documento adjunto.

IMPORTANT NOTICE

NOTICE OF SPECIAL TOLL-FREE COMPLAINT NUMBER ABOUT A PRIVATE PSYCHIATRIC HOSPITAL, CHEMICAL DEPENDENCY TREATMENT CENTER, OR PSYCHIATRIC OR CHEMICAL DEPENDENCY SERVICES AT A GENERAL HOSPITAL, CALL:

1-800-832-9623

Your complaint will be referred to the state agency that regulates the hospital or chemical dependency treatment center.

AVISO IMPORTANTE

AVISO DE NUMERO TELEFONICO GRATIS ESPECIAL PARA QUEJAS PARA SOMETER UNA QUEJA ACERCA DE UN HOSPITAL PSIQUIATRICO PRIVADO, DE CENTRO TRATAMIENTO PARA LA DEPENDENCIA QUIMICA, DE SERVICIOS PSIQUIATRICOS O DE DEPENDENCIA QUIMICA EN UN HOSPITAL GENERAL, LLAME:

1-800-832-9623

Su queja sera referida a la agencia estatal que regula la hospital o centro de tratamiento para la dependencia quimica.

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UNDERSTANDING YOUR COVERAGE

As *you* read the *evidence of coverage*, *you* will see some words are printed in italics. Italicized words may have different meanings in the *evidence of coverage* than in general. Please check the "Glossary" sections for the meaning of the italicized words as they apply to *your* plan.

The *evidence of coverage* gives *you* information about *your* plan. It tells *you* what is covered and what is not covered. It also tells *you* what *you* must do and how much *you* must pay for services. *Your* plan covers many services, but it is important to remember it has limits. Be sure to read *your evidence of coverage* carefully before using *your* benefits.

Covered and non-covered health services

We will provide coverage for services, equipment and supplies that are *covered health services*. All requirements of the *master group contract* apply to *covered health services*.

The date used on the bill *we* receive for *covered health services* or the date confirmed in *your* medical records is the date that will be used when *your* claim is processed to determine the benefit period.

You are responsible to pay a *network provider* the applicable *copayment, coinsurance* and any applicable *deductible* for *covered health services*. The *network provider* will accept *your copayment, coinsurance, any applicable deductible* and the amount *we* pay as payment in full for *covered health services.* Not all services and supplies are *covered health services*, even when they are ordered by a *health care practitioner*. *You* must pay the health care provider any amount due for non-covered health services.

Refer to the "Schedule of Benefits", the "Covered Health Services" and the "Limitations and Exclusions" sections and any rider or amendment attached to the *evidence of coverage* to determine when services or supplies are *covered health services* or non-covered health services.

How your master group contract works

You may have to pay a *deductible* before *we* pay for certain *covered health services*. If a *deductible* applies, and it is met, *we* will pay *covered health services* at the *coinsurance* amount. Refer to the "Schedule of Benefits" to see when the *deductible* applies and the *coinsurance* amount *we* pay. *You* will be responsible for the *coinsurance* amount *we* do not pay.

If an *out-of-pocket limit* applies and it is met, *we* will pay *covered health services* at 100% the rest of the *year*, subject to the *usual and customary fee*.

Our payment for *covered health services* is calculated by applying any *deductible* and *coinsurance* to the net charges. "Net charges" means the total amount billed by the *qualified provider*, less any amounts such as:

- Those negotiated by contract, directly or indirectly, between *us* and the *qualified provider*;
- Those in excess of the *usual and customary fee*; or
- Adjustments related to *our* claims processing edits.

The service and diagnostic information submitted on the *qualified provider's* bill will be used to determine which provision of the "Schedule of Benefits" applies.

Your choice of providers affects your benefits

We will pay a higher percentage most of the time if *you* see a *network provider*, so the amount *you* pay will be lower. *You* must pay any *copayment*, *deductible* or *coinsurance you* owe to the *network provider*. The *network provider* will accept *your copayment, coinsurance* and *deductible,* if any, and the amount *we* pay as payment in full for *covered health services.* Be sure to determine if *your qualifed provider* is a *network provider* before *you* receive services from them.

We may appoint certain *network providers* for certain kinds of services. If *you* do not see the appointed *network provider* for these services, *we* may pay less.

Some *non-network providers* work with *network hospitals. We* will apply the *network provider copayment, deductible* and *coinsurance* to *covered health services* received by non-network pathologists, anesthesiologists, radiologists, neonatologists, assistant surgeons and emergency room physicians working with *network hospitals*. 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*. If possible, *you* may want to check if all health care providers working with *network hospitals* are *network providers*.

Services provided by a *non-network provider* are not covered under the *evidence of coverage* unless:

- *You* are not able to see a *network provider* for *emergency care*; or

- Preauthorized by *us* when *we* determine a *network provider* is not reasonably available. *Preauthorization* will be provided within the time appropriate to the circumstances relating to the delivery of the services and the condition of the patient, but will not exceed five business days following receipt of reasonably requested documentation. Only those services authorized by *us* to be provided by a *non-network provider* will be *covered health services* under the *evidence of coverage.*

We will reimburse the *non-network provider* at the *usual and customary fee* or at an agreed rate between *us* and the *non-network provider* for *emergency care covered health services* and *covered health services* preauthorized by *us*.

Refer to the "Schedule of Benefits" sections to see what *your* benefits are.

Claims processing edits

Payment of *covered health services* for services rendered by a *qualified provider* is also subject to *our* claims processing edits, as determined by *us*. The amount determined to be payable after *we* apply *our* claims processing edits depends on the existence and interaction of several factors. Because the mix of these factors may be different for every claim, the amount paid for a *covered health service* may vary depending on the circumstances. Accordingly, it is not feasible to provide an exhaustive description of the claims processing edits that will be used to determine the amount payable for a *covered health service*, but examples of the most commonly used factors are:

- The intensity and complexity of a service;

- Whether a service is one of multiple services performed at the same service session such that the cost of the service to the *qualified provider* is less than if the service had been provided in a separate service session. For example:

  - Two or more *surgeries* during the same service session; or
  - Two or more radiologic imaging views performed during the same session;

- Whether an assistant surgeon, physician assistant, registered nurse, certified operating room technician or any other *qualified provider*, who is billing independently is involved;

- When a charge includes more than one claim line, whether any service is part of or incidental to the primary service that was provided, or if these services cannot be performed together;

- If the service is reasonably expected to be provided for the diagnosis reported;

- Whether a service was performed specifically for *you*; or

- Whether services can be billed as a complete set of services under one billing code.

We develop *our* claims processing edits based on *our* review of one or more of the following sources, including but not limited to:

- *Medicare* laws, regulations, manuals and other related guidance;
- Appropriate billing practices;
- National Uniform Billing Committee (NUBC);
- American Medical Association (AMA)/Current Procedural Terminology (CPT);
- Centers for Medicare and Medicaid Services (CMS)/Healthcare Common Procedure Coding System (HCPCS);
- UB-04 Data Specifications Manual, and any successor manuals;
- International Classification of Diseases of the U.S. Department of Health and Human Services and the Diagnostic and Statistical Manual of Mental Disorders;
- Medical and surgical specialty societies and associations;
- *Our* medical and pharmacy coverage policies; or
- Generally accepted standards of medical, behavioral health and dental practice based on credible scientific evidence recognized in published peer reviewed medical or dental literature.

Changes to any one of the sources may or may not lead *us* to modify current or adopt new claims processing edits.

Subject to applicable law, *qualified providers* who are *non-network providers* may bill *you* for any amount *we* do not pay even if such amount exceeds the allowed amount after these claims processing edits. Any such amount paid by *you* will not apply to *your deductible* or any *out-of-pocket limit*. *You* will also be responsible for any applicable *deductible, copayment,* or *coinsurance*.

Your qualified provider may access *our* claims processing edits and *our* medical and pharmacy coverage policies at the "For Providers" link on *our* website at www.humana.com. *You* or *your qualified provider* may also call *our* toll-free customer service number listed on *your* ID card to obtain a copy of a policy. *You* should discuss these policies and their availability with any *qualified providers* prior to receiving any services.

How to find a network provider

You may find a list of *network providers* at www.humana.com. This list is subject to change. Please check this list before receiving services from a *qualified provider*. *You* may also call *our* customer service department at the number listed on *your* ID card to determine if a *qualified provider* is a *network provider*, or *we* can send the list to *you*. A *network provider* can only be confirmed by *us*.

Point of service (POS) plan description

Point of service plan means an arrangement under which a *covered person* can choose *covered health services* through this *evidence of coverage* or covered expenses through the companion plan Certificate of Insurance.

This *evidence of coverage* describes *covered health services* provided by *network providers. We* will cover services when received by *you* from *your primary care physician*, or from a *network provider* with or without a *primary care physician* referral. This *evidence of coverage* also describes *covered health services* which *we* may authorize to be provided by *non-network providers*. Please refer to the "Your choice of providers affects your benefits" provision of this *evidence of coverage* for more information.

The companion plan "Certificate of Insurance" describes covered expenses as provided by the larger network of contracted providers, as well as access to providers which are not contracted with *us*. Please refer to the "Your choice of providers affects your benefits" provision of the companion plan "Certificate of Insurance" for more information.

How to use your point of service (POS) plan

You may receive services from a *network provider* or *non-network provider* with *your* POS plan without a referral from *your primary care physician.* Refer to the "Schedule of Benefits" for any *preauthorization* requirements.

Seeking emergency care

If *you* need *emergency care*:

- Go to the nearest *network hospital* emergency room; or
- Find the nearest *hospital* emergency room if *your* condition does not allow *you* to go to a *network hospital*.

You, or someone on *your* behalf, must call *us* within 48 hours after *your admission* to a *non-network hospital* for *emergency care*. If *your* condition does not allow *you* to call *us* within 48 hours after *your admission*, contact *us* as soon as *your* condition allows.

Emergency care includes the treatment and stabilization of an emergency medical condition. Where stabilization of an emergency condition originated in a *hospital* emergency facility, freestanding emergency medical care facility, or comparable facility, treatment subject to such stabilization will be provided as approved by *us*. *We* will approve or deny coverage of post stabilization care as requested by a treating *health care practitioner* or provider within the time appropriate to the circumstances relating to the delivery of the services and the condition of the patient. In no case will *our* approval or denial exceed one hour form the time of the request.

We may transfer *you* to a *network hospital* in the *service area* when *your* condition is stable. *You* must receive services from a *network provider* for any follow-up care for the *network provider copayment, deductible* or *coinsurance* to apply as shown on the "Schedule of Benefits". Follow-up care from a *non-network provider* will not be covered.

Seeking urgent care

If *you* need *urgent care*, *you* must go to the nearest network *urgent care center* for the *network provider* benefit *copayment, deductible* or *coinsurance* to apply. *You* must receive services from a *network provider* for any follow-up care for the *network provider copayment, deductible* or *coinsurance* to apply.

Continuity of care

Provider termination

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 *illness*; 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 illness; 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.

Our relationship with qualified providers

Qualified providers are not *our* agents, employees or partners. All providers are independent contractors. *Qualified providers* make their own clinical judgments or give their own treatment advice without decisions made by *us*.

The *master group contract* will not change what is decided between *you* and *qualified providers* regarding *your* medical condition or treatment options. *Qualified providers* act on *your* behalf when they order services. *You* and *your qualified providers* make all decisions about *your* health care, no matter what *we* cover. *We* are not responsible for anything said or written by a *qualified provider* about *covered health services* and/or what is not covered under this *evidence of coverage*. Please call *our* customer service department at the telephone number listed on *your* ID card if *you* have any questions.

Our financial arrangements with network providers

We have agreements with *network providers* that may have different payment arrangements.

- Many *network providers* are paid on a discounted fee-for-services basis. This means they have agreed to be paid a set amount for each *covered health service*;

- Some *qualified providers* may have capitation agreements. This means the *qualified provider* is paid a set dollar amount each month to care for each *covered person* no matter how many services a *covered person* may receive from the *qualified provider*, such as a *primary care physician* or a *specialty care physician*;

- *Hospitals* may be paid on a Diagnosis Related Group (DRG) basis or a flat fee per day basis for *inpatient* services. *Outpatient* services are usually paid on a flat fee per service or a procedure or discount from their normal charges.

- A *network provider* is required to hold *you* harmless for payment of the cost of *covered health services* for any amount *we* do not pay to the *network provider*.

The evidence of coverage

The *evidence of coverage* is part of the *master group contract* and tells *you* what is covered and not covered and the requirements of the *master group contract*. Nothing in the *evidence of coverage* takes the place of or changes any of the terms of the *master group contract*. The final interpretation of any provision in the *evidence of coverage* is governed by the *master group contract*. If the *evidence of coverage* is different than the *master group contract*, the direct conflict will be resolved according to the terms that are most favorable to the *covered person*. The benefits in the *evidence of coverage* apply if *you* are a *covered person*.

SCHEDULE OF BENEFITS

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

- The level of benefits generally paid for *covered health services*;
- 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.

This "Schedule of Benefits" outlines the coverage and limitations provided under the *master group contract*. A more detailed explanation of *your* coverage and its limitations and exclusions for these benefits is provided in the "Covered Health Services" and "Limitations and Exclusions" sections of this *evidence of coverage*. Please refer to any applicable riders for additional coverage and/or limitations.

Benefits available under this *evidence of coverage* that have a day, visit or specific dollar limit will be applied to the same amounts in the "Certificate of Insurance".

The benefits outlined under the "Schedule of Benefits – Behavioral Health and Serious Mental Illness", "Schedule of Benefits – Transplant Services", "Schedule of Benefits – Pharmacy Services", "Schedule of Benefits – Pediatric Dental", and "Schedule of Benefits – Pediatric Vision Care" sections are not payable under any other Schedule of Benefits of the *master group contract.* All services are subject to the terms and provisions of the *master group contract*, including the *preauthorization* requirements, annual *deductible(s)* and any *out-of-pocket limit(s)*, unless otherwise stated, are applicable.

Network provider verification

This *evidence of coverage* contains multiple benefit levels. Refer to each Schedule of Benefits to see what benefit levels apply to *covered health services*.

Refer to the Online Provider Finder on *our* Website at www.humana.com for a list of *network providers*. *You* may also contact *our* customer service department at the telephone number shown on *your* ID card. This list is subject to change.

Preauthorization requirements

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 ID 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* ID 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 health services*.

SCHEDULE OF BENEFITS (continued)

Annual deductible

An annual *deductible* is a specified dollar amount that *you* must pay for *covered health services* per *year* before most benefits will be paid under the *master group contract*. There are individual and family *network provider deductibles* addressed under both this *evidence of coverage* and in the "Certificate of Insurance". 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 as specified in this *evidence of coverage* and in the "Certificate of Insurance", any remaining *deductible* for a *covered person* in the family will be waived for that *year*.

Any expense incurred by *you* for *covered health services* provided by a *network provider* under this *evidence of coverage* or by a *network provider* under the "Certificate of Insurance" will be applied to the *network provider deductible* as stated in this *evidence of coverage* and in the "Certificate of Insurance".

Deductible	**Deductible amount**
Individual *network provider deductible*	$4,500
Family *network provider deductible*	$9,000

Maximum out-of-pocket limit

The *out-of-pocket limit* is the maximum amount of any *copayments*, *deductibles* and/or *coinsurance* for *covered health services*, which must be paid by *you*, either individually or combined as a covered family, per *year* before a benefit percentage for *covered health services* will be increased. There are individual and family *network provider out-of-pocket limits*.

After the individual *network provider out-of-pocket limit* addressed under both this *evidence of coverage* and in the "Certificate of Insurance" has been satisfied in a *year*, the *network provider* benefit percentage for *covered health services* for that *covered person* will be payable by *us* 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 *master group contract*. After the family *network provider out-of-pocket limit* addressed under both this *evidence of coverage* and in the "Certificate of Insurance" has been satisfied in a *year*, the *network provider* benefit percentage for *covered health services* will be payable by *us* 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 *master group contract.*

Any expense incurred by *you* for *covered health services* provided by a *network provider* under this *evidence of coverage* or by a *network provider* under the "Certificate of Insurance" will be applied equally to the *network provider out-of-pocket limit* as stated in this *evidence of coverage* and in the "Certificate of Insurance".

SCHEDULE OF BENEFITS (continued)

If any *copayment*, *deductible* or *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*.

Maximum out-of-pocket limit	**Maximum out-of-pocket limit amount**
Individual *network provider out-of-pocket limit*	$6,350
Family *network provider out-of-pocket limit*	$12,700

SCHEDULE OF BENEFITS (continued)

Preventive services

Preventive services (including preventive office visits and/exams)

Network provider	Covered in full

Hearing impairment screening (birth to 30 days old and follow-up care to 24 months)

Hearing impairment screening, as required by law, for a *dependent* child from birth through 30 days old and necessary diagnostic follow-up care related to the screening test from birth through the date the child is 24 months old. Benefits not subject to the *deductible* requirement, if any.

Network provider	Covered in full

Immunizations and screenings

Network provider	Covered in full

Noninvasive screening for atherosclerosis and abnormal artery structure

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

Network provider	Covered in full

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

Network provider	Covered in full

Health care practitioner office services

Health care practitioner office visit

Primary care physician	30% *coinsurance* after *network provider deductible*
Specialty care physician	30% *coinsurance* after *network provider deductible*

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

Does not include *advanced imaging*. Refer to "Advanced imaging when performed in a health care practitioner's office" in the "Schedule of Benefits" section.

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

Primary care physician	30% *coinsurance* after *network provider deductible*
Specialty care physician	30% *coinsurance* after *network provider deductible*

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

Primary care physician	30% *coinsurance* after *network provider deductible*
Specialty care physician	30% *coinsurance* after *network provider deductible*

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

Primary care physician	30% *coinsurance* after *network provider deductible*
Specialty care physician	30% *coinsurance* after *network provider deductible*

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

Primary care physician	30% *coinsurance* after *network provider deductible*
Specialty care physician	30% *coinsurance* after *network provider deductible*

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

Primary care physician	30% *coinsurance* after *network provider deductible*
Specialty care physician	30% *coinsurance* after *network provider deductible*

Health care practitioner services at a retail clinic

Health care practitioner office visit in a retail clinic

Primary care physician	30% *coinsurance* after *network provider deductible*

Diagnostic laboratory when performed by a health care practitioner in a retail clinic

Primary care physician	30% *coinsurance* after *network provider deductible*

Injections other than allergy when received by a health care practitioner in a retail clinic

Primary care physician	30% *coinsurance* after *network provider deductible*

Hospital services

Hospital inpatient services

Network hospital	30% *coinsurance* after *network provider deductible*

Health care practitioner inpatient services when provided in a hospital

Primary care physician	30% *coinsurance* after *network provider deductible*
Specialty care physician	30% *coinsurance* after *network provider deductible*

Hospital outpatient surgical services

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

Network hospital	30% *coinsurance* after *network provider deductible*

Health care practitioner outpatient services when provided in a hospital

Includes *outpatient surgery*.

Primary care physician	30% *coinsurance* after *network provider deductible*
Specialty care physician	30% *coinsurance* after *network provider deductible*

Hospital outpatient non-surgical services

Must be performed in a *hospital's outpatient* department. Does not include *advanced imaging*. Refer to "Hospital outpatient advanced imaging" in the "Schedule of Benefits" section.

Network hospital	30% *coinsurance* after *network provider deductible*

Hospital outpatient diagnostic radiology and laboratory

Network hospital	30% *coinsurance* after *network provider deductible*

Hospital outpatient advanced imaging

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

Network hospital	30% *coinsurance* after *network provider deductible*

Pregnancy and newborn benefit

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

Emergency services

Hospital emergency room services

Does not include *advanced imaging*. Refer to "Hospital emergency room advanced imaging" in the "Schedule of Benefits" section.

Network hospital	30% *coinsurance* after *network provider deductible*

Hospital emergency room advanced imaging

Network hospital	30% *coinsurance* after *network provider deductible*

Hospital emergency room health care practitioner services

Network health care practitioner	30% *coinsurance* after *network provider deductible*

Ambulance services

Network provider	30% *coinsurance* after *network provider deductible*

Ambulatory surgical center services

Ambulatory surgical center for outpatient surgery

Network provider	30% *coinsurance* after *network provider deductible*

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

Includes *outpatient surgery*.

Primary care physician	30% *coinsurance* after *network provider deductible*
Specialty care physician	30% *coinsurance* after *network provider deductible*

Autism spectrum disorders

Autism spectrum disorders, as required by law, for a *dependent* child. Benefits are payable for *covered health services* as recommended in the treatment plan by the *health care practitioner*.

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

Durable medical equipment

Network provider	30% *coinsurance* after *network provider deductible*

Free-standing facility services

Free-standing facility non-surgical services

Does not include *advanced imaging*. Refer to "Free-standing facility outpatient advanced imaging" in the "Schedule of Benefits" section.

Network provider	30% *coinsurance* after *network provider deductible*

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

Primary care physician	30% *coinsurance* after *network provider deductible*
Specialty care physician	30% *coinsurance* after *network provider deductible*

Free-standing facility outpatient advanced imaging

Network provider	30% *coinsurance* after *network provider deductible*

Home health care services

Network provider	30% *coinsurance* after *network provider deductible*

Hospice services

Network provider	30% *coinsurance* after *network provider deductible*

Jaw joint benefit

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

Physical medicine and rehabilitative services

Physical therapy, occupational therapy, speech therapy, audiology, cognitive rehabilitation services, and spinal manipulations/ adjustments are limited to a combined maximum 40 visits per *year*.

Network provider	30% *coinsurance* after *network provider deductible*

Respiratory or pulmonary rehabilitation services

Network provider	30% *coinsurance* after *network provider deductible*

Cardiac rehabilitation services

Network provider	30% *coinsurance* after *network provider deductible*

Other therapy

Includes radiation therapy and chemotherapy.

Network provider	30% *coinsurance* after *network provider deductible*

Skilled nursing facility services

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

Network provider	30% *coinsurance* after *network provider deductible*

Health care practitioner services when provided in a skilled nursing facility

Network health care practitioner	30% *coinsurance* after *network provider deductible*

Specialty drugs in a medical place of service

Specialty drugs administered in a health care practitioner's office, free-standing facility and urgent care center

Network provider	30% *coinsurance* after *network provider deductible*

Specialty drugs administered in home health care

Network provider designated by *us* as a preferred provider of *specialty drugs*	Covered in full after *network provider deductible*
Network provider	30% *coinsurance* after *network provider deductible*

Specialty drugs administered in a hospital, skilled nursing facility, ambulance or emergency room

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

Urgent care services

Network provider	30% *coinsurance* after *network provider deductible*

Additional covered expenses

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

SCHEDULE OF BENEFITS – PEDIATRIC DENTAL

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

- The level of benefits generally paid for the *pediatric dental services* under the *master group contract*;
- The amounts of *copayments* and *coinsurance you* are required to pay; and
- The services that require *you* to meet a *deductible* before benefits are paid.

This "Schedule of Benefits – Pediatric Dental" outlines the coverage and limitations provided under the *master group contract.* A more detailed explanation of *your* coverage and its limitations and exclusions for these benefits is provided in the "Covered Health Services – Pediatric Dental" and "Limitations and Exclusions" sections of this *evidence of coverage.* Please refer to this *evidence of coverage* and any applicable riders for additional coverage and/or limitations.

Benefits available under this *evidence of coverage* that have a day, visit, allowance or dollar limit will be applied to the same amounts in the "Certificate of Insurance".

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

Pediatric dental services apply toward the *deductible* and *out-of-pocket limit* of the *master group contract*.

Pediatric dental benefit

Class I services

Network provider	70% *coinsurance* after *network provider deductible*

Class II services

Network provider	70% *coinsurance* after *network provider deductible*

SCHEDULE OF BENEFITS – PEDIATRIC DENTAL (continued)

Class III services

Network provider	70% *coinsurance* after *network provider deductible*

Class IV services

Network provider	70% *coinsurance* after *network provider deductible*

SCHEDULE OF BENEFITS – PEDIATRIC VISION CARE

Reading this "Schedule of Benefits – Pediatric Vision Care" section will help *you* understand:

- The level of benefits generally paid for *pediatric vision care* covered under the *master group contract*;
- The amounts of *copayments* and *coinsurance you* are required to pay; and
- The services that require *you* to meet a *deductible* before benefits are paid.

This "Schedule of Benefits – Pediatric Vision Care" outlines the coverage and limitations provided under the *master group contract*. A more detailed explanation of *your* coverage and its limitations and exclusions for these benefits is provided in the "Covered Health Services – Pediatric Vision Care" and "Limitations and Exclusions" sections of this *evidence of coverage*. Please refer to this *evidence of coverage* and any applicable riders for additional coverage and limitations.

Benefits available under this *evidence of coverage* that have a day, visit, *allowance*, or specific dollar limit will be applied to the same amounts in the "Certificate of Insurance".

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

Expenses covered for *pediatric vision care* apply toward the *deductible* and any *out-of-pocket limit* of the *master group contract.*

Comprehensive eye exam

Limited to one exam per *year*.

Network provider	*Network provider deductible*, then covered in full after $10 *copayment* per visit

Prescription lenses

Single vision lenses, bifocal vision lenses, trifocal vision lenses, and lenticular lenses are limited to one pair of covered prescription lenses per *year*.

Network provider	70% *coinsurance* after *network provider deductible*

SCHEDULE OF BENEFITS – PEDIATRIC VISION CARE (continued)

Standard lens options

Polycarbonate, scratch coating, ultraviolet-coating, blended lenses, intermediate lenses, progressive lenses, photochromatic lenses, polarized lenses, fashion & gradient tinting, oversized lenses, glass-grey prescription sunglass lenses, anti-reflective coating, and hi-index lenses must be selected at the same time covered prescription lenses are selected.

Network provider	70% *coinsurance* after *network provider deductible*

Frames

Limited to one covered new frame per *year*.

Network provider	70% *coinsurance* after *network provider deductible*

Elective contact lenses

(Benefits are in lieu of all other benefits for frames and lenses.)

Limited to a single purchase of up to a 3 month supply of daily disposables, or a 6 month supply of non-daily disposables per *year*.

Network provider	70% *coinsurance* after *network provider deductible*

Medically necessary contact lenses

Network provider	70% *coinsurance* after *network provider deductible*

SCHEDULE OF BENEFITS – PEDIATRIC VISION CARE (continued)

Contact lens fitting and follow-up exam

Network provider	70% *coinsurance* after *network provider deductible*

Low vision

Limited to one comprehensive low vision testing and evaluation per *year*.

Network provider	70% *coinsurance* after *network provider deductible*

Low vision supplementary testing

Limited to 5 diagnostic evaluations beyond the *comprehensive eye exam* in 5 *years*.

Network provider	70% *coinsurance* after *network provider deductible*

Low vision aids

Limited to one *low vision* aid in any 3 *years*, except for video magnification, which is limited to one in any 5 *years*.

Network provider	70% *coinsurance* after *network provider deductible*

SCHEDULE OF BENEFITS - BEHAVIORAL HEALTH AND SERIOUS MENTAL ILLNESS

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

- The level of benefits generally paid for the *mental health services, chemical dependency* and *serious mental illness* services under the *master group contract*;
- 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.

This "Schedule of Benefits – Behavioral Health and Serious Mental Illness" outlines the coverage and limitations provided under the *master group contract*. A more detailed explanation of *your* coverage and its limitations and exclusions for these benefits is provided in the "Covered Health Services – Behavioral Health and Serious Mental Illness" and "Limitations and Exclusions" sections of this *evidence of coverage*. Please refer to this *evidence of coverage* 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 *master group contract*.

Acute inpatient services

We will pay benefits for *covered health services* incurred by *you* due to an *admission* or *confinement* for *acute inpatient services* for *mental health services, chemical dependency* and *serious mental illness* services provided in a *hospital, health care treatment facility*, or *crisis stabilization unit*. *Covered health services* also include an admission or confinement in a *chemical dependency treatment center* for *chemical dependency* services.

Network hospital	30% *coinsurance* after *network provider deductible*

Partial hospitalization services

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

Network provider	30% *coinsurance* after *network provider deductible*

SCHEDULE OF BENEFITS - BEHAVIORAL HEALTH AND SERIOUS MENTAL ILLNESS (continued)

Residential treatment facility services

We will pay benefits for *covered health services* incurred by *you* due to an *admission* or *confinement* for *mental health services, chemical dependency* and *serious mental illness* services provided in a *residential treatment facility* for adults and *residential treatment center for children and adolescents*.

Network provider	30% *coinsurance* after *network provider deductible*

Acute inpatient, partial hospitalization and residential treatment facility health care practitioner services

Network health care practitioner	30% *coinsurance* after *network provider deductible*

Emergency services

We will pay benefits for *covered health services* incurred by *you* for *emergency care* services for *mental health services, chemical dependency* and *serious mental illness* services.

Hospital emergency room services

Does not include *advanced imaging*. Refer to "Hospital emergency room advanced imaging" in the "Schedule of Benefits – Behavioral Health and Serious Mental Illness" section.

Network hospital	30% *coinsurance* after *network provider deductible*

Hospital emergency room advanced imaging

Network hospital	30% *coinsurance* after *network provider deductible*

SCHEDULE OF BENEFITS - BEHAVIORAL HEALTH AND SERIOUS MENTAL ILLNESS (continued)

Hospital emergency room health care practitioner services

Network health care practitioner	30% *coinsurance* after *network provider deductible*

Urgent care services

We will pay benefits for *covered health services* incurred by *you* for *urgent care* services for *mental health services, chemical dependency* and *serious mental illness* services.

Network provider	30% *coinsurance* after *network provider deductible*

Outpatient services

We will pay benefits for *covered health services* incurred by *you* for *outpatient* services for *mental health services, chemical dependency* and *serious mental illness* services.

Health care practitioner office visit

Does not include *behavioral health* therapy in a *health care practitioner's* office. Refer to "Therapy" in the "Schedule of Benefits – Behavioral Health and Serious Mental Illness" section.

Network health care practitioner	30% *coinsurance* after *network provider deductible*

Injections when performed in a health care practitioner's office

Does not include *preventive services* and allergy injections. Refer to "Preventive services" and "Allergy injections when received in a health care practitioner's office" in the "Schedule of Benefits" section.

Network health care practitioner	30% *coinsurance* after *network provider deductible*

SCHEDULE OF BENEFITS - BEHAVIORAL HEALTH AND SERIOUS MENTAL ILLNESS (continued)

Therapy

Includes *outpatient behavioral health* therapy, *behavioral health* therapy in a *health care practitioner's* office and an *intensive outpatient program.*

Network provider	30% *coinsurance* after *network provider deductible*

Outpatient hospital services

Does not include *outpatient behavioral health* therapy. Refer to "Therapy" in the "Schedule of Benefits – Behavioral Health and Serious Mental Illness" section.

Does not include *advanced imaging*. Refer to "Advanced imaging performed in a health care practitioner's office, hospital outpatient department or free-standing facility" in the "Schedule of Benefits – Behavioral Health and Serious Mental Illness" section.

Network hospital	30% *coinsurance* after *network provider deductible*

Advanced imaging performed in a health care practitioner's office, hospital outpatient department or free-standing facility

Network provider	30% *coinsurance* after *network provider deductible*

Home health care services

We will pay benefits for *covered health services* incurred by *you* for home health care services for *mental health services, chemical dependency* and *serious mental illness* services.

Network provider	30% *coinsurance* after *network provider deductible*

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 *master group contract*;
- The amounts of *copayments* or *coinsurance you* are required to pay; and
- The services that require *you* to meet a *deductible* before benefits are paid.

This "Schedule of Benefits – Transplant Services" outlines the coverage and limitations provided under the *master group contract*. A more detailed explanation of *your* coverage and its limitations and exclusions for these benefits is provided in the "Covered Health Services – Transplant Services" and "Limitations and Exclusions" sections of this *evidence of coverage*. Please refer to this *evidence of coverage* and any applicable riders for additional coverage and limitations.

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

Hospital services

Hospital benefits as shown under "Hospital services" in the "Schedule of Benefits" section of the *evidence of coverage* will be payable as follows:

Network hospital designated by *us* as an approved transplant facility	Same as any other *illness* based on location of services and type of provider

Health care practitioner services

Health care practitioner benefits as shown under "Health care practitioner office services" in the "Schedule of Benefits" section of the *evidence of coverage* will be payable as follows:

Network health care practitioner designated by *us* as an approved transplant *health care practitioner*	Same as any other *illness* based on location of services and type of provider

SCHEDULE OF BENEFITS – TRANSPLANT SERVICES (continued)

Direct, non-medical costs

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

- Transportation

Network hospital designated by *us* as an approved transplant facility	Covered in full after *network provider deductible*

- Temporary lodging

Network hospital designated by *us* as an approved transplant facility	Covered in full after *network provider deductible*

SCHEDULE OF BENEFITS – PHARMACY SERVICES

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

- The level of benefits generally paid for the *prescription* drugs, medicines or medications, including *specialty drugs*, covered under the *master group contract*;
- The *copayment* and/or *coinsurance* amount *you* are required to pay;
- The required *deductible* amount to be met, if any, before benefits are paid; and
- *Prior authorization* requirements.

This "Schedule of Benefits – Pharmacy Services" outlines the coverage and limitations provided under the *master group contract*. A more detailed explanation of *your* coverage and its limitations and exclusions for these benefits is provided in the "Covered Health Services – Pharmacy Services", "Limitations and Exclusions" and "Limitations and Exclusions – Pharmacy Services" sections of this *evidence of coverage*. Please refer to this *evidence of coverage* and any applicable riders for additional coverage and/or limitations.

Covered health services for *prescription* drugs and *specialty drugs* obtained from a *network pharmacy* under provisions of this benefit apply toward *your out-of-pocket limit*.

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

All terms used in this "Schedule of Benefits – Pharmacy Services" have the meaning given to them in the "Glossary" section, unless otherwise specifically defined in the "Glossary – Pharmacy Services" section of this *evidence of coverage.* All services are subject to all of the terms, provisions, limitations and exclusions of the *master group contract*, unless otherwise stated.

Prior authorization requirements

Prior authorization and/or *step therapy* is required for certain *prescription* drugs, medicines or medications, including *specialty drugs*. Visit *our* Website at www.humana.com or call the customer service telephone number on *your* identification card to obtain *our drug list* that identifies the drugs, medicines or medications, including *specialty drugs* that require *prior authorization* and/or *step therapy*. The *drug list* is subject to change. Coverage provided in the past is not a guarantee of future coverage.

Your health care practitioner must contact *our* Clinical Pharmacy Review to request and receive *our* approval for *prescription* drugs, medicines or medications, including *specialty drugs* that require *prior authorization* and/or *step therapy*. Benefits are payable only if approved by *us*.

SCHEDULE OF BENEFITS – PHARMACY SERVICES (continued)

Preventive medication coverage

Drugs, medicines or medications and supplies on the Preventive Medication Coverage *drug list* are covered in full when obtained from a *network pharmacy* with a *prescription* from a *health care practitioner*.

Prescription drug cost sharing

You are responsible for any and all *cost share*, when applicable, as specified below. If the dispensing *pharmacy's* charge is less than *your copayment* or *coinsurance* for *prescription* drugs, *you* will be responsible for the dispensing *pharmacy* charge amount. The amount paid by *us* to the dispensing *pharmacy* may not reflect the ultimate cost to *us* for the drug. *Your copayment* or *coinsurance* is made on a per *prescription* fill or refill basis and will not be adjusted if *we* receive any retrospective volume discounts or *prescription* drug rebates.

Retail pharmacy / Specialty pharmacy — Coverage for up to 30-day supply

Network pharmacy	30% *coinsurance* per *prescription* fill or refill after *network provider deductible*

90-day Retail pharmacy

Some retail *pharmacies* participate in *our* program, which allows *you* to receive a 90-day supply of a *prescription* fill or refill. After the *deductible* is met, your cost is based on the applicable benefit amount specified above. *Specialty drugs* are limited to a 30-day supply from a retail *pharmacy* or a *specialty pharmacy*, unless otherwise determined by *us*.

Mail order pharmacy — 90-day supply

Specialty drugs are not included. Refer to the "Retail pharmacy / Specialty pharmacy" provision above for *specialty drug* benefits.

Network pharmacy	30% *coinsurance* per *prescription* fill or refill after *network provider deductible*

COVERED HEALTH SERVICES

This "Covered Health Services" section describes the services that will be considered *covered health services* under the *master group contract*. Benefits will be paid for covered medical services for a *bodily injury* or *illness*, or for specified *preventive services* on a *usual and customary 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 *evidence of coverage*. All terms and provisions of the *master group contract*, including the *preauthorization* requirements specified in this *evidence of coverage*, are applicable to *covered health services*.

Preventive services

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

- 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 must be covered under the Affordable Care Act, refer to the www.healthcare.gov website under the Prevention and Wellness tab or call the customer service telephone number on *your* identification card.

Covered health services also include charges incurred by *you* for the following *preventive services* as required by state law:

- Laboratory, radiology and/or endoscopic services to detect or prevent *illness*.

- A hearing impairment screening for a *dependent* child from birth through 30 days old and diagnostic follow-up care related to the hearing impairment screening for a *dependent* child from birth through 24 months old.

- An annual baseline mammogram for a female *covered person* 35 years of age or older.

- A bone mass measurement for a *qualified individual* to detect low bone mass and determine the risk of osteoporosis and fractures associated with osteoporosis.

- An annual medically recognized diagnostic examination for a female *covered person* 18 years of age or older for the early detection of ovarian cancer and cervical cancer in accordance with guidelines adopted by the American College of Obstetricians and Gynecologists or another similar national organization of medical professionals recognized by the Commissioner. Coverage includes the following procedures approved by the United States Food and Drug Administration (FDA), alone or in combination with a test approved by the FDA for the early detection of the human papillomavirus:

  - A CA 125 blood test; and
  - A conventional pap smear screening; or
  - A screening using liquid-based cytology methods.

