Plan Year 2023

The actual certificate issued may vary from the samples provided based upon final plan selection or other factors. If there is any conflict between the samples provided and the certificate that is issued, the issued certificate will control.

If you are already a member, please sign in or register on Humana.com to view your issued certificate.

TXHJ6EJEN 0123

Important

At Humana, it is important you are treated fairly.

Humana Inc. and its subsidiaries do not discriminate or exclude people because of their race, color, national origin, age, disability, sex, sexual orientation, gender, gender identity, ancestry, ethnicity, marital status, religion, or language. Discrimination is against the law. Humana and its subsidiaries comply with applicable Federal Civil Rights laws. If you believe that you have been discriminated against by Humana or its subsidiaries, there are ways to get help.

- You may file a complaint, also known as a grievance:
  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 their complaint portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by at **U.S. Department of Health and Human Services**, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, DC 20201, **800-368-1019**, **800-537-7697 (TDD)**. Complaint forms are available at **https://www.hhs.gov/ocr/office/file/index.html**.
- **California residents:** You may also call California Department of Insurance toll-free hotline number: **800-927-HELP (4357)**, to file a grievance.

Auxiliary aids and services, free of charge, are available to you. Call the number on your ID card (TTY: 711)

Humana provides 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.

Language assistance services, free of charge, are available to you. Call the number on your ID card (TTY: 711)

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)**... 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)**

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)**

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)**

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

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)**

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

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)**

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)**

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

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

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)**

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

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)**

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)**

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 néé ho'dólzin bikáá'ígíí bee hólne' **(TTY: 711)**

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

Humana.

Administrative Office:
1221 S. Mopac, Suite 200
Austin, TX 78746
1-866-427-7478
Humana.com

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 an 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:

Group Plan Number:

Effective Date:

Product Name:

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.

This *evidence of coverage* along with the "Certificate of Insurance" issued by Humana Insurance Company (the *companion plan*), describe the coverage for this point-of-service product and the manner in which the *health insurance coverage* may be used. This *evidence of coverage* describes *health coverage* for *covered health services* provided by *network providers* and provided by *non-network providers* in limited circumstances. The *companion plan* describes health insurance coverage for covered expenses provided by *network providers* and *non-network providers*.

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

THIS 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.

Have a complaint or need help?

If you have a problem with a claim or your premium, call your insurance company or HMO first. If you can't work out the issue, the Texas Department of Insurance may be able to help.

Even if you file a complaint with the Texas Department of Insurance, you should also file a complaint or appeal through your insurance company or HMO. If you don't, you may lose your right to appeal.

Humana Health Plan of Texas, Inc.

To get information or file a complaint with your insurance company or HMO:

Call: Customer Care at **1-800-448-6262 / TTY Number: 711**
Toll-free: **1-800-448-6262 / TTY Number: 711**

Email: HumanaResolution@Humana.com

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

The Texas Department of Insurance
To get help with an insurance question or file a complaint with the state:
Call with a question: 1-800-252-3439
File a complaint: www.tdi.texas.gov
Email: ConsumerProtection@tdi.texas.gov
Mail: MC 111-1A, P.O. Box 12030, Austin, TX 78711-2030

¿Tiene una queja o necesita ayuda?

Si tiene un problema con una reclamación o con su prima de seguro, llame primero a su compañía de seguros o HMO. Si no puede resolver el problema, es posible que el Departamento de Seguros de Texas (Texas Department of Insurance, por su nombre en inglés) pueda ayudar.

Aun si usted presenta una queja ante el Departamento de Seguros de Texas, también debe presentar una queja a través del proceso de quejas o de apelaciones de su compañía de seguros o HMO. Si no lo hace, podría perder su derecho para apelar.

Humana Health Plan of Texas, Inc.

Para obtener información o para presentar una queja ante su compañía de seguros o HMO:

Llame a: Atención al cliente al **1-800-448-6262 / TTY Number: 711**
Teléfono gratuito: **1-800-448-6262 / TTY Number: 711**

Correo electrónico: HumanaResolution@Humana.com

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

El Departamento de Seguros de Texas
Para obtener ayuda con una pregunta relacionada con los seguros o para presentar una queja ante el estado:
Llame con sus preguntas al: 1-800-252-3439
Presente una queja en: www.tdi.texas.gov
Correo electrónico: ConsumerProtection@tdi.texas.gov
Dirección postal: MC 111-1A, P.O. Box 12030, Austin, TX 78711-2030

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.

Essential health benefits

This *evidence of coverage* does not apply annual dollar limits or lifetime dollar limits to *covered health services* that are *essential health benefits*.

Notice of rights

A health maintenance organization (HMO) plan provides no benefits for services *you* receive from *non-network health care practitioners* or *non-network providers*, with specific exceptions as described in *your evidence of coverage* and below:

- *You* have the right to an adequate network of in-network physicians and providers (known as *network health care practitioners* and *network providers*).
- If *you* believe that the network is inadequate, *you* may file a complaint with the Texas Department of Insurance at www.tdi.texas.gov/consumer/complfrm.html.
- If *your* HMO approves a referral for out-of-network services because no *network health care practitioner* or *network provider* is available, or if *you* have received out-of-network *emergency care*, the HMO must, in most cases, resolve the *non-network health care practitioner's* or *non-network provider's* bill so that *you* only have to pay any applicable *network copayment*, *coinsurance*, and *deductible* amounts.

You may obtain a current directory of *network health care practitioners* or *network providers* at the following website Humana.com or by calling *our* customer service department at the telephone number shown on *your* ID card for assistance in finding available *network health care practitioners* or *non-network providers*. If *you* relied on materially inaccurate directory information, *you* may be entitled to have a claim by a *non-network health care practitioner* or *non-network provider* paid as if it were from a *network health care practitioner* or *network provider*, if *you* present a copy of the inaccurate directory information to the HMO, dated not more than 30 days before *you* received the service.

Covered and non-covered health services

We will provide coverage for services, equipment and supplies that are *covered health services*. All requirements of the *evidence of coverage* 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.

Not all services and supplies are *covered health services*, even when ordered by a *health care practitioner*. *You* must pay the health care provider any amount due for non-covered health services. Refer to "Your choice of providers affects your benefits" provision in this section.

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

How your master group contract works

We may apply a *copayment* or *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 a *copayment*, *deductible* and/or *coinsurance* may apply.

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.

Covered health services are subject to the *usual and customary fee*. *We* will apply the applicable *network provider* benefit level to 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*; or
- Those in excess of the *usual and customary fee*; and
- Adjustments related to *our* claims processing procedures. Refer to the "Claims" section of this *evidence of coverage* for more information on *our* claims processing procedures.

Unless stated otherwise in this *evidence of coverage*, *you* will be responsible to pay:

- The applicable *network provider copayment*, *deductible* and/or *coinsurance*;
- Any amount over the *usual and customary fee* to a *non-network provider*; and
- Any amount not paid by *us*.

However, *we* will apply the *network provider* benefit level and *you* will only be responsible to pay the *network provider copayment*, *deductible* and/or *coinsurance* for *covered health services*, subject to the *usual and customary fee*, if *you* receive the following services from a *non-network provider* in the state of Texas:

- *Emergency care*;

- *Post-stabilization services* until *you* can reasonably be expected to transfer to a *network provider*;
- Services from a *facility-based physician* at a *network facility*;
- Services from a *diagnostic imaging provider* or *laboratory service provider* who are *non-network providers* if the services are associated with a *covered health service* performed by a *network provider*, or in circumstances where *you* are not given the choice of a *network provider*.