- An annual prostate cancer detection exam, including a prostate specific antigen (PSA) test for a male *covered person* 40 years of age or older.

- A medically recognized screening examination for the detection of colorectal cancer for *covered persons* 50 years of age or older and at normal risk for developing colon cancer. Benefits include:

  - An annual fecal occult blood test; and
  - An annual stool DNA test;
  - A flexible sigmoidoscopy every five years; or
  - A colonoscopy or a Computed Tomography (CT) colonography (virtual colonoscopy) every 10 years.

- Noninvasive screening tests for atherosclerosis and abnormal artery structure and function for a *covered person* who is:

  - A male over 45 years of age and younger than 76 years of age; or
  - A female over 55 years of age and younger than 76 years of age; and

    - Is a diabetic; or
    - Is at risk of developing heart disease based on a score derived from Framingham Health Study coronary prediction algorithm, that is immediate or higher.

  Benefits include one of the following screenings every 5 years:

  - A computed tomography (CT) scanning measuring coronary artery calcification; or
  - Ultrasonography measuring carotid intima-media thickness and plaque.

- Routine immunizations.

- Immunizations for adults and children including but not limited to the following from birth through the date of the child's sixth birthday, coverage includes for immunizations against:

  - Diphtheria;
  - Haemophilus influenzae type b;
  - Hepatitis B;
  - Measles;
  - Mumps;
  - Pertussis;
  - Polio, rubella, tetanus, and
  - Varicella, and any other immunization that is required for a covered *dependent* by state or federal law.

- Routine hearing screening.

- Routine vision screening.

Health care practitioner office services

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

Health care practitioner office visit

Covered health services include:

- Office visits for the diagnosis and treatment of an *illness* or *bodily injury*.
- Office visits for prenatal care.
- Office visits for *diabetes self-management training.*
- Diagnostic laboratory and radiology.
- Allergy testing.
- Allergy serum.
- Allergy injections.
- Injections other than allergy.
- *Surgery*, including anesthesia.
- Second surgical opinions.

Health care practitioner services at a retail clinic

We will pay benefits for *covered health services* incurred by *you* for *health care practitioner* services at a *retail clinic* for an *illness* or *bodily injury*.

Hospital services

We will pay benefits for *covered health services* 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 this section.

Hospital inpatient services

Covered health services 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 *usual and customary fee* for a semi-private room in the *hospital* while *confined*.

- Services and supplies, other than *room and board*, provided by a *hospital* while *confined* that include general nursing care; meals and *medically necessary* special diets; use of an operating room; diagnostic laboratory and radiology tests; drugs and medications; anesthesia; special duty nursing; radiation therapy; inhalation therapy; and short-term rehabilitation therapy services.

Health care practitioner inpatient services when provided in a hospital

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

Covered health services 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 allow the *usual and customary fee* for the most complex procedure. For each additional procedure *we* will allow:

  - 50% of *usual and customary fee* for the secondary procedure; and
  - 25% of *usual and customary 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 allow each surgeon 62.5% of the *usual and customary fee* for the procedure.

- Services of a surgical assistant and/or assistant surgeon. *We* will allow the surgical assistants and/or assistant surgeons 20% of the *usual and customary fee* for the *surgery*.

- Services of a physician assistant (P.A.), registered nurse (R.N.) or a certified operating room technician. *We* will allow the physician assistants, registered nurses and certified operating room technicians 10% of the *usual and customary fee* for the *surgery*.

- Anesthesia administered by a *health care practitioner* or certified registered anesthetist attendant for 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 *health care practitioner* 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 *illness* or *bodily injury* being treated results in a *hospital confinement*.

Hospital outpatient services

Covered health services include *outpatient* services and supplies, as outlined in the following provisions, provided in a *hospital's outpatient* department or by other providers.

Covered health services 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 health services 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 that are payable as a *hospital* charge are not payable as a *health care practitioner* charge.

Covered health services include:

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

  - 50% of *usual and customary fee* for the secondary procedure; and
  - 25% of *usual and customary 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 allow each surgeon 62.5% of the *usual and customary fee* for the procedure.

- Services of a surgical assistant and/or assistant surgeon. *We* will allow the surgical assistants and/or assistant surgeons 20% of the *usual and customary fee* for the *surgery*.

- Services of a physician assistant (P.A.), registered nurse (R.N.) or a certified operating room technician. *We* will allow the physician assistants, registered nurses and certified operating room technicians 10% of the *usual and customary fee* 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 health services include services provided in a *hospital's outpatient* department in connection with non-surgical services.

Hospital outpatient advanced imaging

We will pay benefits for *covered health services* incurred by *you* for *outpatient advanced imaging* in a *hospital's outpatient* department.

Pregnancy and newborn benefit

We will pay benefits for *covered health services* incurred by a *covered person* for a pregnancy, including *complications of pregnancy*.

Covered health services 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*, timely post-delivery care determined by recognized medical standards for that care is also covered after discharge in an 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 *evidence of coverage*.

- 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 *illness*;
  - Care and treatment for premature birth; and
  - Medically diagnosed birth defects and abnormalities.

Covered health services also include *cosmetic surgery* specifically and solely for:

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

Emergency services

We will pay benefits for *covered health services* obtained by *you* for *emergency care*, including the treatment and stabilization of an emergency medical condition. *Covered health services* include medical screening examinations or other evaluations required by state or federal law provided in a *hospital* emergency facility, free-standing emergency medical care facility, or emergency comparable facility. Where stabilization of an emergency condition originated in a *hospital* emergency facility, free-standing emergency medical care facility, or comparable emergency facility, treatment subject to such stabilization shall be provided to *covered persons* as approved by *us*, provided that *we* will approve or deny coverage of poststabilization care as requested by a treating *health care practitioner* or provider within the time appropriate to the circumstances relating to the delivery of the services and the condition of the patient, but in no case shall approval or denial exeed one hour form the time of the request.

If *you* are admitted to a *non-network hospital* following *emergency care*, *you* (or someone acting for *you*) must contact *us* within forty-eight (48) hours of *your admission*, or if this is not possible, as soon as *your* medical condition permits.

If *you* are admitted to a *non-network hospital* following *emergency care*, *we* may require *you* be transferred (at *our* expense) to a *network hospital* in the *service area* when *your* condition has been stabilized.

Emergency care provided by a *non-network hospital* or a *non-network health care practitioner* will be covered at the *network provider* benefit *copayment*, *coinsurance* and any applicable *deductible* based on the *usual and customary fee* or an agreed rate between *us* and the *non-network provider*.

Covered health services 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, or comparable emergency facility. These services are subject to the terms, conditions, limitations, and exclusions of the *master group contract*.

Ambulance services

We will pay benefits for *covered health services* incurred by *you* for licensed *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 as specified in the Ambulance benefit on the "Schedule of Benefits".

Ambulatory surgical center services

We will pay benefits for *covered health services* 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

Service that are payable as an *ambulatory surgical center* charge are not payable as a *health care practitioner* charge.

Covered health services include:

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

  - 50% of *usual and customary fee* for the secondary procedure; and
  - 25% of *usual and customary fee* or the third and subsequent procedures.

  If two surgeons work together as primary surgeons performing distinct parts of a single reportable procedure, *we* will allow each surgeon 62.5% of the *usual and customary fee* for the procedure.

- Services of a surgical assistant and/or assistant surgeon. *We* will allow the surgical assistants and/or assistant surgeons 20% of the *usual and customary fee* for the *surgery*.

- Services of a physician assistant (P.A.), registered nurse (R.N.) or a certified operating room technician. *We* will allow the physician assistants, registered nurses and certified operating room technicians 10% of the *usual and customary fee* 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.

Autism spectrum disorders

We will pay benefits for *covered health services* incurred by *covered persons* for:

- Screening a *dependent* for *autism spectrum disorder* (ASD) at the ages of 18 and 24 months; and

- All generally recognized services prescribed in relation to *autism spectrum disorder* (ASD) by the *covered person*'s *health care practitioner* in the treatment plan recommended by that *health care practitioner*.

Individuals providing treatment prescribed for *autism spectrum disorder* (ASD) must be a:

- *Health care practitioner*:

    - Who is licensed, certified, or registered by an appropriate agency of the state of Texas;
    - Whose professional credential is recognized and accepted by an appropriate agency of the United States; or
    - Who is certified as a provider under the TRICARE military health system; or

- An individual acting under the supervision of a *health care practitioner*.

Generally recognized services for *autism spectrum disorder* 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.

Jaw joint benefit

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

The following are *covered health services*:

- A single examination including a history, physical examination, muscle testing, range of motion measurements, and psychological evaluation;
- 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 that does not permanently alter tooth position, jaw position or bite. Benefits for reversible appliance therapy will be based on the *usual and customary 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 health services 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, and full dentures.

Durable medical equipment and diabetes equipment

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

At *our* option, *covered health services* include 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 health service*. In either case, total *covered health services* 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.

Repair and maintenance of purchased *durable medical equipment* and *diabetes equipment* is a *covered health service* 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 health service* 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.

Free-standing facility services

Free-standing non-surgical services

We will pay benefits for *covered health services* for services provided in a *free-standing facility*.

Health care practitioner non-surgical services when 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 facility advanced imaging

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

Home health care services

We will pay benefits for *covered health services* 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 health services* include:

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

Home health care *covered health services* 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*.

Hospice services

We will pay benefits for *covered health services* 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 *master group contract*.

Hospice care benefits are payable as shown on the "Schedule of Benefits" for the following hospice services:

- *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 health services* 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 the *master group contract*.

Physical medicine and rehabilitative services

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

- Physical therapy services;
- Occupational therapy services;
- Spinal manipulations/adjustments;
- Speech therapy or speech pathology services;
- Hearing therapy or audiology services;
- Cognitive rehabilitation services which are not a result of or related to an *acquired brain injury*;
- Radiation therapy;
- Inhalation therapy;
- Respiratory or pulmonary rehabilitation services; and
- Cardiac rehabilitation services.

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

Skilled nursing facility services

We will pay benefits for *covered health services* incurred by *you* for charges made by a *skilled nursing facility* for *room and board*, and for 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.

Health care practitioner services when provided in a skilled nursing facility

Services that are payable as a *skilled nursing facility* charge are not payable as a *health care practitioner* charge.

Covered health services include:

- Medical services furnished by an attending *health care practitioner* to *you* while *you* are *confined* in a *skilled nursing facility.*
- Consultation charges requested by the attending *health care practitioner* during a *confinement* in a *skilled nursing facility.*
- Services of a pathologist.
- Services of a radiologist.

Specialty drugs in a medical place of service

We will pay benefits for *covered health services* incurred by *you* for *specialty drugs* that are administered in the following medical places of service:

- *Health care practitioner's* office;
- *Free-standing facility*;
- *Urgent care center*;
- Home health care;
- *Hospital*;
- *Skilled nursing facility*;
- Ambulance; and
- Emergency room.

Benefits for *specialty drugs* may be subject to *preauthorization* requirements, if any. Please refer to the "Schedule of Benefits" in this *evidence of coverage* for *preauthorization* requirements and contact *us* prior to receiving *specialty drugs*.

Benefits for *specialty drugs* do not include the charge for the actual administration of the *specialty drug*. Payment for the administration of *specialty drugs* is addressed in the "Schedule of Benefits" section of this *evidence of coverage.*

Urgent care center

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

Additional covered health services

We will pay benefits for *covered health services* 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, or 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 to:

  - Restore the previous level of function lost as a result of a *bodily injury* or *illness*; or
  - Improve function caused by a *congenital anomaly*.

  Covered health services for prosthetic devices includes repair or replacement, if not covered by the manufacturer, and if due to:

  - A change in the *covered person's* physical condition causing the device to become non-functional; or
  - Normal wear and tear; or
  - 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 health service* 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.

- Orthotics used to support, align, prevent, or correct deformities.

  Covered health services include professional services related to the fitting of the orthotic and repair and replacement of an orthotic.

  Covered health services 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.

- *Diabetes self-management training.*

- 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.

- *Medically necessary services* received 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*:

  - *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*.

  Covered health services for *outpatient* day treatment services, or other post-acute care treatment services. Including periodic re-evaluation, as necessary, of the care of the *covered person* who:

  - Has an *acquired brain injury;*
  - Has been unresponsive to treatment; and
  - Becomes responsive to treatment at a later date.

- 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
  - Treatment is provided within 24 months of the initial treatment for 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:

  - Excision of partially or completely impacted teeth;

  - Surgical preparation of soft tissues and excision of bone or bone tissue performed with or without extraction or excision of erupted, partially erupted or completely un-erupted teeth;

  - Excisions of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth and related biopsy of bone, tooth, or related tissues when such conditions require pathological examinations;

  - Surgical procedures related to repositioning of teeth, tooth transplantation or re-implantation;

  - Services 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 and abscess;

  - Incision and closure 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 *illness* causing a *functional impairment*.

- Orthodontic treatment for a *congenital anomaly* related to or developed as a result of cleft palate, with or without cleft lip.

- Reconstructive *surgery*:

  - Resulting from a *bodily injury*, infection or other disease of the involved part, when *functional impairment* is present; or
  - Resulting from congenital disease or anomaly of a covered *dependent* child which resulted in a *functional impairment*; or
  - Resulting from craniofacial abnormalities of a covered *dependent* child to improve the function of or attempt to create a normal appearance.

  A *functional impairment* is defined as a direct measurable reduction of physical performance of an organ or body part. Expense incurred for reconstructive *surgery* performed due to the presence of a psychological condition is not covered, unless the condition(s) described above are also met.

- For a *covered person*, who is receiving benefits in connection with a mastectomy, service for:

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

- *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.

- 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 health services include services associated with the administration of the amino-acid based formula.

- Orally administered anticancer medication.

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

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

- The following *habilitative services*, as ordered and performed by a *health care practitioner*, for a *covered person*, with a developmental delay or defect or *congenital anomaly*:

  - Physical therapy services;
  - Occupational therapy services;
  - Spinal manipulations/adjustments;
  - Speech therapy or speech pathology services; and
  - Audiology services.

  Habilitative services apply toward the "Physical medicine and rehabilitative services" maximum number of visits specified in the "Schedule of Benefits".

- Routine costs for a *covered person* participating in an approved Phase I, II, III or IV clinical trial.

  Routine costs include health care services that are otherwise a *covered health service* if the *covered person* were not participating in a clinical trial.

  Routine costs do not include services or items that are:

  - *Experimental, investigational or for research purposes*;
  - Provided only for data collection and analysis that is not directly related to the clinical management of the *covered person*; or
  - Inconsistent with widely accepted and established standards of care for a diagnosis.

  The *covered person* must be eligible to participate in a clinical trial according to the trial protocol with respect to treatment of cancer or other life-threatening disease or condition.

  For the routine costs to be considered a *covered health service*, the approved clinical trial must be a Phase I, II, III or IV clinical trial for the treatment of cancer or the prevention, detection or treatment of a life threatening disease or condition and is:

  - Federally funded or approved by the appropriate federal agency;

  - Approved by 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;

  - The study or investigation is conducted under an investigational new drug application reviewed by the Federal Food and Drug Administration; or

  - The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

- 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* and *telemedicine medical services* for the diagnosis and treatment of an *illness* or *bodily injury*. *Telehealth* or *telemedicine medical services* must be:

  - Services that would otherwise be a *covered health service* if provided during a face-to-face consultation between a *covered person* and a *health care practitioner*;
  - Provided to a *covered person* at the *originating site*; and
  - Provided by a *health care practitioner* at the *distant site*.

  Telehealth and *telemedicine medical services* must comply with:

  - Federal and state licensure requirements;
  - Accreditation standards; and
  - Guidelines of the American Telemedicine Association or other qualified medical professional societies to ensure quality of care.

- *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. Hearing aids are limited to 1 per ear every 36 months.

- 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.

COVERED HEALTH SERVICES – PEDIATRIC DENTAL

This "Covered Health Services – Pediatric Dental" section describes expenses covered under the *master group contract* for *pediatric dental services*. Benefits for *pediatric dental services* will be paid on a *reimbursement limit* basis and as shown in the "Schedule of Benefits – Pediatric Dental," subject to any applicable:

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

Notwithstanding any other provisions of the *master group contract*, expenses covered under this benefit section are not covered under any other provision of the *master group contract*. Any amount in excess of the maximum amount provided under this benefit, if any, is not covered under any other provision in the *master group contract.*

All terms used in this benefit have the same meaning given to them in the *evidence of coverage*, unless otherwise specifically defined in this benefit. Refer to the "Limitations and exclusions" provision in this section and the "Limitations and Exclusions" section of this *evidence of coverage* for *pediatric dental services* not covered by the *master group contract*. All other terms and provisions of the *master group contract* are applicable to expenses covered for *pediatric dental services*.

Definitions

Accidental dental injury means damage to the mouth, teeth and supporting tissue due directly to an *accident*. It does not include damage to the teeth, appliances or prosthetic devices that results from chewing or biting food or other substances.

Clinical review means the review of required/submitted documentation by a *dentist* for the determination of *pediatric dental services*.

Cosmetic means services that are primarily for the purpose of improving appearance, including but not limited to:

- Facings on crowns or pontics (the portion of a fixed bridge between the abutments) posterior to the second bicuspid.
- Characterizations and personalization of prosthetic devices.

Covered person under this "Covered Health Services – Pediatric Dental" and the "Schedule of Benefits – Pediatric Dental" sections means a person who is eligible and enrolled for benefits provided under the *master group contract* up to the end of the month following the date he or she attains age 19.

Dental emergency means a sudden, serious dental condition caused by an *accident* or dental disease that, if not treated immediately, would result in serious harm to the dental health of the *covered person*.

COVERED HEALTH SERVICES – PEDIATRIC DENTAL (continued)

Dentist means an individual, who is duly licensed to practice dentistry or perform *oral surgery* and is acting within the lawful scope of his or her license.

Expense incurred date means the date on which:

- The teeth are prepared for fixed bridges, crowns, inlays or onlays;
- The final impression is made for dentures or partials;
- The pulp chamber of a tooth is opened for root canal therapy;
- A periodontal surgical procedure is performed; or
- The service is performed for services not listed above.

Palliative dental care means treatment used in a *dental emergency* to relieve, ease or alleviate the acute severity of dental pain, swelling or bleeding. *Palliative dental care* treatment usually is performed for, but is not limited to, the following acute conditions:

- Toothache;
- Localized infection;
- Muscular pain; or
- Sensitivity and irritations of the soft tissue.

Services are not considered *palliative dental care* when used in association with any other *pediatric dental services*, except x-rays and/or exams.

Pediatric dental services mean the following services:

- Ordered by a *dentist*.
- Described in the "Pediatric dental" provision in this "Covered Health Services – Pediatric Dental" section.
- Incurred when a *covered person* is insured for that benefit under the *master group contract* on the *expense incurred date*.

Reimbursement limit means the maximum fee allowed for *pediatric dental services*. It is the lesser of:

- The actual cost for the services;
- The fee most often charged in the geographical area where the service was performed;
- The fee most often charged by the provider;
- The fee determined by comparing charges for similar services to a national database adjusted to the geographical area where the services or procedures were performed;
- At *our* choice, the fee determined by using a national Relative Value Scale. Relative Value Scale means a methodology that values procedures and services relative to each other that includes, but is not limited to, a scale in terms of difficulty, work, risk, as well as the material and outside costs of providing the service, as adjusted to the geographic area where the services or procedures were performed;

- In the case of services rendered by providers with whom *we* have agreements, the fee that *we* have negotiated with that provider;

- The fee based on rates negotiated with one or more *network providers* in the geographic area for the same or similar services;

- The fee based on the provider's costs for providing the same or similar services as reported by the provider in the most recent, publicly available *Medicare* cost report submitted annually to the Centers for Medicare and Medicaid Services; or

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

The bill *you* receive for services provided by *non-network providers* may be significantly higher than the *reimbursement limit*. In addition to the *deductible*, *copayments* and *coinsurance*, *you* are responsible for the difference between the *reimbursement limit* and the amount the provider bills *you* for the services. Any amount *you* pay to the provider in excess of the *reimbursement limit* will not apply to *your deductible* or *out-of-pocket limit*.

Treatment plan means a written report on a form satisfactory to *us* and completed by the *dentist* that includes:

- A list of the services to be performed, using the American Dental Association terminology and codes;
- *Your dentist's* written description of the proposed treatment.
- Pretreatment x-rays supporting the services to be performed.
- Itemized cost of the proposed treatment.
- Any other appropriate diagnostic materials (may include x-rays, chart notes, treatment records, etc.) as requested by *us*.

Pediatric dental services benefit

We will pay benefits for *covered health services* incurred by a *covered person* for *pediatric dental services*. *Pediatric dental services* include the following as categorized below. Coverage for a *dental emergency* is limited to *palliative dental care* only:

Class I services

- Periodic and comprehensive oral evaluations. Limited to 2 per *year*.

- Limited, problem focused oral evaluations. Limited to 2 per *year*.

COVERED HEALTH SERVICES – PEDIATRIC DENTAL (continued)

- Periodontal evaluations. Limited to 2 per *year*. Benefit allowed only for a *covered person* showing signs or symptoms of periodontal disease and for patients with risk factors such as smoking, diabetes or related health issues. No benefit is payable when performed with a cleaning (prophylaxis). Benefit is not available when a comprehensive oral evaluation is performed.

- Cleaning (prophylaxis), including all scaling and polishing procedures. Limited to 2 per *year*.

- Intra-oral complete series x-rays (at least 14 films, including bitewings) or panoramic x-ray. Limited to 1 every 5 years. If the total cost of periapical and bitewing x-rays exceeds the cost of a complete series of x-rays, *we* will consider these as a complete series.

- Bitewing x-rays. Limited to 2 sets per *year*.

- Other x-rays, including intra-oral periapical and occlusal and extra-oral x-rays. Limited to x-rays necessary to diagnose a specific treatment.

- Topical fluoride treatment. Limited to 2 per *year*.

- Application of sealants to the occlusal surface of permanent molars that are free of decay and restorations. Limited to 1 per tooth every 3 years.

- Installation of space maintainers for retaining space when a primary tooth is prematurely lost. *Pediatric dental services* do not include separate adjustment expenses.

- Recementation of space maintainers.

- Removal of fixed space maintainers.

Class II services

- Restorative services as follows:

    - Amalgam restorations (fillings). Multiple restorations on one surface are considered one restoration.

    - Composite restorations (fillings) on anterior teeth. Composite restorations on molar and bicuspid teeth are considered an alternate service and will be payable as a comparable amalgam filling. *You* will be responsible for the remaining *expense incurred*. Multiple restorations on one surface are considered one restoration.

    - Pin retention per tooth in addition to restoration that is not in conjunction with core build-up.

    - Non-cast pre-fabricated stainless steel, esthetic stainless steel, and resin crowns on primary teeth that cannot be adequately restored with amalgam or composite restorations.

COVERED HEALTH SERVICES – PEDIATRIC DENTAL (continued)

- Miscellaneous services as follows:

  - *Dental emergency* care for the treatment for initial *palliative dental care* of pain or an *accidental dental injury* to the teeth and supporting structures. *We* will consider the service a separate benefit only if no other service, except for x-rays and problem focused oral evaluation is provided during the same visit.

  - Re-cementing inlays, onlays and crowns.

Class III services

- Restorative services as follows:

  - Initial placement of laboratory-fabricated restorations, for a permanent tooth, when the tooth, as a result of extensive decay or a traumatic injury, cannot be restored with a direct placement filling material. *Pediatric dental services* include inlays, onlays, crowns, veneers, core build-ups and posts, and implant supported crowns and abutments. Limited to 1 per tooth every 5 years. Inlays are considered an alternate service and will be payable as a comparable amalgam filling.

  - Replacement of inlays, onlays, crowns or other laboratory-fabricated restorations for permanent teeth. *Pediatric dental services* include the replacement of the existing major restoration if:

    - It has been 5 years since the prior insertion and is not, and cannot be made serviceable.
    - It is damaged beyond repair as a result of an *accidental dental injury* while in the oral cavity; or
    - Extraction of functioning teeth, excluding third molars or teeth not fully in occlusion with an opposing tooth or prostheses requires the replacement of the prosthesis.

- Periodontic services as follows:

  - Periodontal scaling and root planing. Limited to 1 per quadrant every 2 years.

  - Periodontal maintenance (at least 30 days following periodontal therapy), unless a cleaning (prophylaxis) is performed on the same day. Limited to 4 every year.

  - Periodontal and osseous surgical procedures, including bone replacement, tissue regeneration, gingivectomy, gingivoplasty, and graft procedures. Limited to 1 per quadrant every 3 years.

  - Occlusal adjustments when performed in conjunction with a periodontal surgical procedure. Limited to 1 per quadrant every 3 years.

  Separate fees for pre- and post-operative care and re-evaluation within 3 months are not considered *pediatric dental services*.

COVERED HEALTH SERVICES – PEDIATRIC DENTAL (continued)

- Endodontic procedures as follows:

  - Root canal therapy, including root canal treatments and root canal fillings for permanent teeth and primary teeth. Any test, intraoperative, x-rays, laboratory or any other follow-up care is considered integral to root canal therapy.

  - Root canal retreatment, including root canal treatments and root canal fillings for permanent and primary teeth. Any test, intraoperative, x-rays, exam, laboratory or any other follow-up care is considered integral to root canal therapy.

  - Periradicular surgical procedures for permanent teeth, including apicoectomy, root amputation, tooth reimplementation, bone graft, and surgical isolation.

  - Partial pulpotomy for apexogenesis for permanent teeth.

  - Vital pulpotomy for primary teeth.

  - Pulp debridement, pupal therapy (resorbable) for permanent and primary teeth.

  - Apexification/recalcification for permanent and primary teeth.

- Prosthodontics services as follows:

  - Denture adjustments when done by a *dentist*, other than the one providing the denture, or adjustments performed more than six months after initial installation.

  - Initial placement of bridges, complete dentures, and partial dentures. Limited to 1 every 5 years. *Pediatric dental services* include pontics, inlays, onlays, and crowns. Limited to 1 per tooth every 5 years.

  - Replacement of bridges, complete dentures, and partial dentures. *Pediatric dental services* include the replacement of the existing prosthesis if:

    - It has been 5 years since the prior insertion and is not, and cannot be made serviceable;
    - It is damaged beyond repair as a result of an *accidental dental injury* while in the oral cavity; or
    - Extraction of functioning teeth, excluding third molars or teeth not fully in occlusion with an opposing tooth or prostheses requires the replacement of the prosthesis.

  - Tissue conditioning.

  - Denture relines or rebases. Limited to 1 every 3 years after 6 months of installation.

  - Post and core build-up in addition to partial denture retainers with or without core build up. Limited to 1 per tooth every 5 years.

COVERED HEALTH SERVICES – PEDIATRIC DENTAL (continued)

- The following simple oral surgical services as follows:

  - Extraction of coronal remnants of a primary tooth.
  - Extraction of an erupted tooth or exposed root for permanent and primary teeth.

- Implant services, subject to *clinical review*. Dental implants and related services, including implant supported crowns, abutments, bridges, complete dentures, and partial dentures. Limited to 1 per tooth every 5 years. *Pediatric dental services* do not include an implant if it is determined a standard prosthesis or restoration will satisfy the dental need.

- Miscellaneous services as follows:

  - Recementing of bridges and implants.
  - Repairs of bridges, complete dentures, immediate dentures, partial dentures, and crowns.

- General anesthesia or conscious sedation subject to *clinical review* and administered by a *dentist* in conjunction with covered oral surgical procedures, periodontal and osseous surgical procedures, and periradicular surgical procedures, for *pediatric dental services*. General anesthesia is not considered a *pediatric dental service* if administered for, including but not limited to, the following:

  - Pain control, unless the *covered person* has a documented allergy to local anesthetic.
  - Anxiety.
  - Fear of pain.
  - Pain management.
  - Emotional inability to undergo a surgical procedure.

Class IV services

Orthodontic treatment when *medically necessary*

Covered health services for orthodontic treatment includes those that are:

- For the treatment of and appliances for tooth guidance, interception and correction.
- Related to covered orthodontic treatment, including:

  - X-rays.
  - Exams.
  - Space retainers.
  - Study models.

Covered health services do not include services to alter vertical dimensions, restore or maintain the occlusion. Such procedures include, but are not limited to, equilibration, periodontal splinting, full mouth rehabilitation, and restoration for misalignment of teeth.

COVERED HEALTH SERVICES – PEDIATRIC DENTAL (continued)

Integral service

Integral services are additional charges related to materials or equipment used in the delivery of dental care. The following services are considered integral to the dental service and will not be paid separately:

- Local anesthetics.
- Bases.
- Pulp testing.
- Pulp caps.
- Study models/diagnostic casts.
- *Treatment plans*.
- Occlusal (biting or grinding surfaces of molar and bicuspid teeth) adjustments.
- Nitrous oxide.
- Irrigation.
- Tissue preparation associated with impression or placement of a restoration.

Pretreatment plan

We suggest that if dental treatment is expected to exceed $300, *you* or *your dentist* should submit a *treatment plan* to *us* for review before *your* treatment. The *treatment plan* should include:

- A list of services to be performed using the American Dental Association terminology and codes.
- *Your dentist's* written description of the proposed treatment.
- Pretreatment x-rays supporting the services to be performed.
- Itemized cost of the proposed treatment.
- Any other appropriate diagnostic materials that *we* may request.

We will provide *you* and *your dentist* with an estimate for benefits payable based on the submitted *treatment plan*. This estimate is not a guarantee of what *we* will pay. It tells *you* and *your dentist* in advance about the benefits payable for the *pediatric dental services* in the *treatment plan*.

An estimate for services is not necessary for a *dental emergency*.

Pretreatment plan process and timing

An estimate for services is valid for 90 days after the date *we* notify *you* and *your dentist* of the benefits payable for the proposed *treatment plan* (subject to *your* eligibility of coverage). If treatment will not begin for more than 90 days after the date *we* notify *you* and *your dentist*, *we* recommend that *you* submit a new *treatment plan*.

COVERED HEALTH SERVICES – PEDIATRIC DENTAL (continued)

Alternate services

If two or more services are acceptable to correct a dental condition, *we* will base the benefits payable on the least expensive *pediatric dental service* that produces a professionally satisfactory result, as determined by *us*. *We* will pay up to the *reimbursement limit* for the least costly *pediatric dental service* and subject to any applicable *deductible* and *coinsurance*. *You* will be responsible for any amount exceeding the *reimbursement limit*.

If *you* or *your dentist* decides on a more costly service, payment will be limited to the *reimbursement limit* for the least costly service and will be subject to any *deductible* and *coinsurance*. *You* will be responsible for any amount exceeding the *reimbursement limit*.

Limitations and exclusions

Refer to the "Limitations and Exclusions" section of this *evidence of coverage* for additional exclusions. Unless specifically stated otherwise, no benefit will be provided for, or on account of, the following items:

- Any expense arising from the completion of forms.
- Any expense due to *your* failure to keep an appointment.
- Any expense for a service *we* consider *cosmetic*, unless it is due to an *accidental dental injury*.
- Expenses incurred for:
  - Precision or semi-precision attachments.
  - Overdentures and any endodontic treatment associated with overdentures.
  - Other customized attachments.
  - Any services for 3D imaging (cone beam images).
  - Temporary and interim dental services.
  - Additional charges related to materials or equipment used in the delivery of dental care.
- Charges for services rendered:
  - In a dental facility or *health care treatment facility* sponsored or maintained by the *employer* under this plan or an employer of any *covered person* covered by the *master group contract*.
  - By an employee of any *covered person* covered by the *master group contract*.

  For the purposes of this exclusion, *covered person* means the *employee* and the *employee's dependents* enrolled for benefits under the *master group contract* and as defined in the "Glossary" section.

COVERED HEALTH SERVICES – PEDIATRIC DENTAL (continued)

- Any service related to:

  - Altering vertical dimension of teeth or changing the spacing or shape of the teeth.
  - Restoration or maintenance of occlusion.
  - Splinting teeth, including multiple abutments, or any service to stabilize periodontally weakened teeth.
  - Replacing tooth structures lost as a result of abrasion, attrition, erosion, or abfraction.
  - Bite registration or bite analysis.

- Infection control, including but not limited to, sterilization techniques.

- Expenses incurred for services performed by someone other than a *dentist*, except for scaling and teeth cleaning and the topical application of fluoride, which can be performed by a licensed dental hygienist. The treatment must be rendered under the supervision and guidance of the *dentist* in accordance with generally accepted dental standards.

- Any *hospital*, surgical or treatment facility, or for services of an anesthesiologist or anesthetist.

- *Prescription* drugs or pre-medications, whether dispensed or prescribed.

- Any service that:

  - Is not eligible for benefits based on the *clinical review.*
  - Does not offer a favorable prognosis.
  - Does not have uniform professional acceptance.
  - Is deemed to be experimental or investigational in nature.

- Preventive control programs including, but not limited to, oral hygiene instructions, plaque control, take-home items, prescriptions and dietary planning.

- Replacement of any lost, stolen, damaged, misplaced or duplicate major restoration, prosthesis or appliance.

- Any caries susceptibility testing, laboratory tests, saliva samples, anaerobic cultures, sensitivity testing or charges for oral pathology procedures.

- The following services when performed at the same time as a root canal:

  - Partial pulpotomy for apexogensis.
  - Vital pulpotomy.
  - Pulp debridment or pupal therapy.

COVERED HEALTH SERVICES - PEDIATRIC VISION CARE

This "Covered Health Services – Pediatric Vision Care" section describes expenses covered under the *master group contract* for *pediatric vision care*. Benefits for *pediatric vision care* will be paid on a *reimbursement limit* basis and as shown in the "Schedule of Benefits – Pediatric Vision Care", subject to any applicable:

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

Notwithstanding any other provisions of the *master group contract*, expenses covered under this benefit section are not covered under any other provision of the *master group contract*. Any amount in excess of the maximum amount provided under this benefit, if any, is not covered under any other provision in the *master group contract.*

All terms used in this benefit have the same meaning given to them in the *evidence of coverage*, unless otherwise specifically defined in this benefit. Refer to the "Limitations and exclusions" provision in this section and the "Limitations and Exclusions" section of this *evidence of coverage* for *pediatric vision care* expenses not covered by the *master group contract.* All other terms and provisions of the *master group contract* are applicable to expenses covered for *pediatric vision care*.

Definitions

Comprehensive eye exam means an exam of the complete visual system, which includes: case history; monocular and binocular visual acuity, with or without present corrective lenses; neurological integrity (pupil response); biomicroscopy (external exam); visual field testing (confrontation); ophthalmoscopy (internal exam); tonometry (intraocular pressure); refraction (with recorded visual acuity); extraocular muscle balance assessment; dilation as required; present prescription analysis; specific recommendation; assessment plan; and provider signature.

Contact lens fitting and follow-up means an exam, which includes: keratometry; diagnostic lens testing; instruction for insertion and removal of contact lenses; additional biomicroscopy with and without lens.

Covered person under this "Covered Health Services – Pediatric Vision Care" section and the "Schedule of Benefits – Pediatric Vision Care" section means a person who is eligible and enrolled for benefits provided under the *master group contract* up to the end of the month following the date he or she attains age 19.

Low vision means *severe vision problems* as diagnosed by an Ophthalmologist or Optometrist that cannot be corrected with regular prescription lenses or contact lenses and reduces a person's ability to function at certain or all tasks.

Materials means frames, lenses and lens options, or contact lenses, and low vision aids.

COVERED HEALTH SERVICES - PEDIATRIC VISION CARE (continued)

Pediatric vision care means the services and *materials* specified in the "Pediatric vision care benefit" provision in this section for a *covered person*.

Reimbursement limit is the maximum fee allowed for a *pediatric vision care*. *Reimbursement limit for pediatric vision care* is the lesser of:

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

The bill *you* receive for services provided by, or *materials* obtained from, *non-network providers* may be significantly higher than the *reimbursement limit*. In addition to *deductibles, copayments* and *coinsurance*, *you* are responsible for the difference between the *reimbursement limit* and the amount the provider bills *you* for the services or *materials*. Any amount *you* pay to the provider in excess of the *reimbursement limit* will not apply to *your deductible* or *out-of-pocket limit*.

COVERED HEALTH SERVICES - PEDIATRIC VISION CARE (continued)

Severe vision problems mean the best-corrected acuity is:

- 20/200 or less in the better eye with best conventional spectacle or contact lens prescription;
- A demonstrated constriction of the peripheral fields in the better eye to 10 degrees or less from the fixation point; or
- The widest diameter subtends an angle less than 20 degrees in the better eye.

Pediatric vision care benefit

We will pay benefits for *covered health services* incurred by a *covered person* for *pediatric vision care*. *Covered health services* for *pediatric vision care* are:

- *Comprehensive eye exam*.

- Prescription lenses, including polycarbonate, scratch coating, ultraviolet-coating, blended lenses, intermediate lenses, progressive lenses, photochromatic lenses, polarized lenses, fashion and gradient tinting, oversized lenses, glass-grey prescription sunglass lenses, anti-reflective coating, and hi-index lenses. If a *covered person* sees a *network provider*, the *network provider* of *materials* will show the *covered person* the selection of lens options covered by the *master group contract*. If a *covered person* selects a lens option that is not included in the lens option selection the *master group contract* covers, the *covered person* is responsible for the difference in cost between the *network provider* of *materials* reimbursement amount for covered lens options and the retail price of the lens options selected.

- Frames available from a selection of covered frames. If a *covered person* sees a *network provider*, the *network provider* of *materials* will show the *covered person* the selection of frames covered by the *master group contract*. If a *covered person* selects a frame that is not included in the frame selection the *master group contract* covers, the *covered person* is responsible for the difference in cost between the *network provider* of *materials* reimbursement amount for covered frames and the retail price of the frame selected.

- Elective contact lenses available from a selection of covered contact lenses, *contact lens fitting and follow-up*. If a *covered person* sees a *network provider*, the *network provider* of *materials* will inform the *covered person* of the contact lens selection covered by the *master group contract*. If a *covered person* selects a contact lens that is not part of the contact lens selection the *master group contract* covers, the *covered person* is responsible for the difference in cost between the lowest cost contact lens available from the contact lens selection covered by the *master group contract* and the cost of the contact lens selected.

- *Medically necessary* contact lenses under the following circumstances:

    - Visual acuity cannot be corrected to 20/70 in the better eye, except by use of contact lenses;
    - Anisometropia;
    - Keratoconus;
    - Aphakia;

- High ametropia of either +10D or -10D in any meridian;
- Pathological myopia;
- Aniseikonia;
- Aniridia;
- Corneal Disorders;
- Post-traumatic Disorders; or
- Irregular Astigmatism.

Prior authorization is required for *medically necessary* contact lenses. *We* must be contacted by telephone at the customer service number on *your* ID card, by *electronic mail*, or in writing to request prior authorization. If prior authorization is not obtained, *you* will be responsible for a prior authorization penalty. The benefit payable for *medically necessary* contact lenses will be reduced 50%, after any applicable *deductible* and coinsurance. This prior authorization penalty will apply if *you* received the *medically necessary* contact lenses when prior authorization is required and not obtained.

- *Low vision* services includes the following:

  - Comprehensive low vision testing and evaluation.
  - Low vision supplementary testing.
  - Low vision aids include only the following:

    - Spectacle-mounted magnifiers.
    - Hand-held and stand magnifiers.
    - Hand held or spectacle-mounted telescopes.
    - Video magnification.

  Prior authorization is required for *low vision* services. *We* must be contacted by telephone at the customer service number on *your* ID card, by *electronic mail*, or in writing to request prior authorization. If prior authorization is not obtained, *you* will be responsible for a prior authorization penalty. The benefit payable for *low vision* services will be reduced to 50%, after any applicable *deductible* and *coinsurance*. This prior authorization penalty will apply if *you* received the *low vision* services when prior authorization is required and not obtained.

Limitations and exclusions

In addition to the "Limitations and Exclusions" section of this *evidence of coverage* and any limitations specified in the "Schedule of Benefits – Pediatric Vision Care", benefits for *pediatric vision care* are limited as follows:

- In no event will benefits exceed the lesser of the limits of the *master group contract*, shown in the "Schedule of Benefits – Pediatric Vision Care" or in the "Schedule of Benefits" of this *evidence of coverage*.

COVERED HEALTH SERVICES - PEDIATRIC VISION CARE (continued)

- *Materials* covered by the *master group contract* that are lost, stolen, broken, or damaged will only be replaced at normal intervals as specified in the "Schedule of Benefits – Pediatric Vision Care".

- Basic cost for frames covered by the *master group contract*. The *covered person* is responsible for lens options selected, including but not limited to:

    - Sunglasses, prescription and plano; or
    - Groove, drill or notch, and roll and polish.

Refer to the "Limitations and Exclusions" section of this *evidence of coverage* for additional exclusions. Unless specifically stated otherwise, no benefits for *pediatric vision care* will be provided for, or on account of, the following items:

- Orthoptic or vision training and any associated supplemental testing.
- Two or more pair of glasses, in lieu of bifocals or trifocals.
- Medical or surgical treatment of the eye, eyes or supporting structures.
- Any services and *materials* required by an *employer* as a condition of employment.
- Safety lenses and frames.
- Contact lenses, when benefits for frames and lenses are received.
- Oversized 61 and above lens or lenses.
- Cosmetic items.
- Any services or *materials* not listed in this benefit section as a covered benefit or in the "Schedule of Benefits – Pediatric Vision Care".
- Expenses for missed appointments.
- Any charge from a providers' office to complete and submit claim forms.
- Treatment relating to or caused by disease.
- Non-prescription *materials* or vision devices.
- Costs associated with securing *materials*.
- Pre- and post-operative services.
- Orthokeratology.
- Maintenance of *materials*.
- Refitting or change in lens design after initial fitting.
- Artistically painted lenses.

COVERED HEALTH SERVICES - BEHAVIORAL HEALTH

The "Covered Health Services – Behavioral Health" section describes the services that will be considered *covered health services* for *mental health services* and *chemical dependency* services under the *master group contract*. Benefits for *mental health services* and *chemical dependency* services will be paid on a *usual and customary* fee basis and as shown in the "Schedule of Benefits – Behavioral Health" 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 *master group contract,* including the *preauthorization* requirements specified in this *certificate,* are applicable to *covered health services*.

This "Covered Health Services - Behavioral Health" section does not include services for *serious mental illness.*

Acute inpatient services and partial hospitalization services

We will pay benefits for *covered health services* incurred by *you* for *acute 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.* Two days of *partial hospitalization* is equal to one day of *inpatient* care. A *health care practitioner* must certify that the *partial hospitalization* being provided is in lieu of hospitalization.

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

Health care practitioner inpatient and partial hospitalization services

We will pay benefits for *covered health services* 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, psychiatric day treatment facility, crisis stabilization unit,* or *residential treatment center for children and adolescents.*

COVERED HEALTH SERVICES - BEHAVIORAL HEALTH (continued)

Outpatient therapy and office therapy services

We will pay benefits for *covered health services* 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*, *psychiatric day treatment facility*, *crisis stabilization unit*, 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.

COVERED HEALTH SERVICES - TRANSPLANT SERVICES

This "Covered Health Services – Transplant Services" section describes the services that will be considered *covered health services* for transplant services under the *master group contract*. Benefits for transplant services will be paid as shown in the "Schedule of Benefits – Transplant Services" subject to any applicable:

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

Refer to the "Limitations and Exclusions" section listed in this *evidence of coverage* for transplant services not covered by the *master group contract*. All terms and provisions of the *master group contract* are applicable to *covered health services*.

Transplant covered health services

We will pay benefits for *covered health services* incurred by *you* for a transplant that is preauthorized and approved by *us*. *We* must be notified of the initial transplant evaluation and given a reasonable opportunity to review the clinical results to determine if the transplant will be covered. *You* or *your health care practitioner* must contact *our* Transplant Management Department by calling the Customer Service number on *your* ID card when in need of a transplant. *We* will advise *your health care practitioner* once coverage of the requested transplant is approved by *us*. Benefits are payable only if the transplant is approved by *us.*

Covered health service for a transplant includes pre-transplant services, transplant inclusive of any integral chemotherapy and associated services, post-discharge services, and treatment of complications after transplantation for or in connection with only the following procedures:

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

Multiple transplantations performed simultaneously are considered one transplant surgery.

Corneal transplants and porcine heart valve implants are tissues, which are considered part of regular plan benefits and are subject to other applicable provisions of the *master group contract*.

COVERED HEALTH SERVICES - TRANSPLANT SERVICES (continued)

The following are *covered health services* for an approved transplant and all related complications:

- *Hospital* and *health care practitioner* services.

- Acquisition for transplants and associated donor costs, including pre-transplant services, the acquisition procedure, and any complications resulting from the acquisition. Donor costs for post-discharge services and treatment of complications for or in connection with acquisition for an approved transplant will not exceed the transplant treatment period of 365 days from the date of *hospital* discharge following acquisition.

- Direct, non-medical costs for:

  - The *covered person* receiving the 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 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 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 transplant and the designated caregiver(s) or support person(s) are limited to a combined maximum coverage per transplant, as specified in the "Schedule of Benefits – Transplant Services" section in this *evidence of coverage*.

Covered health services for post-discharge services and treatment of complications for or in connection with an approved transplant are limited to the transplant treatment period of 365 days from the date of *hospital* discharge following transplantation of an approved transplant received while *you* were covered by *us.* After this transplant treatment period, regular plan benefits and other provisions of the *master group contract* are applicable.

COVERED HEALTH SERVICES – PHARMACY SERVICES

This "Covered Health Services – Pharmacy Services" section describes *covered health services* under the *master group contract* for *prescription* drugs, including *specialty drugs*, dispensed by a *pharmacy*. Benefits are subject to applicable *cost share* shown on the "Schedule of Benefits – Pharmacy Services" section of this *evidence of coverage*.

Refer to the "Limitations and Exclusions", "Limitations and Exclusions – Pharmacy Services", "Glossary" and "Glossary – Pharmacy Services" sections in this *evidence of coverage*. All terms and provisions of the *master group contract*, including *prior authorization* requirements specified in the "Schedule of Benefits – Pharmacy Services" of this *evidence of coverage*, are applicable.

Coverage description

We will cover *prescription* drugs that are received by *you* under this "Covered Health Services – Pharmacy Services" section. Benefits may be subject to *dispensing limits*, *prior authorization* and *step therapy* requirements, if any.

Covered *prescription* drugs are:

- Drugs, medicines or medications and *specialty drugs* that under federal or state law may be dispensed only by *prescription* from a *health care practitioner*.
- Drugs, medicines or medications and *specialty drugs* included on *our drug list*.
- Drug prescribed for intended use for off-label indications recognized through peer-reviewed medical literature;
- Insulin and *diabetes supplies.*
- Contraceptive drugs and contraceptive drug delivery implants approved by the FDA.
- *Self-administered injectable drugs* approved by *us*.
- Hypodermic needles, syringes or other methods of delivery when prescribed by a *health care practitioner* for use with insulin or *self-administered injectable drugs.* (Hypodermic needles, syringes or other methods of delivery used in conjunction with covered drugs may be available at no cost to *you*).
- Enteral formulas and nutritional supplements for the treatment of phenylketonuria (PKU) or other inherited metabolic disease, or as otherwise determined by *us*.

- Amino-acid based elemental formulas ordered to treat the following diagnoses 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.

- Spacers and/or peak flow meters for the treatment of asthma.

- Drugs, medicines or medications on the Preventive Medication Coverage *drug list* with a *prescription* from a *health care practitioner*.

Notwithstanding any other provisions of the *master group contract*, *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.

About our drug list

Prescription drugs, medicines or medications, including *specialty drugs* and *self-administered injectable drugs* prescribed by *health care practitioners* and covered by *us* are specified on *our* printable *drug list*. The *drug list* identifies categories of drugs, medicines or medications by levels. It also indicates *dispensing limits*, *specialty drug* designation 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. *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* or *specialty drug lists;*
- 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 *master group contract*. *We* will provide written notice no later than 60 days prior to the *effective date* of the change.

Pharmacy standard exception request

If a clinically appropriate drug is not included on *our drug list*, *you* may contact *us* by phone, electronically, or in writing to request coverage of that specific drug or *specialty drug* (a standard exception request). A standard exception request may be initiated by *you*, *your* appointed representative, or the prescribing *health care practitioner* by calling the customer service number on *your* identification card or visiting *our* Website at www.humana.com. *We* will respond to a standard exception request no later than 72 hours after the receipt date of the request.

As part of the standard exception request, the prescribing *health care practitioner* should include an oral or written statement that provides justification to support the need for the prescribed drug not included on *our drug list* to treat the *covered person's* condition, including a statement that:

- All covered drugs on the *drug list* on any tier will be or have been ineffective;
- Would not be as effective as the drug not included on the *drug list*; or
- Would have adverse effects.

If *we* grant a standard exception request for coverage of a prescribed drug that is not on *our drug list*, *we* will cover the prescribed drug for the duration of the *prescription*, including refills. Any applicable *cost share* for the *prescription* will apply toward the *out-of-pocket limit*.

If *we* deny a standard exception request, *you* have the right to an independent review of *our* decision, as described below in the "Pharmacy external exception request" provision.

Pharmacy expedited exception request

If a clinically appropriate drug is not included on *our drug list*, an expedited exception request based on exigent circumstances may be initiated by *you*, *your* appointed representative, or *your* prescribing *health care practitioner* by calling the customer service number on *your* identification card or visiting *our* Website at www.humana.com. *We* will respond to an expedited exception request within 24 hours of receipt of the request. An exigent circumstance exists when a *covered person* is:

- Suffering from a health condition that may seriously jeopardize their life, health, or ability to regain maximum function; or
- Undergoing a current course of treatment using a drug not included on the *drug list*.

As part of the expedited review request, the prescribing *health care practitioner* should include an oral or written:

- Statement that an exigent circumstance exists and explain the harm that could reasonably be expected to the *covered person* if the requested drug is not provided within the timeframes of the standard drug exception request process; and

- Justification supporting the need for the prescribed drug not included on *our drug list* to treat the *covered person's* condition, including a statement that:

    - All covered drugs on the *drug list* on any tier will be or have been ineffective;
    - Would not be as effective as the drug not included on the *drug list*; or
    - Would have adverse effects.

If *we* grant an expedited exception based on exigent circumstances for coverage of the prescribed drug that is not on *our drug list*, *we* will provide access to the prescribed drug:

- Without unreasonable delay; and
- For the duration of the exigent circumstance.

Any applicable *cost share* for the *prescription* will apply toward the *out-of-pocket limit*.

If *we* deny an expedited exception request, *you* have the right to an independent review of *our* decision, as described below in the "Pharmacy external exception request" provision.

Pharmacy external exception request

If *we* deny a request for a standard exception or an expedited exception, *you*, *your* appointed representative, or the prescribing *health care practitioner* may initiate an external exception request for the original exception request and the denial of that request to be reviewed by an independent review organization (IRO).

The IRO's decision to either uphold or reverse the denial of the original exception request will be provided orally or in writing to *you*, *your* appointed representative, or the prescribing *health care practitioner* no later than:

- 24 hours after receipt of an external exception review request if the original exception request was expedited.
- 72 hours after receipt of an external exception review request if the original exception request was standard.

LIMITATIONS AND EXCLUSIONS

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 health service*.

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

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

- An *illness* or *bodily injury* arising out of, or in the course of, any employment for wage, gain or profit. This exclusion applies whether or not *you* have Workers' Compensation coverage. This exclusion does not apply to an *employee* that is sole proprietor, partner, or corporate officer if the sole proprietor, partner or corporate officer is not eligible to receive Workers' Compensation benefits.

- 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.

- 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 *illness* or *bodily injury*.

- Any service *you* would not be legally required to pay for in the absence of this coverage.

- *Illness* 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*.

- Services provided to *you*, if *you* do not comply with the *master group contract's* requirements. These include services:

  - Not provided by a *network provider*, unless required for *emergency care*;
  - Received in an emergency room, unless required because of *emergency care*;
  - Which require *preauthorization* if *preauthorization* was not obtained.

- 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*.

LIMITATIONS AND EXCLUSIONS (continued)

- Any service that is not rendered by the billing provider.

- Any service not substantiated in the medical records of the billing provider.

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

- 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.

- 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, investigational or for research purposes* except for clinical trials.

  If any drug, biological product, device, medical treatment, or procedure is denied for *experimental, investigational or research purposes*, please reference the "Complaint and Appeals Procedures" section of this *evidence of coverage* for the provision on the Appeals process to an Internal Review Organization (IRO) for further information.

- Vitamins, except for *preventive services* with a *prescription* from a *health care practitioner*, 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 *evidence of coverage* .

- Over-the-counter, non-prescription medications, unless for drugs, medicines or medications or supplies on the Preventive Medication Coverage *drug list* with a *prescription* from a *health care practitioner.*

- Over-the-counter medical items or supplies that can be provided or prescribed by a *health care practitioner* but are also available without a written order or *prescription*, except for *preventive services*.

- Immunizations required for foreign travel for a *covered person* of any age.

- Growth hormones, except as otherwise specified in the pharmacy services sections of this *evidence of coverage*.

LIMITATIONS AND EXCLUSIONS (continued)

- *Prescription* drugs and *self-administered injectable* drugs, except as specified in the "Covered Expenses – Pharmacy Services" section in this *evidence of coverage* or 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*.

- 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.

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

- No benefit is payable for or in connection with transplant if:

  - The expense relates to storage of cord blood and stem cells, unless it is an integral part of a transplant approved by *us*.

  - *We* do not approve coverage for the 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 *master group contract.*

- The expense relates to the donation or acquisition of an organ for a recipient who is not covered by *us*.

- The expense relates to donor costs that are payable in whole or in part by any other group plan, insurance company, organization, or person other than the donor's family or estate.

- The expense relates to a transplant performed outside of the United States and any care resulting from that transplant.

- 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; or
  - Sensory integration therapy.

- *Cosmetic surgery* and cosmetic services or devices, except as otherwise stated in this *evidence of coverage*.

- Hair prosthesis, hair transplants or implants and wigs.

- Dental services, appliances or supplies for treatment of the teeth, gums, jaws or alveolar processes, including but not limited to, any *oral surgery*, *endodontic services* or *periodontics*, implants and related procedures, orthodontic procedures, and any dental services related to a *bodily injury* or *illness* unless otherwise stated in this *evidence of coverage.*

- The following types of care of the feet:

  - Shock wave therapy of the feet;
  - The treatment of weak, strained, flat, unstable or unbalanced feet;
  - Hygienic care, and the treatment of superficial lesions of the feet, such as corns, calluses, or hyperkeratoses;
  - The treatment of tarsalgia, metatarsalgia, or bunion, except surgically;
  - The cutting of toenails, except the removal of the nail matrix;
  - Heel wedges, lifts, or shoe inserts; and
  - Arch supports (foot orthotics) or orthopedic shoes, except for diabetes or hammer toe.

- *Custodial care* and *maintenance care*.

LIMITATIONS AND EXCLUSIONS (continued)

- Any loss contributed to, caused by:

  - War or any act of war, whether declared or not;
  - Insurrection; or
  - Any conflict involving armed forces of any authority.

- *Illness* 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 any *illness* or *bodily injury* resulting from an act of domestic violence or a medical condition (including both physical and mental health conditions) or in case of *emergency care*, the initial medical screening examination, treatment and stabilization of an emergency condition.

- Expenses for any membership fees or program fees, 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 a weight loss *surgery*.

- Charges 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 and stethoscopes;
  - Communication systems, 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*.

LIMITATIONS AND EXCLUSIONS (continued)

- 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, except as otherwise specified in the "Covered Health Services – Transplant Services" section.

- Communications or travel time.

- 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.

- *Alternative medicine*.

- Acupuncture, unless:

  - The treatment is *medically necessary,* 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 the midwife is licensed.

- Vision examinations or testing for the purposes of prescribing corrective lenses, except *comprehensive eye exams* provided under the "Covered Expenses – Pediatric Vision Care" section in this *evidence of coverage.*

- Orthoptic/vision training (eye exercises).

- Radial keratotomy, refractive keratoplasty or any other *surgery* or procedure to correct myopia, hyperopia or stigmatic error.

- The purchase or fitting of eyeglasses or contact lenses, except as:

  - The result of an *accident* or following cataract *surgery* as stated in this *evidence of coverage.*
  - Otherwise specified in the "Covered Health Services – Pediatric Vision Care" section in this *evidence of coverage*.

LIMITATIONS AND EXCLUSIONS (continued)

- 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.

- Employment, school, sport or camp physical examinations or for the purposes of obtaining insurance.

- Care and treatment of non-covered procedures or services.

- Treatment of complications of non-covered procedures or services.

- Services prior to the *effective date* or after the termination date of *your* coverage under the *master group contract*. Coverage will be extended as required by state law and described in the "Understanding Your Coverage" and the "Extension of Benefits" sections.

- *Pre-surgical/procedural testing* duplicated during a *hospital confinement*.

LIMITATIONS AND EXCLUSIONS – PHARMACY SERVICES

The "Limitations and Exclusions – Pharmacy Services" section describes the limitations and exclusions under the *master group contract* that apply to *prescription* drugs, including *specialty drugs*, dispensed by a *pharmacy*. Please refer to the "Limitations and Exclusions" section of this *evidence of coverage* for additional limitations.

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

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

- *Legend drugs,* which are not deemed *medically necessary* by *us*.
- *Prescription* drugs not included on the *drug list*.
- Any amount exceeding the *default rate*.
- *Specialty drugs* for which coverage is not approved by *us*.
- Drugs and/or ingredients not approved by the FDA, including bulk compounding ingredients.
- 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 an *illness* or *bodily injury* not covered under the *master group contract*.
- Any drug, medicine or medication that is either:
  - Labeled "Caution-limited by federal law to investigational use"; or
  - *Experimental, investigational* or *for research purposes,*

  even though a charge is made to *you*.
- Allergen extracts.
- Therapeutic devices or appliances, including, but not limited to:
  - Hypodermic needles and syringes (except when prescribed by a *health care practitioner* 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.

LIMITATIONS AND EXCLUSIONS – PHARMACY SERVICES (continued)

- Dietary supplements, except enteral formulas and nutritional supplements for the treatment of phenylketonuria (PKU) or other inherited metabolic disease. Refer to the "Covered Health Services" section of the *evidence of coverage* for coverage of low protein modified foods.

- Nutritional products.

- Minerals.

- Growth hormones for idiopathic short stature or any other condition, unless there is a laboratory confirmed diagnosis of growth hormone deficiency, or as otherwise determined by *us*.

- Herbs and vitamins, except prenatal (including greater than one milligram of folic acid), pediatric multi-vitamins with fluoride and vitamins on the Preventive Medication Coverage *drug list*.

- 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 and drugs or medicines on the Preventive Medication Coverage *drug list*; 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.

- 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).

LIMITATIONS AND EXCLUSIONS – PHARMACY SERVICES (continued)

- *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 on an *inpatient* basis by the facility. *Inpatient* facilities include, but are not limited to:

  - *Hospital*;
  - *Chemical dependency treatment center*;
  - *Crisis stabilization unit*;
  - *Psychiatric day treatment facility*;
  - *Residential treatment center for children and adolescents;*
  - *Skilled nursing facility*; or
  - Hospice facility.

- Injectable drugs, including, but not limited to:

  - Immunizing agents, unless for *preventive services* determined by *us* to be dispensed by or administered in a *pharmacy*;
  - Biological sera;
  - Blood;
  - Blood plasma; or
  - *Self-administered injectable drugs* or *specialty drugs* for which *prior authorization* or *step therapy* is not obtained from *us*.

- *Prescription* fills or 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* fill 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* fill or refill.

- Any portion of a *prescription* fill 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* fill or refill.

- Any portion of a *specialty drug prescription* fill or refill that exceeds a 30-day supply, unless otherwise determined by *us*.

- Any portion of a *prescription* fill 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*.

LIMITATIONS AND EXCLUSIONS – PHARMACY SERVICES (continued)

- Any drug for which *we* require *prior authorization* or *step therapy* and it is not obtained.
- Any drug for which a charge is customarily not made.
- Any drug, medicine or medication received by *you*:
  - Before becoming covered; or
  - After the date *your* coverage 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* fill or refill for drugs, medicines or medications that are lost, stolen, spilled, spoiled, or damaged.
- Drug delivery implants and other implant systems or devices.
- 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*.
- *Prescriptions* filled at a *non-network pharmacy*, except for *prescriptions* required during an emergency.

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 *us* and the *group plan sponsor*; and
- The *employee* is in an *active status.*

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 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.

Enrollment

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

Employee enrollment

The *employee* must enroll, as agreed to by the *group plan sponsor* 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.

Health status will not be used to determine premium rates. *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.

Dependent enrollment

If electing *dependent* coverage, the *employee* must enroll eligible *dependents*, as agreed to by the *group plan sponsor* 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.

Health status will not be used to determine premium rates. *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.

Newborn and adopted dependent enrollment

A newborn *dependent* will be automatically covered from the date of birth to 31 days of age. An adopted *dependent* will be automatically covered from the date of adoption or placement of the child with the *employee* for the purpose of adoption, or 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*; whichever occurs first, for 31 days.

If additional premium is not required to add additional *dependents* and if *dependent* child coverage is in force as of the newborn's date of birth in the case of newborn *dependents* or the earlier of the date of adoption or placement of the child with the *employee* for purposes of adoption in case of adopted *dependents*, coverage will continue beyond the initial 31 days. *You* must notify *us* to make sure *we* have accurate records to administer benefits.

If premium is required to add *dependents you* must enroll the *dependent* child and pay the additional premium within 31 days:

- Of the newborn's date of birth; or
- Of the date of adoption or placement of the child with the *employee* for the purpose of adoption or 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*, to add the child to *your* plan, whichever occurs first.

If enrollment is requested more than 31 days after the date of birth, date of adoption or placement with the *employee* for the purpose of adoption, and additional premium is required, the *dependent* 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.

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 *master group contract,* 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, legal separation 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; 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 *master group contract*; and
  - You enroll within 31 days after the *special enrollment date*; or

- You are an *employee* or *dependent* eligible for coverage under the *master group contract*, 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 *master group contract*, 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*.

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 master group contract* or added to the *master group contract*, 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 *master group contract* 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*.

Open enrollment

Eligible employees or *dependents*, who did not enroll for coverage under the *master group contract* 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.

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.

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* who 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*.

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* who 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.

Newborn and adopted dependent effective date

The *effective date* of coverage for a newborn *dependent* is the date of birth if the newborn is not a *late applicant*.

The *effective date* of coverage for an adopted *dependent* is the date of adoption or the date of placement with the *employee* for the purpose of adoption, or 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,* whichever occurs first, if the *dependent* child is not a *late applicant*.

Premium is due for any period of *dependent* coverage whether or not the *dependent* is subsequently enrolled, unless specifically not allowed by applicable law. Additional premium may not be required when *dependent* coverage is already in force.

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 *master group contract year* as agreed to by the *group plan sponsor* and *us*.

Retired employee coverage

Retired employee eligibility date

Retired *employees* are eligible if the *group plan sponsor* requested such coverage on the Employer Group Application and the request is approved by *us*. An *employee* who retires while covered under the *master group contract,* 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.

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.

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.

REPLACEMENT OF COVERAGE

Applicability

This "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 *master group contract* and:

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

Benefits available for *covered health services* under the *master group contract* will be reduced by any benefits payable by the Prior Plan during an extension period.

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 *master group contract* if the expense incurred:

- Was applied to the deductible amount under the Prior Plan; and
- Qualifies as a *covered health service* under the *master group contract*; and
- Would have served to partially or fully satisfy the *deductible* amount under the *master group contract* for the *year* in which *your* coverage becomes effective.

Waiting period credit

If the *employee* had not completed the initial *waiting period* under the *group plan sponsor'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 *master group contract*, if any. The *employee* will then be eligible for coverage under the *master group contract* when the balance of the *waiting period* has been satisfied.

Out-of-pocket limit

Any amount applied to the Prior Plan's *network out-of-pocket limit* or stop-loss limit will be credited toward the satisfaction of any *network out-of-pocket limit* of the *master group contract* if the amount applied under the Prior Plan:

- Qualifies as a *covered health service* under the *master group contract*; and
- Would have served to partially or fully satisfy the *out-of-pocket limit* under the *master group contract* for the *year* in which *your* coverage becomes effective.

TERMINATION PROVISIONS

Termination of coverage

The date of termination, as described in this "Termination Provisions" section, is the end of the month, as specified 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 *master group contract.* 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, coverage will terminate at the end of that month, as specified on the Employer Group Application (EGA).

Otherwise, coverage terminates on the earliest of the following:

- The date the *master group contract* terminates;
- The end of the period for which required premiums were due to *us* and not received by *us*. If a *covered person* receives services during a grace period granted to the *group plan sponsor* for the late payment of required premium, the *covered person* will be held liable for the services received. The grace period is explained in the "Miscellaneous Provisions" section;
- The end of the month in which the *employee* terminated employment with the *employer*;
- The end of the month the *employee* no longer qualified as an *employee*;
- The end of the month *you* fail to be eligible as stated in the Employer Group Application (EGA);
- The end of the month in which the *employee* entered full-time military, naval or air service;
- The end of the month in which the *employee* retired, except if the Employer Group Application (EGA) provides coverage for retired *employees* and the retiree is eligible as specified in the Employer Group Application (EGA);
- For a *dependent*, the end of the month in which the *employee's* coverage terminates;
- For a *dependent*, the end of the month in which the *employee* ceases to be eligible for *dependent* coverage;
- The end of the month in which *your dependent* no longer qualifies as a *dependent*;

- For any benefit, the date the benefit is deleted from the *master group contract*;

- The end of the month in which the *group plan sponsor* receives *your* written notice requesting termination of coverage, or the date *you* request for termination in such notice, if later.

- 15 days following written notice of the date fraud or an intentional misrepresentation of a material fact has been committed by *you*. For more information on fraud and intentional misrepresentation, refer to the "Fraud" provision in the "Miscellaneous Provisions" section of this *evidence of coverage*.

Termination for cause

We will terminate *your* coverage on the date we specify with at least 15 days prior written notice 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* for those services.

- If *you* or the *group plan sponsor* perpetrate fraud 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 or alteration of a claim, identification card or other identification.

EXTENSION OF BENEFITS

Extension of coverage for total disability

We extend limited coverage if:

- The *master group contract* terminates while *you* are *totally disabled* due to a *bodily injury* or *illness* that occurs while the *master group contract* 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 *master group contract*; or

Benefits are payable only for those expenses incurred for the same *illness* or *bodily injury* which caused *you* to be *totally disabled*. Coverage 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 is reached; or
- The last day of a 90 consecutive day period following the date the *master group contract* terminated.

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

CONTINUATION

Continuation options in the event of termination

If coverage terminates:

- It may be continued as described in the "State continuation of coverage" 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 coverage" and "Continuation of coverage for dependents" provisions follow.

State continuation of coverage

A *covered person* whose coverage terminates shall have the right to continuation under the *master group contract* as follows:

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

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

In order to be eligible for this option:

- The *employee* must have been continuously covered under the *master group contract* 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 covered by *Medicare*;
- The *covered person* has similar benefits under another group or individual plan whether insured or self-insured;
- The *covered person* is covered for similar benefits under another group plan whether insured or self-insured; or
- Similar benefits are provided for 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 completion of any period of continuation provided under COBRA or any covered person eligible for 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 *group plan sponsor* is responsible for sending *us* the premium payments for those individuals who choose to continue their coverage. If the *group plan sponsor* fails to make proper payment of the premiums to *us*, *we* are relieved of all liability for any coverage that was continued and the liability will rest with the *group plan sponsor*.

Continuation of coverage for dependents

Continuation of coverage is available for *dependents* that are no longer eligible for the coverage provided by the *master group contract* because 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 health status.

CONTINUATION (continued)

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

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

- The *group plan sponsor* 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 *group plan sponsor* 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 *group plan sponsor* 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 *group plan sponsor* is responsible for sending *us* the premium payments for those individuals who choose to continue their coverage.

The option to continue coverage is not available if:

- The *master group contract* terminates;

- The *dependent* was not covered by the *master group contract* and the Prior Plan replaced by the *master group contract* 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 (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 *master group contract* terminates.

The *group plan sponsor* is responsible for sending *us* the premium payments for those individuals who choose to continue their coverage. If the *group plan sponsor* fails to make proper payment of the premiums to *us*, *we* are relieved of all liability for any coverage that was continued and the liability will rest with the *group plan sponsor*.

COORDINATION OF BENEFITS

Coordination of benefits

This "Coordination of Benefits" (COB) provision applies when a *covered person* has health care coverage under more than one *plan*. *Plan* is defined below.

The order of benefit determination rules determine the order in which each *plan* will pay a claim for benefits. The *plan* that pays first is called the primary *plan*. The primary *plan* must pay benefits in accordance with its policy terms without regard to the possibility that another *plan* may cover some expenses. The *plan* that pays after the primary *plan* is the secondary *plan*. The secondary *plan* may reduce the benefits it pays so that payments from all *plan*s equal 100% of the total *allowable expense*.

Definitions

The following definitions are used exclusively in this coordination of benefits provision.

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

Plan includes:

- Group, blanket or franchise accident and health insurance policies, excluding disability income protection coverage;
- Individual and group health maintenance organization evidences of coverage;
- Individual accident and health insurance policies;
- Individual and group preferred provider benefit *plan*s and exclusive provider benefit *plan*s;
- Group insurance contracts, individual insurance contracts and subscriber contracts that pay or reimburse for the cost of dental care;
- Medical care components of individual and group long-term care contracts;
- Uninsured arrangements of group or group-type coverage;
- Medical benefits coverage in automobile insurance contracts;
- Medicare or other governmental benefits, as permitted by law; or
- Limited benefit coverage that is not issued to supplement individual or group in-force policies.

Plan does not include:

- Disability income protection coverage;
- Texas Health Insurance Pool;
- Workers' compensation insurance coverage;
- Hospital confinement indemnity coverage or other fixed indemnity coverage;

- Specified disease coverage;
- Supplemental benefit coverage;
- Accident only coverage;
- Specified accident coverage;
- School accident-type coverages that cover students for accidents only, including athletic injuries, either on a "24-hour" or a "to and from school" basis;
- Benefits provided in long-term care insurance contracts for non-medical services, for example, personal care, adult day care, homemaker services, assistance with activities of daily living, respite care, and custodial care or for contracts that pay a fixed daily benefit without regard to expenses incurred or the receipt of services;
- Medicare supplement policies;
- A state *plan* under Medicaid;
- A governmental *plan* that, by law, provides benefits that are in excess of those of any private insurance *plan*;
- Other non-governmental *plan*; or
- An individual accident and health insurance policy that is designed to fully integrate with other policies through a variable deductible.

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.*

Prescription drug coverage under a Prescription Drug Benefit will be considered a separate *plan* for the purposes of COB and will only be coordinated with other *prescription* drug coverage.

This plan means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other *plans.* Any other part of the contract providing health care benefits is separate from *this plan.* A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with like benefits, and may apply other separate COB provisions to coordinate other benefits.

The order of benefit determination rules determine whether *this plan* is a primary *plan* or secondary *plan* when the person has health care coverage under more than one *plan*. When *this plan* is primary, it determines payment for its benefits first before those of any other *plan* without considering any other *plan*'s benefits. When *this plan* is secondary, it determines its benefits after those of another *plan* and may reduce the benefits it pays so that all *plan* benefits equal 100% of the total *allowable expense*.

COORDINATION OF BENEFITS (continued)

Allowable expense is a health care expense, including deductibles, coinsurance, and copayments, that is covered at least in part by any *plan* covering the person. When a *plan* provides benefits in the form of services, the reasonable cash value of each service will be considered an *allowable expense* and a benefit paid. An expense that is not covered by any *plan* covering the person is not an *allowable expense*. In addition, any expense that a health care provider or physician by law or in accord with a contractual agreement is prohibited from charging a *covered person* is not an *allowable expense*.

The following are examples of expenses that are not *allowable expenses*:

- The difference between the cost of a semi-private hospital room and a private hospital room is not an *allowable expense*, unless one of the *plan*s provides coverage for private hospital room expenses.

- If a person is covered by two or more *plan*s that do not have negotiated fees and compute their benefit payments based on the usual and customary fees, allowed amounts, or relative value schedule reimbursement methodology, or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an *allowable expense*.

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

- If a person is covered by one *plan* that does not have negotiated fees and that calculates its benefits or services based on usual and customary fees, allowed amounts, relative value schedule reimbursement methodology, or other similar reimbursement methodology, and another *plan* that provides its benefits or services based on negotiated fees, the primary *plan*'s payment arrangement must be the *allowable expense* for all *plan*s. However, if the health care provider or physician has contracted with the secondary *plan* to provide the benefit or service for a specific negotiated fee or payment amount that is different than the primary *plan*'s payment arrangement and if the health care provider's or physician's contract permits, the negotiated fee or payment must be the *allowable expense* used by the secondary *plan* to determine its benefits.

- The amount of any benefit reduction by the primary *plan* because a *covered person* has failed to comply with the *plan* provisions is not an *allowable expense*. Examples of these types of *plan* provisions include second surgical opinions, *preauthorization* of admissions, and preferred health care provider and physician arrangements.

Allowed amount is the amount of a billed charge that a carrier determines to be covered for services provided by a non-network health care provider or physician. The allowed amount includes the carrier's payment and any applicable deductible, copayment, or coinsurance amounts for which the insured is responsible.

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

Custodial parent is the parent with the right to designate the primary residence of a child by a court order under the Texas Family Code or other applicable law, or in the absence of a court order, is the parent with whom the child resides more than one-half of the calendar year, excluding any temporary visitation.

Order of benefit determination rules

When a person is covered by two or more *plan*s, the rules for determining the order of benefit payments are as follows:

- The primary *plan* pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other *plan*.

- Except as provided in the bullet below, a *plan* that does not contain a COB provision that is consistent with this policy is always primary unless the provisions of both *plan*s state that the complying *plan* is primary.

- Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage must 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 calculating payment of its benefits only when it is secondary to that other *plan*.

- If the primary *plan* is a closed panel *plan* and the secondary *plan* is not, the secondary *plan* must pay or provide benefits as if it were the primary *plan* when a *covered person* uses a non-network health care provider or physician, except for emergency services or authorized referrals that are paid or provided by the primary *plan*.

- When multiple contracts providing coordinated coverage are treated as a single *plan* under this provision, this section applies only to the *plan* as a whole, and coordination among the component contracts is governed by the terms of the contracts. If more than one carrier pays or provides benefits under the *plan*, the carrier designated as primary within the *plan* must be responsible for the *plan*'s compliance with this provision.

- If a person is covered by more than one secondary *plan*, the order of benefit determination rules of this provision decide the order in which secondary *plan*s' benefits are determined in relation to each other. Each secondary *plan* must take into consideration the benefits of the primary *plan* or *plan*s and the benefits of any other *plan* that, under the rules of this contract, has its benefits determined before those of that secondary *plan*.

COORDINATION OF BENEFITS (continued)

Each *plan* determines its order of benefits using the first of the following rules that apply:

- **Nondependent or *dependent***: The *plan* that covers the person other than as a dependent, for example as an *employee*, member, policyholder, subscriber, or retiree, is the primary *plan*, and the *plan* that covers the person as a dependent is the secondary *plan*. 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, then the order of benefits between the two plans is reversed so that the *plan* covering the person as an *employee*, member, policyholder, subscriber, or retiree is the secondary *plan* and the other *plan* is the primary *plan*. An example includes a retired *employee*.