We will apply the *network provider* benefit level and *you* will only be responsible to pay the *network provider copayment*, *deductible* and/or *coinsurance* based on the *qualified payment amount* for *covered health services* when you receive the following services from a *non-network provider*:

- *Air ambulance* services;
- *Emergency care* outside the state of Texas;
- *Ancillary services* when *you* are at a *network facility* outside the state of Texas;
- *Ancillary services*, other than those provided by a *facility based physician*, when *you* are at a *network facility* in the state of Texas;
- Services that are not considered *ancillary services* when *you* are at a *network facility*, and *you* did not consent to the *non-network provider* to obtain such services; or
- *Post-stabilization services* provided outside the state of Texas when:
  - The attending *qualified provider* determines *you* are not able to travel by non-medical transportation to obtain services from a *network provider*; and
  - *You* do not consent to the *non-network provider* to obtain such services.

Any *network provider copayment*, *deductible* and/or *coinsurance you* pay a *non-network* provider for the specific services listed above will be applied to the *network provider out-of-pocket limit*.

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 any maximum benefit and all other terms, provisions, limitations, and exclusions of the *master group contract*.

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 health services* through the *companion plan* "Certificate of Insurance."

This *evidence of coverage* describes *health coverage* for *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 *health coverage* for *covered health services* provided by *non-network providers* in limited circumstances. Please refer to the "Your choice of providers affects your benefits" provision in this "Understanding Your Coverage" section of this *evidence of coverage* for more information.

The *companion plan* "Certificate of Insurance" describes health insurance coverage covered expenses provided by *network providers* and *non-network providers*. Please refer to the "Your choice of providers affects your benefits" provision in the "Understanding Your Coverage" section of the *companion plan* "Certificate of Insurance" for more information.

Your choice of providers affects your benefits

We will pay benefits, if *you* see a *network provider*. Be sure to check if *your qualified provider* is a *network provider* before seeing them.

We may designate certain *network providers* for specific services covered by the *master group contract*, as described in the "Schedule of Benefits" section. If *you* choose the *network provider* designated by *us* for the specific services, *we* may pay more. If *you* choose a *network provider* not designated by *us* for the specific services, *we* may pay less.

If *you* receive the services specified in the "Transplant services and immune effector cell therapy" provision in the "Covered Health Services" section, *you* must receive such services from a contracted *network hospital* transplant program within the National Transplant Network for *covered health services* to be payable at the *network provider* benefit level, as specified in the "Schedule of Benefits" section in this *evidence of coverage*. The National Transplant Network is the network of *hospital* solid organ transplant, hematopoietic stem cell transplant, and *immune effector cell therapy* programs and their affiliated physicians and health care providers that are approved *network providers*.

Network providers have a signed agreement with *us* to provide *covered health services* at an agreed rate and will accept *your* payment of any applicable *copayment*, *deductible* and/or *coinsurance* and the amount paid by *us* as the full payment.

NOTICE: Although *covered health services* may be or have been provided to *you* at a *network facility*, other professional services may be or have been provided at or through the *network health care treatment facility* by physicians and other *health care practitioners* who are *non-network providers*. Non-network *facility-based physicians* or other *health care practitioners* may balance bill *you* for amounts not paid by the health benefit plan. *You* should contact *us* if *you* receive a bill.

We will apply the *network provider* benefit level and *you* will only be responsible to pay the *network provider copayment*, *deductible* and/or *coinsurance* for *covered health services* when *you* receive the following services from a *non-network provider*:

- Services from a *facility-based physician* at a *network facility* in the state of Texas;
- *Ancillary services*, other than those provided by a *facility based physician*, when *you* are at a *network facility* in the state of Texas;

- *Ancillary services* when *you* are at a *network facility* outside the state of Texas;

- Services not considered *ancillary services* when *you* are at a *network facility*, and *you* did not consent to the *non-network provider* to obtain such services;

- *Post-stabilization services*, provided in the state of Texas, until *you* can reasonably be expected to transfer to a *network provider*;

- *Post-stabilization services* provided outside the state of Texas when:

  - The attending *qualified provider* determines *you* are not able to travel by non-medical transportation to obtain services from a *network provider*; and
  - *You* do not consent to the *non-network provider* to obtain such services; and

- Services performed by a *diagnostic imaging provider* or *laboratory service provider*, in the state of Texas, if the service is associated with a *covered health service* performed by a *network provider*, or in circumstances where *you* are not given the choice of a *network provider.*

If a *network provider* is not available for services other than those listed above, to *you* through a *network provider*, *we* will apply the *network provider copayment, deductible* and/or *coinsurance* to *covered health services* for services received from a *non-network provider* when authorized by *us*.

For all other services, *you* receive from a *non-network provider*, *you* will be responsible to pay the *non-network provider copayment*, *deductible* and/or *coinsurance* addressed in the "Certificate of Insurance," and *you* may also be responsible to pay any amount over the *usual and customary fee* for *covered expenses* including:

- Services that are not considered *ancillary services* when *you* are at a *network facility* and *you* consent to the *non-network provider* to obtain such services;

- *Post-stabilization services* provided in the state of Texas and *you* do not transfer to a *network provider*; and

- *Post-stabilization services* provided outside the state of Texas when:

  - The attending *qualified provider* determines *you* are able to travel by non-medical transportation to obtain services from a *network provider*; and
  - *You* consent to the *non-network provider* to obtain such services.

Benefits for services *you* choose to receive from *non-network providers* are described in the "Your choice of providers affects your benefits" provision of the "Understanding Your Coverage" section in the *companion plan*.

Refer to the "Schedule of Benefits" sections in the "Certificate of Insurance" and in this *evidence of coverage* to see what *your network provider* and *non-network provider* benefits are.

How to find a network provider

You may find a list of *network providers* at 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*.

Seeking emergency care

If *you* need *emergency care*, go to the nearest emergency facility, free-standing emergency medical care facility, or comparable emergency facility.

You, or someone on *your* behalf, must call *us* within 48 hours after *your admission* to a *non-network hospital* for *emergency care*.

Seeking urgent care

If *you* need *urgent care*, *you* must go to the nearest *urgent care center* or call an *urgent care qualified provider*. *You* must receive *urgent care* services from a *network provider* for the *network provider copayment*, *deductible* or *coinsurance* to apply.

Continuity of care

You or *your qualified provider* may elect continuity of care as of the date the following events occur:

- The *qualified provider* terminates as a *network provider*;
- The terms of a *network provider's* participation in the network changes in a manner that terminates a benefit for a service *you* are receiving as a continuing care patient; or
- The *master group contract* terminates.

We will apply the *network provider* benefit level to *covered health services* related to *your* treatment as a continuing care patient. *You* will be responsible for the *network provider copayment*, *deductible* and/or *coinsurance* until the earlier of:

- 90 days from the date *we* notify *you* the *qualified provider* is no longer a *network provider*;
- 90 days from the date *we* notify *you* the terms of a *network provider's* participation in the network changes in a manner that terminates a benefit for a service *you* are receiving as a continuing care patient;
- 90 days from the date *we* notify *you* this *master group contract* terminates;

- In the case of a pregnancy, 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 terminal *illness*, nine months from the date *we* notify *you* the *qualified provider* is no longer a *network provider* or nine months from the date *we* notify *you* the terms of a *network provider's* participation in the network changes in a manner that terminates a benefit for a service *you* are receiving as a continuing care patient; or

- The date *you* are no longer a continuing care patient.

For the purposes of this "Continuity of care" provision, special circumstance means *you* are a continuing care patient at the time continuity of care becomes available, and *you* are undergoing treatment from the *network provider* for:

- A disability;
- An acute *illness* or *bodily injury*;
- A *life-threatening* or complex *illness* or *bodily injury*;
- *Inpatient* care;
- A scheduled non-elective *surgery* and any related post-surgical care;
- A pregnancy; or
- A terminal illness.

Continuity of care is not available if:

- The *qualified provider's* participation in *our* network is terminated due to medical competence or professional behavior; or
- *Your* coverage terminates, however the *policy* remains in effect.

All terms and provisions of the *master group contract* are applicable to this "Continuity of care" provision.

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 *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 *network providers* may have capitation agreements. This means the *network 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 *network 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*.

COVERED HEALTH SERVICES

This "Covered Health Services" section describes the services that will be considered *covered health services* under the *master group contract* for *preventive services* and medical services for a *bodily injury* and *illness*. Benefits will be paid as specified in the "How your master group contract works" provision in the "Understanding Your Coverage" section and as shown on the "Schedules of Benefits," subject to any applicable:

- *Preauthorization* requirements;
- *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* apply.

Preventive services

Covered health services include the *preventive services* appropriate for *you* as 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 United States Preventive Services Task Force (USPSTF).
- 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* under the Affordable Care Act, refer to the www.healthcare.gov website under the Preventive Care tab or call the customer service telephone number on *your* ID card.

Covered health services include the following *preventive services* as required by state law:

- Childhood immunizations for a *dependent* from birth through the date of the child's sixth birthday:
    - Diphtheria;
    - Haemophilus influenzae type b;
    - Hepatitis B;
    - Measles;
    - Mumps;
    - Pertussis;
    - Polio, rubella, tetanus;
    - Varicella;
    - Rotovirus; and
    - Any other immunization that is required for a covered *dependent* by state or federal law.

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

- Mammograms as follows:

  - An annual screening by all forms of low-dose mammogram for the presence of occult breast cancer provided for a female *covered person* 35 years of age or older. Low-dose mammography includes digital mammography and breast tomosynthesis (three-dimensional images).

  - A diagnostic imaging, using mammography, ultrasound imaging or magnetic resonance if the *covered person* has a personal history of breast cancer, dense breast tissue or an abnormality of the breast is:

    - Detected by a physician or *covered person*;
    - Seen by a physician on a screening mammogram;
    - Previously identified by a physician as probably benign in a breast for which follow-up imaging is recommended by a physician.

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

- 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.

- 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 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;
  - A screening using liquid-based cytology methods; or
  - Any other test or screening approved by the FDA for the detection of ovarian cancer.

- 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* 45 years of age or older and at normal risk for developing colon cancer. Benefits include:

- Services with an A or B rating in the current recommendations by the USPSTF, and those assigned with an A or B rating in future recommendations; and
- A follow-up colonoscopy if the results of the initial colonoscopy, test or procedure were abnormal.

- 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 hearing screenings.

- Routine vision screenings (not including refractions).

Health care practitioner office services

We will pay the following benefits for *covered health services* incurred by *you* for *health care practitioner* home and 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:

- Home and office visits for the diagnosis and treatment of an *illness* or *bodily injury*.
- Home and office visits for prenatal care.
- Home and office visits for diabetes.
- 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 , refer to the "Emergency services" provision 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; 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.

- Services of an *assistant surgeon*.

- Services of a *surgical assistant*.

- 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.
- Services of an *assistant surgeon*.
- Services of a *surgical assistant*.
- 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 in a *hospital* for 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 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, 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* or *birthing center* facility charges for the *confinement* period immediately following birth. A *deductible* and/or *copayment*, if applicable, will be required for any subsequent *hospital admission*.

If determined by the *covered person* and *your health care practitioner*, coverage is available in a *birthing center*. *Covered health services* in a *birthing center* include:

- An uncomplicated, vaginal delivery; and
- Immediate care after delivery for the *covered person* and the newborn.

Emergency services

We will pay benefits for *covered health services* obtained by *you* for an *emergency medical condition* including:

- A medical screening examination or other evaluation required by state or federal law to be provided in the emergency facility of a *hospital* or comparable facility that is necessary to determine if an *emergency medical condition* exists;
- Treatment and stabilization of an emergency medical condition;
- Supplies related to a service described in this "Emergency services" provision.

Emergency care provided by a *non-network provider* will be covered at the *network provider* benefit level specified in the "Emergency services" benefit in the "Schedule of Benefits." *You* will only be responsible to pay the *non-network provider* as follows for *emergency care*:

- The *network provider copayment*, *deductible* and/or *coinsurance* based on the *usual and customary fee* for services received in the state of Texas; and
- The *network provider copayment*, *deductible* and/or *coinsurance* based on the *qualified payment amount* for services received outside the state of Texas.

Benefits under this "Emergency services" provision must be for an *emergency medical condition* as defined in the "Glossary" section.

Ambulance services

We will pay benefits for *covered health services* incurred by *you* for licensed *ambulance* and *air ambulance* services to, from or between medical facilities for *emergency care*.

Ambulance and *air ambulance* services for *emergency care* provided by a *non-network provider* will be covered at the *network provider* benefit level, as specified in the "Ambulance services" benefit in the "Schedule of Benefits" section. *You* are required to pay the following:

- For *ambulance* services, *you* will only be responsible to pay the *network provider copayment*, *deductible* and/or *coinsurance* based on the *usual and customary fee*.

- For *air ambulance* services, *you* will only be responsible to pay the *network provider copayment*, *deductible* and/or *coinsurance* based on the *qualified payment amount*.

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

Services 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.
- Services of an *assistant surgeon*.
- Services of a *surgical assistant*.
- Anesthesia administered by a *health care practitioner* or certified registered anesthetist attendant for a *surgery*.
- Services of a pathologist.
- Services of a radiologist.

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 in 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*. New or improved *diabetes equipment* approved by the FDA may be a *covered health service* if determined to be *medically necessary* and appropriate by the treating *health care practitioner* or other provider. *Diabetes equipment* will be dispensed as written unless a substitution is approved by the *health care practitioner* who issues the written order for the equipment.

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 purchase price is considered 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; and
- Repair or maintenance is not a result of misuse or abuse; 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; and
- 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 facility diagnostic laboratory and radiology services

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

Health care practitioner 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* provided by a *home health care agency*. All home health care services and supplies must be provided on a part-time 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. Each additional four hours or less is considered an additional visit.

Home health care *covered health services* are limited to:

- Care provided by a *nurse*;
- Physical, occupational, respiratory, or speech therapy;
- Home infusion therapy. Refer to the *specialty drug* provision in the" Schedule of Benefits – Pharmacy Services" section to determine how benefits for infusion therapy are paid;
- Medical social work and nutrition services;
- Medical supplies, except for *durable medical 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 in 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 aide services for up to eight hours in any one day; and
- Medical supplies, drugs and medicines 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*;
- 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; and
- Services of a radiologist.

Specialty drug medical benefit

We will pay benefits for *covered health services* incurred by *you* for *specialty drugs* provided by or obtained from a *qualified provider* in the following locations:

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

Specialty drugs may be subject to *preauthorization* requirements. Refer to the "Schedule of Benefits" in this *evidence of coverage* for *preauthorization* requirements and contact *us* prior to receiving *specialty drugs*. Coverage for certain *specialty drugs* administered to *you* by a *qualified provider* in a *hospital's outpatient* department may only be granted as described in the "Access to non-formulary drugs" provision in the "Covered Health Services – Pharmacy Services" section in this *evidence of coverage*.

Specialty drug benefits do not include the charge for the actual administration of the *specialty drug*. Benefits for the administration of *specialty drugs* are based on the location of the service and type of provider.

Transplant services and immune effector cell therapy

We will pay benefits for *covered health services* incurred by *you* for covered transplants and *immune effector cell therapies* approved by the FDA, including but not limited to Chimeric Antigen Receptor Therapy (CAR-T). The transplant services and *immune effector cell therapy* must be preauthorized and approved by *us*.