- ***Dependent* child covered under more than one *plan***: Unless there is a court order stating otherwise, *plan*s covering a dependent child must determine the order of benefits using the following rules that apply:

  - For a dependent child whose parents are married or are living together, whether or not they have ever been married:

    - The *plan* of the parent whose birthday falls earlier in the calendar year is the primary *plan*; or
    - If both parents have the same birthday, the *plan* that has covered the parent the longest is the primary *plan.*

  - For a dependent child whose parents are divorced, separated, or not living together, whether or not they have ever been married:

    - If a court order states that one parent is responsible for the dependent 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 *plan* years commencing after the *plan* is given notice of the court decree.

    - If a court order states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of a dependent child whose parents are married or are living together, whether or not they have ever been married must determine the order of benefits.

    - If a court order states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of a dependent child whose parents are married or are living together, whether or not they have ever been married must determine the order of benefits.

    - If there is no court order allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

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

- For a dependent child covered under more than one *plan* of individuals who are not the parents of the child, the provisions of a dependent child whose parents are married or are living together, whether or not they have ever been married or a dependent child whose parents are divorced, separated, or not living together, whether or not they have ever been married must determine the order of benefits as if those individuals were the parents of the child.

- For a dependent child who has coverage under either or both parents' *plan*s and has his or her own coverage as a dependent under a spouse's *plan*, the *plan* that has covered the person as an *employee*, member, policyholder, subscriber, or retiree longer is the primary *plan*, and the *plan* that has covered the person the shorter period is the secondary *plan* applies.

- In the event the dependent child's coverage under the spouse's *plan* began on the same date as the dependent child's coverage under either or both parents' *plan*s, the order of benefits must be determined by applying the birthday rule for a dependent child whose parents are married or are living together, whether or not they have ever been married to the dependent child's parent(s) and the dependent's spouse.

- **Active, retired, or laid-off *employee***: The *plan* that covers a person as an active *employee* who is neither laid off nor retired, is the primary *plan*. The *plan* that covers that same person as a retired or laid-off *employee* is the secondary *plan*. The same would hold true if a person is a dependent of an active *employee* and that same person is a dependent of a retired or laid-off *employee*. If the *plan* that covers the same person as a retired or laid-off *employee* or as a dependent of a retired or laid-off *employee* does not have this rule, and as a result, the *plan*s do not agree on the order of benefits, this rule does not apply. This rule does not apply if the Nondependent or *dependent* rule can determine the order of benefits.

- **COBRA or state continuation coverage**. If a person whose coverage is provided under COBRA or under a right of continuation provided by state or other federal law is covered under another *plan*, the *plan* covering the person as an *employee*, member, subscriber, or retiree or covering the person as a *dependent* of an *employee*, member, subscriber, or retiree is the primary *plan*, and the COBRA, state, or other federal continuation coverage is the secondary *plan*. If the other *plan* does not have this rule, and as a result, the *plan*s do not agree on the order of benefits, this rule does not apply. This rule does not apply if the Nondependent or *dependent* rule can determine the order of benefits.

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

If the preceding rules do not determine the order of benefits, the *allowable expenses* must be shared equally between the *plan*s meeting the definition of *plan*. In addition, *this plan* will not pay more than it would have paid had it been the primary *plan*.

COORDINATION OF BENEFITS (continued)

Effect on the benefits of this plan

When *this plan* is secondary, it may reduce its benefits so that the total benefits paid or provided by all *plan*s are not more than the total *allowable expenses*. In determining the amount to be paid for any claim, the secondary *plan* will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any *allowable expense* under its *plan* that is unpaid by the primary *plan*. The secondary *plan* may then reduce its payment by the amount so that, when combined with the amount paid by the primary *plan*, the total benefits paid or provided by all *plan*s for the claim equal 100% of the total *allowable expense* for that claim. In addition, the secondary *plan* must credit to its *plan* deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

If a *covered person* is enrolled in two or more closed panel *plan*s 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 must not apply between that *plan* and other closed panel *plan*s.

Compliance with Federal and State laws concerning confidential 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 *plan*s. *We* will comply with federal and state law concerning confidential information for the purpose of applying these rules and determining benefits payable under *this plan* and other *plan*s covering the person claiming benefits. Each person claiming benefits under *this plan* must give *us* any facts it needs to apply those rules and determine benefits.

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 that 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 the reasonable cash value of the benefits provided in the form of services.

Right of recovery

If the amount of the payments made by *us* is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has 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.

COORDINATION OF BENEFITS FOR MEDICARE ELIGIBLES

General coordination of benefits with Medicare

If *you* are covered under both *Medicare* and this *evidence of coverage*, federal law mandates that *Medicare* is the secondary plan in most situations. 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 *evidence of coverage* will be coordinated to the extent benefits are payable under *Medicare*, as allowed by federal statutes and regulations.

You are considered to be eligible for *Medicare* on the earliest date coverage under *Medicare* could have become effective for *you*.

Coordination of benefits with Medicare Part B

If *you* are eligible for *Medicare Part B*, the *Medicare* program that provides medical insurance benefits, but are not enrolled, *your* benefits under the *master group contract* may be coordinated as if *you* were enrolled in *Medicare Part B*. *We* may not pay benefits to the extent that benefits would have been payable under *Medicare Part B*, if *you* had enrolled. Therefore, it is important that *you* enroll in *Medicare Part B* if *you* are eligible to do so.

CLAIMS

Notice of claim

Network providers will submit claims to *us* on *your* behalf. If *you* utilize a *non-network provider* for *covered health services, 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.

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

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

If *you* receive services outside the United States or from a foreign provider, *you* must also submit the following information along with *your* complete claim:

- *Your* proof of payment to the provider for the services received outside the United States or from a foreign provider;
- Complete medical information and medical records;
- *Your* proof of travel outside of the United States, such as airline tickets or passport stamps, if *you* traveled to receive the services; and
- The foreign provider's fee schedule if the provider uses a billing agency.

The forms necessary for filing proof of loss are available at www.humana.com. 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.

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.

Within 15 business days of receiving proof of loss which is satisfactory to *us*, *we* will:

- Provide the *covered person* written notice of *our* decision to accept or reject a claim. Notices of rejection of a claim will contain reason(s) for denial; or
- Advise the *covered person* of the reasons why additional time will be needed to make a decision.

A decision to accept or reject a *covered person's* claim will be made no later than the 45th day following the date notice was sent that additional time was needed.

If a *covered person* receives written notice that a claim will be paid in whole or in part, payment will be made not later than the 5th business day after the date of such written notice.

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.

To whom benefits are payable

If *you* receive services from a *network provider*, *we* will pay the provider directly for all *covered health services*. *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.

Time of payment of claims

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

Right to request overpayments

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

- Made in error;
- Made to *you* or any party on *your* behalf, where *we* determine such payment made is greater than the amount payable under the *master group contract*;
- 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*, if any.

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 or records from any provider as requested by *us*;
- Providing information regarding the circumstances of *your illness*, *bodily injury* or *accident*;
- Providing information about other insurance coverage and benefits, including information related to any *bodily injury* or *illness* for which another party may be liable to pay compensation or benefits;
- Providing copies of claims and settlement demands submitted to third parties in relation to a *bodily injury* or *illness*;
- Disclosing details of liability settlement agreements reached with third parties in relation to a *bodily injury* or *illness*; and
- Providing information *we* request to administer the *master group contract*.

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.

Recovery rights

You as well as *your dependents* agree to the following, as a condition of receiving benefits under the *master group contract*.

Duty to cooperate in good faith

The *covered person* is obligated to assist *us* and *our* agents in order to protect *our* recovery rights by:

- Promptly notifying *us* that *you* have asked anyone other than *us* to make payment for *your* injuries;
- Obtaining *our* consent before releasing any party from liability for payment of medical expenses;
- Providing *us* with a copy of any relevant information, including legal notices, arising from the *covered person's* injury and its treatment and delivering such documents as *we* or *our* agents reasonably require to secure *our* recovery rights;
- Taking all action to assist *our* enforcement of recovery rights and doing nothing after loss to prejudice *our* recovery rights; and
- Agreeing to not attempt to avoid *our* recovery rights by designating all (or any disproportionate part) of any recovery as exclusively for "pain and suffering".

If the *covered person* fails to cooperate with *us*, *we* shall be entitled to recover from *you* any payments made by *us* from *you*.

Duplication of benefits/other insurance

We will not provide duplicate coverage for benefits under this *master group contract* when a *covered person* has or is entitled to:

- Receive benefits;
- Recovery for damages; or
- Settlement proceeds, as a result of their *bodily injuries* from any other coverage including, but not limited to:

    - The medical benefits coverage in automobile insurance contracts;
    - Other group coverage (including student plans);or
    - Direct recoveries from liable parties, premises medical pay or any other insurer providing coverage that would apply to pay your medical expenses.

Benefits will be determined as described in the "Coordination of Benefits" section.

Where there is such coverage or other recovery sources, *we* will not duplicate other sources of recovery available to *you* or the *covered person*, and shall be considered secondary, except where specifically prohibited. Where duplicate sources of recovery exist, *we* shall have the right to be repaid from whoever has received the overpayment from *us* to the extent of the duplication with other sources of recovery.

We will not duplicate coverage under this *contract* whether or not *you* or the *covered person* has made a claim under the other applicable coverage or recovery sources.

When applicable, *you* and/or the *covered person* are required to provide *us* with authorization to obtain information about the other coverage or recovery sources 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.

Workers' compensation

This *master group contract* excludes coverage for *illness* or *bodily injury* for which Workers' Compensation or similar coverage is available.

If benefits are paid by *us*, and *we* determine that the benefits were for treatment of *bodily injury* or *illness* 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 shall have first priority to recover amounts *we* have paid and the reasonable value of services and benefits provided under a managed care agreement from any funds that are paid or payable by Workers' Compensation or similar coverage as a result of any *illness* or *bodily injury*, and *we* shall not be required to contribute to attorney fees or recovery expenses under a Common Fund or similar doctrine.

Our right to recover from funds that are paid or payable by Workers' Compensation or similar coverage will apply even though:

- The Workers' Compensation carrier does not accept responsibility to provide benefits;
- There is no final determination that *bodily injury* or *illness* 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.

As a condition to receiving benefits from *us*, *you* hereby agree, in consideration for the coverage provided by the *master group contract*, *you* will notify *us* of any Workers' Compensation claim *you* make, and *you* agree to reimburse *us* as described above. If *we* are precluded from exercising *our* recovery rights to recover from funds that are paid by Workers' Compensation or similar coverage *we* will exercise *our* right to recover against *you*.

Right of subrogation

If *we* provide benefits for a loss incurred by a *covered person* due to an accident or injury *we* have the right to recover those benefits from any party that is responsible for the medical expenses or benefits related to that accident or injury.

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 *master group contract*. *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 including self-insured entities;
- Medical payments/expense coverage under any automobile, homeowners, premises or similar coverages if premiums for that coverage were not paid by a *covered person* or an immediate *family member* of a *covered person*;
- Uninsured or underinsured motorist coverage if premiums for that coverage were not paid by a *covered person* or an immediate *family member* of a *covered person*; or
- Workers' Compensation or other similar coverage;

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

If *you* do not pursue recovery against another party or their insurance carrier, *we* shall have first priority to recover amounts *we* have paid and the reasonable value of *covered health services* and benefits provided under a managed care agreement from any funds that are paid or payable as a result of any *illness* or *bodily injury*.

If *you* pursue recovery against another party their insurance carrier without representation by an attorney, *we* shall be entitled to recover the lesser of:

- One-half of total amount recoverable by *you*; or
- The total cost of benefits provided by *us* as a result of *your* injury.

If *you* retain an attorney to pursue recovery against another party, *we* shall be entitled to recover the lesser of:

- One-half of total amount recoverable by *you*, after a reduction for the amount of fees costs owed by *you* to the attorney; or
- The total cost of benefits provided by *us* as a result of *your* injury; minus a reduction for a proportionate share of attorney fees and procurement costs.

Our right of recovery exists regardless of whether available funds are sufficient to fully compensate the *covered person* for their *illness* or *bodily injury*. If *we* are precluded from exercising *our* right of subrogation, *we* may exercise *our* right of reimbursement.

Right of reimbursement

If benefits are paid under the *master group contract* and *you* recover from any legally responsible person, or insurance carrier described above under "Our Right of Subrogation", *we* have the right to recover from *you*.

The *covered person* 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 *effective date* of this *master group contract*, any *covered person* recovers payment from and releases any legally responsible person or insurance carrier described under “Our Right of Subrogation” from liability for future medical expenses relating to an *illness* or *bodily injury*, *we* shall have a continuing right to reimbursement from *you* or that *covered person* to the extent of the benefits *we* provided with respect to that *illness* or *bodily injury*. This right, however, shall apply only to the extent of such payment and to the reasonable value of *covered health services* and benefits provided under a managed care agreement and only to the extent not limited or precluded by law in the state whose laws govern this *master group contract*, including any whole or similar rule.

The obligation to reimburse *us* for the amounts *we* are entitled to recover under “Our Right of Subrogation” exists, regardless of whether the settlement, compromise or judgment designates the recovery as including or excluding medical expenses. The obligation to reimburse *us* exists regardless of whether the amounts received or payable to *you* or the *covered person* are sufficient to fully compensate *you* or the *covered person* for the *illness* or *bodily injury*.

COMPLAINT AND APPEAL PROCEDURES

Appeal and external review rights

If a *covered person* is dissatisfied with a determination of a claim, he or she may appeal the decision. The *covered person* should appeal to *us* in writing to the address given on the denial letter received or to *us* at the following address:

Grievance and Appeal Department
P.O. Box 14546
Lexington, KY 40512-4546

Such appeals will be handled on a timely basis and appropriate records will be kept on all appeals.

Once *we* receive the request, *we* will make a review of the claim, and provide notice of *our* decision following any processes or timeframes required by state law.

A covered person also has the right to request an external review of an adverse claim determination. For questions on appeal and external review rights, a *covered person* can call the telephone number on the back of their ID card.

If you need help with appeals, complaints or the external review process, contact the Texas Department of Insurance (TDI) Consumer Protection. Call TDI 1-800-252-3439. You can also send an email to ConsumerProtection@tdi.texas.gov or a written request to:

Texas Department of Insurance
Consumer Protection Section
Mail Code 111-1A
P.O. Box 149091
Austin, TX 78714-9091

Definitions

Adverse determination means a denial, reduction, or termination of, or a failure to provide or make a payment on behalf of any payor (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 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.

The term does not include a denial of health care services due to the failure to request prospective or concurrent utilization review.

For *prescription drug* coverage, an *adverse determination* includes a denial to provide benefits for a *prescription drug* if:

- The *prescription drug* is not included on *our drug list*; and
- *Your health care practitioner* has determined *the prescription drug* is *medically necessary*.

Complaint means any dissatisfaction expressed by a *covered person* orally or in writing to *us* with any aspect of *our* operation, including but not limited to, dissatisfaction with plan administration, procedures related to the review or appeal of an *adverse determination*, the denial, reduction, or termination of a service for reasons not related to medical necessity, the way a service is provided; or disenrollment decisions. A *complaint* is not a misunderstanding or a problem of misinformation that is resolved promptly by supplying the appropriate information to the satisfaction of the *covered person* and does not include *adverse determinations*.

Complaint process

If a *covered person* notifies *us* orally or in writing of a *complaint*, *we* will, not later than the fifth business day after the date of the receipt of the *complaint*, send to the *covered person* a letter acknowledging the date *we* received the *complaint*. This letter will also include Humana's *complaint* procedures and time frames for resolution. If the *complaint* was received orally, *we* will enclose a one-page *complaint* form.

We will investigate and send a letter with *our* resolution to the *covered person*. The total time for acknowledging, investigating and resolving the *covered person's complaint* will not exceed 30 calendar days after the date *we* receive the *complaint*.

Appeals to the plan

If the *complaint* is not resolved to the *covered person's* satisfaction, the *covered person* has the right either to appear in person before a complaint appeal panel where the *covered person* normally receives health care services, unless another site is agreed to by the *covered person*, or to address a written appeal to the complaint appeal panel. *We* shall complete the appeals process not later than the 30th calendar day after the date of the receipt of the request for appeal.

- *We* shall send an acknowledgment letter to the *covered person* not later than the fifth business day after the date of receipt of the request for appeal.

- *We* shall appoint members to the complaint appeal panel, which shall advise *us* on the resolution of the dispute. The complaint appeal panel shall be composed of an equal number of *our* staff, health care practitioners, and other persons covered under a health plan provided by *us*. A member of the complaint appeal panel may not have been previously involved in the disputed decision.

- Not later than the fifth business day before the scheduled meeting of the panel, unless the *covered person* agrees otherwise, *we* shall provide to the *covered person* or *covered person's* designated representative:

  - Any documentation to be presented to the panel by *our* staff;
  - The specialization of any *health care practitioner* consulted during the investigation; and
  - The name and affiliation of each of *our* representatives on the panel.

- The *covered person* or the *covered person's* designated representative if the *covered person* is a minor or disabled, are entitled to:

  - Appear in person before the complaint appeal panel;
  - Present alternative expert testimony; and
  - Request the presence of and question any person responsible for making the prior determination that resulted in the appeal.

Investigation and resolution of appeals relating to ongoing emergencies or denials of continued stays for hospitalization shall be concluded in accordance with the medical or dental immediacy of the condition but in no event to exceed one working day after the *covered person's* request for appeal. Due to the ongoing emergency or continued hospital stay, and at the *covered person's* request, *we* shall provide, a review by a *health care practitioner* who has not previously reviewed the case and is of the same or similar specialty as typically manages the medical condition, procedure, or treatment under discussion for review of the appeal.

The *health care practitioner* reviewing the appeal may interview the *covered person* or the *covered person's* designated representative and shall render a decision on the appeal. Initial notice of the decision may be delivered orally if followed by written notice of the determination within three calendar days.

Notice of *our* final decision on the appeal must include a statement of the specific medical determination, clinical basis, and contractual criteria used to reach the final decision.

Notification of adverse determinations

The *adverse determination* notification must be provided to the *covered person's* provider including the health care provider who rendered the service, the *covered person*, or the person acting on behalf of the *covered person* who is hospitalized at the time of the *adverse determination*, within one working day by telephone or electronic transmission; within the time appropriate to the circumstances relating to the delivery of the services and the condition of the *covered person*, but in no case to exceed one hour from notification when denying post-stabilization care subsequent to emergency treatment as requested by a treating *health care practitioner*.

Appeals of adverse determinations

A *covered person*, a person acting on behalf of the *covered person*, or the *covered person's health care practitioner* has the right to appeal an *adverse determination* relating to medical necessity for denial of a service orally or in writing.

When *we* receive an appeal, *we* will, within five working days from the receipt of the appeal, send to the appealing party a letter acknowledging the date of *our* receipt of the appeal. This letter will include the appeal procedures and the timeframes required for resolution. If an appeal of an *adverse determination* is received orally, included in the acknowledgement letter will be a one-page appeal form to the appealing party.

After review of the appeal of an *adverse determination*, *we* will issue a response letter to the *covered person*, or a person acting on behalf of the *covered person* and the *covered person's health care practitioner* explaining the resolution of the appeal as soon as practical, but in no case later than the 30th calendar day after the date *we* receive the appeal. If the appeal is for:

- *Emergency care*;
- Denial of a continued stay for hospitalized patients; or
- Denial of *prescription* drugs or intravenous infusions for which the patient is receiving benefits under the *master group contract*,

the time frame for resolution will be based on the medical or dental immediacy of the condition, procedure or treatment, but may not exceed one working day from the date the request is received. The resolution letter will contain the clinical basis for the appeal's denial, the specialty of the *health care practitioner* making the denial, and notice of the appealing party's right to seek review of the denial by an independent review organization (IRO).

If the appeal of an *adverse determination* is denied, a provider can within 10 working days request in writing good cause for having a particular type of specialty provider review the case, the appeal denial shall be reviewed by a *network provider* in the same or similar specialty who typically treats the medical condition, performs the procedure, or provides the treatment under discussion for review in the *adverse determination*, and such specialty review will be completed within 15 business days of receipt of the request from the provider.

Filing complaints with the Texas Department of Insurance

Any person, including persons who have attempted to resolve *complaints* through *our complaint* and appeal process and who are dissatisfied with the resolution, may report an alleged violation to the Texas Department of Insurance, P. O. Box 149091, Austin, Texas 78714-9091.

The commissioner shall investigate a *complaint* against *us* to determine compliance within 60 days after the Texas Department of Insurance's receipt of the *complaint* and all information necessary for the department to determine compliance. The commissioner may extend the time necessary to complete an investigation in the event any of the following circumstances occur:

- Additional information is needed;
- An on-site review is necessary;
- *We*, the *health care practitioner*, or the *covered person* does not provide all documentation necessary to complete the investigation; or
- Other circumstances beyond the control of the department occur.

Appeals process to internal review organization (IRO)

In a circumstance involving a *life threatening* condition or denial of *prescription* drugs or intravenous infusions for which the *covered person* is receiving benefits under the *master group contract*, the *covered person* is entitled to an immediate appeal to an independent review organization (IRO) and is not required to comply with procedures for an internal review of *our adverse determination*. The procedure for filing an immediate appeal to an IRO is included in *our* initial denial notice.

We shall permit any party whose appeal of an *adverse determination* is denied by *us* to seek review of that determination by an independent review organization assigned to the appeal. The procedure for requesting an IRO review is included in *our* appeal resolution letter.

The appeal process does not prohibit the *covered person* from pursuing other appropriate remedies, including injunctive relief, a declaratory judgment, or relief available under law, if the requirement of exhausting the process for appeal and review places the *covered person's* health in serious jeopardy.

Exhaustion of remedies

All levels of the appeal process applicable to *you* and any regulatory/statutory review process available to *you* under state or federal law are suggested to be completed before *you* file a legal action. Completion of these administrative and/or regulatory processes assures that both *you* and *we* have a full and fair opportunity to resolve any disputes regarding the terms and conditions contained in the *master group contract*.

Legal actions and limitations

No lawsuit with respect to plan benefits may 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.

DISCLOSURE PROVISIONS

Employee assistance program

We may provide *you* access to an employee assistance program (EAP). The EAP may include confidential, telephonic consultations and work-life services. The EAP provides *you* with short-term, problem solving services for issues that may otherwise affect *your* work, personal life or health. The EAP is designed to provide *you* with information and assistance regarding *your* issue and may also assist *you* with finding a medical provider or local community resource.

The services provided by the EAP are not *covered health services* under the *master group contract*, therefore the *copayments*, *deductible* or *coinsurance* do not apply. However, there may be additional costs to *you*, if *you* obtain services from a professional or organization the EAP has recommended or has referred *you* to. The EAP does not provide medical care. *You* are not required to participate in the EAP before using *your* benefits under the *master group contract*, and the EAP services are not coordinated with *covered health* under the *master group contract*. The decision to participate in the EAP is voluntary, and *you* may participate at any time during the *year*. Refer to the marketing literature for additional information.

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:

- "Participatory" wellness programs do not require *you* to meet a standard related to a health factor. Examples of participatory wellness programs may include, but are not limited to, membership in a fitness center, certain preventive testing, or attending a no-cost health education seminar.

- "Health-contingent" wellness programs require *you* to attain certain wellness goals that are related to a health factor. Examples of health contingent wellness programs may include, but are not limited to, completing a 5k event, lowering blood pressure or ceasing the use of tobacco.

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 participatory or health contingent wellness programs. These rewards may include, but are not limited to, payment for all or a portion of a participatory wellness program, items such as merchandise, gift cards, travel and merchandise discounts. The rewards may also include, but are not limited to, discounts or credits toward premium or a reduction in *copayments*, *deductibles* or *coinsurance*, as permitted under applicable state and federal laws. Such insurance premium or benefit rewards may be made available at the individual or *group* health plan level. 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.

DISCLOSURE PROVISIONS (continued)

We are committed to helping *you* achieve *your* best health. Some wellness programs may be offered only to *covered persons* with particular health factors. If *you* think *you* might be unable to meet a standard for a reward under a health contingent wellness program, *you* might qualify for an opportunity to earn the same reward by different means. Please call the telephone number listed on *your* ID card or in the marketing literature issued 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 will work with *you* (and, if *you* wish, with *your health care practitioner*) to find a wellness program with the same reward that is right for *you* in light of *your* health status.

We may require proof in writing from *your* health care practitioner that *your* medical condition prevents *you* from taking part in the available activities.

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 evidence of coverage*.

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. If eligible, *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 evidence of coverage*.

MISCELLANEOUS PROVISIONS

Entire contract

The entire contract is made up of the *master group contract,* the Employer Group Application of the *group plan sponsor*, incorporated by reference herein, and the applications or enrollment forms, if any, of the *covered persons*.

Additional group plan sponsor responsibilities

In addition to responsibilities outlined in the *master group contract*, the *group plan sponsor* is responsible for:

- Collection of premium; and
- Providing access to:

    - Benefit plan documents;
    - Renewal notices and *master group contract* modification information; and
    - Information regarding continuation rights.

No *group plan sponsor* has the power to change or waive any provision of the *master group contract.*

Evidence of Coverage

An *evidence of coverage* setting forth a statement of benefits to which the *employee* and the *employee's* covered *dependents* are entitled will be available at www.humana.com or in writing when requested. The *employer* is responsible for providing *employees* access to the *evidence of coverage*.

This *evidence of coverage* is part of the *master group contract* that controls *our* obligations regarding coverage. No document that is viewed as being not consistent with the *master group contract* shall take precedence over it. This is true, also, when this *evidence of coverage* is incorporated by reference into a summary description of plan benefits prepared and distributed by the administrator of a group plan subject to ERISA. This *evidence of coverage* 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 *evidence of coverage* respecting coverage, the terms of this *evidence of coverage* will control.

Incontestability

All statements made by the *group plan sponsor* or by an *employee* are considered to be representations, not warranties. This means that the statements are considered to be truthful and are made to the best of the *group plan sponsor* or *employee's* knowledge and belief. No statement will be used to void, cancel or non-renew the *master group contract,* or reduce the benefits it provides unless it is contained in a written application and a copy is furnished to the person making such statement or his or her representative.

After two years from the effective date of the *master group contract*, no misstatement made by the *group plan sponsor*, except a fraudulent misstatement made in the group application may be used to void the *master group contract.*

After *you* are covered without interruption for two years, *we* cannot contest the validity of *your* coverage except for fraud or an intentional misrepresentation of material fact on the enrollment application.

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

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

We reserve the right to increase the premium in accordance with applicable law upon a 60 day written notice to the *group plan sponsor.*

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, we* reserve the right to *rescind your* coverage after *we* provide *you* a 30 calendar day advance written notice that coverage will be *rescinded*. *You* have the right to appeal the *rescission*.

Clerical error or misstatement

If it is determined that information about a *covered person* was omitted or misstated in error, an adjustment may be made in premiums and/or coverage in effect. This provision applies to *you* and to *us*.

Modification of master group contract

The *policy* may be modified by *us*, upon renewal of the *policy*, as permitted by state and federal law. The *policyholder* will be notified in writing or *electronically* at least 60 days prior to the effective date of the change.

The *master group contract* may be modified by agreement between *us* and the *group plan sponsor* 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 *master group contract*. No agent has authority to modify the *master group contract*, or waive any of the *master group contract* provisions, to extend the time of premium payment, or bind *us* by making any promise or representation.

MISCELLANEOUS PROVISIONS (continued)

Discontinuation of coverage

If *we* decide to discontinue offering a particular group health plan:

- The *group plan sponsor*, *employees* and *covered persons* will be notified of such discontinuation at least 90 days prior to the date of discontinuation of such coverage; and
- The *group plan sponsor* will be given the option to purchase all other group plans providing medical benefits that are being offered by *us* at such time.

Premium contributions

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

Your employer is liable for premiums from the time *you* are no longer eligible for coverage under this *master group contract* until the end of the month in which *we* are notified by the *group plan sponsor* that *you* are no longer eligible for coverage under this *master group contract*. *You* will remain a *covered person* under this *master group contract* until the end of that period.

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*.

Assignment

The *master group contract* and its benefits may not be assigned by the *group plan sponsor*.

Conformity with statutes

Any provision of the *master group contract* 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).

GLOSSARY

Terms printed in italic type in this *evidence of coverage* have the meaning indicated below. Defined terms are printed in italic type wherever found in this *evidence of coverage*.

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.

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.

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 or for the number of hours per week determined by the *group plan sponsor* or as specified in the *participation criteria* established by a *large employer*;
- For 48 weeks a year; and
- Is maintaining a bona fide *employer-employee* relationship with the *group plan sponsor* of the *master group contract* on a regular basis.

Each day of a regular vacation and any regular non-working holiday are 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 an *illness* 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 supplements and medicine, holistic medicine, homeopathy, hypnosis, macrobiotics, massage therapy, naturopathy, ozone therapy, reflexotherapy, relaxation response, rolfing, shiatsue, yoga and chelation therapy.

Ambulance means a professionally operated ground or air 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 *illness* 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.

Assisted living facility means an establishment that furnishes, in one or more facilities, food and shelter to four or more persons who are unrelated to the proprietor of the establishment and provides personal care services.

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

B

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

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

Bone marrow means the transplant of human blood precursor cells. 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, from a matched related or unrelated donor or cord blood. The term *bone marrow* includes the harvesting, the transplantation and the integral chemotherapy components.

C

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.

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.

Coinsurance means the amount expressed as a percentage of the *covered health service* that *you* must pay.

Community reintegration services means services that facilitate the continuum of care as an affected individual transitions into the community.

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 *you* are in *observation status*.

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

Congenital anomaly means an abnormality of the body that is present from the time of birth.

Copayment means the specified dollar amount *you* must pay to a provider for *covered health services* regardless of any amounts that may be paid by *us*.

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 health services means *medically necessary* health care services or routine *preventive services* which are:

- *Medically necessary* services to treat an *illness* or *bodily injury* such as:
  - Procedures;
  - *Surgeries*;
  - Consultations;
  - Advice;
  - Diagnosis;
  - Referrals;
  - Treatment;
  - Supplies;
  - Drugs;
  - Devices; or
  - Technologies;
- *Preventive services*;
- *Pediatric dental services*;
- *Pediatric vision care*;
- *Prescription* drugs, including *specialty drugs*, dispensed by a *pharmacy*.

To be considered a *covered health service*, services must be:

- Ordered by a *health care practitioner*;
- Authorized, furnished or prescribed by a *qualified provider*;
- For the benefits described herein, subject to any maximum benefit and all other terms, provisions, limitations and exclusions of the *master group contract*; and
- Obtained when *you* are covered for that benefit under the *master group contract* on the date that the service is rendered.

Covered person means the *employee* or the *employee's dependents* who are enrolled for benefits provided under the *master group contract.*

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

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;

- 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*.

D

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

Covered health services applied to the *deductible* listed in this *evidence of coverage* will be applied to the *deductible* listed in the "Certificate of Insurance".

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, unless the biting or chewing injury is a result of an act of domestic violence or a medical condition (including both physical and mental health conditions).

Dependent means a covered *employee's*:

- Legally recognized spouse or *domestic partner*;

- Natural born child, step-child, legally adopted child, or child placed for adoption, 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 court order, an administrative order, or a medical support order including 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 court order, an administrative order, or a medical support order including a 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 *master group contract.*

- *Domestic partner's* natural born child, step-child, legally adopted child, or child placed for adoption whose age is less than the limiting age;

  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 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 receiving financial support from *you*; or
- Eligible for other coverage through employment.

A covered *dependent* child who attains the limiting age while covered under the *master group contract* remains eligible if the covered *dependent* child is:

- Permanently mentally or physically handicapped;
- 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 prior to the covered *dependent* child attaining the limiting age.

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, external and implantable, 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 corresponding 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 agents for controlling blood sugar levels; prescriptive non-insulin injectable 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.

Distant site means the location of a *health care practitioner* at the time a *telehealth* or *telemedicine* service is provided.

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 not 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 6 months and, periodically thereafter, to require proof that the *domestic partner* relationship continues to exist.

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 *illness* 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*; and
- It is provided in the most cost effective manner required by *your* condition, including, at *our* discretion, rental or purchase.

GLOSSARY (continued)

E

Effective date means the date *your* coverage begins under the *master group contract*.

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* plan of the *group plan sponsor* 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 *illness* 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 failure to get immediate medical care for the *bodily injury* or *illness* to result in:

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

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

Endodontic services mean the following dental procedures, related tests or treatment and follow-up care:

- Root canal therapy and root canal fillings;
- Periadacular *surgery*;
- Apicoectomy;
- Partial pulpotomy; or
- Vital pulpotomy.

Evidence of Coverage means this benefit plan document that outlines the benefits, provisions and limitations of the *master group contract*.

Experimental, ***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 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, (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.

F

Family member means *you* or *your* spouse or *domestic partner*. It also means *your* or *your* spouse's or *domestic partner'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 determined by the *group plan sponsor*.

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

G

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

Group plan sponsor means the legal entity identified as the *group plan sponsor* on the face page of the *master group contract* or "Evidence of Coverage" who establishes, sponsors and endorses an employee benefit plan for health care coverage.

H

Habilitative services means health care services and devices that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Health care practitioner means a practitioner professionally licensed by the appropriate state agency to provide *preventive services* or diagnose or treat an *illness* 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 coverage means medical coverage under any hospital or medical service policy or *evidence of coverage*, 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 and meets the following requirements:

- It must primarily provide skilled nursing services and other therapeutic services under the supervision of physicians or registered nurses;
- It must be operated according to established processes and procedures by a group of professional medical people, including physicians and *nurses*;
- It must maintain clinical records on all patients; and
- It must be licensed by the jurisdiction where it is located, if licensure is required. It must be operated according to the laws of that jurisdiction which pertains to agencies providing home health care.

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 that is 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 operated 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 *illness* and, as estimated by their physicians, are expected to live 18 months as a result of that *illness*.

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; and
- 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*.

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.

I

Illness 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*.

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;
- In vitro fertilization;
- 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.

J

K

L

Large employer means an *employer* who employed an average of at least 51 *employees* on business days during the preceding calendar year and who employs at least one *employee* 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 *master group contract* more than 31 days after his or 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.

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.

Master group contract means the document describing the benefits *we* provide as agreed to by *us* and the *group plan sponsor*.

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 an *illness* 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 *illness* 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 *illness* 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.

Morbid 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.

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.

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.

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

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.

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.).

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 *employees* have an opportunity to enroll themselves and their eligible *dependents* for coverage under the *master group contract.*

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 surgical procedures, including gingivectomies.

Originating site means the location of a *covered person* at the time the *telehealth* or *telemedicine* service is being furnished.

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

Covered expenses paid by *you* and applied to the *out-of-pocket limit* in this *evidence of coverage* will be applied to the *out-of-pocket limit* listed in the "Certificate of Insurance".

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*.

P

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

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:

- *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. *Periodontics* includes the following dental procedures, related tests or treatment and follow-up care:

- Periodontal maintenance;
- Scaling and root planing;
- Gingivectomy;
- Gingivoplasty; or
- Osseous surgical procedures.

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

Post-acute transition services means *services* that facilitate the continuum of care beyond the initial neurological insult through rehabilitation and community reintegration.

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 *illness* 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, except *primary care physician* services, gynecological and obstetrical services and *emergency care* 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 health service* according to the terms and provisions of the *master group contract.*

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 or as otherwise required by state law.

- 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 www.healthcare.gov website or call the customer service telephone number on *your* identification card.

Primary care physician means a *network health care practitioner* with a specialty of internal medicine, pediatrics or family medicine/general practice who provides initial and primary care services to *covered persons*, maintains the continuity of *covered persons* medical care and helps direct *covered persons* to *specialty care physicians* and other providers.

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.

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.

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.

Qualified provider means a person, facility or any other health care provider:

- That is licensed by the appropriate state agency to:
  - Diagnose or treat an *illness* or *bodily injury*;
  - Provide *preventive services*;
  - Provide *pediatric dental services*; or
  - Provide *pediatric vision care*;
- That provides services within the scope of their license; and
- Whose primary purpose is to provide health care services.

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.

Remediation means the process or processes of restoring or improving a specific function.

Rescission, ***rescind*** or ***rescinded*** means a cancellation or discontinuance of coverage that has a retroactive effect.

Residential treatment center for children and adolescents means a child-care institution that:

- Provides residential care and treatment for emotionally disturbed children and adolescents; 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.

Residential treatment facility means an institution that:

- Is licensed as a 24-hour residential facility for *behavioral health* treatment, although <u>not</u> licensed as a *hospital*;
- Provides a multidisciplinary treatment plan in a controlled environment, under the supervision of a physician who is able to provide treatment on a daily basis;
- Provides supervision and treatment by a Ph.D. psychologist, licensed therapist, psychiatric nursing staff or registered nurse;

- Provides programs such as social, psychological, family counseling and rehabilitative training, age appropriate for the special needs of the age group of patients, with focus on reintegration back into the community; and

- Provides structured activities throughout the day and evening, for a minimum of 6 hours a day.

Residential treatment is utilized to provide structure, support and reinforcement of the treatment required to reverse the course of behavioral deterioration.

Retail clinic means a *health care treatment facility*, located in a retail store, that is often staffed by nurse practitioners and physician assistants who provide minor medical services on a "walk-in" basis (no appointment required).

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*, *illness*, birth abnormality, congenital defect following birth and care resulting from prematurity is not considered *routine nursery care*.

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*.

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.

Service area means the geographic area designated by *us*, or as otherwise agreed upon between the *group plan sponsor* and *us* and approved by the Department of Insurance of the state in which the *master group contract* is issued, if such approval is required. The *service area* is the geographic area where the *network provider* services are available to *you*. A description of the *service area* is provided in the provider directories.

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 one but not more than 50 *employees* on business days during the preceding calendar year and who employs at least one *employee* on the first day of the *year*. All subsidiaries or affiliates of the *group plan sponsor* are considered one *employer* when the conditions specified in the "Subsidiaries or Affiliates" section of the *master group contract* are met.

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 *evidence of coverage*.

Specialty care physician means a *health care practitioner* who has received training in a specific medical field other than the specialties listed as primary care.