You or *your health care practitioner* must call *our* Transplant Department at 866-421-5663 to request and obtain *preauthorization* from *us* for covered transplants and *immune effector cell therapies*. *We* must be notified of the initial evaluation and given a reasonable opportunity to review the clinical results to determine if the requested transplant or *immune effector cell therapy* will be covered. *We* will advise *your health care practitioner* once coverage is approved by *us*. Benefits are payable only if the transplant or *immune effector cell therapy* is approved by *us*.

Covered health services for a transplant include 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;

- *Stem cell*;
- 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 solid organ transplants performed simultaneously are considered one transplant *surgery*. Multiple *stem cell* or *immune effector cell therapy* infusions occurring as part of one treatment plan is considered one event.

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*.

The following are *covered health services* for an approved transplant or *immune effector cell therapy* and all related complications:

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

- Acquisition of cell therapy products for *immune effector cell therapy*, acquisition of *stem cells* or solid organs for transplants and associated donor costs, or an FDA approved artificial device, including pre-transplant or *immune effector cell therapy* services, the acquisition procedure, and any complications resulting from the harvest and/or acquisition. Donor costs for post-discharge services and treatment of complications will not exceed the treatment period of 365 days from the date of discharge following harvest and/or acquisition.

- Non-medical travel and lodging costs for:

  - The *covered person* receiving the transplant or *immune effector cell therapy*, if the *covered person* lives more than 100 miles from the transplant or *immune effector cell therapy* facility designated by *us*; and

  - One caregiver or support person (two, when the *covered person* receiving the transplant or *immune effector cell therapy* is under 18 years of age), if the caregiver or support person lives more than 100 miles from the transplant or *immune effector cell therapy* facility designated by *us*.

  Non-medical travel and lodging costs include:

  - Transportation to and from the designated transplant or *immune effector cell therapy* facility where the transplant or *immune effector cell therapy* is performed; and
  - Temporary lodging at a prearranged location when requested by the designated transplant or *immune effector cell therapy* facility and approved by *us*.

  All non-medical travel and lodging costs for transplant and *immune effector cell therapy* are payable as specified in the "Schedule of Benefits" 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 or *immune effector cell therapy* are limited to the treatment period of 365 days from the date of 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.

Urgent care services

We will pay benefits for *urgent care covered health services* incurred by *you* for charges made by an *urgent care center* or an *urgent care qualified provider*.

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, blood plasma and blood plasma expanders, 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 and supplies, including but not limited to limbs, eyes and professional services related to the fitting and use of the devices. *Covered health services* includes the same prosthetic devices covered by *Medicare*, limited to the most appropriate model of prosthetic device that adequately meets the medical needs of the *covered person*, as determined by the treating *health care practitioner*.

  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.

- Cochlear implants and external components, including an external speech processor and controller for a *covered person* when *medically necessary*.

  Replacement or upgrade of a cochlear implant may be a *covered health service* when *medically necessary* and audiologically necessary. Replacement of the external speech processor and controller may occur once every 36 months.

Coverage also includes habilitation and rehabilitation as necessary for educational gain.

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

  Covered health services include:

  - The same orthotic devices covered by *Medicare*, limited to the most appropriate model of orthotic device that adequately meets the medical needs of the *covered person*, as determined by the treating *health care practitioner*;

  - Professional services related to the fitting and use of the orthotic; and

  - Repair and replacement of an orthotic except when due to misuse or loss.

  Covered health services do not include:

  - Repair or replacement of 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.*

- Radiation therapy.

- Inhalation therapy.

- 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*, *neurophysiological*, *neuropsychological*, and *psychophysiological testing* or *treatment*;
  - *Neurofeedback therapy*;
  - *Remediation*;
  - *Post-acute transition services* and *community reintegration services*, including *outpatient day*

treatment services or other *post-acute-care treatment services*.

To ensure appropriate *post-acute-care treatment* is provided, *covered health services* includes reasonable expenses related to periodic re-evaluation 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*.

  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*.

- *Teledentistry dental services*.

- Reconstructive *surgery* resulting from:

  - A *bodily injury*, infection or other disease of the involved part, when *functional impairment* is present;

  - Congenital disease or anomaly that resulted in a *functional impairment*; or

  - *Craniofacial abnormalities*. Reconstructive *surgery* for *craniofacial abnormalities* is a *surgery* to improve the function of or attempt to create a normal appearance of, an abnormal structure caused by congenital defects, developmental deformities, trauma, infections, or disease.

  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 lymphedemas.

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

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

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

- 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 cancer treatment medications.

- Private duty nursing while *you* are *hospital confined*.

- 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."

- *Palliative care*.

- Routine foot care for a *covered person* with diabetes as follows:

  - Hygienic care, and the treatment of superficial lesions of the feet, such as corns, calluses or hyperkeratosis;
  - Treatment of tarsalgia, metatarsalgia or bunion;
  - The cutting of toenails, including the removal of the nail matrix;
  - Heel wedges, lifts or shoe inserts; and
  - Arch supports (foot orthotics) or orthopedic shoes.

- Newborn screening tests required by the Health and Safety Code, including the cost and administration of a newborn screening test kit provided by the Department of State Health Services.

- 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 prevention, detection or 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 prevention, detection or treatment of cancer or other *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 FDA; or

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

- *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 services* if provided during a face-to-face consultation between a *covered person* and a *health care practitioner*; and
  - Provided to a *covered person* at a different physical location than the *health care practitioner*.

  Covered health services do not include a *telehealth service* or *telemedicine medical service* provided by only synchronous or asynchronous audio interaction, including:

  - An audio-only telephone consultation;
  - A text-only e-mail message; or
  - A facsimile transmission.

  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. Coverage includes:

  - The purchase, fitting or advice on the care of hearing aids for *covered persons* 18 years of age or younger, including the provision of ear molds; or
  - Implantable hearing devices; and
  - Habilitation and rehabilitation as necessary for educational gain.

  Coverage for hearing aids and implantable hearing devices is limited to 1 per ear every 36 months.

- Rehabilitative and habilitative therapies provided to a *dependent* child that 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.

  Rehabilitative and habilitative therapies provided under this provision are not subject to any visit limit applicable to other rehabilitative or *habilitative services* specified in this *evidence of coverage*.

COVERED HEALTH SERVICES - BEHAVIORAL HEALTH AND SERIOUS MENTAL ILLNESS

This "Covered Health Services – Behavioral Health and Serious Mental Illness" section describes the services that will be considered *covered health services* for *mental health services*, *chemical dependency* and *serious mental illness* under the *master group contract*. Benefits will be paid as specified in the "How your master group contract works" provision of the "Understanding Your Coverage" section and as shown in the "Schedule of Benefits – Behavioral Health and Serious Mental Illness." Refer to the "Schedule of Benefits" for any service not specifically listed in the "Schedule of Benefits – Behavioral Health and Serious Mental Illness." Benefits are subject to any applicable:

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

Benefits and services under this section are provided under the same terms and conditions, meaning without any quantitative or non-quantitative treatment limitations that are more restrictive than are applied to medical and surgical treatment.

Refer to the "Limitations and Exclusions" section listed in this *evidence of coverage*. All terms and provisions of the *master group contract* apply.

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*, and *chemical dependency* and *serious mental illness* 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.

Acute inpatient health care practitioner services

We will pay benefits for *covered health services* incurred by *you* for *mental health services*, *chemical dependency* and *serious mental illness* provided by a *health care practitioner*, including *telehealth* or *telemedicine*, in a *hospital* or *health care treatment facility*, *chemical dependency treatment center*, *crisis stabilization unit*, *psychiatric day treatment facility*, *residential treatment center for children and adolescents*, or *residential treatment facility for adults*.

Emergency services

We will pay benefits for *covered health services* obtained by *you* for an *emergency medical condition*, including the treatment and stabilization of an *emergency medical condition* for *mental health services*, and *chemical dependency* and *serious mental illness*. This includes:

- A medical screening examination or other evaluation required by state or federal law to be provided in the emergency facility of a *hospital* or comparable facility that is necessary to determine if an *emergency medical condition* exists;

- Treatment and stabilization of an *emergency medical condition* for *mental health services*, *chemical dependency* and *serious mental illness*; and

- Supplies related to a service described in this "Emergency services" provision.

Emergency care provided by a *non-network provider* will be covered at the *network provider* benefit level specified in the "Emergency services" benefit in the "Schedule of Benefits" or "Schedule of Benefits – Behavioral Health and Serious Mental Illness" sections of this *evidence of coverage*." *You* will only be responsible to pay the *non-network provider* as follows for *emergency care*:

- The *network provider copayment*, *deductible* and/or *coinsurance* based on the *usual and customary fee* for services received in the state of Texas; and
- The *network provider copayment*, *deductible* and/or *coinsurance* based on the *qualified payment amount* for services received outside the state of Texas.

Benefits under this "Emergency services" provision are not available if the services provided are not for an *emergency medical condition*.

Urgent care services

We will pay benefits for *urgent care covered health services* incurred by *you* for charges made by an *urgent care center* or an *urgent care qualified provider* for *mental health services*, *chemical dependency* and *serious mental illness*.

Outpatient services

We will pay benefits for *covered health services* incurred by *you* for *mental health services*, *chemical dependency* and *serious mental illness*, including services in a *health care practitioner* office, *retail clinic* or *health care treatment facility*. Coverage includes *outpatient* therapy, *intensive outpatient programs*, *partial hospitalization* in a *hospital* or *health care treatment facility*, *crisis stabilization unit*, *telehealth* and *telemedicine*, and other *outpatient* services.

Skilled nursing facility services

We will pay benefits for *covered health services* incurred by *you* in a *skilled nursing facility* for *mental health services*, *chemical dependency* and *serious mental illness*. *Your confinement* to a *skilled nursing facility* must be based upon a written recommendation of a *health care practitioner*.

Covered health services also include *health care practitioner* services for *behavioral health* and *serious mental illness* during *your confinement* in a *skilled nursing facility*.

Home health care services

We will pay benefits for *covered health services* incurred by *you*, in connection with a *home health care plan*, for *mental health services*, *chemical dependency* and *serious mental illness*. All home health care services and supplies must be provided on a part-time basis to *you* in conjunction with the approved *home health care plan*.

Home health care *covered health services* include services provided by a *health care practitioner* who is a *behavioral health* professional, such as a counselor, psychologist or psychiatrist.

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*.

Specialty drug benefit

We will pay benefits for *covered health services* incurred by *you* for *behavioral health specialty drugs* provided by or obtained from a *qualified provider* in the following locations:

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

Specialty drugs may be subject to *preauthorization* requirements. Refer to the "Schedule of Benefits" in this *evidence of coverage* for *preauthorization* requirements and contact *us* prior to receiving *specialty drugs*. Coverage for certain *specialty drugs* administered to *you* by a *qualified provider* in a *hospital's outpatient* department may only be granted as described in the "Access to non-formulary drugs" provision in the "Covered Health Services – Pharmacy Services" section in this *evidence of coverage*.

Specialty drug benefits do not include the charge for the actual administration of the *specialty drug*. Benefits for the administration of *specialty drugs* are based on the location of the service and type of provider.

Residential treatment facility services

We will pay benefits for *covered health services* incurred by *you* for *mental health services*, *chemical dependency* and *serious mental illness* provided while *inpatient* or *outpatient* in a *residential treatment facility*.

Autism spectrum disorders

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

- Screening of a *dependent* for *autism spectrum disorder* at the ages of 18 and 24 months; and
- All generally recognized services prescribed in relation to *autism spectrum disorder* 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* 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;
  - 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 *autism spectrum disorders*.

Autism spectrum disorder benefits are payable for *covered health services* as recommended in the treatment plan by the *health care practitioner.*

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* apply, including *prior authorization* requirements specified in the "Schedule of Benefits – Pharmacy Services" of this *evidence of coverage*.

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*.

- Drugs prescribed to treat a chronic, disabling, or *life-threatening illness* if the intended use of the drug is for off-label indications recognized through peer-reviewed medical literature;

- Insulin and *diabetes supplies*. New or improved *diabetes supplies* approved by the FDA, including improved insulin or another *prescription* drug, may be a *covered health service* if determined to be *medically necessary* and appropriate by the treating *health care practitioner* or other provider. Insulin and *diabetes supplies* will be dispensed as written unless a substitution is approved by the *health care practitioner* who issues the written order for the supplies or medication.

- Emergency refills of insulin or the following insulin-related equipment or supplies:

    - Needles;
    - Syringes;
    - Cartridge systems;
    - Prefilled pen systems;
    - Glucose meters;
    - Continuous glucose monitor supplies; and
    - Test strips.

An emergency refill of insulin is limited to a 30-day supply. An emergency refill of insulin-related equipment or supplies is limited to the lesser of a 30-day supply or the smallest available package.

- Contraceptive drugs and contraceptive drug delivery implants approved by the FDA.

- Eye drops included on *our drug list* that are *prescribed* by a *health care practitioner* to treat a chronic eye disease or condition.

- *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 prescribed or ordered by a *health care practitioner* 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. Any *prescription* contraceptive drug or device approved by the FDA is not subject to a review period.

Prescription drug coverage restrictions

If *we* determine *you* are using *prescription* drugs in a potentially abusive, excessive, or harmful manner, *your* coverage of *pharmacy* services may be limited in one or more of the following ways:

- By restricting *your pharmacy* services to a single *network pharmacy* store or physical location of *your* choice;

- By restricting *your specialty pharmacy* services to a specific *specialty pharmacy* of *your* choice, if the *network pharmacy* store or physical location for *pharmacy* services is unable to provide or is not contracted with *us* to provide covered *specialty pharmacy* services; and

- By restricting all *your prescriptions* to be prescribed by a specific *network health care practitioner* of *your* choice.

When *we* determine it is necessary to restrict *your pharmacy* services, only *prescriptions* obtained from the specific *network pharmacy* store or physical location or *specialty pharmacy* will be eligible to be considered *covered health services*. Additionally, only *prescriptions* prescribed by the *network health care practitioner* will be eligible to be considered *covered health services*.

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 and indicates *dispensing limits*, *specialty drug* designation, any applicable *prior authorization* and/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 Humana.com or calling the customer service telephone number on *your* ID 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.

Access to medically necessary contraceptives

In addition to *preventive services*, contraceptives on *our drug list* and non-formulary contraceptives may be covered at no *cost share* when *your health care practitioner* contacts *us*. *We* will defer to the *health care practitioner's* recommendation that a particular method of contraception or FDA-approved

contraceptive is determined to be *medically necessary*. The *medically necessary* determination made by *your health care practitioner* may include severity of side effects, differences in permanence and reversibility of contraceptives, and ability to adhere to the appropriate use of the contraceptive item or service.

Access to non-formulary drugs

A drug not included on *our drug list* is a non-formulary drug. If a *health care practitioner* prescribes a clinically appropriate non-formulary drug, *you* can request coverage of the non-formulary drug through a standard exception request or an expedited exception request. If *you* are dissatisfied with *our* decision of an exception request, *you* have the right to an external review as described in the "Non-formulary drug exception request external review" provision of this section.

Non-formulary drug standard exception request

A standard exception request for coverage of a clinically appropriate non-formulary drug may be initiated by *you*, *your* appointed representative, or the prescribing *health care practitioner* by calling the customer service number on *your* ID card, in writing, or *electronically* by visiting *our* website at 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 non-formulary drug 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 non-formulary drug; or
- Would have adverse effects.

If *we* grant a standard exception request to cover a prescribed, clinically appropriate non-formulary drug, *we* will cover the prescribed non-formulary 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 external review as described in the "Non-formulary drug exception request external review" provision of this section.