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.

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 *illness*, 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.

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.

Usual and customary fee for a *covered health service*, other than *emergency care* services provided by *non-network providers* or *non-network provider* services preauthorized by *us* when *we* determine a *network provider* is not reasonably available, 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 standard fee based upon rates negotiated 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 based upon the provider's cost 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.

Usual and customary fee for a *covered health service* for:

- *Emergency care* services provided by *non-network providers*; and
- *Non-network provider* services *preauthorized* by *us* when *we* determine a *network provider i*s not reasonably available,

is an amount equal to the greatest of:

- The fee negotiated with *network providers*;
- The fee calculated using the same method to determine payments for *non-network provider* services; or
- The fee paid by *Medicare* for the same services.

V

W

Waiting period means the period of time, elected by the *group plan sponsor*, that must pass before an *employee* is eligible for coverage under the *master group contract*. The *waiting period* for a *small employer* may not exceed 90 days from the first day of employment.

We, us or ***our*** means the offering company as shown on the cover page of this *master group contract* and *evidence of coverage*.

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 *master group contract*, the first *year* begins for *you* on the *effective date* of *your* coverage and ends on the following December 31st.

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

Z

GLOSSARY – PHARMACY SERVICES

All terms used in the "Schedule of Benefits – Pharmacy Services," "Covered Health Services – Pharmacy Services" and "Limitations and Exclusions – Pharmacy Services" sections have the same meaning given to them in the "Glossary" section of this *evidence of coverage*, unless otherwise specifically defined below:

A

B

Brand-name drug 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*.

C

Copayment means the specified dollar amount to be paid by *you* toward the cost of each separate *prescription* fill or refill dispensed by a *pharmacy*.

Cost share means any *deductible* and *coinsurance* that *you* must pay per *prescription* fill or refill.

D

Default rate means the fee based on rates negotiated by *us* or other payers with one or more *network providers* in a geographic area determined by *us* for the same or similar prescription fill or refill.

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

Drug list means a list of covered *prescription* drugs, medicines or medications and supplies specified by *us*. The *drug list* identifies categories of drugs, medicines or medications and supplies by applicable levels, if any, and indicates applicable *dispensing limits, specialty drug* designation 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* ID card to obtain the *drug list*.

E

F

G

Generic drug 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*.

H

I

J

K

L

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".

GLOSSARY – PHARMACY SERVICES (continued)

M

Mail order pharmacy means a *pharmacy* that provides covered *mail order pharmacy* services, as defined by *us*, and delivers covered *prescription* drug, medicine or medication fills or refills through the mail to *covered persons*.

N

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

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

as defined by *us*, to *covered persons*, including covered *prescription* fills or refills delivered to *your* home or health care provider.

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

as defined by *us*, to *covered persons*, including covered *prescription* fills or refills delivered to *your* home or health care provider.

O

P

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* drugs, medicines or 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* and provided to a *pharmacist* for *your* benefit and used for the treatment of a *sickness* or *bodily injury*, which is covered under this plan, or for drugs, medicines or medications on the Preventive Medication Coverage *drug list*. The drug, medicine or medication must be obtainable only by *prescription* or must be obtained by *prescription* for drugs, medicines or medications on the Preventive Medication Coverage *drug list*. The *prescription* may be given to the *pharmacist* verbally, *electronically* or in writing by the *health care practitioner*. The *prescription* must include at least:

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

Prior authorization means the required prior approval from *us* for the coverage of certain *prescription* drugs, medicines or medications, including *specialty drugs*. The required prior approval from *us* for coverage includes the dosage, quantity and duration, as appropriate for *your* diagnosis, age and gender.

Q

R

S

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:

- Be injected, infused or require close monitoring by a *health care practitioner* or clinically trained individual;
- 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 medications, including *specialty drugs*. *We* may also require *you* to try similar drugs, medicine or medication, including *specialty drugs* that have been determined to be safe, effective and more cost-effective for most people with *your* condition. Alternatives may include over-the-counter drugs, *generic drugs* and *brand-name drugs*.

T

U

V

W

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Y

Z

PRIVACY AND CONFIDENTIALITY 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*.

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

This amendment modifies the *master group contract* as follows:

The Privacy and Confidentiality Statement is removed from the *master group contract* and replaced with the following:

Privacy and confidentiality statement

We understand the importance of keeping protected 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 health services* provided to *you* by *health care practitioners*, *hospitals* or other entities.

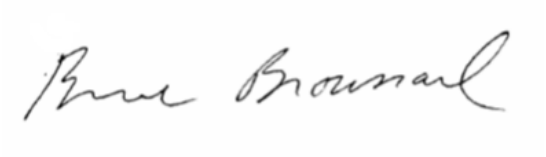
We may also use and disclose *your* PHI to conduct other health plan operational activities.

PRIVACY AND CONFIDENTIALITY AMENDMENT (continued)

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 to, *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.
H203600TX 08/08

Humana Health Plan of Texas, Inc.



Bruce Broussard
President

(512) 338-6100
1221 S. Mopac, Suite 200
Austin, Texas 78746

OFFERED BY
Humana Health Plan of Texas, Inc.

NOTICE OF CERTAIN MANDATORY BENEFITS

This notice is to advise you of certain coverage and/or benefits provided by your contract with Humana Health Plan of Texas, Inc.

Mastectomy or Lymph Node Dissection

Minimum Inpatient Stay: If due to treatment of breast cancer, any person covered by this plan has either a mastectomy or a lymph node dissection, this plan will provide coverage for inpatient care for a minimum of:

(a) 48 hours following a mastectomy, and
(b) 24 hours following a lymph node dissection.

The minimum number of inpatient hours is not required if the covered person receiving the treatment and the attending physician determine that a shorter period of inpatient care is appropriate.

Prohibitions: We may not (a) deny any covered person eligibility or continued eligibility or fail to renew this plan solely to avoid providing the minimum inpatient hours; (b) provide money payments or rebates to encourage any covered person to accept less than the minimum inpatient hours; (c) reduce or omit the amount paid to the attending physician, or otherwise penalize the physician, because the physician required a covered person to receive the minimum inpatient hours; or (d) provide financial or other incentives to the attending physician to encourage the physician to provide care that is less than the minimum hours.

Coverage and/or Benefits for Reconstruction Surgery after Mastectomy

Coverage and/or benefits are provided to each covered person for reconstructive surgery after mastectomy, including:

(a) All stages of the reconstruction of the breast on which mastectomy has been performed;
(b) Surgery and reconstruction of the other breast to achieve a symmetrical appearance; and
(c) Prostheses and treatment of physical complications, including lymphedemas, at all stages of mastectomy.

The coverage and/or benefits must be provided in the manner determined to be appropriate in consultation with the covered person and the attending physician. Please refer to the schedule of benefits in the attached certificate of coverage for any specific deductible, copayments, or coinsurance they may be applicable to these benefits.

Prohibitions: We may not (a) offer the covered person a financial incentive to forego breast reconstruction or waive the coverage and/or benefits referenced above; (b) condition, limit, or deny any covered person's eligibility or continued eligibility to enroll in the plan or fail to renew this plan solely to avoid providing the coverage and/or benefits referenced above; or (c) reduce or limit the amount paid to the physician or provider, nor otherwise penalize, or provide a financial incentive to induce the physician or provider to provide care to a covered person in a manner inconsistent with the coverage and/or benefits referenced above.

NOTICE OF CERTAIN MANDATORY BENEFITS (continued)

Examinations for Detection of Prostate Cancer

Benefits are provided for each covered male for an annual medically recognized diagnostic examination for the detection of prostate cancer. Benefits include:

(a) A physical examination for the detection of prostate cancer; and
(b) A prostate-specific antigen test for each covered male who is

1) At least 50 years of age; or
2) At least 40 years of age with a family history of prostate cancer or other prostate cancer risk factor.

Inpatient Stay following Birth of a Child

For each person covered for maternity/childbirth benefits, we will provide inpatient care for the mother and her newborn child in a health care facility for a minimum of:

(a) 48 hours following an uncomplicated vaginal delivery, and
(b) 96 hours following an uncomplicated delivery by cesarean section.

This benefit does not require a covered female who is eligible for maternity/childbirth benefits to (a) give birth in a hospital or other health care facility or (b) remain in a hospital or other health care facility for the minimum number of hours following birth of the child.

If a covered mother or her newborn child is discharged before the 48 or 96 hours have expired, we will provide coverage for postdelivery care. Postdelivery care includes parent education, assistance and training in breast-feeding and bottle-feeding and the performance of any necessary and appropriate clinical tests. A physician, registered nurse or other appropriate licensed health care provider will provide care, and the mother will have the option of receiving the care at her home, the health care provider's office or a health care facility.

Prohibitions: We may not (a) modify the terms of this coverage based on any covered person requesting less than the minimum coverage required; (b) offer the mother financial incentives or other compensation for waiver of the minimum number of hours required; (c) refuse to accept a physician's recommendation for a specified period of inpatient care made in consultation with the mother if the period recommended by the physician does not exceed guidelines for prenatal care developed by nationally recognized professional associations of obstetricians and gynecologists or pediatricians; (d) reduce payments or reimbursements below the usual and customary rate; or (e) penalize a physician for recommending inpatient care for the mother and/or the newborn child.

Coverage for tests for detection of colorectal cancer

Benefits are provided, for each person enrolled in the plan who is 50 years of age or older and at normal risk for developing colon cancer, for expenses incurred in conducting a medically recognized screening examination for the detection of colorectal cancer. Benefits include the covered person's choice of:

(a) A fecal occult blood test performed annually and a flexible sigmoidoscopy performed every five years,
(b) A colonoscopy performed every 10 years.

NOTICE OF CERTAIN MANDATORY BENEFITS (continued)

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 Health Plan of Texas, Inc. at 1-866-4ASSIST (1-866-427-7478), or write us at 14614 Lexington, KY, 40512-4614.

NOTICE OF COVERAGE FOR ACQUIRED BRAIN INJURY

Your health benefit plan coverage for an acquired brain injury includes the following services when they are medically necessary:

- 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 Health Plan of Texas, Inc. Green Bay Service Center, P.O. Box 14618, Lexington, KY 40512-4618.

Humana.

Discrimination is Against the Law

Humana Inc. and its subsidiaries comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Humana Inc. and its subsidiaries do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Humana Inc. and its subsidiaries provide:

- Free auxiliary aids and services, such as qualified sign language interpreters, video remote interpretation, and written information in other formats to people with disabilities when such auxiliary aids and services are necessary to ensure an equal opportunity to participate.
- Free language services to people whose primary language is not English when those services are necessary to provide meaningful access, such as translated documents or oral interpretation.

If you need these services, call the number on your ID card or, if you use a TTY, call 711.

If you believe that Humana Inc. and its subsidiaries have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Discrimination Grievances
P.O. Box 14618
Lexington, KY 40512-4618

If you need help filing a grievance, call the number on your ID card or, if you use a TTY, call 711.

You can also file a civil rights complaint with the **U.S. Department of Health and Human Services**, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**

Multi-Language Interpreter Services

English: ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call the number on your ID card (TTY: 711).

Español (Spanish): ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al número que figura en su tarjeta de identificación (TTY: 711).

繁體中文 (Chinese): 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電會員卡上的電話號碼 (TTY：711)。

Tiếng Việt (Vietnamese): CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số điện thoại ghi trên thẻ ID của quý vị (TTY: 711).

한국어 (Korean): 주의 : 한국어를 사용하시는 경우 , 언어 지원 서비스를 무료로 이용하실 수 있습니다 . ID 카드에 적혀 있는 번호로 전화해 주십시오 (TTY: 711).

Tagalog (Tagalog – Filipino): PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tawagan ang numero na nasa iyong ID card (TTY: 711).

Русский (Russian): ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Наберите номер, указанный на вашей карточке-удостоверении (телетайп: 711).

Kreyòl Ayisyen (French Creole): ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele nimewo ki sou kat idantite manm ou (TTY: 711).

Français (French): ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le numéro figurant sur votre carte de membre (ATS : 711).

Polski (Polish): UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Proszę zadzwonić pod numer podany na karcie identyfikacyjnej (TTY: 711).

Português (Portuguese): ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para o número presente em seu cartão de identificação (TTY: 711).

Italiano (Italian): ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero che appare sulla tessera identificativa (TTY: 711).

Deutsch (German): ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Wählen Sie die Nummer, die sich auf Ihrer Versicherungskarte befindet (TTY: 711).

日本語 (Japanese): 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。お手持ちの ID カードに記載されている電話番号までご連絡ください (TTY：711)。

فارسی (Farsi):

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد.
با شماره تلفن روی کارت شناسایی تان تماس بگیرید (TTY: 711).

Diné Bizaad (Navajo): Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, námboo ninaaltsoos yézhí, bee nééh ho'dólzin bikáá'ígíí bee hólne' (TTY: 711).

العربية (Arabic):

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم الهاتف الموجود على بطاقة الهوية الخاصة بك (رقم هاتف الصم والبكم: 711).

Humana.

Administrative Office:
1100 Employers Boulevard
Green Bay, Wisconsin 54344

Certificate of Insurance
Humana Insurance Company

Policyholder: SPECIALTY COMPOSITES

Policy Number: 737070

Effective Date: 12/01/2016

Product Name: TXFF0003 COIN

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.

This *certificate* is a companion to the "Evidence of Coverage" issued to *you* by Humana Health Plan of Texas, Inc. (the *HMO*). A *covered person* is not required to first use the benefits outlined in this *certificate* prior to utilizing the benefits outlined in the "Evidence of Coverage".

Bruce Broussard
President

THIS CONSUMER CHOICE OF BENEFITS HEALTH INSURANCE PLAN, EITHER IN WHOLE OR IN PART, DOES NOT PROVIDE STATE-MANDATED HEALTH BENEFITS NORMALLY REQUIRED IN ACCIDENT AND SICKNESS INSURANCE POLICIES IN TEXAS. THIS STANDARD HEALTH BENEFIT PLAN MAY PROVIDE A MORE AFFORDABLE HEALTH INSURANCE POLICY FOR YOU ALTHOUGH, AT THE SAME TIME, IT MAY PROVIDE YOU WITH FEWER HEALTH BENEFITS THAN THOSE NORMALLY INCLUDED AS STATE-MANDATED HEALTH BENEFITS IN POLICIES IN TEXAS. PLEASE CONSULT WITH YOUR INSURANCE AGENT TO DISCOVER WHICH STATE-MANDATED HEALTH BENEFITS ARE EXCLUDED IN THIS POLICY.

THE INSURANCE *POLICY* UNDER WHICH THIS *CERTIFICATE* IS ISSUED IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE AND DOES NOT REPLACE 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 01/16

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) 490-1007
Web: www.tdi.texas.gov
Email: ConsumerProtection@tdi.texas.gov

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

7. **ATTACH THIS NOTICE TO YOUR POLICY:** This notice is for information only and does not become a part or condition of the attached document.
200500TX 01/16 (2)

AVISO IMPORTANTE
Para obtener información o para presentar una queja:

Usted puede llamar al número de teléfono gratuito de Humana Insurance Company's para obtener información o para presentar una queja al:

1-866-4ASSIST

Usted también puede escribir a Humana Insurance Company:

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

Usted puede comunicarse con el Departamento de Seguros de Texas para obtener información sobre compañías, coberturas, derechos o quejas al:

1-800-252-3439

Usted puede escribir al Departamento de Seguros de Texas a:
P.O. Box 149104
Austin, TX 78714-9104
FAX #: (512) 490-1007
Sitio web: www.tdi.texas.gov
Email: ConsumerProtection@tdi.texas.gov

DISPUTAS POR PRIMAS DE SEGUROS O RECLAMACIONES: Si tiene una disputa relacionada con su prima de seguro o con una reclamación, usted debe comunicarse con la compañía primero. Si la disputa no es resuelta, usted puede comunicarse con el Departamento de Seguros de Texas.

ADJUNTE ESTE AVISO A SU PÓLIZA:
Este aviso es solamente para propósitos informativos y no se convierte en parte o en condición del documento adjunto.

UNDERSTANDING YOUR COVERAGE

As *you* read the *certificate*, *you* will see some words are printed in italics. Italicized words may have different meanings in the *certificate* than in general. Refer to the "Glossary" sections for the meaning of the italicized words as they apply to *your* plan.

The *certificate* gives *you* information about *your* plan. It tells *you* what is covered and what is not covered. It also tells *you* what *you* must do and how much *you* must pay for services. *Your* plan covers many services, but it is important to remember it has limits. Be sure to read *your certificate* carefully before using *your* benefits.

Covered and non-covered expenses

We will provide coverage for services, equipment and supplies that are *covered expenses*. All requirements of the *policy* apply to *covered expenses*.

The date used on the bill *we* receive for *covered expenses* or the date confirmed in *your* medical records is the date that will be used when *your* claim is processed to determine the benefit period.

You must pay the health care provider any amount due that *we* do not pay. Not all services and supplies are a *covered expense*, even when they are ordered by a *health care practitioner*.

Refer to the "Schedule of Benefits", the "Covered Expenses" and the "Limitations and Exclusions" sections and any rider or amendment attached to the *certificate* to see when services or supplies are *covered expenses* or are non-covered expenses.

How your policy works

You may have to pay a *deductible* before *we* pay for certain *covered expenses*. If a *deductible* applies, and it is met, *we* will pay *covered expenses* at the *coinsurance* amount. Refer to the "Schedule of Benefits" to see when the *deductible* applies and the *coinsurance* amount *we* pay. *You* will be responsible for the *coinsurance* amount *we* do not pay.

If an *out-of-pocket limit* applies, and it is met, *we* will pay *covered expenses* at 100% the rest of the *year*, subject to the *maximum allowable fee*.

Our payment for *covered expenses* is calculated by applying any *deductible* and *coinsurance* to the net charges. "Net charges" means the total amount billed by the *qualified provider*, less any amounts such as:

- Those negotiated by contract, directly or indirectly, between *us* and the *qualified provider*;
- Those in excess of the *maximum allowable fee*; or
- Adjustments related to *our* claims processing edits.

The service and diagnostic information submitted on the *qualified provider's* bill will be used to determine which provision of the "Schedule of Benefits" applies.

Your choice of providers affects your benefits

We will pay a higher percentage and the amount *you* pay will be lower most of the time if *you* see a *network provider*. *You* must pay any *copayment*, *deductible* or *coinsurance* to the *network provider*. Be sure to check if *your qualified provider* is a *network provider* before seeing them.

We may appoint certain *network providers* for certain kinds of services. If *you* do not see the appointed *network provider* for these services, *we* may pay less.

We will pay a lower percentage and the amount *you* pay will be higher if *you* choose to see a *non-network provider*. *Non-network providers* have not signed an agreement with *us* for lower costs for *covered expenses* and they may bill *you* for any amount over the *maximum allowable fee*. *You* will have to pay this amount and any *copayment*, *deductible* and *coinsurance* to the *non-network provider*. Any amount for *covered expenses you* pay over the *maximum allowable fee* will not apply to *your deductible* or any *out-of-pocket limit*.

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*."

Some *non-network providers* work with *network hospitals*. *We* will apply the *network provider copayment*, *deductible* and *coinsurance* to *covered expenses* received by non-network pathologists, anesthesiologists, radiologists, neonatologists, assistant surgeons and emergency room physicians working with *network hospitals*. However, *you* may still have to pay these *non-network providers* any amount over the *maximum allowable fee*. If possible, *you* may want to check if all health care providers working with *network hospitals* are *network providers*.

We will apply the *network provider copayment*, *deductible* and *coinsurance* to *covered expenses you* receive from a *non-network provider*:

- If *you* are not able to see a *network provider* for *emergency care*; or
- When *we* determine a *network provider* is not reasonably available and *preauthorization* is received from *us* to see a *non-network provider*.

Non-network providers have not signed an agreement with *us* for lower costs for *covered expenses* and may bill *you* for any amount over the *maximum allowable fee*. *You* will have to pay this amount and any *copayment*, *deductible* and *coinsurance* to the *non-network provider*. When *you* provide *us* proof of any amount *you* pay to the *non-network provider* over the *maximum allowable fee*, *we* will apply that amount to *your network provider deductible* and *out-of-pocket limit* when *covered expenses* are for:

- *Emergency care* services provided by *non-network providers*; or
- *Non-network provider* services preauthorized by *us* when *we* determine a *network provider* is not reasonably available.

Refer to the "Schedule of Benefits" sections to see what *your network provider* and *non-network provider* benefits are.

Claims processing edits

Payment of *covered expenses* for services rendered by a *qualified provider* is also subject to *our* claims processing edits, as determined by *us*. The amount determined to be payable after *we* apply *our* claims processing edits depends on the existence and interaction of several factors. Because the mix of these factors may be different for every claim, the amount paid for a *covered expense* may vary depending on the circumstances. Accordingly, it is not feasible to provide an exhaustive description of the claims processing edits that will be used to determine the amount payable for a *covered expense*, but examples of the most commonly used factors are:

- The intensity and complexity of a service;

- Whether a service is one of multiple services performed at the same service session such that the cost of the service to the *qualified provider* is less than if the service had been provided in a separate service session. For example:

  - Two or more *surgeries* during the same service session; or
  - Two or more radiologic imaging views performed during the same session;

- Whether an assistant surgeon, physician assistant, registered nurse, certified operating room technician or any other *qualified provider*, who is billing independently is involved;

- When a charge includes more than one claim line, whether any service is part of or incidental to the primary service that was provided, or if these services cannot be performed together;

- If the service is reasonably expected to be provided for the diagnosis reported;

- Whether a service was performed specifically for *you*; or

- Whether services can be billed as a complete set of services under one billing code.

We develop *our* claims processing edits in *our* sole discretion based on *our* review of one or more of the following sources, including but not limited to:

- *Medicare* laws, regulations, manuals and other related guidance;
- Appropriate billing practices;
- National Uniform Billing Committee (NUBC);
- American Medical Association (AMA)/Current Procedural Terminology (CPT);
- Centers for Medicare and Medicaid Services (CMS)/Healthcare Common Procedure Coding System (HCPCS);
- UB-04 Data Specifications Manual, and any successor manuals;
- International Classification of Diseases of the U.S. Department of Health and Human Services and the Diagnostic and Statistical Manual of Mental Disorders;
- Medical and surgical specialty societies and associations;
- *Our* medical and pharmacy coverage policies; or
- Generally accepted standards of medical, behavioral health and dental practice based on credible scientific evidence recognized in published peer reviewed medical or dental literature.

Changes to any one of the sources may or may not lead *us* to modify current or adopt new claims processing edits.

Subject to applicable law, *qualified providers* who are *non-network providers* may bill *you* for any amount *we* do not pay even if such amount exceeds the allowed amount after these claims processing edits. Any such amount paid by *you* will not apply to *your deductible*, or any *out-of-pocket limit*, unless *you* provide *us* proof the amount *you* paid to the *non-network provider* are *covered expenses* for *emergency care* services or *non-network provider* services preauthorized by *us* when *we* determine a *network provider* is not reasonably available. *You* will also be responsible for any applicable *deductible*, *copayment*, or *coinsurance*.

Your qualified provider may access *our* claims processing edits and *our* medical and pharmacy coverage policies at the "For Providers" link on *our* website at www.humana.com. *You* or *your qualified provider* may also call *our* toll-free customer service number listed on *your* ID card to obtain a copy of a policy. *You* should discuss these policies and their availability with any *qualified providers*, who are *non-network providers*, prior to receiving any services.

How to find a network provider

You may find a list of *network providers* at www.humana.com. This list is subject to change. Please check this list before receiving services from a *qualified provider*. *You* may also call *our* customer service department at the number listed on *your* ID card to determine if a *qualified provider* is a *network provider*, or *we* can send the list to *you*. A *network provider* can only be confirmed by *us*.

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.

How to use your point of service (POS) plan

You may receive services from a *network provider* or a *non-network provider* without a referral. Refer to the "Schedule of Benefits" for any *preauthorization* requirements.

Seeking emergency care

If *you* need *emergency care*:

- Go to the nearest *network hospital* emergency room; or
- Find the nearest *hospital* emergency room if *your* condition does not allow *you* to go to a *network hospital*.

You, or someone on *your* behalf, must call *us* within 48 hours after *your admission* to a *non-network hospital* for *emergency care*. If *your* condition does not allow *you* to call *us* within 48 hours after *your admission*, contact *us* as soon as *your* condition allows. *We* may transfer *you* to a *network hospital* in the *service area* when *your* condition is stable. *You* must receive services from a *network provider* for any follow-up care for the *network provider copayment*, *deductible* or *coinsurance* to apply.

Seeking urgent care

If *you* need *urgent care*, go to the nearest network *urgent care center* to receive the *network provider* benefit limit. *You* must receive services from a *network provider* for any follow-up care for the *network provider copayment*, *deductible* or *coinsurance* to apply.

Our relationship with qualified providers

Qualified providers are not *our* agents, employees or partners. All providers are independent contractors. *Qualified providers* make their own clinical judgments or give their own treatment advice without coverage decisions made by *us*.

The *policy* will not change what is decided between *you* and *qualified providers* regarding *your* medical condition or treatment options. *Qualified providers* act on *your* behalf when they order services. *You* and *your qualified providers* make all decisions about *your* health care, no matter what *we* cover. *We* are not responsible for anything said or written by a *qualified provider* about *covered expenses* and/or what is not covered under this *certificate*. Call *our* customer service department at the telephone number listed on *your* ID card if *you* have any questions.

Our financial arrangements with network providers

We have agreements with *network providers* that may have different payment arrangements:

- Many *network providers* are paid on a discounted fee-for-services basis. This means they have agreed to be paid a set amount for each *covered expense*;

- Some *qualified providers* may have capitation agreements. This means the *qualified provider* is paid a set dollar amount each month to care for each *covered person* no matter how many services a *covered person* may receive from the *qualified provider*, such as a primary care physician or a specialist;

- *Hospitals* may be paid on a Diagnosis Related Group (DRG) basis or a flat fee per day basis for *inpatient* services. *Outpatient* services are usually paid on a flat fee per service or procedure or a discount from their normal charges.

The certificate

The *certificate* is part of the insurance *policy* and tells *you* what is covered and not covered and the requirements of the *policy*. Nothing in the *certificate* takes the place of or changes any of the terms of the *policy*. The final interpretation of any provision in the *certificate* is governed by the *policy*. If the *certificate* is different than the *policy*, the provisions of the *policy* will apply. The benefits in the *certificate* apply if *you* are a *covered person*.
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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* 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.

This "Schedule of Benefits" outlines the 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 limitations.

Benefits available under this *certificate* that have a day, visit, allowance or specific dollar limit will be applied to the same amounts in the "Evidence of Coverage".

The benefits outlined under the "Schedule of Benefits – Behavioral Health and Serious Mental Illness", "Schedule of Benefits – Transplant Services", "Schedule of Benefits – Pharmacy Services" "Schedule of Benefits – Pediatric Dental", and "Schedule of Benefits – Pediatric Vision Care" sections are not payable under any other Schedule of Benefits of the *policy*. However, all other terms and provisions of the *policy*, including the *preauthorization* requirements, annual *deductible(s)* and any *out-of-pocket limit(s)*, unless otherwise stated, are applicable.

Network provider verification

This *certificate* contains multiple benefit levels. Refer to each Schedule of Benefits to see what benefit levels apply to *covered expenses*.

Refer to the Online Provider Finder on *our* Website at www.humana.com for a list of *network providers*. *You* may also contact *our* customer service department at the telephone number shown on *your* ID card. This list is subject to change.

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, or *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.

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* addressed under both this *certificate* and the "Evidence of Coverage". 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 as specified in this *certificate* and in the "Evidence of Coverage ", any remaining *deductible* for a *covered person* in the family will be waived for that *year*.

Any expense incurred by *you* for *covered expenses* provided by a *network provider* under this *certificate* or by a *network provider* under the "Evidence of Coverage" will be applied to the *network provider deductible* as stated in this *certificate* and in the "Evidence of Coverage". 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*	$4,500
Family *network provider deductible*	$9,000
Individual *non-network provider deductible*	$13,500
Family *non-network provider deductible*	$27,000

Maximum out-of-pocket limit

The *out-of-pocket limit* is the maximum amount of any *copayments*, *deductibles* and *coinsurance* for *covered expenses*, which must be paid by *you*, either individually or combined as a covered family, per *year* before a benefit percentage for *covered expenses* will be increased. There are individual and family *network provider* and *non-network provider out-of-pocket limits*.

After the individual *network provider out-of-pocket limit* addressed under both this *certificate* and in the "Evidence of Coverage" has been satisfied in a *year*, the *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 *network provider out-of-pocket limit* addressed under both this *certificate* and in the "Evidence of Coverage" has been satisfied in a *year*, the *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*.

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*.

Any expense incurred by *you* for *covered expenses* provided by a *network provider* under this *certificate* or by a *network provider* under the "Evidence of Coverage" will be applied to the *network provider out-of-pocket limit* as stated in this *certificate* and in the "Evidence of Coverage". 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 any *copayment*, *deductible* or *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*.

Out-of-pocket expenses for covered transplants provided by a *non-network provider* and *prescriptions* and *specialty drugs* obtained from a *non-network pharmacy* or non-network *specialty pharmacy*, and *specialty drugs* provided by or obtained from a *non-network provider* do not apply towards any *out-of-pocket limit*.

SCHEDULE OF BENEFITS (continued)

Maximum out-of-pocket limit	**Maximum out-of-pocket limit amount**
Individual *network provider out-of-pocket limit*	$6,350
Family *network provider out-of-pocket limit*	$12,700
Individual *non-network provider out-of-pocket limit*	$19,050
Family *non-network provider out-of-pocket limit*	$38,100

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Preventive services

Preventive services

Network provider	100% benefit payable
Non-network provider	50% 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	50% 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	50% benefit payable after *non-network provider deductible*

Hearing impairment screening (birth to 30 days old and follow-up care to 24 months)

Hearing impairment screening, as required by law, for a *dependent* child from birth through 30 days old and necessary diagnostic follow-up care related to the screening test from birth through the date the child is 24 months old. Benefits not subject to the *deductible* requirement, if any.

Network provider	100% benefit payable
Non-network provider	50% benefit payable

Noninvasive screening for atherosclerosis and abnormal artery structure

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

Network provider	100% benefit payable
Non-network provider	50% benefit payable after *non-network provider deductible*

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

Network provider	100% benefit payable
Non-network provider	50% benefit payable after *non-network provider deductible*

Health care practitioner office services

Health care practitioner office visit

Level 1 network health care practitioner	70% benefit payable after *network provider deductible*
Level 2 network health care practitioner	70% benefit payable after *network provider deductible*
Non-network health care practitioner	50% benefit payable after *non-network provider deductible*

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

Does not include *advanced imaging*. Refer to "Advanced imaging when performed in a health care practitioner's office" in the "Schedule of Benefits" section.

Level 1 network health care practitioner	70% benefit payable after *network provider deductible*
Level 2 network health care practitioner	70% benefit payable after *network provider deductible*
Non-network health care practitioner	50% benefit payable after *non-network provider deductible*

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

Level 1 network health care practitioner	70% benefit payable after *network provider deductible*
Level 2 network health care practitioner	70% benefit payable after *network provider deductible*
Non-network health care practitioner	50% benefit payable after *non-network provider deductible*

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

Level 1 network health care practitioner	70% benefit payable after *network provider deductible*
Level 2 network health care practitioner	70% benefit payable after *network provider deductible*
Non-network health care practitioner	50% benefit payable after *non-network provider deductible*

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

Level 1 network health care practitioner	70% benefit payable after *network provider deductible*
Level 2 network health care practitioner	70% benefit payable after *network provider deductible*
Non-network health care practitioner	50% 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	70% benefit payable after *network provider deductible*
Level 2 network health care practitioner	70% benefit payable after *network provider deductible*
Non-network health care practitioner	50% 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	70% benefit payable after *network provider deductible*
Level 2 network health care practitioner	70% benefit payable after *network provider deductible*
Non-network health care practitioner	50% benefit payable after *non-network provider deductible*

Health care practitioner services at a retail clinic

Health care practitioner office visit in a retail clinic

Level 1 network health care practitioner	70% benefit payable after *network provider deductible*
Non-network health care practitioner	50% benefit payable after *non-network provider deductible*

Diagnostic laboratory when performed by a health care practitioner in a retail clinic

Level 1 network health care practitioner	70% benefit payable after *network provider deductible*
Non-network health care practitioner	50% benefit payable after *non-network provider deductible*

Injections other than allergy when received by a health care practitioner in a retail clinic

Level 1 network health care practitioner	70% benefit payable after *network provider deductible*
Non-network health care practitioner	50% benefit payable after *non-network provider deductible*

Hospital services

Hospital inpatient services

Network hospital	70% benefit payable after *network provider deductible*
Non-network hospital	50% benefit payable after *non-network provider deductible*

SCHEDULE OF BENEFITS (continued)

Health care practitioner inpatient services when provided in a hospital

Level 1 network health care practitioner	70% benefit payable after *network provider deductible*
Level 2 network health care practitioner	70% benefit payable after *network provider deductible*
Non-network health care practitioner	50% benefit payable after *non-network provider deductible*

Hospital outpatient surgical services

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

Network hospital	70% benefit payable after *network provider deductible*
Non-network hospital	50% 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	70% benefit payable after *network provider deductible*
Level 2 network health care practitioner	70% benefit payable after *network provider deductible*
Non-network health care practitioner	50% benefit payable after *non-network provider deductible*

Hospital outpatient non-surgical services

Must be performed in a *hospital's outpatient* department. Does not include *advanced imaging*. Refer to "Hospital outpatient advanced imaging" in the "Schedule of Benefits" section.

Network hospital	70% benefit payable after *network provider deductible*
Non-network hospital	50% benefit payable after *non-network provider deductible*

Hospital outpatient diagnostic radiology and laboratory

Network hospital	70% benefit payable after *network provider deductible*
Non-network hospital	50% benefit payable after *non-network provider deductible*

Hospital outpatient advanced imaging

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

Network hospital	70% benefit payable after *network provider deductible*
Non-network hospital	50% 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

Does not include *advanced imaging*. Refer to "Hospital emergency room advanced imaging" in the "Schedule of Benefits" section.

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

Hospital emergency room advanced imaging

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

Hospital emergency room health care practitioner services

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

Ambulance services

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

Ambulatory surgical center services

Ambulatory surgical center for outpatient surgery

Network provider	70% benefit payable after *network provider deductible*
Non-network provider	50% benefit payable after *non-network provider deductible*

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

Includes *outpatient surgery*.

Level 1 network health care practitioner	70% benefit payable after *network provider deductible*
Level 2 network health care practitioner	70% benefit payable after *network provider deductible*
Non-network health care practitioner	50% benefit payable after *non-network provider deductible*

Autism spectrum disorders

Autism spectrum disorders, as required by law, for a *dependent* child. Benefits are payable for *covered expenses* as recommended in the treatment plan by the *health care practitioner*.

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

Durable medical equipment

Network provider	70% benefit payable after *network provider deductible*
Non-network provider	50% benefit payable after *non-network provider deductible*

Free-standing facility services

Free-standing facility non-surgical services

Does not include *advanced imaging*. Refer to "Free-standing facility outpatient advanced imaging" in the "Schedule of Benefits" section.

Network provider	70% benefit payable after *network provider deductible*
Non-network provider	50% benefit payable after *non-network provider deductible*

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

Level 1 network health care practitioner	70% benefit payable after *network provider deductible*
Level 2 network health care practitioner	70% benefit payable after *network provider deductible*
Non-network health care practitioner	50% benefit payable after *non-network provider deductible*

Free-standing facility outpatient advanced imaging

Network provider	70% benefit payable after *network provider deductible*
Non-network provider	50% benefit payable after *non-network provider deductible*

Home health care services

Network provider	70% benefit payable after *network provider deductible*
Non-network provider	50% benefit payable after *non-network provider deductible*

Hospice services

Network provider	70% benefit payable after *network provider deductible*
Non-network provider	50% benefit payable after *non-network provider deductible*

Jaw joint benefit

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

Physical medicine and rehabilitative services

Physical therapy, occupational therapy, speech therapy, audiology, cognitive rehabilitation services, and spinal manipulations/adjustments are limited to a combined maximum 40 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	70% benefit payable after *network provider deductible*
Non-network provider	50% benefit payable after *non-network provider deductible*

Respiratory or pulmonary rehabilitation services

Network provider	70% benefit payable after *network provider deductible*
Non-network provider	50% benefit payable after *non-network provider deductible*

Cardiac rehabilitation services

Network provider	70% benefit payable after *network provider deductible*
Non-network provider	50% benefit payable after *non-network provider deductible*

Other therapy

Includes radiation therapy and chemotherapy.

Network provider	70% benefit payable after *network provider deductible*
Non-network provider	50% benefit payable after *non-network provider deductible*

Skilled nursing facility services

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

Network provider	70% benefit payable after *network provider deductible*
Non-network provider	50% benefit payable after *non-network provider deductible*

Health care practitioner services when provided in a skilled nursing facility

Network health care practitioner	70% benefit payable after *network provider deductible*
Non-network health care practitioner	50% benefit payable after *non-network provider deductible*

Specialty drugs in a medical place of service

Specialty drugs administered in a health care practitioner's office, free-standing facility and urgent care center

Network provider	70% benefit payable after *network provider deductible*
Non-network provider	50% benefit payable after *non-network provider deductible*

Specialty drugs administered in home health care

Network provider designated by *us* as a preferred provider of *specialty drugs*	100% benefit payable after *network provider deductible*
Network provider	70% benefit payable after *network provider deductible*
Non-network provider	50% benefit payable after *non-network provider deductible*

Specialty drugs administered in a hospital, skilled nursing facility, ambulance or emergency room

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

Urgent care services

Network provider	70% benefit payable after *network provider deductible*
Non-network provider	50% 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.
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SCHEDULE OF BENEFITS – PEDIATRIC DENTAL

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

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

This "Schedule of Benefits – Pediatric Dental" outlines the 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 – Pediatric Dental" and "Limitations and Exclusions" sections of this *certificate*. Please refer to this *certificate* and any applicable riders for additional coverage and limitations.