Non-formulary drug expedited exception request

An expedited exception request for coverage of a clinically appropriate non-formulary drug 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* ID card, in writing or *electronically* by visiting *our* website at 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 non-formulary drug.

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 non-formulary drug is not provided within the timeframes of the standard exception request; and

- Justification supporting the need for the prescribed non-formulary drug 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 non-formulary drug; or
  - Would have adverse effects.

If *we* grant an expedited exception request to cover a prescribed, clinically appropriate non-formulary drug based on exigent circumstances, *we* will provide access to the prescribed non-formulary 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 external review as described in the "Non-formulary drug exception request external review" provision of this section.

Non-formulary drug exception request external review

You, *your* appointed representative, or *your* prescribing *health care practitioner* have the right to an external review by an independent review organization if *we* deny a non-formulary drug standard or expedited exception request. To request an external review, refer to the exception request decision letter for instructions or call the customer service number on *your* ID card for assistance.

Step therapy exception request

Your health care practitioner may submit to *us* a written request for an exception to *step therapy* for a clinically appropriate *prescription* drug. The *health care practitioner* should submit the written *step therapy* exception request using the *prior authorization* form. The *health care practitioner* can obtain the *prior authorization* form on *our* website at Humana.com or by calling customer service at the phone number provided on the back of *your* ID card.

A covered *prescription* drug for the treatment of *stage four advanced*, *metastatic cancer* and *associated conditions* will not be subject to *step therapy* when the *prescription* drug is:

- Consistent with best practices for the treatment of *stage four advanced*, *metastatic cancer* or an *associated condition*;
- Supported by peer-reviewed, evidence-based medical literature; and
- Approved by the FDA.

We will approve *your health care practitioner's* written *step therapy* exception request when the request includes the prescribing *health care practitioner's* written statement and supporting documentation that:

- The *prescription* drug requiring *step therapy*;
  - Is contraindicated;
  - Will likely cause an adverse reaction in or physical or mental harm to *you*;
  - Is expected to be ineffective based on *your* known clinical characteristics and the known characteristics of the *prescription* drug regimen;

- *You* previously discontinued taking the *prescription* drug required under *step therapy*, or another *prescription* drug in the same pharmacologic class or with the same mechanism of action as the required drug, while under the health benefit plan currently in force or while covered under another health benefit plan because the *prescription* drug was not effective or had a diminished effect, or because of an adverse event;

- The *prescription* drug requiring *step therapy* is not in *your* best interest, based on clinical appropriateness, because use of the drug is expected to:
  - Cause a significant barrier to *your* adherence to or compliance with *your* plan of care;
  - Worsen a comorbid condition; or
  - Decrease *your* ability to achieve or maintain reasonable functional ability in performing daily activities; or

- The *prescription* drug subject to *step therapy* was prescribed for *your* condition and:
  - *You* received benefits for the *prescription* drug under this health benefit plan or a prior health benefit plan;
  - *You* are stable on a *prescription* drug selected by *your health care practitioner* for the medical condition under consideration; and
  - The change in *your prescription* drug regimen required by *step therapy* is expected to be ineffective or cause harm to *you* based on the treatment of *your* disease or medical condition and the known characteristics of the required *prescription* drug regimen.

A *step therapy* exception request will be considered granted if *we* do not deny a *step therapy* exception request before:

- 72 hours after *we* receive the request; or
- 24 hours after *we* receive the request that the prescribing *health care practitioner* reasonably believes denial of the *step therapy* exception request could cause death or serious harm to *you*.

If *we* deny a *step therapy* exception request, *we* will provide *your* prescribing *health care practitioner* the reason for the denial, an alternative covered medication, and *your* right to appeal *our* decision as outlined in the "Complaint and Appeals Procedures" section.

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* which is covered under any Workers' Compensation or similar law. This limitation also applies to a *covered person* who is not covered by Workers' Compensation and lawfully chose not to be.

- Care and treatment given in a *hospital* owned or run by any government entity, unless *you* are legally required to pay for such care and treatment. However, care and treatment provided by military *hospitals* to *covered persons* who are armed services retirees and their *dependents* are not excluded.

- 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*.

- Services, or any portion of a service, for which no charge is made.

- Services, or any portion of a service, *you* would not be required to pay for, or would not have been charged for, in the absence of this coverage.

- Any portion of the amount *you* owe for a services that the provider waives, rebates or discounts, including *your copayment*, *deductible* or *coinsurance*.

- *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*:

  - By a *non-network provider*, unless the services provided by a *non-network provider* are for any of the limited circumstances specified in the "Your choice of providers affects your benefits" provision of this *evidence of coverage*; and

  - When received in an emergency room, unless required for *emergency care.*

- Private duty nursing, unless *medically necessary* while *you* are *hospital confined*.

- Services rendered by a standby physician, *surgical assistant* or *assistant surgeon*, unless *medically necessary*.

- Any service 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*, except as allowed by state law for *covered health services* provided by a dentist.

- *Ambulance* and *air 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 for research purposes*, please reference the "Complaint and Appeals Procedures" section of this *evidence of coverage* for the provision on the "Appeals process to an independent 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*.

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

- *Prescription* drugs and *self-administered injectable* drugs, except as specified in the "Covered Health Services – 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*, *residential treatment facility for adults*, *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*.

- Certain *specialty drugs* administered by a *qualified provider* in a *hospital's outpatient* department, except as specified in the "Access to non-formulary drugs" provision in the "Covered Health Services - Pharmacy Services" section of this *evidence of coverage*.

- For a *covered person* 19 years of age or older, hearing aids, the fitting of hearing aids or advice on their care; implantable hearing devices, except for cochlear implants as otherwise stated in this *evidence of coverage*.

- Services received in an emergency room, unless required because of *emergency care*.

- *Hospital inpatient* services when *you* are in *observation status*.

- *Infertility services*; or reversal of elective sterilization.

- In vitro fertilization regardless of the reason for treatment.

- Services for or in connection with a transplant or *immune effector cell therapy* if:

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

  - Not approved by *us*, 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 or tissue for a recipient who is not covered by *us*.

  - The expense relates to a transplant or *immune effector cell therapy* performed outside of the United States and any care resulting from that transplant or *immune effector cell therapy*. This exclusion applies even if the *employee* and *dependents* live outside the United States and the *employee* is in *active status* with the *employer* sponsoring the *master group contract*.

- Services provided for:

  - Immunotherapy for recurrent abortion;
  - Chemonucleolysis;
  - 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 hyperkeratosis;
  - The treatment of tarsalgia, metatarsalgia or bunion, except surgically;
  - The cutting of toenails, except the removal of the nail matrix;
  - Shoe inserts, except as covered by *Medicare*;
  - Heel wedges or lifts; and
  - Arch supports (foot orthotics) or orthopedic shoes, except for diabetes, hammer toe and as covered by *Medicare*.

- *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 EXCLUSIONS (continued)

- Services relating to an *illness* or *bodily injury* as a result of:

  - Engagement in an illegal profession or 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, unless prescribed by a *health care practitioner* for *preventive services* and ambulatory blood pressure monitoring is not available to confirm diagnosis of hypertension;

    - 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*.

- 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 "Transplant services and immune effector cell therapy" provision under the "Covered Health Services" section.

- Communications or travel time.

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

- *Illness* 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 a *health care practitioner* certifies that the pregnancy endangers the life of the mother or places the mother in serious risk of substantial impairment of a major bodily function.

- *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.

- 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*.

LIMITATIONS AND EXCLUSIONS (continued)

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

- 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.

- Expenses for:

  - Employment;
  - School;
  - Sport;
  - Camp;
  - Travel; or
  - 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

This "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 not approved by the FDA.
- 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 and nutritional products, 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.