Benefits available under this *certificate* that have a day, visit, allowance, or specific dollar limit will be applied to the same amounts in the "Evidence of Coverage."

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

Pediatric dental services apply toward the *deductible* and *out-of-pocket limit* of the *policy*.

Pediatric dental services benefit

Class I services

Network provider	70% benefit payable after *network provider deductible*
Non-network provider	50% benefit payable after *non-network provider deductible*

Class II services

Network provider	70% benefit payable after *network provider deductible*
Non-network provider	50% benefit payable after *non-network provider deductible*

SCHEDULE OF BENEFITS – PEDIATRIC DENTAL (continued)

Class III services

Network provider	70% benefit payable after *network provider deductible*
Non-network provider	50% benefit payable after *non-network provider deductible*

Class IV services

Network provider	70% benefit payable after *network provider deductible*
Non-network provider	50% benefit payable after *non-network provider deductible*

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SCHEDULE OF BENEFITS – PEDIATRIC VISION CARE

Reading this "Schedule of Benefits – Pediatric Vision Care" section will help *you* understand:

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

This "Schedule of Benefits – Pediatric Vision Care" outlines the 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 – Pediatric Vision Care" and "Limitations and Exclusions" sections of this *certificate*. Please refer to this *certificate* and any applicable riders for additional coverage and limitations.

Benefits available under this *certificate* that have a day, visit, *allowance* or specific dollar limit will be applied to the same amounts in the "Evidence of Coverage".

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

Expenses covered for *pediatric vision care* apply toward the *deductible* and any *out-of-pocket limit* of the *policy*.

Comprehensive eye exam

Limited to one exam per *year*.

Network provider	*Network provider deductible*, then 100% benefit payable after $10 *copayment* per visit
Non-network provider	50% benefit payable after *non-network provider deductible*

Prescription lenses

Single vision lenses, bifocal vision lenses, trifocal vision lenses, and lenticular lenses are limited to one pair of covered prescription lenses per *year*.

Network provider	70% benefit payable after *network provider deductible*
Non-network provider	50% benefit payable after *non-network provider deductible*

SCHEDULE OF BENEFITS – PEDIATRIC VISION CARE (continued)

Standard lens options

Polycarbonate, scratch coating, ultraviolet-coating, blended lenses, intermediate lenses, progressive lenses, photochromatic lenses, polarized lenses, fashion & gradient tinting, oversized lenses, glass-grey prescription sunglass lenses, anti-reflective coating, and hi-index lenses must be selected at the same time covered prescription lenses are selected.

Network provider	70% benefit payable after *network provider deductible*
Non-network provider	50% benefit payable after *non-network provider deductible*

Frames

Limited to one covered new frame per *year*.

Network provider	70% benefit payable after *network provider deductible*
Non-network provider	50% benefit payable after *non-network provider deductible*

Elective contact lenses

(Benefits are in lieu of all other benefits for frames and lenses.)

Limited to a single purchase of up to a 3 month supply of daily disposables, or a 6 month supply of non-daily disposables per *year*.

Network provider	70% benefit payable after *network provider deductible*
Non-network provider	50% benefit payable after *non-network provider deductible*

SCHEDULE OF BENEFITS – PEDIATRIC VISION CARE (continued)

Medically necessary contact lenses

Network provider	70% benefit payable after *network provider deductible*
Non-network provider	50% benefit payable after *non-network provider deductible*

Contact lens fitting and follow-up exam

Network provider	70% benefit payable after *network provider deductible*
Non-network provider	50% benefit payable after *non-network provider deductible*

Low vision

Limited to one comprehensive low vision testing and evaluation per *year*.

Network provider	70% benefit payable after *network provider deductible*
Non-network provider	50% benefit payable after *non-network provider deductible*

SCHEDULE OF BENEFITS – PEDIATRIC VISION CARE (continued)

Low vision supplementary testing

Limited to 5 diagnostic evaluations beyond the *comprehensive eye exam* in 5 *years*.

Network provider	70% benefit payable after *network provider deductible*
Non-network provider	50% benefit payable after *non-network provider deductible*

Low vision aids

Limited to one *low vision* aid in any 3 *years* except for video magnification, which is limited to one in any 5 *years*.

Network provider	70% benefit payable after *network provider deductible*
Non-network provider	50% benefit payable after *non-network provider deductible*

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SCHEDULE OF BENEFITS - BEHAVIORAL HEALTH AND SERIOUS MENTAL ILLNESS

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

- The level of benefits generally paid for the *mental health services, chemical dependency* services and *serious mental illness* 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.

This "Schedule of Benefits – Behavioral Health and Serious Mental Illness" outlines the 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 Serious Mental Illness" 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*.

Acute inpatient services

We will pay benefits for *covered expenses* incurred by *you* due to an *admission* or *confinement* for *acute inpatient services* for *mental health services, chemical dependency* services and *serious mental illness* services provided in a *hospital*, *health care treatment facility*, or *crisis stabilization unit*. *Covered expenses* also include an admission or confinement in a *chemical dependency treatment center* for *chemical dependency* services.

Network hospital	70% benefit payable after *network provider deductible*
Non-network hospital	50% benefit payable after *non-network provider deductible*

Partial hospitalization services

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

Network provider	70% benefit payable after *network provider deductible*
Non-network provider	50% benefit payable after *non-network provider deductible*

SCHEDULE OF BENEFITS - BEHAVIORAL HEALTH AND SERIOUS MENTAL ILLNESS (continued)

Residential treatment facility services

We will pay benefits for *covered expenses* incurred by *you* due to an *admission* or *confinement* for *mental health services, chemical dependency* services and *serious mental illness* services provided in a *residential treatment facility for adults* and *residential treatment center for children and adolescents.*

Network provider	70% benefit payable after *network provider deductible*
Non-network provider	50% benefit payable after *non-network provider deductible*

Acute inpatient, partial hospitalization and residential treatment facility health care practitioner services

Network health care practitioner	70% benefit payable after *network provider deductible*
Non-network health care practitioner	50% benefit payable after *non-network provider deductible*

Emergency services

We will pay benefits for *covered expenses* incurred by *you* for *emergency care* services for *mental health services, chemical dependency* services and *serious mental illness* services.

Hospital emergency room services

Does not include *advanced imaging*. Refer to "Hospital emergency room advanced imaging" in the "Schedule of Benefits – Behavioral Health and Serious Mental Illness" section.

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

SCHEDULE OF BENEFITS - BEHAVIORAL HEALTH AND SERIOUS MENTAL ILLNESS (continued)

Hospital emergency room advanced imaging

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

Hospital emergency room health care practitioner services

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

Urgent care services

We will pay benefits for *covered expenses* incurred by *you* for *urgent care* services for *mental health services, chemical dependency* services and *serious mental illness* services.

Network provider	70% benefit payable after *network provider deductible*
Non-network provider	50% benefit payable after *non-network provider deductible*

Outpatient services

We will pay benefits for *covered expenses* incurred by *you* for *outpatient* services for *mental health services, chemical dependency* services and *serious mental illness* services.

SCHEDULE OF BENEFITS - BEHAVIORAL HEALTH AND SERIOUS MENTAL ILLNESS (continued)

Health care practitioner office visit

Does not include *behavioral health* therapy in a *health care practitioner's* office. Refer to "Therapy" in the "Schedule of Benefits – Behavioral Health and Serious Mental Illness" section.

Network health care practitioner	70% benefit payable after *network provider deductible*
Non-network health care practitioner	50% benefit payable after *non-network provider deductible*

Injections when performed in a health care practitioner's office

Does not include *preventive services* and allergy injections. Refer to "Preventive services" and "Allergy injections when received in a health care practitioner's office" in the "Schedule of Benefits" section.

Network health care practitioner	70% benefit payable after *network provider deductible*
Non-network health care practitioner	50% benefit payable after *non-network provider deductible*

Therapy

Includes *outpatient behavioral health* therapy, *behavioral health* therapy in a *health care practitioner's* office and an *intensive outpatient program.*

Network provider	70% benefit payable after *network provider deductible*
Non-network provider	50% benefit payable after *non-network provider deductible*

SCHEDULE OF BENEFITS - BEHAVIORAL HEALTH AND SERIOUS MENTAL ILLNESS (continued)

Outpatient hospital services

Does not include *outpatient behavioral health* therapy. Refer to "Therapy" in the "Schedule of Benefits – Behavioral Health and Serious Mental Illness" section.

Does not include *advanced imaging*. Refer to "Advanced imaging performed in a health care practitioner's office, hospital outpatient department or free-standing facility" in the "Schedule of Benefits – Behavioral Health and Serious Mental Illness" section.

Network hospital	70% benefit payable after *network provider deductible*
Non-network hospital	50% benefit payable after *non-network provider deductible*

Advanced imaging performed in a health care practitioner's office, hospital outpatient department or free-standing facility

Network provider	70% benefit payable after *network provider deductible*
Non-network provider	50% benefit payable after *non-network provider deductible*

Home health care services

We will pay benefits for *covered expenses* incurred by *you* for home health care services for *mental health services, chemical dependency* and *serious mental illness* services.

Network provider	70% benefit payable after *network provider deductible*
Non-network provider	50% benefit payable after *non-network provider deductible*

SCH-BHSMITX 01/16

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* or *coinsurance you* are required to pay; and
- The services that require *you* to meet a *deductible* before benefits are paid.

This "Schedule of Benefits – Transplant Services" outlines the 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 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 transplant services received from *non-network providers* will not exceed the transplant *non-network provider* benefit limit of $35,000 per covered transplant.

Hospital services

Hospital benefits as shown under "Hospital services" in the "Schedule of Benefits" section 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 transplant *non-network provider* benefit limit.

SCHEDULE OF BENEFITS – TRANSPLANT SERVICES (continued)

Health care practitioner services

Health care practitioner benefits as shown under "Health care practitioner office services" in the "Schedule of Benefits" section 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 transplant *non-network provider* benefit limit.

Direct, non-medical costs

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

- Transportation

Network hospital designated by *us* as an approved transplant facility	70% benefit payable after *network provider deductible*
Non-network hospital	50% benefit payable after *non-network provider deductible*

- Temporary lodging

Network hospital designated by *us* as an approved transplant facility	70% benefit payable after *network provider deductible*
Non-network hospital	50% benefit payable after *non-network provider deductible*

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SCHEDULE OF BENEFITS – PHARMACY SERVICES

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

- The level of benefits generally paid for the *prescription* drugs, medicines or medications, including *specialty drugs*, covered under the *policy*;
- The *copayment* and/or *coinsurance* amount *you* are required to pay;
- The required *deductible* amount to be met, if any, before benefits are paid; and
- *Prior authorization* requirements.

This "Schedule of Benefits – Pharmacy Services" outlines the 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 – Pharmacy Services", "Limitations and Exclusions" and "Limitations and Exclusions – Pharmacy Services" sections of this *certificate*. Please refer to this *certificate* and any applicable riders for additional coverage and/or limitations.

Covered expenses for *prescription* drugs and *specialty drugs* obtained from a *network pharmacy* under provisions of this benefit apply toward *your out-of-pocket limit*.

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

All terms used in this "Schedule of Benefits – Pharmacy Services" have the meaning given to them in the "Glossary" section, unless otherwise specifically defined in the "Glossary – Pharmacy Services" section of this *certificate*. All services are subject to all of the terms, provisions, limitations and exclusions of the *policy*, unless otherwise stated.

Prior authorization requirements

Prior authorization and/or *step therapy* is required for certain *prescription* drugs, medicines or medications, including *specialty drugs*. Visit *our* Website at www.humana.com or call the customer service telephone number on *your* identification card to obtain *our drug list* that identifies the drugs, medicines or medications, including *specialty drugs* that require *prior authorization* and/or *step therapy*. The *drug list* is subject to change. Coverage provided in the past is not a guarantee of future coverage.

Your health care practitioner must contact *our* Clinical Pharmacy Review to request and receive *our* approval for *prescription* drugs, medicines or medications, including *specialty drugs* that require *prior authorization* and/or *step therapy*. Benefits are payable only if approved by *us*.

Preventive medication coverage

Drugs, medicines or medications and supplies on the Preventive Medication Coverage *drug list* are covered in full when obtained from a *network pharmacy* with a *prescription* from a *health care practitioner*.

SCHEDULE OF BENEFITS – PHARMACY SERVICES (continued)

Prescription drug cost sharing

You are responsible for any and all *cost share*, when applicable, as specified below. If the dispensing *pharmacy's* charge is less than *your copayment* or *coinsurance* for *prescription* drugs, *you* will be responsible for the dispensing *pharmacy* charge amount. The amount paid by *us* to the dispensing *pharmacy* may not reflect the ultimate cost to *us* for the drug. *Your copayment* or *coinsurance* is made on a per *prescription* fill or refill basis and will not be adjusted if *we* receive any retrospective volume discounts or *prescription* drug rebates.

Retail pharmacy / Specialty pharmacy	**Coverage for up to 30-day supply**
Network pharmacy	70% benefit payable per *prescription* fill or refill after *network provider deductible*
Non-network pharmacy	50% benefit payable per *prescription* fill or refill after *non-network provider deductible*

90-day Retail pharmacy

Some retail *pharmacies* participate in *our* program, which allows *you* to receive a 90-day supply of a *prescription* fill or refill. After the *deductible* is met, your cost is based on the applicable benefit amount specified above. *Specialty drugs* are limited to a 30-day supply from a retail *pharmacy* or a *specialty pharmacy*, unless otherwise determined by *us*.

Mail order pharmacy	**90-day supply**

Specialty drugs are not included. Refer to the "Retail pharmacy / Specialty pharmacy" provision above for *specialty drug* benefits.

Network pharmacy	70% benefit payable per *prescription* fill or refill after *network provider deductible*
Non-network pharmacy	50% benefit payable per *prescription* fill or refill after *non-network provider deductible*

SCHEDULE OF BENEFITS – PHARMACY SERVICES (continued)

Non-network pharmacy claims

When a *non-network pharmacy* is used, *you* must pay for the *prescription* fill 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 any applicable *cost share* shown above, *you* are also responsible for 100% of the difference between the *default rate* and the *non-network pharmacy's* charge. Any amount *you* pay to a *non-network pharmacy* does not apply toward any *out-of-pocket limit* under the *policy*. The charge received from a *non-network pharmacy* for a *prescription* fill or refill may be higher than the *default rate*.

COVERED EXPENSES

This "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*.

Preventive services

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

- 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 www.healthcare.gov website or call the customer service telephone number on *your* identification card.

Preventive screenings and immunizations

- Laboratory, radiology and/or endoscopic services to detect or prevent *sickness*.

Covered expenses include charges incurred by *you* for the following *preventive services* as required by state law:

- A hearing impairment screening for a *dependent* child from birth through 30 days old and diagnostic follow-up care related to the hearing impairment screening for a *dependent* child from birth through 24 months old.

- An annual mammogram for a female *covered person* 35 years of age or older.

- A bone mass measurement for a *qualified individual* to detect low bone mass and determine the risk of osteoporosis and fractures associated with osteoporosis.

- An annual medically recognized diagnostic examination for a female *covered person* 18 years of age or older for the early detection of ovarian cancer and cervical cancer in accordance with guidelines adopted by the American College of Obstetricians and Gynecologists or another similar national organization of medical professionals recognized by the Commissioner. Coverage includes the following procedures approved by the United States Food and Drug Administration (FDA), alone or in combination with a test approved by the FDA for the early detection of the human papillomavirus:

  - A CA 125 blood test; and
  - A conventional pap smear screening; or
  - A screening using liquid-based cytology methods.

- An annual prostate cancer detection exam, including a prostate specific antigen (PSA) test for a male *covered person* 40 years of age or older.

- A medically recognized screening examination for the detection of colorectal cancer for *covered persons* 50 years of age or older and at normal risk for developing colon cancer. Benefits include:

  - An annual fecal occult blood test; and
  - An annual stool DNA test;
  - A flexible sigmoidoscopy every five years; or
  - A colonoscopy or a Computed Tomography (CT) colonography (virtual colonoscopy) every 10 years.

- Noninvasive screening tests for atherosclerosis and abnormal artery structure and function for a *covered person* who is:

  - A male over 45 years of age and younger than 76 years of age; or
  - A female over 55 years of age and younger than 76 years of age and

    - Is a diabetic; or
    - Is at risk of developing heart disease based on a score derived from Framingham Health Study coronary prediction algorithm, that is immediate or higher.

  Benefits include one of the following screenings every 5 years:

  - A computed tomography (CT) scanning measuring coronary artery calcification; or
  - Ultrasonography measuring carotid intima-media thickness and plaque.

- Routine immunizations for *covered persons* under the age of 18. TB tine tests and allergy desensitization injections are <u>not</u> considered routine immunizations.

- Immunizations against influenza and pneumonia.

Health care practitioner office services

We will pay the following benefits for *covered expenses* incurred by *you* for *health care practitioner* office visit services. *You* must incur the *health care practitioner's* services 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.
- Allergy testing.
- Allergy serum.
- Allergy injections.
- Injections other than allergy.
- *Surgery*, including anesthesia.
- Second surgical opinions.

Health care practitioner services at a retail clinic

We will pay benefits for *covered expenses* incurred by *you* for *health care practitioner* services at a *retail clinic* for a *sickness* or *bodily injury*.

Health care practitioner telemedicine medical service

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

Health care practitioner telehealth service

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

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" provision of this 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 *confined*.

- Services and supplies, other than *room and board*, provided by a *hospital* while *confined*.

Health care practitioner inpatient services when provided in a hospital

Services that 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 allow the *maximum allowable fee* for the most complex procedure. For each additional procedure *we* will allow:

  - 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 allow each surgeon 62.5% of the *maximum allowable fee* for the procedure.

- Services of a surgical assistant and/or assistant surgeon. *We* will allow the surgical assistants and/or assistant surgeon 20% of the *maximum allowable fee* for the *surgery*.

- Services of a physician assistant (P.A.), registered nurse (R.N.) or a certified operating room technician. *We* will allow the physician assistants, registered nurses and certified operating room technicians 10% of the *maximum allowable fee* 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 *health care practitioner* 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 that 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 allow the *maximum allowable fee* for the most complex procedure. For each additional procedure *we* will allow:

  - 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 allow each surgeon 62.5% of the *maximum allowable fee* for the procedure.

- Services of a surgical assistant and/or assistant surgeon. *We* will allow the surgical assistants and/or assistant surgeons 20% of the *maximum allowable fee* for the *surgery*.

- Services of a physician assistant (P.A.), registered nurse (R.N.) or a certified operating room technician. *We* will allow the physician assistants, registered nurses and certified operating room technicians 10% of the *maximum allowable fee* 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.

Hospital outpatient advanced imaging

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

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 anomaly* of a covered *dependent* child that 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*.

Emergency services

We 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 as specified in the Emergency Care benefit on the "Schedule of Benefits", subject to the *maximum allowable fee*. *Non-network providers* have not signed an agreement with us for lower costs for services and may bill *you* for any amount over 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*.

Ambulance services

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

Ambulance services for *emergency care* provided by a *non-network* provider will be covered at the *network provider* benefit as specified in the Ambulance benefit on the "Schedule of Benefits", subject to the *maximum allowable fee*. *Non-network providers* have not signed an agreement with us for lower costs for services and may bill *you* for any amount over the *maximum allowable fee*. *You* may be required to pay any amount not paid by *us*.

Ambulatory surgical center services

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 that 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 allow the *maximum allowable fee* for the most complex procedure. For each additional procedure *we* will allow:

  - 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 allow each surgeon 62.5% of the *maximum allowable fee* for the procedure.

- Services of a surgical assistant and/or assistant surgeon. *We* will allow the surgical assistants and/or assistant surgeons 20% of the *maximum allowable fee* for the *surgery*.

- Services of a physician assistant (P.A.), registered nurse (R.N.) or a certified operating room technician. *We* will allow the physician assistants, registered nurses and certified operating room technicians 10% of the *maximum allowable fee* 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.

Autism spectrum disorders

We will pay benefits for *covered expenses* incurred by *covered dependents* for *autism spectrum disorder* (ASD) services provided by a *health care practitioner*. Benefits are payable for *covered expenses* as recommended in the treatment plan by the *health care practitioner*.

Covered expenses include:

- Screenings of a covered *dependent* for *autism spectrum disorders* at the ages of 18 and 24 months;
- 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.

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.

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.

Health care practitioner non-surgical services when 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 facility outpatient advanced imaging

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

Home health care services

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;
- Home infusion 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*.

Hospice services

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:

- *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 member*s* 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 aide 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*.

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 that 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, and full dentures.

Physical medicine and rehabilitative services

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 delay or defect as ordered by a *health care practitioner* and performed by a *health care practitioner*:

- Physical therapy services;
- Occupational therapy services;
- Spinal manipulations/adjustments;
- Speech therapy or speech pathology services;
- Hearing therapy or audiology services;
- Cognitive rehabilitation services which are not a result of or related to an *acquired brain injury*;
- Respiratory or pulmonary rehabilitation services; and
- Cardiac rehabilitation services.

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

Skilled nursing facility services

We will pay benefits for *covered expenses* incurred by *you* for charges made by a *skilled nursing facility* for *room and board* and for 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.

Health care practitioner services when provided in a skilled nursing facility

Services that are payable as a *skilled nursing facility* charge are not payable as a *health care practitioner* charge.

Covered expenses include:

- Medical services furnished by an attending *health care practitioner* to *you* while *you* are *confined* in a *skilled nursing facility.*
- Consultation charges requested by the attending *health care practitioner* during a *confinement* in a *skilled nursing facility.*
- Services of a pathologist.
- Services of a radiologist.

Specialty drugs in a medical place of service

We will pay benefits for *covered expenses* incurred by *you* for *specialty drug* that are administered in the following medical places of service:

- *Health care practitioner's* office;
- *Free-standing facility*;
- *Urgent care center*;
- Home health care;
- *Hospital*;
- *Skilled nursing facility*;
- Ambulance; and
- Emergency room.

Benefits for *specialty drugs* may be subject to *preauthorization* requirements, if any. Please refer to the "Schedule of Benefits" in this *certificate* for *preauthorization* requirements and contact *us* prior to receiving *specialty drugs*.

Benefits for *specialty drugs* do not include the charge for the actual administration of the *specialty drug*. Payment for the administration of *specialty drugs* is addressed in the "Schedule of Benefits" section of this *certificate*.

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*.

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, or 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 to:

  - Restore the previous level of function lost as a result of a *bodily injury* or *sickness*; or
  - Improve function caused by a *congenital anomaly*.

  Covered expense for prosthetic devices includes repair or replacement, if not covered by the manufacturer, and if due to:

  - A change in the *covered person's* physical condition causing the device to become non-functional; or
  - Normal wear and tear; or
  - 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.

- *Medically necessary services* received 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:

  - *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.*

  Covered expenses for *outpatient* day treatment services, or other post-acute care treatment services. Including periodic re-evaluation, as necessary, of the care of the *covered person* who:

  - Has an *acquired brain injury*;
  - Has been unresponsive to treatment; and
  - Becomes responsive to treatment at a later date.

- 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
  - Treatment is provided within 24 months of the initial treatment for 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:

  - Excision of partially or completely impacted teeth;

  - Surgical preparation of soft tissues and excision of bone or bone tissue performed with or without extraction or excision of erupted, partially erupted or completely un-erupted teeth;

  - Excisions of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth and related biopsy of bone, tooth, or related tissues when such conditions require pathological examinations;

  - Surgical procedures related to repositioning of teeth, tooth transplantation or re-implantation;

  - Services 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 and abscess;

  - Incision and closure 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*.

- Orthodontic treatment for a *congenital anomaly* related to or developed as a result of cleft palate, with or without cleft lip.

- 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.

- Reconstructive *surgery* resulting from:

  - A *bodily injury*, infection or other disease of the involved part, when a *functional impairment* is present; or
  - A *congenital anomaly* of a covered *dependent* child that resulted in a *functional impairment*.

  Expenses for reconstructive *surgery* due to a psychological condition are not considered a *covered expense*, unless the condition(s) described above are also met.

- *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.

- The following *habilitative services*, as ordered and performed by a *health care practitioner*, for a *covered person*, with a developmental delay or defect or *congenital anomaly*:

  - Physical therapy services;
  - Occupational therapy services;
  - Spinal manipulations/adjustments;
  - Speech therapy or speech pathology services; and
  - Audiology services.

  Habilitative services apply toward the "Physical medicine and rehabilitative services" maximum number of visits specified in the "Schedule of Benefits".

- Routine costs for a *covered person* participating in an approved Phase I, II, III or IV clinical trial.

  Routine costs include health care services that are otherwise a *covered expense* if the *covered person* were not participating in a clinical trial.

  Routine costs do not include services or items that are:

  - *Experimental*, *investigational* or *for research purposes*;
  - Provided only for data collection and analysis that is not directly related to the clinical management of the *covered person*; or
  - Inconsistent with widely accepted and established standards of care for a diagnosis.

The *covered person* must be eligible to participate in a clinical trial according to the trial protocol with respect to treatment of cancer or other life-threatening disease or condition.

For the routine costs to be considered a *covered expense*, the approved clinical trial must be a Phase I, II, III or IV clinical trial for the treatment of cancer or the prevention, detection or treatment of a life threatening disease or condition and is:

- Federally funded or approved by the appropriate federal agency;
- Approved by 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;
- The study or investigation is conducted under an investigational new drug application reviewed by the Federal Food and Drug Administration; or
- The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

- 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*.

- 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.

- *Diabetes self-management training.*

- *Telehealth* and *telemedicine* services for the diagnosis and treatment of a *sickness* or *bodily injury*. *Telehealth* or *telemedicine* services must be:

  - Services that would otherwise be a *covered expense* if provided during a face-to-face consultation between a *covered person* and a *health care practitioner*;
  - Provided to a *covered person* at the *originating site*; and
  - Provided by a *health care practitioner* at the *distant site*.

Telehealth and *telemedicine* services must comply with:

- Federal and state licensure requirements.
- Accreditation standards.
- Guidelines of the American Telemedicine Association or other qualified medical professional societies to ensure quality of care.

- *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. Limited to 1 per ear every 36 months.

- 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.

- Orally administered anticancer medication.

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

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COVERED EXPENSES – PEDIATRIC DENTAL

This "Covered Expenses – Pediatric Dental" section describes expenses covered under the *policy* for *pediatric dental services*. Benefits for *pediatric dental services* will be paid on a *reimbursement limit* basis and as shown in the "Schedule of Benefits – Pediatric Dental," subject to any applicable:

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

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

All terms used in this benefit have the same meaning given to them in this *certificate*, unless otherwise specifically defined in this benefit. Refer to the "Limitations and exclusions" provision in this section and the "Limitations and Exclusions" section of this *certificate* for *pediatric dental services* not covered by the *policy*. All other terms and provisions of the *policy* are applicable to expenses covered for *pediatric dental services*.

Definitions

Accidental dental injury means damage to the mouth, teeth and supporting tissue due directly to an *accident*. It does not include damage to the teeth, appliances or prosthetic devices that results from chewing or biting food or other substances.

Clinical review means the review of required/submitted documentation by a *dentist* for the determination of *pediatric dental services*.

Cosmetic means services that are primarily for the purpose of improving appearance, including but not limited to:

- Facings on crowns or pontics (the portion of a fixed bridge between the abutments) posterior to the second bicuspid.
- Characterizations and personalization of prosthetic devices.

Covered person under this "Covered Expenses – Pediatric Dental" and the "Schedule of Benefits – Pediatric Dental" sections means a person, who is eligible and enrolled for benefits provided under the *policy* up to the end of the month following the date he or she attains age 19.

Dental emergency means a sudden, serious dental condition caused by an *accident* or dental disease that, if not treated immediately, would result in serious harm to the dental health of the *covered person*.

Dentist means an individual, who is duly licensed to practice dentistry or perform *oral surgery* and is acting within the lawful scope of his or her license.

Expense incurred date means the date on which:

- The teeth are prepared for fixed bridges, crowns, inlays or onlays;
- The final impression is made for dentures or partials;
- The pulp chamber of a tooth is opened for root canal therapy;
- A periodontal surgical procedure is performed; or
- The service is performed for services not listed above.

Palliative dental care means treatment used in a *dental emergency* to relieve, ease or alleviate the acute severity of dental pain, swelling or bleeding. *Palliative dental care* treatment usually is performed for, but is not limited to, the following acute conditions:

- Toothache;
- Localized infection;
- Muscular pain; or
- Sensitivity and irritations of the soft tissue.

Services are not considered *palliative dental care* when used in association with any other *pediatric dental services*, except x-rays and/or exams.

Pediatric dental services mean the following services:

- Ordered by a *dentist*.
- Described in the "Pediatric dental" provision in this "Covered Expenses – Pediatric Dental" section.
- Incurred when a *covered person* is insured for that benefit under the *policy* on the *expense incurred date*.

Reimbursement limit means the maximum fee allowed for *pediatric dental services*. It is the lesser of:

- The actual cost for services;

- The fee most often charged in the geographical area where the service was performed;

- The fee most often charged by the provider;

- The fee determined by comparing charges for similar services to a national database adjusted to the geographical area where the services or procedures were performed;

- At *our* choice, the fee determined by using a national Relative Value Scale. Relative Value Scale means a methodology that values procedures and services relative to each other that includes, but is not limited to, a scale in terms of difficulty, work, risk, as well as the material and outside costs of providing the service, as adjusted to the geographic area where the services or procedures were performed;

- In the case of services rendered by providers with whom *we* have agreements, the fee that *we* have negotiated with that provider;

- The fee based on rates negotiated with one or more *network providers* in the geographic area for the same or similar services;

- The fee based on the provider's costs for providing the same or similar services as reported by the provider in the most recent, publicly available *Medicare* cost report submitted annually to the Centers for Medicare and Medicaid Services; or

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

The bill *you* receive for services provided by *non-network providers* may be significantly higher than the *reimbursement limit*. In addition to the *deductible*, *copayments* and *coinsurance*, *you* are responsible for the difference between the *reimbursement limit* and the amount the provider bills *you* for the services. Any amount *you* pay to the provider in excess of the *reimbursement limit* will not apply to *your deductible* or *out-of-pocket limit*.

Treatment plan means a written report on a form satisfactory to *us* and completed by the *dentist* that includes:

- A list of the services to be performed, using the American Dental Association terminology and codes;
- *Your dentist's* written description of the proposed treatment.
- Pretreatment x-rays supporting the services to be performed.
- Itemized cost of the proposed treatment.
- Any other appropriate diagnostic materials (may include x-rays, chart notes, treatment records, etc.) as requested by *us*.

Pediatric dental services benefit

We will pay benefits for *covered expenses* incurred by a *covered person* for *pediatric dental services*. *Pediatric dental services* include the following, as categorized below. Coverage for a *dental emergency* is limited to *palliative dental care* only:

Class I services

- Periodic and comprehensive oral evaluations. Limited to 2 per *year*.

- Limited, problem focused oral evaluations. Limited to 2 per *year*.

- Periodontal evaluations. Limited to 2 per *year*. Benefit allowed only for a *covered person* showing signs or symptoms of periodontal disease and for patients with risk factors such as smoking, diabetes or related health issues. No benefit is payable when performed with a cleaning (prophylaxis). Benefit is not available when a comprehensive oral evaluation is performed.

- Cleaning (prophylaxis), including all scaling and polishing procedures. Limited to 2 per *year*.
- Intra-oral complete series x-rays (at least 14 films, including bitewings) or panoramic x-ray. Limited to 1 every 5 years. If the total cost of periapical and bitewing x-rays exceeds the cost of a complete series of x-rays, *we* will consider these as a complete series.
- Bitewing x-rays. Limited to 2 sets per *year*.
- Other x-rays, including intra-oral periapical and occlusal and extra-oral x-rays. Limited to x-rays necessary to diagnose a specific treatment.
- Topical fluoride treatment. Limited to 2 per *year*.
- Application of sealants to the occlusal surface of permanent molars that are free of decay and restorations. Limited to 1 per tooth every 3 years.
- Installation of space maintainers for retaining space when a primary tooth is prematurely lost. *Pediatric dental services* do not include separate adjustment expenses.
- Recementation of space maintainers.
- Removal of fixed space maintainers.

Class II services

- Restorative services as follows:
  - Amalgam restorations (fillings). Multiple restorations on one surface are considered one restoration.
  - Composite restorations (fillings) on anterior teeth. Composite restorations on molar and bicuspid teeth are considered an alternate service and will be payable as a comparable amalgam filling. *You* will be responsible for the remaining *expense incurred*. Multiple restorations on one surface are considered one restoration.
  - Pin retention per tooth in addition to restoration that is not in conjunction with core build-up.
  - Non-cast pre-fabricated stainless steel, esthetic stainless steel, and resin crowns on primary teeth that cannot be adequately restored with amalgam or composite restorations.
- Miscellaneous services as follows:
  - *Dental emergency* care for the treatment for initial *palliative dental care* of pain or an *accidental dental injury* to the teeth and supporting structures. *We* will consider the service a separate benefit only if no other service, except for x-rays and problem focused oral evaluation is provided during the same visit.
  - Re-cementing inlays, onlays and crowns.

Class III services

- Restorative services as follows:

  - Initial placement of laboratory-fabricated restorations, for a permanent tooth, when the tooth, as a result of extensive decay or a traumatic injury, cannot be restored with a direct placement filling material. *Pediatric dental services* include inlays, onlays, crowns, veneers, core build-ups and posts, and implant supported crowns and abutments. Limited to 1 per tooth every 5 years. Inlays are considered an alternate service and will be payable as a comparable amalgam filling.

  - Replacement of inlays, onlays, crowns or other laboratory-fabricated restorations for permanent teeth. *Pediatric dental services* include the replacement of the existing major restoration if:

    - It has been 5 years since the prior insertion and is not, and cannot be made serviceable.
    - It is damaged beyond repair as a result of an *accidental dental injury* while in the oral cavity; or
    - Extraction of functioning teeth, excluding third molars or teeth not fully in occlusion with an opposing tooth or prostheses requires the replacement of the prosthesis.

- Periodontic services as follows:

  - Periodontal scaling and root planing. Limited to 1 per quadrant every 2 years.

  - Periodontal maintenance (at least 30 days following periodontal therapy), unless a cleaning (prophylaxis) is performed on the same day. Limited to 4 every year.

  - Periodontal and osseous surgical procedures, including bone replacement, tissue regeneration, gingivectomy, gingivoplasty, and graft procedures. Limited to 1 per quadrant every 3 years.

  - Occlusal adjustments when performed in conjunction with a periodontal surgical procedure. Limited to 1 per quadrant every 3 years.

  Separate fees for pre- and post-operative care and re-evaluation within 3 months are not considered *pediatric dental services*.

- Endodontic procedures as follows:

  - Root canal therapy, including root canal treatments and root canal fillings for permanent teeth and primary teeth. Any test, intraoperative, x-rays, laboratory or any other follow-up care is considered integral to root canal therapy.

  - Root canal retreatment, including root canal treatments and root canal fillings for permanent and primary teeth. Any test, intraoperative, x-rays, exam, laboratory, or any other follow-up care is considered integral to root canal therapy.

  - Periradicular surgical procedures for permanent teeth, including apicoectomy, root amputation, tooth reimplementation bone graft, and surgical isolation.

- Partial pulpotomy for apexogenesis for permanent teeth.

- Vital pulpotomy for primary teeth.

- Pulp debridement, pupal therapy (resorbable) for permanent and primary teeth.

- Apexification/recalcification for permanent and primary teeth.

- Prosthodontics services as follows:

  - Denture adjustments when done by a *dentist*, other than the one providing the denture, or adjustments performed more than six months after initial installation.

  - Initial placement of bridges, complete dentures, and partial dentures. Limited to 1 every 5 years. *Pediatric dental services* include pontics, inlays, onlays, and crowns. Limited to 1 per tooth every 5 years.

  - Replacement of bridges, complete dentures and partial dentures. *Pediatric dental services* include the replacement of the existing prosthesis if:

    - It has been 5 years since the prior insertion and is not, and cannot be made serviceable;
    - It is damaged beyond repair as a result of an *accidental dental injury* while in the oral cavity; or
    - Extraction of functioning teeth, excluding third molars or teeth not fully in occlusion with an opposing tooth or prostheses requires the replacement of the prosthesis.

  - Tissue conditioning.

  - Denture relines or rebases. Limited to 1every 3 years after 6 months of installation.

  - Post and core build-up in addition to partial denture retainers with or without core build up. Limited to 1 per tooth every 5 years.

- The following simple oral surgical services as follows:

  - Extraction of coronal remnants of a primary tooth.
  - Extraction of an erupted tooth or exposed root for permanent and primary teeth.

- Implant services, subject to *clinical review.* Dental implants and related services, including implant supported crowns, abutments, bridges, complete dentures, and partial dentures. Limited to 1 per tooth every 5 years. *Pediatric dental services* do not include an implant if it is determined a standard prosthesis or restoration will satisfy the dental need.

- Miscellaneous services as follows:

  - Recementing of bridges and implants.

  - Repairs of bridges, complete dentures, immediate dentures, partial dentures, and crowns.

- General anesthesia or conscious sedation subject to *clinical review* and administered by a *dentist* in conjunction with covered oral surgical procedures, periodontal and osseous surgical procedures, and periradicular surgical procedures, for *pediatric dental services*. General anesthesia is not considered a *pediatric dental service* if administered for, including but not limited to, the following:

    - Pain control, unless the *covered person* has a documented allergy to local anesthetic.
    - Anxiety.
    - Fear of pain.
    - Pain management.
    - Emotional inability to undergo a surgical procedure.

Class IV services

Orthodontic treatment when *medically necessary*.