- Non-prescription, over-the-counter minerals, except as specified on the Preventive Medication Coverage *drug list* when obtained from a *network pharmacy* with a *prescription* from a *health care practitioner*.

- 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* when obtained from a *network pharmacy* with a *prescription* from a *health care practitioner*.

- Anabolic steroids.

- Any drug used for the purpose of weight loss.

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

- Compounded drugs that:

  - Are prescribed for a use or route of administration that is not FDA approved or compendia supported;
  - Are prescribed without a documented medical need for specialized dosing or administration;
  - Only contain ingredients that are available over-the-counter;
  - Only contain non-commercially available ingredients; or
  - Contain ingredients that are not FDA approved, including bulk compounding powders.

- Abortifacients (drugs used to induce abortions).

- *Infertility services* including medications.

- Any drug prescribed for impotence and/or sexual dysfunction.

LIMITATIONS AND EXCLUSIONS – PHARMACY SERVICES (continued)

- Any drug, medicine or medication that is consumed or injected at the place where the *prescription* is given, or dispensed by the *health care practitioner*.

- The administration of covered medication(s).

- *Prescriptions* that are to be taken by or administered to *you*, in whole or in part, while *you* are a patient in a facility where drugs are ordinarily provided 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*;
  - *Residential treatment facility for adults*;
  - *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*;

- Exceeds the duration-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*, except for refills of *prescription* eye drops when:
    - The product is written for additional fills;
    - The refill does not exceed the total quantity of dosage units authorized by the prescribing provider on the original *prescription*; and
    - The eye drop refill is dispensed on or before the last day of the prescribed dosage period and not earlier than the:
        - 21st day after the date a 30-day supply is dispensed;
        - 42nd day after the date a 60-day supply is dispensed; or
        - 63rd day after the date a 90-day supply is dispensed.

- 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.
- Treatment for onychomycosis (nail fungus).
- 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 the *group plan sponsor* and *us*; 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.

We reserve the right to require an *eligible employee* to submit evidence of health status. No eligible *employee* will be refused enrollment or charged a different premium than other *group* members based on *health status-related factors.* *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.

We reserve the right to require an eligible *dependent* to submit evidence of health status. No eligible *dependent* will be refused enrollment or charged a different premium than other *group* members based on *health status-related factors.* *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 newborn *dependents you* must enroll the newborn *dependent* child and pay the additional premium within 31 days of the newborn's date of birth. In case of an adopted child, *you* have the option to enroll the adopted child and pay the additional premium within:

- 31 days after *you* are a party in a suit for adoption; or
- 31 days of the date the adoption is final.

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 the *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

A newborn *dependent* of the *employee* will be covered automatically from the date of birth to 31 days of age. To continue coverage for the newborn *dependent* beyond the initial 31-day period, *you* must notify *us* within 31 days of the date of birth.

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* were covered under the *employer's* Prior Plan on the day before the effective date of the *master group contract*; and
- *You* are insured for medical coverage on 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* under the *master group contract* if the medical expense was:

- Incurred in the same calendar year the *master group contract* first becomes effective; and
- Applied to the network deductible amount under the Prior Plan.

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 *out-of-pocket limit* or stop-loss limit will not be credited toward the satisfaction of any *out-of-pocket limit* of the *master group contract*.

Any medical expense applied to the Prior Plan's network *out-of-pocket limit* or stop-loss limit will be credited to *your network provider out-of-pocket limit* under the *master group contract* if the medical expense was incurred in the same calendar year the *master group contract* first 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 and *your employer* must notify *us* as soon as possible if *you* or *your dependent* no longer meets the eligibility requirements of the *master group contract*. Notice must 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 EGA.

When *we* receive the *employer's* request to terminate coverage retroactively, the *employer's* termination request will not be permitted. An *employer* is liable for premiums from the time the *covered person* is no longer eligible for coverage under the *master group contract* until the end of the month in which *we* are notified by the *employer* that a *covered person* is no longer eligible for coverage under the *master group contract*. This individual will remain a *covered person* under the *master group contract* until the end of that period.

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 paid to *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 *group plan sponsor* is allowed a grace period of 31 days following the premium due date for the payment of required premium;
- 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 EGA provides coverage for retired *employees* and the retiree is eligible as specified in the 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.

- The date fraud or an intentional misrepresentation of a material fact has been committed by *you.* *We* will not terminate *your* coverage until *we* provide a 30 calendar day advance written notice to *you.* The notice will include appeal rights as may be required by law. 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 a 30-day 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* any amount *we* paid 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.*

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.

A *covered person* must provide written notice of the election to continue coverage 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 *group plan sponsor* within 45 days after the date of the election for continuation of coverage. Subsequent premium payments will be payable to the *group plan sponsor* 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; or
- The date on which the *covered person* is covered for similar benefits under another group or individual policy.

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.

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;
- A *dependent* becomes eligible for similar group coverage either on an insured or self-insured basis;
- 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 *plans* 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 *plans* and exclusive provider benefit *plans*;
- 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*.

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 *plans* provides coverage for private hospital room expenses.

- If a person is covered by two or more *plans* 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 *plans* 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 *plans*. 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 *plans*, 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 *plans* 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 *plans*' benefits are determined in relation to each other. Each secondary *plan* must take into consideration the benefits of the primary *plan* or *plans* and the benefits of any other *plan* that, under the rules of this contract, has its benefits determined before those of that secondary *plan*.

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, *plans* 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' *plans* 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' *plans*, 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 *plans* 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 *plans* 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 *plans* meeting the definition of *plan*. In addition, *this plan* will not pay more than it would have paid had it been the primary *plan*.

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 *plans* 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 *plans* 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 *plans* and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one *closed panel plan*, COB must not apply between that *plan* and other closed panel *plans*.

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 *plans*. *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 *plans* 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.

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.

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* may have to 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* ID card or at *our* website at 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 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 *you* incur such loss. *Your* claims will not be reduced or denied if it was not reasonably possible to give such proof within that time period.

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.

Your claims may be reduced or denied if written or *electronic* proof of loss is not provided to *us* within one year after the date proof of loss is required, unless *your* failure to timely provide that proof of loss is due to *your* legal incapacity as determined by an appropriate court of law.

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* will not require a medical examination for a *covered person* whose coverage has terminated and elects continuation of coverage. *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.

Benefit payments for *covered health services* rendered by a *non-network provider* are due and owing solely to *you* or *your* assignee. *You* or *your* assignee are responsible for all payments to the *non-network provider*. However, *we* will pay the *non-network provider* directly for the amount *we* owe if *you* or *your* assignee request *we* direct a payment of selected medical benefits to the health care provider on whose charge the claim is based and *we* consent to this request.

When *you* or a *non-network provider* submit a claim to *us* for the *covered health services we* apply the *network provider copayment, deductible* and/or *coinsurance* to, specified in the "How your master group contract works" provision in the "Understanding Your Coverage" section of this *evidence of coverage*, *we* will pay the *non-network provider* directly.

Any payment made directly to the *non-network provider* will not constitute the assignment of any legal obligation to the *non-network provider*.
If *you* submit a claim for payment to *us*, *we* will pay *you* directly for the *covered health services*. *You* are then responsible to pay all charges to the provider when *we* pay *you* directly for *covered health services*.

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.

Claims processing procedures

Qualified provider services are subject to *our* claims processing procedures. *We* use *our* claims processing procedures to determine payment of *covered health services*. *Our* claims processing procedures include, but are not limited to, claims processing edits and claims payment policies, as determined by *us*. *Your qualified provider* may access *our* claims processing edits and claims payment policies on *our* website at Humana.comby clicking on "For Providers" and "Claims Resources."