Covered expenses for orthodontic treatment includes those that are:

- For the treatment of and appliances for tooth guidance, interception and correction.
- Related to covered orthodontic treatment, including:

    - X-rays.
    - Exams.
    - Space retainers.
    - Study models.

Covered expenses do not include services to alter vertical dimensions, restore or maintain the occlusion. Such procedures include, but are not limited to, equilibration, periodontal splinting, full mouth rehabilitation, and restoration for misalignment of teeth.

Integral service

Integral services are additional charges related to materials or equipment used in the delivery of dental care. The following services are considered integral to the dental service and will not be paid separately:

- Local anesthetics.
- Bases.
- Pulp testing.
- Pulp caps.
- Study models/diagnostic casts.
- *Treatment plans*.
- Occlusal (biting or grinding surfaces of molar and bicuspid teeth) adjustments.
- Nitrous oxide.
- Irrigation.
- Tissue preparation associated with impression or placement of a restoration.

COVERED EXPENSES – PEDIATRIC DENTAL (continued)

Pretreatment plan

We suggest that if dental treatment is expected to exceed $300, *you* or *your dentist* should submit a *treatment plan* to *us* for review before *your* treatment. The *treatment plan* should include:

- A list of services to be performed using the American Dental Association terminology and codes.
- *Your dentist's* written description of the proposed treatment.
- Pretreatment x-rays supporting the services to be performed.
- Itemized cost of the proposed treatment.
- Any other appropriate diagnostic materials that *we* may request.

We will provide *you* and *your dentist* with an estimate for benefits payable based on the submitted *treatment plan*. This estimate is not a guarantee of what *we* will pay. It tells *you* and *your dentist* in advance about the benefits payable for the *pediatric dental services* in the *treatment plan*.

An estimate for services is not necessary for a *dental emergency*.

Pretreatment plan process and timing

An estimate for services is valid for 90 days after the date *we* notify *you* and *your dentist* of the benefits payable for the proposed *treatment plan* (subject to *your* eligibility of coverage). If treatment will not begin for more than 90 days after the date *we* notify *you* and *your dentist*, *we* recommend that *you* submit a new *treatment plan*.

Alternate services

If two or more services are acceptable to correct a dental condition, *we* will base the benefits payable on the least expensive *pediatric dental service* that produces a professionally satisfactory result, as determined by *us*. *We* will pay up to the *reimbursement limit* for the least costly *pediatric dental service* and subject to any applicable *deductible* and *coinsurance*. *You* will be responsible for any amount exceeding the *reimbursement limit*.

If *you* or *your dentist* decides on a more costly service, payment will be limited to the *reimbursement limit* for the least costly service and will be subject to any *deductible* and *coinsurance*. *You* will be responsible for any amount exceeding the *reimbursement limit*.

Limitations and exclusions

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

- Any expense arising from the completion of forms.

- Any expense due to *your* failure to keep an appointment.

COVERED EXPENSES – PEDIATRIC DENTAL (continued)

- Any expense for a service *we* consider *cosmetic*, unless it is due to an *accidental dental injury*.

- Expenses incurred for:

  - Precision or semi-precision attachments.
  - Overdentures and any endodontic treatment associated with overdentures.
  - Other customized attachments.
  - Any services for 3D imaging (cone beam images).
  - Temporary and interim dental services.
  - Additional charges related to materials or equipment used in the delivery of dental care.

- Charges for services rendered:

  - In a dental facility or *health care treatment facility* sponsored or maintained by the *employer* under this plan or an employer of any *covered person* covered by the *policy*.
  - By an employee of any *covered person* covered by the *policy*.

  For the purposes of this exclusion, *covered person* means the *employee* and the *employee's dependents* enrolled for benefits under the *policy* and as defined in the "Glossary" section.

- Any service related to:

  - Altering vertical dimension of teeth or changing the spacing and/or shape of the teeth.
  - Restoration or maintenance of occlusion.
  - Splinting teeth, including multiple abutments, or any service to stabilize periodontally weakened teeth.
  - Replacing tooth structures lost as a result of abrasion, attrition, erosion, or abfraction.
  - Bite registration or bite analysis.

- Infection control, including but not limited to, sterilization techniques.

- Expenses incurred for services performed by someone other than a *dentist*, except for scaling and teeth cleaning and the topical application of fluoride, which can be performed by a licensed dental hygienist. The treatment must be rendered under the supervision and guidance of the *dentist* in accordance with generally accepted dental standards.

- Any *hospital*, surgical or treatment facility, or for services of an anesthesiologist or anesthetist.

- *Prescription* drugs or pre-medications, whether dispensed or prescribed.

- Any service that:

  - Is not eligible for benefits based on the *clinical review.*
  - Does not offer a favorable prognosis.
  - Does not have uniform professional acceptance.
  - Is deemed to be experimental or investigational in nature.

COVERED EXPENSES – PEDIATRIC DENTAL (continued)

- Preventive control programs including, but not limited to, oral hygiene instructions, plaque control, take-home items, prescriptions and dietary planning.

- Replacement of any lost, stolen, damaged, misplaced or duplicate major restoration, prosthesis or appliance.

- Any caries susceptibility testing, laboratory tests, saliva samples, anaerobic cultures, sensitivity testing or charges for oral pathology procedures.

- The following services when performed at the same time as a root canal:

  - Partial pulpotomy for apexogensis.
  - Vital pulpotomy.
  - Pulp debridment or pupal therapy.

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COVERED EXPENSES – PEDIATRIC VISION CARE

This "Covered Expenses – Pediatric Vision Care" section describes expenses covered under the *policy* for *pediatric vision care*. Benefits for *pediatric vision care* will be paid on a *reimbursement limit* basis and as shown in the "Schedule of Benefits – Pediatric Vision Care," subject to any applicable:

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

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

All terms used in this benefit have the same meaning given to them in this *certificate*, unless otherwise specifically defined in this benefit. Refer to the "Limitations and exclusions" provision in this section and the "Limitations and Exclusions" section of this *certificate* for *pediatric vision care* expenses not covered by the *policy*. All other terms and provisions of the *policy* are applicable to expenses covered for *pediatric vision care*.

Definitions

Comprehensive eye exam means an exam of the complete visual system, which includes: case history; monocular and binocular visual acuity, with or without present corrective lenses; neurological integrity (pupil response); biomicroscopy (external exam); visual field testing (confrontation); ophthalmoscopy (internal exam); tonometry (intraocular pressure); refraction (with recorded visual acuity); extraocular muscle balance assessment; dilation as required; present prescription analysis; specific recommendation; assessment plan; and provider signature.

Contact lens fitting and follow-up means an exam, which includes: keratometry; diagnostic lens testing; instruction for insertion and removal of contact lenses; additional biomicroscopy with and without lens.

Covered person under this "Covered Expenses – Pediatric Vision Care" section and the "Schedule of Benefits – Pediatric Vision Care" section means a person, who is eligible and enrolled for benefits provided under the *policy* up to the end of the month following the date he or she attains age 19.

Low vision means *severe vision problems* as diagnosed by an Ophthalmologist or Optometrist that cannot be corrected with regular prescription lenses or contact lenses and reduces a person's ability to function at certain or all tasks.

Materials means frames, lenses and lens options, or contact lenses, and low vision aids.

Pediatric vision care means the services and *materials* specified in the "Pediatric vision care benefit" provision in this section for a *covered person*.

Reimbursement limit means the maximum fee allowed for *pediatric vision care*. *Reimbursement limit* for *pediatric vision care* is the lesser of:

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

The bill *you* receive for services provided by, or *materials* obtained from, *non-network providers* may be significantly higher than the *reimbursement limit*. In addition to *deductibles*, *copayments* and *coinsurance*, *you* are responsible for the difference between the *reimbursement limit* and the amount the provider bills *you* for the services or *materials*. Any amount *you* pay to the provider in excess of the *reimbursement limit* will not apply to *your deductible* or *out-of-pocket limit*.

Severe vision problems mean the best-corrected acuity is:

- 20/200 or less in the better eye with best conventional spectacle or contact lens prescription;
- A demonstrated constriction of the peripheral fields in the better eye to 10 degrees or less from the fixation point; or
- The widest diameter subtends an angle less than 20 degrees in the better eye.

COVERED EXPENSES – PEDIATRIC VISION CARE (continued)

Pediatric vision care benefit

We will pay benefits for *covered expenses* incurred by a *covered person* for *pediatric vision care*. *Covered expenses* for *pediatric vision care* are:

- *Comprehensive eye exam*.

- Prescription lenses, including polycarbonate, scratch coating, ultraviolet-coating, blended lenses, intermediate lenses, progressive lenses, photochromatic lenses, polarized lenses, fashion and gradient tinting, oversized lenses, glass-grey prescription sunglass lenses, anti-reflective coating, and hi-index lenses. If a *covered person* sees a *network provider*, the *network provider* of *materials* will show the *covered person* the selection of lens options covered by the *policy*. If a *covered person* selects a lens option that is not included in the lens option selection the *policy* covers, the *covered person* is responsible for the difference in cost between the *network provider* of *materials* reimbursement amount for covered lens options and the retail price of the lens options selected.

- Frames available from a selection of covered frames. If a *covered person* sees a *network provider*, the *network provider* of *materials* will show the *covered person* the selection of frames covered by the *policy*. If a *covered person* selects a frame that is not included in the frame selection the *policy* covers, the *covered person* is responsible for the difference in cost between the *network provider* of *materials* reimbursement amount for covered frames and the retail price of the frame selected.

- Elective contact lenses available from a selection of covered contact lenses, *contact lens fitting and follow-up*. If a *covered* person sees a *network provider*, the *network provider* of *materials* will inform the *covered person* of the contact lens selection covered by the *policy*. If a *covered person* selects a contact lens that is not part of the contact lens selection the *policy* covers, the *covered person* is responsible for the difference in cost between the lowest cost contact lens available from the contact lens selection covered by the *policy* and the cost of the contact lens selected.

- *Medically necessary* contact lenses under the following circumstances:

    - Visual acuity cannot be corrected to 20/70 in the better eye, except by use of contact lenses;
    - Anisometropia;
    - Keratoconus;
    - Aphakia;
    - High ametropia of either +10D or -10D in any meridian;
    - Pathological myopia;
    - Aniseikonia;
    - Aniridia;
    - Corneal Disorders;
    - Post-traumatic Disorders; or
    - Irregular Astigmatism.

Prior authorization is required for *medically necessary* contact lenses. *We* must be contacted by telephone at the customer service number on *your* ID card, by *electronic mail*, or in writing to request prior authorization. If prior authorization is not obtained, *you* will be responsible for a prior authorization penalty. The benefit payable for *medically necessary* contact lenses will be reduced 50%, after any applicable *deductible* and *coinsurance*. This prior authorization penalty will apply if *you* received the *medically necessary* contact lenses from either a *network provider* or *non-network provider* when prior authorization is required and not obtained.

- *Low vision* services include the following:

    - Comprehensive low vision testing and evaluation.
    - Low vision supplementary testing.
    - Low vision aids include only the following:

        - Spectacle-mounted magnifiers.
        - Hand-held and stand magnifiers.
        - Hand held or spectacle-mounted telescopes.
        - Video magnification.

Prior authorization is required for *low vision* services. *We* must be contacted by telephone at the customer service number on *your* ID card, by *electronic mail*, or in writing to request prior authorization. If prior authorization is not obtained, *you* will be responsible for a prior authorization penalty. The benefit payable for *low vision* services will be reduced 50%, after any applicable *deductible* and *coinsurance*. This prior authorization penalty will apply if *you* received the *low vision* services from either a *network provider* or *non-network provider* when prior authorization is required and not obtained.

Limitations and exclusions

In addition to the "Limitations and Exclusions" section of this *certificate* and any limitations specified in the "Schedule of Benefits – Pediatric Vision Care," benefits for *pediatric vision care* are limited as follows:

- In no event will benefits exceed the lesser of the limits of the *policy*, shown in the "Schedule of Benefits – Pediatric Vision Care" or in the "Schedule of Benefits" of this *certificate*.

- *Materials* covered by the *policy* that are lost, stolen, broken, or damaged will only be replaced at normal intervals as specified in the "Schedule of Benefits – Pediatric Vision Care."

- Basic cost for frames covered by the *policy*. The *covered person* is responsible for lens options selected, including but not limited to:

    - Sunglasses, prescription and plano; or
    - Groove, drill or notch, and roll and polish.

COVERED EXPENSES – PEDIATRIC VISION CARE (continued)

Refer to the "Limitations and Exclusions" section of this *certificate* for additional exclusions. Unless specifically stated otherwise, no benefits for *pediatric vision care* will be provided for, or on account of, the following items:

- Orthoptic or vision training and any associated supplemental testing.
- Two or more pair of glasses, in lieu of bifocals or trifocals.
- Medical or surgical treatment of the eye, eyes or supporting structures.
- Any services and *materials* required by an *employer* as a condition of employment.
- Safety lenses and frames.
- Contact lenses, when benefits for frames and lenses are received.
- Cosmetic items.
- Any services or *materials* not listed in this benefit section as a covered benefit or in the "Schedule of Benefits – Pediatric Vision Care."
- Expenses for missed appointments.
- Any charge from a provider's office to complete and submit claim forms.
- Treatment relating to or caused by disease.
- Non-prescription *materials* or vision devices.
- Costs associated with securing *materials*.
- Pre- and post-operative services.
- Orthokeratology.
- Maintenance of *materials*.
- Refitting or change in lens design after initial fitting.
- Artistically painted lenses.

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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

This "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 "Limitations and Exclusions" section listed in this *certificate* for transplant services not covered by the *policy*. All terms and provisions of the *policy* are applicable to *covered expenses*.

Transplant covered expenses

We will pay benefits for *covered expenses* incurred by *you* for a transplant that is preauthorized and approved by *us*. *We* must be notified of the initial transplant evaluation and given a reasonable opportunity to review the clinical results to determine if the transplant will be covered. *You* or *your health care practitioner* must contact *our* Transplant Management Department by calling the Customer Service number on *your* ID card when in need of a transplant. *We* will advise *your health care practitioner* once coverage of the requested transplant is approved by *us*. Benefits are payable only if the transplant is approved by *us*.

Covered expense for a transplant includes pre-transplant services, transplant inclusive of any integral chemotherapy and associated services, post-discharge services, and treatment of complications after transplantation for or in connection with only the following procedures:

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

Multiple transplantations performed simultaneously are considered one transplant surgery.

Corneal transplants and porcine heart valve implants are tissues, which are considered part of regular plan benefits and are subject to other applicable provisions of the *policy*.

COVERED EXPENSES - TRANSPLANT SERVICES (continued)

The following are *covered expenses* for an approved transplant and all related complications:

- *Hospital* and *health care practitioner* services.

- Acquisition for transplants and associated donor costs, including pre-transplant services, the acquisition procedure, and any complications resulting from the acquisition. Donor costs for post-discharge services and treatment of complications for or in connection with acquisition for an approved transplant will not exceed the transplant treatment period of 365 days from the date of *hospital* discharge following acquisition.

- Direct, non-medical costs for:

  - The *covered person* receiving the 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 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 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 transplant and the designated caregiver(s) or support person(s) are limited to a combined maximum coverage per transplant as specified in the "Schedule of Benefits – Transplant Services" section in this *certificate*.

Covered expenses for post-discharge services and treatment of complications for or in connection with an approved transplant are limited to the transplant treatment period of 365 days from the date of *hospital* discharge following transplantation of an approved transplant received while *you* were covered by *us.* After this transplant treatment period, regular plan benefits and other provisions of the *policy* are applicable.
210200TX 01/16

COVERED EXPENSES – PHARMACY SERVICES

This "Covered Expenses – Pharmacy Services" section describes *covered expenses* under the *policy* for *prescription* drugs, including *specialty drugs*, dispensed by a *pharmacy*. Benefits are subject to applicable *cost share* shown on the "Schedule of Benefits – Pharmacy Services" section of this *certificate*.

Refer to the "Limitations and Exclusions", "Limitations and Exclusions – Pharmacy Services", "Glossary" and "Glossary – Pharmacy Services" sections in this *certificate*. All terms and provisions of the *policy*, including *prior authorization* requirements specified in the "Schedule of Benefits – Pharmacy Services" of this *certificate*, are applicable.

Coverage description

We will cover *prescription* drugs that are received by *you* under this "Covered Expenses – Pharmacy Services" section. Benefits may be subject to *dispensing limits*, *prior authorization* and *step therapy* requirements, if any.

Covered *prescription* drugs are:

- Drugs, medicines or medications and *specialty drugs* that under federal or state law may be dispensed only by *prescription* from a *health care practitioner*.
- Drugs, medicines or medications and *specialty drugs* included on *our drug list*.
- Insulin and *diabetes supplies*.
- Contraceptive drugs and contraceptive drug delivery implants approved by the FDA.
- *Self-administered injectable drugs* approved by *us*.
- Hypodermic needles, syringes or other methods of delivery when prescribed by a *health care practitioner* for use with insulin or *self-administered injectable drugs*. (Hypodermic needles, syringes or other methods of delivery used in conjunction with covered drugs may be available at no cost to *you*).
- Enteral formulas and nutritional supplements for the treatment of phenylketonuria (PKU) or other inherited metabolic disease, or as otherwise determined by *us*.
- Spacers and/or peak flow meters for the treatment of asthma.
- Drugs, medicines or medications on the Preventive Medication Coverage *drug list* with a *prescription* from a *health care practitioner*.

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.

About our drug list

Prescription drugs, medicines or medications, including *specialty drugs* and *self-administered injectable drugs* prescribed by *health care practitioners* and covered by *us* are specified on *our* printable *drug list*. The *drug list* identifies categories of drugs, medicines or medications by levels. It also indicates *dispensing limits*, *specialty drug* designation 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* or *specialty drug lists;*
- 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 *master group contract*. *We* will provide written notice no later than 60 days prior to the *effective date* of the change.

Pharmacy standard exception request

If a clinically appropriate drug is not included on *our drug list*, *you* may contact *us* by phone, electronically, or in writing to request coverage of that specific drug or *specialty drug* (a standard exception request). A standard exception request may be initiated by *you*, *your* appointed representative, or the prescribing *health care practitioner* by calling the customer service number on *your* identification card or visiting *our* Website at www.humana.com. *We* will respond to a standard exception request no later than 72 hours after the receipt date of the request.

As part of the standard exception request, the prescribing *health care practitioner* should include an oral or written statement that provides justification to support the need for the prescribed drug not included on *our drug list* to treat the *covered person's* condition, including a statement that:

- All covered drugs on the *drug list* on any tier will be or have been ineffective;
- Would not be as effective as the drug not included on the *drug list*; or
- Would have adverse effects.

If *we* grant a standard exception request for coverage of a prescribed drug that is not on *our drug list*, *we* will cover the prescribed drug for the duration of the *prescription*, including refills. Any applicable *cost share* for the *prescription* will apply toward the *out-of-pocket limit*.

If *we* deny a standard exception request, *you* have the right to an independent review of *our* decision, as described below in the "Pharmacy external exception request" provision.

Pharmacy expedited exception request

If a clinically appropriate drug is not included on *our drug list*, an expedited exception request based on exigent circumstances may be initiated by *you*, *your* appointed representative, or *your* prescribing *health care practitioner* by calling the customer service number on *your* identification card or visiting *our* Website at www.humana.com. *We* will respond to an expedited exception request within 24 hours of receipt of the request. An exigent circumstance exists when a *covered person* is:

- Suffering from a health condition that may seriously jeopardize their life, health, or ability to regain maximum function; or
- Undergoing a current course of treatment using a drug not included on the *drug list*.

As part of the expedited review request, the prescribing *health care practitioner* should include an oral or written:

- Statement that an exigent circumstance exists and explain the harm that could reasonably be expected to the *covered person* if the requested drug is not provided within the timeframes of the standard drug exception request process; and

- Justification supporting the need for the prescribed drug not included on *our drug list* to treat the *covered person's* condition, including a statement that:

    - All covered drugs on the *drug list* on any tier will be or have been ineffective;
    - Would not be as effective as the drug not included on the *drug list*; or
    - Would have adverse effects.

If *we* grant an expedited exception based on exigent circumstances for coverage of the prescribed drug that is not on *our drug list*, *we* will provide access to the prescribed drug:

- Without unreasonable delay; and
- For the duration of the exigent circumstance.

Any applicable *cost share* for the *prescription* will apply toward the *out-of-pocket limit*.

If *we* deny an expedited exception request, *you* have the right to an independent review of *our* decision, as described below in the "Pharmacy external exception request" provision.

Pharmacy external exception request

If *we* deny a request for a standard exception or an expedited exception, *you*, *your* appointed representative, or the prescribing *health care practitioner* may initiate an external exception request for the original exception request and the denial of that request to be reviewed by an independent review organization (IRO).

The IRO's decision to either uphold or reverse the denial of the original exception request will be provided orally or in writing to *you*, *your* appointed representative, or the prescribing *health care practitioner* no later than:

- 24 hours after receipt of an external exception review request if the original exception request was expedited.
- 72 hours after receipt of an external exception review request if the original exception request was standard.

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LIMITATIONS AND EXCLUSION

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*.

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

- 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. This exclusion applies whether or not *you* have Workers' Compensation coverage. This exclusion does not apply to an *employee* that is sole proprietor, partner, or corporate officer if the sole proprietor, partner or corporate officer is not eligible to receive Workers' Compensation benefits.

- 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.

- 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*.

- 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 by the billing provider.

- Any service not substantiated in the medical records of the billing provider.

LIMITATIONS AND EXCLUSION (continued)

- Expenses for services, *prescriptions*, equipment or supplies received outside the United States or from a foreign provider unless:

  - For *emergency care*;

  - The *employee* is traveling outside the United States due to employment with the *employer* sponsoring this *policy* and the services are not covered under any Workers' Compensation or similar law; or

  - The *employee* and *dependents* live outside the United States and the *employee* is in *active status* with the *employer* sponsoring this *policy*.

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

- 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.

- 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*, *investigational* or *for research purposes* except for clinical trials.

- Vitamins, except for *preventive services* with a *prescription* from a *health care practitioner*, 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 (except for medications for controlling the blood sugar level, including insulin), unless for drugs, medicines or medications or supplies on the Preventive Medication Coverage *drug list* with a *prescription* from a *health care practitioner*.

- Over-the-counter medical items or supplies that can be provided or prescribed by a *health care practitioner* but are also available without a written order or *prescription*, except for *preventive services*.

- Immunizations required for foreign travel for a *covered person* of any age.

- Growth hormones, except as otherwise specified in the pharmacy services sections of this *certificate*.

LIMITATIONS AND EXCLUSION (continued)

- *Prescription* drugs and *self-administered injectable drugs*, except as specified in the "Covered Expenses – Pharmacy Services" section in this *certificate* or unless administered to *you*:

  - While an *inpatient* in a *hospital*, *skilled nursing facility*, *health care treatment facility* or *residential treatment facility for adults*; *chemical dependency treatment center,* or *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*.

- 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.

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

- No benefit is payable for or in connection with a transplant if:

  - The expense relates to storage of cord blood and stem cells, unless it is an integral part of a transplant approved by *us*.

  - *We* do not approve coverage for the 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 donor costs that are payable in whole or in part by any other group plan, insurance company, organization, or person other than the donor's family or estate.

- The expense relates to a transplant performed outside of the United States and any care resulting from that transplant.

- 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; or
  - Sensory integration therapy.

- *Cosmetic surgery* and cosmetic services or devices, unless for reconstructive *surgery* resulting from craniofacial abnormalities of a covered *dependent* child to improve the function of or attempt to create a normal appearance.

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

- Dental services, appliances or supplies for treatment of the teeth, gums, jaws or alveolar processes, including but not limited to, any *oral surgery*, *endodontic services* or *periodontics*, 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.

LIMITATIONS AND EXCLUSION (continued)

- *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 any *sickness* or *bodily injury* resulting from an act of domestic violence or a medical condition (including both physical and mental health conditions).

- Expenses for any membership fees or program fees, including but not limited to, health clubs, health spas, 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*.

- 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 and stethoscopes;
  - Communication system, telephone, television or computer systems and related equipment or similar items or equipment;
  - Communication devices, except after surgical removal of the larynx or a diagnosis of permanent lack of function of the larynx.

- 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.

- Communications or travel time.

LIMITATIONS AND EXCLUSION (continued)

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

- *Sickness* or *bodily injury* for which no-fault medical payment or expense coverage benefits are paid or payable under any homeowners, premises or any other similar coverage.

- Elective medical or surgical abortion unless:

  - The pregnancy would endanger the life of the mother; or
  - The pregnancy is a result of rape or incest.

- *Alternative medicine.*

- Acupuncture, unless:

  - The treatment is *medically necessary*, 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 the midwife is licensed.

- Vision examinations or testing for the purposes of prescribing corrective lenses, except *comprehensive eye exams* provided under the "Covered Expenses – Pediatric Vision Care" section in this *certificate*.

- Orthoptic/vision training (eye exercises).

- Radial keratotomy, refractive keratoplasty or any other *surgery* or procedure to correct myopia, hyperopia or stigmatic error.

- 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*.
  - Otherwise specified in the "Covered Expenses – Pediatric Vision Care" section in this *certificate*.

- Services and supplies which are:

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

LIMITATIONS AND EXCLUSION (continued)

- Marriage counseling.
- *Court-ordered behavioral health* services.
- 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.
- 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 as required by state law.
- *Pre-surgical/procedural testing* duplicated during a *hospital confinement.*

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LIMITATIONS AND EXCLUSIONS – PHARMACY SERVICES

The "Limitations and Exclusions – Pharmacy Services" section describes the limitations and exclusions under the *policy* that apply to *prescription* drugs, including *specialty drugs*, dispensed by a *pharmacy*. Please refer to the "Limitations and Exclusions" section of this *certificate* for additional limitations.

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

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

- *Legend drugs,* which are not deemed *medically necessary* by *us*.
- *Prescription* drugs not included on the *drug list*.
- Any amount exceeding the *default rate*.
- *Specialty drugs* for which coverage is not approved by *us*.
- Drugs and/or ingredients not approved by the FDA, including bulk compounding ingredients.
- 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*, *investigational* or *for research purposes*,

  even though a charge is made to *you*.
- Allergen extracts.
- Therapeutic devices or appliances, including, but not limited to:
  - Hypodermic needles and syringes (except when prescribed by a *health care practitioner* 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.

LIMITATIONS AND EXCLUSIONS – PHARMACY SERVICES (continued)

- 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.

- Minerals.

- Growth hormones for idiopathic short stature or any other condition, unless there is a laboratory confirmed diagnosis of growth hormone deficiency, or as otherwise determined by *us*.

- Herbs and vitamins, except prenatal (including greater than one milligram of folic acid), pediatric multi-vitamins with fluoride and vitamins on the Preventive Medication Coverage *drug list*.

- 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 and drugs or medicines on the Preventive Medication Coverage *drug list*; 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.

- 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).

LIMITATIONS AND EXCLUSIONS – PHARMACY SERVICES (continued)

- *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 on an *inpatient* basis by the facility. *Inpatient* facilities include, but are not limited to:

  - *Hospital*;
  - *Chemical dependency treatment center*;
  - *Crisis stabilization unit*;
  - *Psychiatric day treatment facility*;
  - *Residential treatment center for children and adolescents*;
  - *Skilled nursing facility*; or
  - Hospice facility.

- Injectable drugs, including, but not limited to:

  - Immunizing agents, unless for *preventive services* determined by *us* to be dispensed by or administered in a *pharmacy*;
  - Biological sera;
  - Blood;
  - Blood plasma; or
  - *Self-administered injectable drugs* or *specialty drugs* for which *prior authorization* or *step therapy* is not obtained from *us*.

- *Prescription* fills or 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* fill 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* fill or refill.

- Any portion of a *prescription* fill 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* fill or refill.

- Any portion of a *specialty drug prescription* fill or refill that exceeds a 30-day supply, unless otherwise determined by *us*.

- Any portion of a *prescription* fill 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 *we* require *prior authorization* or *step therapy* and it is not obtained.

LIMITATIONS AND EXCLUSIONS – PHARMACY SERVICES (continued)

- Any drug for which a charge is customarily not made.

- Any drug, medicine or medication received by *you*:

  - Before becoming covered; or
  - After the date *your* coverage 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* fill or refill for drugs, medicines or medications that are lost, stolen, spilled, spoiled, or damaged.

- Drug delivery implants and other implant systems or devices.

- 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.*

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ELIGIBILITY AND EFFECTIVE DATES

Point of service eligibility

To be eligible for the coverage provided through this *certificate*, *you* and *your dependents* must meet the eligibility requirements and be enrolled under the *HMO master group contract*.

Point of service effective date

The effective date for the coverage provided through this *certificate* is stated in the "Evidence of Coverage".
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REPLACEMENT OF COVERAGE

Applicability

This "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.

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;
- Qualifies as a *covered expense* under the *policy*; and
- Would have served to partially or fully satisfy the *deductible* amount under the *policy* for the *year* in which *your* coverage becomes effective.

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.

Out-of-pocket limit

Any amount applied to the Prior Plan's *network out-of-pocket limit* or stop-loss limit will be credited toward the satisfaction of *network out-of-pocket limit* of the *policy* if the amount applied under the Prior Plan:

- Qualifies as a *covered expense* under the *policy*; and
- Would have served to partially or fully satisfy the *out-of-pocket limit* under the *policy* for the *year* in which *your* coverage becomes effective.

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TERMINATION PROVISIONS

Point of service - termination

Your coverage under the *policy* will terminate on the date *you* fail to meet the eligibility requirements of the *HMO master group contract* and are no longer enrolled under the *HMO master group contract*.
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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*.

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 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.
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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.
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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

COORDINATION OF BENEFITS

Coordination of benefits

This "Coordination of Benefits" (COB) provision applies when a *covered person* has health care coverage under more than one *plan*. *Plan* is defined below.

The order of benefit determination rules determine the order in which each *plan* will pay a claim for benefits. The *plan* that pays first is called the primary *plan*. The primary *plan* must pay benefits in accordance with its policy terms without regard to the possibility that another *plan* may cover some expenses. The *plan* that pays after the primary *plan* is the secondary *plan*. The secondary *plan* may reduce the benefits it pays so that payments from all *plan*s equal 100% of the total *allowable expense*.

Definitions

The following definitions are used exclusively in this coordination of benefits provision.

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

Plan includes:

- Group, blanket or franchise accident and health insurance policies, excluding disability income protection coverage;
- Individual and group health maintenance organization evidences of coverage;
- Individual accident and health insurance policies;
- Individual and group preferred provider benefit *plan*s and exclusive provider benefit *plan*s;
- Group insurance contracts, individual insurance contracts and subscriber contracts that pay or reimburse for the cost of dental care;
- Medical care components of individual and group long-term care contracts;
- Uninsured arrangements of group or group-type coverage;
- Medical benefits coverage in automobile insurance contracts;
- Medicare or other governmental benefits, as permitted by law; or
- Limited benefit coverage that is not issued to supplement individual or group in-force policies.

Plan does not include:

- Disability income protection coverage;
- Texas Health Insurance Pool;
- Workers' compensation insurance coverage;
- Hospital confinement indemnity coverage or other fixed indemnity coverage;

- Specified disease coverage;
- Supplemental benefit coverage;
- Accident only coverage;
- Specified accident coverage;
- School accident-type coverages that cover students for accidents only, including athletic injuries, either on a "24-hour" or a "to and from school" basis;
- Benefits provided in long-term care insurance contracts for non-medical services, for example, personal care, adult day care, homemaker services, assistance with activities of daily living, respite care, and custodial care or for contracts that pay a fixed daily benefit without regard to expenses incurred or the receipt of services;
- Medicare supplement policies;
- A state *plan* under Medicaid;
- A governmental *plan* that, by law, provides benefits that are in excess of those of any private insurance *plan*;
- Other non-governmental *plan*; or
- An individual accident and health insurance policy that is designed to fully integrate with other policies through a variable deductible.

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.*

Prescription drug coverage under a Prescription Drug Benefit will be considered a separate *plan* for the purposes of COB and will only be coordinated with other *prescription* drug coverage.

This plan means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other *plan*s. Any other part of the contract providing health care benefits is separate from *this plan*. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with like benefits, and may apply other separate COB provisions to coordinate other benefits.

The order of benefit determination rules determine whether *this plan* is a primary *plan* or secondary *plan* when the person has health care coverage under more than one *plan*. When *this plan* is primary, it determines payment for its benefits first before those of any other *plan* without considering any other *plan*'s benefits. When *this plan* is secondary, it determines its benefits after those of another *plan* and may reduce the benefits it pays so that all *plan* benefits equal 100% of the total *allowable expense*.

COORDINATION OF BENEFITS (continued)

Allowable expense is a health care expense, including deductibles, coinsurance, and copayments, that is covered at least in part by any *plan* covering the person. When a *plan* provides benefits in the form of services, the reasonable cash value of each service will be considered an *allowable expense* and a benefit paid. An expense that is not covered by any *plan* covering the person is not an *allowable expense*. In addition, any expense that a health care provider or physician by law or in accord with a contractual agreement is prohibited from charging a *covered person* is not an *allowable expense*.

The following are examples of expenses that are not *allowable expenses*:

- The difference between the cost of a semi-private hospital room and a private hospital room is not an *allowable expense*, unless one of the *plan*s provides coverage for private hospital room expenses.

- If a person is covered by two or more *plan*s that do not have negotiated fees and compute their benefit payments based on the usual and customary fees, allowed amounts, or relative value schedule reimbursement methodology, or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an *allowable expense*.

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

- If a person is covered by one *plan* that does not have negotiated fees and that calculates its benefits or services based on usual and customary fees, allowed amounts, relative value schedule reimbursement methodology, or other similar reimbursement methodology, and another *plan* that provides its benefits or services based on negotiated fees, the primary *plan*'s payment arrangement must be the *allowable expense* for all *plan*s. However, if the health care provider or physician has contracted with the secondary *plan* to provide the benefit or service for a specific negotiated fee or payment amount that is different than the primary *plan*'s payment arrangement and if the health care provider's or physician's contract permits, the negotiated fee or payment must be the *allowable expense* used by the secondary *plan* to determine its benefits.

- The amount of any benefit reduction by the primary *plan* because a *covered person* has failed to comply with the *plan* provisions is not an *allowable expense*. Examples of these types of *plan* provisions include second surgical opinions, *preauthorization* of admissions, and preferred health care provider and physician arrangements.

Allowed amount is the amount of a billed charge that a carrier determines to be covered for services provided by a non-network health care provider or physician. The allowed amount includes the carrier's payment and any applicable deductible, copayment, or coinsurance amounts for which the insured is responsible.

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

Custodial parent is the parent with the right to designate the primary residence of a child by a court order under the Texas Family Code or other applicable law, or in the absence of a court order, is the parent with whom the child resides more than one-half of the calendar year, excluding any temporary visitation.

Order of benefit determination rules

When a person is covered by two or more *plan*s, the rules for determining the order of benefit payments are as follows:

- The primary *plan* pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other *plan*.

- Except as provided in the bullet below, a *plan* that does not contain a COB provision that is consistent with this policy is always primary unless the provisions of both *plan*s state that the complying *plan* is primary.

- Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage must 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 calculating payment of its benefits only when it is secondary to that other *plan*.

- If the primary *plan* is a closed panel *plan* and the secondary *plan* is not, the secondary *plan* must pay or provide benefits as if it were the primary *plan* when a *covered person* uses a non-network health care provider or physician, except for emergency services or authorized referrals that are paid or provided by the primary *plan*.

- When multiple contracts providing coordinated coverage are treated as a single *plan* under this provision, this section applies only to the *plan* as a whole, and coordination among the component contracts is governed by the terms of the contracts. If more than one carrier pays or provides benefits under the *plan*, the carrier designated as primary within the *plan* must be responsible for the *plan*'s compliance with this provision.

- If a person is covered by more than one secondary *plan*, the order of benefit determination rules of this provision decide the order in which secondary *plan*s' benefits are determined in relation to each other. Each secondary *plan* must take into consideration the benefits of the primary *plan* or *plan*s and the benefits of any other *plan* that, under the rules of this contract, has its benefits determined before those of that secondary *plan*.

COORDINATION OF BENEFITS (continued)

Each *plan* determines its order of benefits using the first of the following rules that apply:

- **Nondependent or *dependent***: The *plan* that covers the person other than as a dependent, for example as an *employee*, member, policyholder, subscriber, or retiree, is the primary *plan*, and the *plan* that covers the person as a dependent is the secondary *plan*. 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, then the order of benefits between the two plans is reversed so that the *plan* covering the person as an *employee*, member, policyholder, subscriber, or retiree is the secondary *plan* and the other *plan* is the primary *plan*. An example includes a retired *employee*.

- ***Dependent* child covered under more than one *plan***: Unless there is a court order stating otherwise, *plan*s covering a dependent child must determine the order of benefits using the following rules that apply:

  - For a dependent child whose parents are married or are living together, whether or not they have ever been married:

    - The *plan* of the parent whose birthday falls earlier in the calendar year is the primary *plan*; or
    - If both parents have the same birthday, the *plan* that has covered the parent the longest is the primary *plan.*

  - For a dependent child whose parents are divorced, separated, or not living together, whether or not they have ever been married:

    - If a court order states that one parent is responsible for the dependent 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 *plan* years commencing after the *plan* is given notice of the court decree.

    - If a court order states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of a dependent child whose parents are married or are living together, whether or not they have ever been married must determine the order of benefits.

    - If a court order states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of a dependent child whose parents are married or are living together, whether or not they have ever been married must determine the order of benefits.

    - If there is no court order allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

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

- For a dependent child covered under more than one *plan* of individuals who are not the parents of the child, the provisions of a dependent child whose parents are married or are living together, whether or not they have ever been married or a dependent child whose parents are divorced, separated, or not living together, whether or not they have ever been married must determine the order of benefits as if those individuals were the parents of the child.

- For a dependent child who has coverage under either or both parents' *plan*s and has his or her own coverage as a dependent under a spouse's *plan*, the *plan* that has covered the person as an *employee*, member, policyholder, subscriber, or retiree longer is the primary *plan*, and the *plan* that has covered the person the shorter period is the secondary *plan* applies.

- In the event the dependent child's coverage under the spouse's *plan* began on the same date as the dependent child's coverage under either or both parents' *plan*s, the order of benefits must be determined by applying the birthday rule for a dependent child whose parents are married or are living together, whether or not they have ever been married to the dependent child's parent(s) and the dependent's spouse.

- **Active, retired, or laid-off *employee***: The *plan* that covers a person as an active *employee* who is neither laid off nor retired, is the primary *plan*. The *plan* that covers that same person as a retired or laid-off *employee* is the secondary *plan*. The same would hold true if a person is a dependent of an active *employee* and that same person is a dependent of a retired or laid-off *employee*. If the *plan* that covers the same person as a retired or laid-off *employee* or as a dependent of a retired or laid-off *employee* does not have this rule, and as a result, the *plan*s do not agree on the order of benefits, this rule does not apply. This rule does not apply if the Nondependent or *dependent* rule can determine the order of benefits.

- **COBRA or state continuation coverage**. If a person whose coverage is provided under COBRA or under a right of continuation provided by state or other federal law is covered under another *plan*, the *plan* covering the person as an *employee*, member, subscriber, or retiree or covering the person as a *dependent* of an *employee*, member, subscriber, or retiree is the primary *plan*, and the COBRA, state, or other federal continuation coverage is the secondary *plan*. If the other *plan* does not have this rule, and as a result, the *plan*s do not agree on the order of benefits, this rule does not apply. This rule does not apply if the Nondependent or *dependent* rule can determine the order of benefits.

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

If the preceding rules do not determine the order of benefits, the *allowable expenses* must be shared equally between the *plan*s meeting the definition of *plan*. In addition, *this plan* will not pay more than it would have paid had it been the primary *plan*.

COORDINATION OF BENEFITS (continued)

Effect on the benefits of this plan

When *this plan* is secondary, it may reduce its benefits so that the total benefits paid or provided by all *plan*s are not more than the total *allowable expenses*. In determining the amount to be paid for any claim, the secondary *plan* will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any *allowable expense* under its *plan* that is unpaid by the primary *plan*. The secondary *plan* may then reduce its payment by the amount so that, when combined with the amount paid by the primary *plan*, the total benefits paid or provided by all *plan*s for the claim equal 100% of the total *allowable expense* for that claim. In addition, the secondary *plan* must credit to its *plan* deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

If a *covered person* is enrolled in two or more closed panel *plan*s 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 must not apply between that *plan* and other closed panel *plan*s.

Compliance with Federal and State laws concerning confidential 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 *plan*s. *We* will comply with federal and state law concerning confidential information for the purpose of applying these rules and determining benefits payable under *this plan* and other *plan*s covering the person claiming benefits. Each person claiming benefits under *this plan* must give *us* any facts it needs to apply those rules and determine benefits.

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 that 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 the reasonable cash value of the benefits provided in the form of services.

Right of recovery

If the amount of the payments made by *us* is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has 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.

COORDINATION OF BENEFITS FOR MEDICARE ELIGIBLES

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. 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.

Coordination of benefits with Medicare Part B

If *you* are eligible for *Medicare Part B*, the *Medicare* program that provides medical insurance benefits, but are not enrolled, *your* benefits under the *policy* may be coordinated as if *you* were enrolled in *Medicare Part B*. *We* may not pay benefits to the extent that benefits would have been payable under *Medicare Part B*, if *you* had enrolled. Therefore, it is important that *you* enroll in *Medicare Part B* if *you* are eligible to do so.
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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* within 20 days after the date of any loss coverage by the policy, or as soon as is reasonably possible thereafter. Notice must be sent to *us* at *our* mailing address shown on *your* identification documentation or *our* Website at www.humana.com.

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.

If *you* receive services outside the United States or from a foreign provider, *you* must also submit the following information along with *your* complete claim:

- *Your* proof of payment to the provider for the services received outside the United States or from a foreign provider;
- Complete medical information and medical records;
- *Your* proof of travel outside of the United States, such as airline tickets or passport stamps, if *you* traveled to receive the services; and
- The foreign provider's fee schedule if the provider uses a billing agency.

The forms necessary for filing proof of loss are available at www.humana.com. 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.

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.

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.

CLAIMS (continued)

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.

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*.

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.

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.

Right to request overpayments

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

- Made in error;
- Made to *you* 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*.

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 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;
- Providing copies of claims and settlement demands submitted to third parties in relation to a *bodily injury* or *sickness*;
- Disclosing details of liability settlement agreements reached with third parties in relation to a *bodily injury* or *sickness*; 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.

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.

Recovery rights

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

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 served 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*.

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, 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 <u>not</u> 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.

Workers' compensation

This *policy* excludes coverage for *sickness* or *bodily injury* for which Workers' Compensation or similar coverage is available.

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 shall have first priority to recover benefits *we* have paid from any funds that are paid or payable by Workers' Compensation or similar coverage as a result of any *sickness* or *bodily injury*, and *we* shall not be responsible for contributing to any attorney fees or recovery expenses under a Common Fund or similar doctrine.

Our right to recover from funds that are paid or payable by Workers' Compensation or similar coverage will apply even though:

- The Workers' Compensation carrier does not accept responsibility to provide benefits;
- There is no final determination 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.

As a condition to receiving benefits from *us*, *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. If *we* are precluded from exercising *our* recovery rights to recover from funds that are paid by Workers' Compensation or similar coverage *we* will exercise *our* right to recover against *you*.

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, including self-insured entities;
- Medical payments/expense coverage under any automobile, homeowners, premises or similar coverages;
- Workers' Compensation or other similar coverage; and
- 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. *We* shall have first priority to recover benefits *we* have paid from any funds that are paid or payable as a result of any *sickness* or *bodily injury*, regardless of whether available funds are sufficient to fully compensate *you* for *your sickness* or *bodily injury*.

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

Right of reimbursement

If benefits are paid under the *policy*, and *you* recover from any legally responsible person, their insurer, or medical payment/expense, Workers' Compensation, 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 medical payment/expense, Workers' Compensation, 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.

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 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 homeowner's, premises or similar coverage, *we* have the right to recover from *you*, or whomever *we* have paid an amount equal to the amount *we* paid.

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*. *We* shall not be responsible to contribute to the cost of legal fees or expenses incurred by *you* under any Common Fund or similar doctrine 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.
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COMPLAINT AND APPEAL PROCEDURES

Appeal and external review rights

If a *covered person* is dissatisfied with a determination of a claim, he or she may appeal the decision. The *covered person* should appeal to *us* in writing to the address given on the denial letter received.

Grievance and Appeal Department
P.O. Box 14546
Lexington, KY 40512-4546

Such appeals will be handled on a timely basis and appropriate records will be kept on all appeals.

Once *we* receive the request, *we* will make a review of the claim, and provide notice of *our* decision following any processes or timeframes required by state law.

A covered person also has the right to request an external review of an adverse claim determination. For questions on appeal and external review rights, a *covered person* can call the telephone number on the back of their ID card.

If you need help with appeals, complaints or the external review process, contact the Texas Department of Insurance (TDI) Consumer Protection. Call TDI at 1-800-252-3439. You can also send an email to ConsumerProtection@tdi.texas.gov or a written request to:

Texas Department of Insurance
Consumer Protection Section
Mail Code 111-1A
P.O. Box 149091
Austin, TX 78714-9091

Definitions

Adverse determination means a denial, reduction, or termination of, or a failure to provide or make a payment on behalf of any payor (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 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.

The term does not include a denial of health care services due to the failure to request prospective or concurrent utilization review.

For *prescription drug* coverage, an *adverse determination* includes a denial to provide benefits for a *prescription drug* if:

- The *prescription drug* is not included on *our drug list*; and
- *Your health care practitioner* has determined the *prescription drug* is *medically necessary.*

Complaint means any dissatisfaction expressed by a *covered person* orally or in writing to *us* with any aspect of *our* operation, including but not limited to, dissatisfaction with plan administration, procedures related to the review or appeal of an *adverse determination*, the denial, reduction, or termination of a service for reasons not related to medical necessity, the way a service is provided; or disenrollment decisions. A *complaint* is not a misunderstanding or a problem of misinformation that is resolved promptly by supplying the appropriate information to the satisfaction of the *covered person* and does not include *adverse determinations*.

Complaint process

If a *covered person* notifies *us* orally or in writing of a *complaint*, *we* will, not later than the fifth business day after the date of the receipt of the *complaint*, send to the *covered person* a letter acknowledging the date *we* received the *complaint*. This letter will also include Humana's *complaint* procedures and time frames for resolution.

We will investigate and send a letter with *our* resolution to the *covered person*. The total time for acknowledging, investigating and resolving the *covered person's complaint* will not exceed 30 calendar days after the date *we* receive the *complaint*. *We* shall complete the appeals process not later than the 30th calendar day after the date of the receipt of the request for appeal. *We* shall send an acknowledgment letter to the *covered person* not later than the fifth business day after the date of receipt of the request for appeal.

Investigation and resolution of appeals relating to ongoing emergencies or denials of continued stays for hospitalization shall be concluded in accordance with the medical or dental immediacy of the condition but in no event to exceed one working day after the *covered person's* request for appeal. Due to the ongoing emergency or continued hospital stay, and at the *covered person's* request, *we* shall provide, a review by a *health care practitioner* who has not previously reviewed the case and is of the same or similar specialty as typically manages the medical condition, procedure, or treatment under discussion for review of the appeal.

The *health care practitioner* reviewing the appeal may interview the *covered person* or the *covered person's* designated representative and shall render a decision on the appeal. Initial notice of the decision may be delivered orally if followed by written notice of the determination within three calendar days.

Notice of *our* final decision on the appeal must include a statement of the specific medical determination, clinical basis, and contractual criteria used to reach the final decision.

Notification of adverse determinations

The *adverse determination* notification must be provided to the *covered person's* provider including the health care provider who rendered the service, the *covered person*, or the person acting on behalf of the *covered person* who is hospitalized at the time of the *adverse determination*, within one working day by telephone or electronic transmission; within the time appropriate to the circumstances relating to the delivery of the services and the condition of the *covered person*, but in no case to exceed one hour from notification when denying post-stabilization care subsequent to emergency treatment as requested by a treating *health care practitioner*.

COMPLAINT AND APPEAL PROCEDURES (continued)

Appeals of adverse determinations

A *covered person*, a person acting on behalf of the *covered person*, or the *covered person's health care practitioner* has the right to appeal an *adverse determination* relating to medical necessity for denial of a service orally or in writing.

When *we* receive an appeal, *we* will, within five working days from the receipt of the appeal, send to the appealing party a letter acknowledging the date of *our* receipt of the appeal. This letter will include the appeal procedures and the timeframes required for resolution. If an appeal of an *adverse determination* is received orally, included in the acknowledgement letter will be a one-page appeal form to the appealing party.

After review of the appeal of an *adverse determination*, *we* will issue a response letter to the *covered person*, or a person acting on behalf of the *covered person* and the *covered person's health care practitioner* explaining the resolution of the appeal as soon as practical, but in no case later than the 30th calendar day after the date *we* receive the appeal. If the appeal is for:

- *Emergency care*;
- Denial of a continued stay for hospitalized patients; or
- Denial of *prescription* drugs or intravenous infusions for which the patient is receiving benefits under the *policy*,

the time frame for resolution will be based on the medical or dental immediacy of the condition, procedure or treatment, but may not exceed one working day from the date the request is received. The resolution letter will contain the clinical basis for the appeal's denial, the specialty of the *health care practitioner* making the denial, and notice of the appealing party's right to seek review of the denial by an independent review organization (IRO).

If the appeal of an *adverse determination* is denied, a provider can within 10 working days request in writing good cause for having a particular type of specialty provider review the case, the appeal denial shall be reviewed by a *network provider* in the same or similar specialty who typically treats the medical condition, performs the procedure, or provides the treatment under discussion for review in the *adverse determination*, and such specialty review will be completed within 15 business days of receipt of the request from the provider.

Filing complaints with the Texas Department of Insurance

Any person, including persons who have attempted to resolve *complaints* through *our complaint* and appeal process and who are dissatisfied with the resolution, may report an alleged violation to the Texas Department of Insurance, P. O. Box 149091, Austin, Texas 78714-9091.

The commissioner shall investigate a *complaint* against *us* to determine compliance within 60 days after the Texas Department of Insurance's receipt of the *complaint* and all information necessary for the department to determine compliance. The commissioner may extend the time necessary to complete an investigation in the event any of the following circumstances occur:

- Additional information is needed;
- An on-site review is necessary;
- *We*, the *health care practitioner*, or the *covered person* does not provide all documentation necessary to complete the investigation; or
- Other circumstances beyond the control of the department occur.

Appeals process to internal review organization (IRO)

In a circumstance involving a *life threatening* condition, or denial of *prescription* drugs or intravenous infusions for which the *covered person* is receiving benefits under the *policy*, the *covered person* is entitled to an immediate appeal to an independent review organization (IRO) and is not required to comply with procedures for an internal review of *our adverse determination*. The procedure for filing an immediate appeal to an IRO is included in *our* initial denial notice.

We shall permit any party whose appeal of an *adverse determination* is denied by *us* to seek review of that determination by an independent review organization assigned to the appeal. The procedure for requesting an IRO review is included in *our* appeal resolution letter.

The appeal process does not prohibit the *covered person* from pursuing other appropriate remedies, including injunctive relief, a declaratory judgment, or relief available under law, if the requirement of exhausting the process for appeal and review places the *covered person's* health in serious jeopardy.

Exhaustion of remedies

All levels of the appeal process applicable to *you* and any regulatory/statutory review process available to *you* under state or federal law are suggested to be completed before *you* file a legal action. Completion of these administrative and/or regulatory processes assures that both *you* and *we* have a full and fair opportunity to resolve any disputes regarding the terms and conditions contained in the *master group contract*.

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 lawsuit may be brought after the expiration of three years after the time written proof of loss is required to be furnished.

DISCLOSURE PROVISIONS

Employee assistance program

We may provide *you* access to an employee assistance program (EAP). The EAP may include confidential, telephonic consultations and work-life services. The EAP provides *you* with short-term, problem solving services for issues that may otherwise affect *your* work, personal life or health. The EAP is designed to provide *you* with information and assistance regarding *your* issue and may also assist *you* with finding a medical provider or local community resource.

The services provided by the EAP are not *covered expenses* or insured benefits under the *policy*, therefore the *copayments*, *deductible* or *coinsurance* do not apply. However, there may be additional costs to *you*, if *you* obtain services from a professional or organization the EAP has recommended or has referred *you* to. The EAP does not provide medical care. *You* are not required to participate in the EAP before using *your* insured benefits under the *policy*, and the EAP services are not coordinated with *covered expenses* under the *policy*. The decision to participate in the EAP is voluntary, and *you* may participate at any time during the *year*. Refer to the marketing literature for additional information.

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:

- "Participatory" wellness programs do not require *you* to meet a standard related to a health factor. Examples of participatory wellness programs may include, but are not limited to, membership in a fitness center, certain preventive testing, or attending a no-cost health education seminar.

- "Health-contingent" wellness programs require *you* to attain certain wellness goals that are related to a health factor. Examples of health contingent wellness programs may include, but are not limited to, completing a 5k event, lowering blood pressure or ceasing the use of tobacco.

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 participatory or health contingent wellness programs. These rewards may include, but are not limited to, payment for all or a portion of a participatory wellness program, items such as merchandise, gift cards, travel and merchandise discounts. The rewards may also include, but are not limited to, discounts or credits toward premium or a reduction in *copayments*, *deductibles* or *coinsurance*, as permitted under applicable state and federal laws. Such insurance premium or benefit rewards may be made available at the individual or *group* health plan level. 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.

We are committed to helping *you* achieve *your* best health. Some wellness programs may be offered only to *covered persons* with particular health factors. If *you* think *you* might be unable to meet a standard for a reward under a health contingent wellness program, *you* might qualify for an opportunity to earn the same reward by different means. Please call the telephone number listed on *your* ID card or in the marketing literature issued 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 will work with *you* (and, if *you* wish, with *your health care practitioner*) to find a wellness program with the same reward that is right for *you* in light of *your* health status.

We may require proof in writing from *your* health care practitioner that *your* medical condition prevents *you* from taking part in the available activities.

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. If eligible, *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*.

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*. However, it will be *our* sole discretion as to whether *we* will apply the Shared Savings Program on a case by case basis. *We* cannot guarantee that services rendered by *non-network providers* 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.

DISCLOSURE PROVISIONS (continued)

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* ID card. 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.
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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.

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; and
    - Information regarding continuation rights.

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

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 at www.humana.com or in writing when requested. The *policyholder* is responsible for providing *employees* access to the *certificate*.

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 <u>not</u> 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.

Incontestability

No misstatement made by the *policyholder*, except for fraud or an intentional misrepresentation of a material fact made in the application may be used to void the *policy*.

MISCELLANEOUS PROVISIONS (continued)

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

- Nonpayment of premium; or
- Any fraud or intentional misrepresentation of a material fact 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.

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*, *we* reserve the right to *rescind your* coverage after *we* provide *you* a 30 calendar day advance written notice that coverage will be *rescinded*. *You* have the right to appeal the *rescission*.

Clerical error or misstatement

If it is determined that information about a *covered person* was omitted or misstated in error, an adjustment may be made in premiums and/or coverage in effect. This provision applies to *you* and to *us*.

Modification of policy

The *policy* may be modified by *us*, upon renewal of the *policy*, as permitted by state and federal law. The *policyholder* will be notified in writing or *electronically* at least 60 days prior to the effective date of the change.

The *policy* may be modified 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.

MISCELLANEOUS PROVISIONS (continued)

Corrections due to clerical errors or clarifications that do not change benefits are not modifications of the *policy* and may be made by *us* at any time without prior consent of, or notice to, the *policyholder*.

Discontinuation of coverage

If *we* decide to discontinue offering a particular group health policy:

- The *policyholder*, *employees* and *covered persons* will be notified of such discontinuation at least 90 days prior to the date of discontinuation of such coverage; and
- The *policyholder* will be given the option to purchase all other group health plans providing medical benefits that are being offered by *us* at such time.

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.

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*.

Assignment

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

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).
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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*.

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 determined by the *policyholder* or as specified in the *participation criteria* established by a *large employer*;
- 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 are 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*.

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.

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 supplements and medicine, holistic medicine, homeopathy, hypnosis, macrobiotics, massage therapy, naturopathy, ozone therapy, reflexotherapy, relaxation response, rolfing, shiatsue, yoga and chelation therapy.

Ambulance means a professionally operated ground or air 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.

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. 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, from a matched related or unrelated donor or cord blood. The term *bone marrow* includes the harvesting, the transplantation and the integral chemotherapy components.

C

Certificate means this benefit plan document that 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.

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 individuals brain-behavioral deficits.

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

Community reintegration services means services that facilitate the continuum of care as an affected individual transitions into the community.

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 *you* are in *observation status*.

Congenital anomaly means an abnormality of the body that is present from the time of birth.

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 *you* must pay to a provider for *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 to treat a *sickness* or *bodily injury*, such as:
    - Procedures;
    - *Surgeries*;
    - Consultations;
    - Advice;
    - Diagnosis;
    - Referrals;
    - Treatment;
    - Supplies;
    - Drugs;
    - Devices; or
    - Technologies;
- *Preventive services*;
- *Pediatric dental services*;
- *Pediatric vision care*;
- *Prescription* drugs, including *specialty drugs*, dispensed by a *pharmacy*.

To be considered a *covered expense*, services must be:

- Ordered by a *health care practitioner*;
- Authorized, furnished or prescribed by a *qualified provider*;
- 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* 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.

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;

- 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*.

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 *covered expenses*. *Covered expenses* applied to the *deductible* listed in this *certificate* will be applied to the *deductible* listed in the "Evidence of Coverage".

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, unless the biting or chewing injury is a result of an act of domestic violence or a medical condition (including both physical and mental health conditions).

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 and whose age is less than the limiting age;

- 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 depe7ndent 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*.

- *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; or grandchild, if the grandchild is dependent on the *employee* for Federal Income Tax purposes at the time of application

  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, foster child, including where the great grandchild, 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 receiving 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;
- 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 prior to the covered *dependent* child attaining the limiting age.

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 agents for controlling blood sugar levels; prescriptive non-insulin injectable 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.

Distant site means the location of a *health care practitioner* at the time a *telehealth* or *telemedicine* service is provided.

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 <u>one</u> *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 not 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 6 months and, periodically thereafter, to require proof that the *domestic partner* relationship continues to exist.

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 *skilled nursing facility*; and
- It is provided in the most cost effective manner required by *your* condition, including, rental or purchase.

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* also 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.

Endodontic services mean the following dental procedures, related tests or treatment and follow-up care:

- Root canal therapy and root canal fillings;
- Periadacular *surgery*;
- Apicoectomy;
- Partial pulpotomy; or
- Vital pulpotomy.

Experimental, ***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 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; (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.

F

Family member means *you* or *your* spouse or *domestic partner*. It also means *your* or *your* spouse's or *domestic partner'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 determined by the *policyholder*.

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

G

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

H

Habilitative services means health care services and devices that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Health care practitioner means a practitioner professionally licensed by the appropriate state agency to provide *preventive services* or 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 or *serious mental illness* services and is primarily established and operating within the scope of its license.

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.

HMO means Humana Health Plan of Texas, Inc., a licensed health maintenance organization.

Home health care agency means a *home health care agency* or *hospital*, licensed by the Texas Department of Health and which meets all of the following requirements:

- It must primarily provide skilled nursing services and other therapeutic services under the supervision of physicians or registered nurses;
- It must be operated according to established processes and procedures by a group of professional medical people, including physicians and *nurses*;
- It must maintain clinical records on all patients; and
- It must be licensed by the jurisdiction where it is located, if licensure is required. It must be operated according to the laws of that jurisdiction, which pertains to agencies providing home health care.

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 that is 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; and
- 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*.

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.

I

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.

J

K

L

Large employer means an *employer* who employed an average of at least 51 *employees* on business days during the preceding calendar year and who employs at least one *employee* 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 or her *eligibility date*, later than the time period specified in the "Special enrollment" provision, or after the *open enrollment period*.

Level 1 network health care practitioner means a *network health care practitioner* practicing in a *health care treatment facility* or *retail clinic:*

- With a specialty of pediatric or internal medicine; or
- Who is a general practitioner, nurse practitioner, physician assistant or registered nurse.

Level 2 network health care practitioner means a *network health care practitioner*, practicing in a *health care treatment facility*, who has received training in a specific medical field other than those listed in the *level 1 network health care practitioner* definition.

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.

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*, other than *emergency care* services provided by *non-network providers* in a *hospital's* emergency department 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.

Maximum allowable fee for a *covered expense* for *emergency care* services provided by *non-network providers* in a *hospital's* emergency department is an amount equal to the greatest of:

- The usual or customary charge for the service;
- The fee negotiated with *network providers*;
- The fee calculated using the same method to determine payments for *non-network provider* services; or
- The fee paid by *Medicare* for the same services.

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 over the *maximum allowable fee* will not apply to *your out-of-pocket limit* or *deductible*.

When *you* provide *us* proof of any amount *you* pay to the *non-network provider* over the *maximum allowable fee*, *we* will apply that amount to *your network provider out-of-pocket limit* and *deductible* when *covered expenses* are for:

- *Emergency care* services provided by *non-network providers*; and
- *Non-network provider* services preauthorized by *us* when *we* determine a *network provider* is not reasonably available.

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 mental, nervous or emotional conditions classified in the Diagnostic and Statistical Manual of Mental Disorders.

Morbid 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.

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.

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.

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

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.

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.).

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 *employees* have an opportunity to enroll themselves and their eligible *dependents* for coverage under the *policy.*

Options II means the health care benefits package offered through Humana Health Plan of Texas, Inc. and Humana Insurance Company.

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 surgical procedures, including gingivectomies.

Originating site means the location of a *covered person* at the time a *telehealth* or *telemedicine* service is being furnished.

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

Covered expenses paid by *you* and applied to the *out-of-pocket limit* in this *certificate* will be applied to the *out-of-pocket* listed in the "Evidence of Coverage".

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*.

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:

- *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. *Periodontics* includes the following dental procedures, related tests or treatment and follow-up care:

- Periodontal maintenance;
- Scaling and root planing;
- Gingivectomy;
- Gingivoplasty; or
- Osseous *surgery*.

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

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

Policyholder means the legal entity identified as the group plan sponsor on the face page of the master group contract or "Evidence of Coverage" who establishes, sponsors and endorses an employee benefit plan for health care coverage.

Post-acute transition services means *services* that facilitate the continuum of care beyond the initial neurological insult through rehabilitation and community reintegration.

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*.

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 www.healthcare.gov website 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.

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.

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.

Qualified provider means a person, facility or any other health care provider:

- That is licensed by the appropriate state agency to:

    - Diagnose or treat a *sickness* or *bodily injury*;
    - Provide *preventive services*;
    - Provide *pediatric dental services*; or
    - Provide *pediatric vision care*;

- That provides services within the scope of their license; and
- Whose primary purpose is to provide health care services.

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.

Remediation means the process(es) of restoring or improving a specific function.

Rescission, ***rescind*** or ***rescinded*** means a cancellation or discontinuance of coverage that has a retroactive effect.

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.

Residential treatment is utilized to provide structure, support and reinforcement of the treatment required to reverse the course of behavioral deterioration.

Residential treatment facility for adults means an institution that:

- Is licensed as a 24-hour residential facility for *behavioral health* treatment, although not licensed as a *hospital*;
- Provides a multidisciplinary treatment plan in a controlled environment, under the supervision of a physician who is able to provide treatment on a daily basis;
- Provides supervision and treatment by a Ph.D. psychologist, licensed therapist, psychiatric nursing staff or registered nurse;
- Provides programs such as social, psychological, family counseling and rehabilitative training, age appropriate for the special needs of the age group of patients, with focus on reintegration back into the community; and
- Provides structured activities throughout the day and evening, for a minimum of 6 hours a day.

Residential treatment is utilized to provide structure, support and reinforcement of the treatment required to reverse the course of behavioral deterioration.

Retail clinic means a *health care treatment facility*, located in a retail store, that is often staffed by nurse practitioners and physician assistants who provide minor medical services on a "walk-in" basis (no appointment required).

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 not considered *routine nursery care*.

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);
- Pervasive development disorders;
- 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 one, but not more than 50 *employees* on business days during the preceding calendar year and who employs at least one *employee* on the first day of the *year*. All subsidiaries or affiliates of the *policyholder* are considered one *employer* when the conditions specified in the "Subsidiaries or Affiliates" section of the *policy* are met.

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.

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.

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.

V

W

Waiting period means the period of time, elected by the *policyholder*, that 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*.

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

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GLOSSARY – PHARMACY SERVICES

All terms used in the "Schedule of Benefits – Pharmacy Services," "Covered Expenses – Pharmacy Services" and "Limitations and Exclusions – Pharmacy Services" sections have the same meaning given to them in the "Glossary" section of this *certificate*, unless otherwise specifically defined below:

A

B

Brand-name drug 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*.

C

Copayment means the specified dollar amount to be paid by *you* toward the cost of each separate *prescription* fill or refill dispensed by a *pharmacy*.

Cost share means any *deductible* and *coinsurance* that *you* must pay per *prescription* fill or refill.

D

Default rate means the fee based on rates negotiated by *us* or other payers with one or more *network providers* in a geographic area determined by *us* for the same or similar prescription fill or refill.

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

Drug list means a list of covered *prescription* drugs, medicines or medications and supplies specified by *us*. The *drug list* identifies categories of drugs, medicines or medications and supplies by applicable levels, if any, and indicates applicable *dispensing limits*, *specialty drug* designation 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* ID card to obtain the *drug list*.

E

F

G

Generic drug 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*.

H

I

J

K

L

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".

GLOSSARY – PHARMACY SERVICES (continued)

M

Mail order pharmacy means a *pharmacy* that provides covered *mail order pharmacy* services, as defined by *us*, and delivers covered *prescription* drug, medicine or medication fills or refills through the mail to *covered persons*.

N

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

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

as defined by *us*, to *covered persons*, including covered *prescription* fills or refills delivered to *your* home or health care provider.

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

as defined by *us*, to *covered persons*, including covered *prescription* fills or refills delivered to *your* home or health care provider.

O

P

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* drugs, medicines or 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 written by a *health care practitioner* and provided to a *pharmacist* for *your* benefit and used for the treatment of a *sickness* or *bodily injury*, which is covered under this plan, or for drugs, medicines or medications on the Preventive Medication Coverage *drug list*. The drug, medicine or medication must be obtainable only by *prescription* or must be obtained by *prescription* for drugs, medicines or medications on the Preventive Medication Coverage *drug list*. The *prescription* may be given to the *pharmacist* verbally, *electronically* or in writing by the *health care practitioner*. The *prescription* must include at least:

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

Prior authorization means the required prior approval from *us* for the coverage of certain *prescription* drugs, medicines or medications, including *specialty drugs*. The required prior approval from *us* for coverage includes the dosage, quantity and duration, as appropriate for *your* diagnosis, age and gender.

Q

R

S

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:

- Be injected, infused or require close monitoring by a *health care practitioner* or clinically trained individual;
- 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 medications, including *specialty drugs*. *We* may also require *you* to try similar drugs, medicine or medication, including *specialty drugs* that have been determined to be safe, effective and more cost-effective for most people with *your* condition. Alternatives may include over-the-counter drugs, *generic drugs* and *brand-name drugs*.

T

U

V

W

X

Y

Z

Texas Department of Insurance Notice

You have the right to an adequate network of preferred providers (also known as "network providers").

- If you believe that the network is inadequate, you may file a complaint with the Texas Department of Insurance.

- If you obtain out-of-network services because no preferred provider was reasonably available, you may be entitled to have the claim paid at the in-network rate and your out-of-pocket expenses counted toward your in-network deductible and out-of-pocket maximum.

You have the right to obtain advance estimates:

- Of the amounts that the providers may bill for projected services, from your out-of-network provider; and
- Of the amounts that the insurer may pay for the projected services, from your insurer.

You may obtain a current directory of preferred providers at the following website www.humana.com or by calling our toll free customer service number listed on your ID card for assistance in finding available preferred providers. If the directory is materially inaccurate, you may be entitled to have an out-of-network claim paid at the in-network level of benefits.

- If you are treated by a provider or hospital that is not a preferred provider, you may be billed for anything not paid by the insurer.

- If the amount you owe to an out-of-network hospital-based radiologist, anesthesiologist, pathologist, emergency department physician, assistant surgeons, or neonatologist is greater than $500 (not including your copayment, coinsurance, and deductible responsibilities) for services received in a network hospital, you may be entitled to have the parties participate in a teleconference, and, if the result is not to your satisfaction, in a mandatory mediation at no cost to you. You can learn more about mediation at the Texas Department of Insurance website: www.tdi.texas.gov/consumer/cpmmediation.html.

Toll Free: 800-558-4444
1100 Employers Blvd.
Green Bay,WI 54344

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 Health Plan of Texas, Inc.

Mastectomy or Lymph Node Dissection

Minimum Inpatient Stay: If due to treatment of breast cancer, any person covered by this plan has either a mastectomy or a lymph node dissection, this plan will provide coverage for inpatient care for a minimum of:

(c) 48 hours following a mastectomy, and
(d) 24 hours following a lymph node dissection.

The minimum number of inpatient hours is not required if the covered person receiving the treatment and the attending physician determine that a shorter period of inpatient care is appropriate.

Prohibitions: We may not (a) deny any covered person eligibility or continued eligibility or fail to renew this plan solely to avoid providing the minimum inpatient hours; (b) provide money payments or rebates to encourage any covered person to accept less than the minimum inpatient hours; (c) reduce or omit the amount paid to the attending physician, or otherwise penalize the physician, because the physician required a covered person to receive the minimum inpatient hours; or (d) provide financial or other incentives to the attending physician to encourage the physician to provide care that is less than the minimum hours.

Coverage and/or Benefits for Reconstruction Surgery after Mastectomy

Coverage and/or benefits are provided to each covered person for reconstructive surgery after mastectomy, including:

(a) All stages of the reconstruction of the breast on which mastectomy has been performed;
(b) Surgery and reconstruction of the other breast to achieve a symmetrical appearance; and
(c) Prostheses and treatment of physical complications, including lymphedemas, at all stages of mastectomy.

The coverage and/or benefits must be provided in the manner determined to be appropriate in consultation with the covered person and the attending physician. Please refer to the schedule of benefits in the attached certificate of coverage for any specific deductible, copayments, or coinsurance they may be applicable to these benefits.

Prohibitions: We may not (a) offer the covered person a financial incentive to forego breast reconstruction or waive the coverage and/or benefits referenced above; (b) condition, limit, or deny any covered person's eligibility or continued eligibility to enroll in the plan or fail to renew this plan solely to avoid providing the coverage and/or benefits referenced above; or (c) reduce or limit the amount paid to the physician or provider, nor otherwise penalize, or provide a financial incentive to induce the physician or provider to provide care to a covered person in a manner inconsistent with the coverage and/or benefits referenced above.

NOTICE OF CERTAIN MANDATORY BENEFITS (continued)

Examinations for Detection of Prostate Cancer

Benefits are provided for each covered male for an annual medically recognized diagnostic examination for the detection of prostate cancer. Benefits include:

(a) A physical examination for the detection of prostate cancer; and
(b) A prostate-specific antigen test for each covered male who is

3) At least 50 years of age; or
4) At least 40 years of age with a family history of prostate cancer or other prostate cancer risk factor.

Inpatient Stay following Birth of a Child

For each person covered for maternity/childbirth benefits, we will provide inpatient care for the mother and her newborn child in a health care facility for a minimum of:

(a) 48 hours following an uncomplicated vaginal delivery, and
(b) 96 hours following an uncomplicated delivery by cesarean section.

This benefit does not require a covered female who is eligible for maternity/childbirth benefits to (a) give birth in a hospital or other health care facility or (b) remain in a hospital or other health care facility for the minimum number of hours following birth of the child.

If a covered mother or her newborn child is discharged before the 48 or 96 hours have expired, we will provide coverage for postdelivery care. Postdelivery care includes parent education, assistance and training in breast-feeding and bottle-feeding and the performance of any necessary and appropriate clinical tests. A physician, registered nurse or other appropriate licensed health care provider will provide care, and the mother will have the option of receiving the care at her home, the health care provider's office or a health care facility.

Prohibitions: We may not (a) modify the terms of this coverage based on any covered person requesting less than the minimum coverage required; (b) offer the mother financial incentives or other compensation for waiver of the minimum number of hours required; (c) refuse to accept a physician's recommendation for a specified period of inpatient care made in consultation with the mother if the period recommended by the physician does not exceed guidelines for prenatal care developed by nationally recognized professional associations of obstetricians and gynecologists or pediatricians; (d) reduce payments or reimbursements below the usual and customary rate; or (e) penalize a physician for recommending inpatient care for the mother and/or the newborn child.

NOTICE OF CERTAIN MANDATORY BENEFITS (continued)

Coverage for tests for detection of colorectal cancer

Benefits are provided, for each person enrolled in the plan who is 50 years of age or older and at normal risk for developing colon cancer, for expenses incurred in conducting a medically recognized screening examination for the detection of colorectal cancer. Benefits include the covered person's choice of:

(a) A fecal occult blood test performed annually and a flexible sigmoidoscopy performed every five years,
(b) A colonoscopy performed every 10 years.

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 customer service at 1-866-4ASSIST (1-866-427-7478) or write us at Humana, Green Bay Services Center, 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 when they are medically necessary:

- 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, unless preempted by state or federal law.

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**

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 getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

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 and other members of your family when group health coverage would otherwise end. For more 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)

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called 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, 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 you to lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced; or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you to lose your coverage under the Plan because of the following qualifying events:

- 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 they lose coverage under the Plan because of the following events:

- 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".

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the employer, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

FEDERAL NOTICES (continued)

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. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- Commencement of a proceeding in bankruptcy with respect to the employer; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage 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.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also 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 Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum 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 COBRA continuation coverage;

- ***Second qualifying event extension of 18-month period of continuation coverage*** - If your family experiences another qualifying event during the 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 the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

FEDERAL NOTICES (continued)

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period". Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

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 the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, 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 www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep your plan informed of address changes

To protect your family's rights, let the Plan Administrator know about 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.

FEDERAL NOTICES (continued)

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.

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.

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.

FEDERAL NOTICES (continued)

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.

If your 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.

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 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, unless preempted by state or federal law.

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 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.

An *adverse benefit determination* also includes any rescission of coverage. A rescission of coverage is not eligible for *external review.*

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".

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.

Appeal and External Review Notice (continued)

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.

Appeal and External Review Notice (continued)

- ***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 claims* 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.

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.

Appeal and External Review Notice (continued)

Contact information

For questions about your rights, this notice, or assistance, you can contact: Humana, Inc. at www.humana.com or the Employee Benefits Security Administration at 1-866-444-EBSA (3272).

You may contact the *commissioner* for assistance at any time at the address and telephone number below:

Texas Department of Insurance
333 Guadalupe
Austin, TX 78701

Mailing address:
PO Box 149104
Austin, TX 78714-9104

Phone: 800-578-4677 or 800-252-3439
TDD: 512-322-4238
Website: http://www.tdi.texas.gov/index.html

Consumer Protection (111-1A)
PO Box 149091
Austin, TX 78714-9091

Email: ConsumerProtection@tdi.texas.gov
Website: http://www.tdi.texas.gov/consumer/

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.

Appeal and External Review Notice (continued)

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;
- ***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.

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.

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;

- 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.

Appeal and External Review Notice (continued)

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.

Appeal and External Review Notice (continued)

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*.

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.

Appeal and External Review Notice (continued)

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.

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.