Claims processing procedures include the interaction of a number of factors. The amount determined to be payable for a *covered health service* may be different for each claim because the mix of factors may vary. Accordingly, it is not feasible to provide an exhaustive description of the claims processing procedures, but examples of the most commonly used factors are:

- The complexity of a service;
- Whether a service is one of multiple same day services such that the cost of the service to the *qualified provider* is less than if the service had been provided on a different day. For example:
    - Two or more *surgeries* performed the same day;
    - Two or more endoscopic procedures performed during the same day; or
    - Two or more therapy services performed the same day;
- Whether a *co-surgeon*, *assistant surgeon*, *surgical assistant*, 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;
- Whether 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 procedures based on *our* review of correct coding initiatives, national benchmarks, industry standards, and industry sources such as the following, including any successors of the same:

- *Medicare* laws, regulations, manuals and other related guidance;
- Federal and state laws, rules and regulations, including instructions published in the Federal Register;
- National Uniform Billing Committee (NUBC) guidance including the UB-04 Data Specifications Manual;
- American Medical Association's (AMA) Current Procedural Terminology (CPT®) and associated AMA publications and services;
- Centers for Medicare & Medicaid Services' (CMS) Healthcare Common Procedure Coding System (HCPCS) and associated CMS publications and services;
- International Classification of Diseases (ICD);
- American Hospital Association's Coding Clinic Guidelines;
- Uniform Billing Editor;
- American Psychiatric Association's (APA) Diagnostic and Statistical Manual of Mental Disorders (DSM) and associated APA publications and services;

- Food and Drug Administration guidance;
- Medical and surgical specialty societies and associations;
- Industry-standard utilization management criteria and/or care guidelines;
- *Our* medical and pharmacy coverage policies; and
- Generally accepted standards of medical, behavioral health and dental practice based on credible scientific evidence recognized in published peer reviewed literature.

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

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 *we* apply claims processing procedures. 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*.

You should discuss *our* claims processing edits, claims payment policies and medical or pharmacy coverage policies and their availability with any *qualified provider* prior to receiving any services. *You* or *your qualified provider* may access *our* claims processing edits and claims payment policies on *our* website at Humana.com by clicking on "For Providers" and "Coverage Policies." *Our* medical and pharmacy coverage policies may be accessed on *our* website at Humana.com under "Medical Resources" by clicking "Coverage Policies." *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 claims processing edit, claims payment policy or coverage policy.

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 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*, *out-of-pocket limit* or *copayment 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. Written notice must be received by *us* at least 10 days before releasing any party from liability for payment of medical expenses. Notice shall be sent to *us* at *our* mailing address shown on *your* identification card;

- 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.

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 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 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 third party or their carrier including self-insured entities;
- Medical payments/expense or no-fault 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 *bodily injury*.

If *you* pursue recovery against another party or 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 *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*, subject to the recovery limits under Chapter 140 of the Texas Civil Practice and Remedies Code.

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 a *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 *bodily injury*. This right, however, shall apply only to the extent of such payment.

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 *bodily injury*.

COMPLAINT AND APPEAL PROCEDURES

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 benefit determination* by an *independent review organization (IRO)*.

For questions on appeal and external review rights, a *covered person* can call the telephone number on the back of their ID card.

You may contact the Texas Department of Insurance (TDI) Consumer Protection for assistance with complaints, appeals or the external review process. Call the TDI at 1-800-252-3439. *You* can file a complaint at www.tdi.texas.gov or send an email to ConsumerProtection@tdi.texas.gov. Written requests may be sent to:

Texas Department of Insurance
Consumer Protection Section
Mail Code 111-1A
P.O. Box 12030
Austin, TX 78711-2030

We will not retaliate in any way if *you* or any person acting on *your* behalf files an appeal or *complaint* against *us*.

Definitions

Adverse determination means a determination by *us* or a utilization review agent that health care services provided or proposed to be provided to a *covered person* are not *medically necessary* or are not appropriate, or are experimental or investigational, or are protected under the Federal No Surprises Act. Adverse determination 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:

- Of a *step therapy* exception request; and
- 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.*

Adverse benefit determination, for the purpose of external review, means a determination by *us* that involves:

- Medical judgment (including, but not limited to *medically necessary* services, appropriateness, health care setting, level of care, or effectiveness of a *covered health service*;
- *Our* determination the treatment is experimental or investigational;
- *Our* determination whether *you* are entitled to a reasonable alternative standard for a reward under a wellness program;
- *Our* determination whether *we* are complying with the non-quantitative treatment limitation provisions under Federal MHPAEA; or
- Any *rescission* of coverage.

An *adverse benefit determination* also includes claims protected under the Federal No Surprises Act.

For *prescription drug* coverage, an *adverse benefit determination* includes a denial:

- Of a *step therapy* exception request; and
- 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.*

External review is not available to resolve disputes about eligibility to participate in the *group* health plan, other than those disputes that are related to *rescissions*.

Complaint means any dissatisfaction expressed 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* or person acting on the *covered person's* behalf and does not include *adverse determinations*.

Independent review organization (IRO) means MAXIMUS Federal Services, a Federal contractor that conducts independent external reviews of *adverse benefit determinations*.

MAXIMUS Federal Services,
3750 Monroe Avenue, Suite 705, Pittsford, NY 14534.
Fax: 1-888-866-6190
Expedited review phone number: 1-888-866-6205, ext. 3326
Expedited review email address: FERP@maximus.com
Secure website: externalappeal.com. Refer to the "Request a Review Online" heading on the website.

Urgent-care means care in which the timeframe 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 treatment.

Humana will make a determination of whether treatment is *urgent-care*. However, any claim a physician, with knowledge of a *covered person's* medical condition, determines is *urgent-care* will be treated as *urgent-care*.

Complaint process

If a *covered person* or person acting on the *covered person's* behalf (claimant) 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 the claimant 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 o*ur* resolution to the claimant. The total time for acknowledging, investigating and resolving the *complaint* will not exceed 30 calendar days after the date *we* receive the *complaint*.

Complaints concerning an emergency or a denial of a continued 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 *we* receive the *complaint*.

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

- *We* shall send an acknowledgment letter to the claimant not later than the fifth business day after the date of receipt of the written request.

- *We* shall appoint members to the complaint panel, which shall advise *us* on the resolution of the dispute. The complaint panel shall be composed of an equal number of o*ur* staff, *health care practitioners*, and other persons covered under a health plan provided by *us*. A member of the complaint 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 claimant agrees otherwise, *we* shall provide to the claimant:

    - 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 claimant, is entitled to:

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

Notice of *our* final decision will be provided no later than 30 calendar days from receipt of the request.

Notification of adverse determinations

The *adverse determination* notification must be provided:

- For a *covered person* who is hospitalized at the time of the *adverse determination*:

  - Within one working day, notice will be sent by telephone or *electronically* to the *covered person's* provider;
  - Within 3 working days, *we* will follow-up with a letter to the *covered person* or person acting on the *covered person's* behalf (claimant) and the *covered person's* provider;

- For a *covered person* who is not hospitalized at the time of the *adverse determination*, notice will be provided in writing to the *covered person's* provider within three working days;

- 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*;

- If *we* seek to discontinue coverage of *prescription drugs* or intravenous infusions for which *you* are receiving benefits under this *evidence of coverage*, *you* will be notified no later than the 30th day before the date on which coverage will be discontinued.

- In the case of an *adverse determination* of a retrospective utilization review, notification will be provided in writing to *you* and the treating *health care practitioner* not later than 30 days after the claim is received. An extension of 15 days may be granted if necessary due to matters beyond *our* control and notice is provided to *you* and the treating *health care practitioner* before the expiration of the initial 30 day period.

Internal appeal

A *covered person* or a person acting on the *covered person's* behalf (claimant) has the right to appeal an *adverse determination* orally or in writing. The appeal must be made within 180 days from receipt of the *adverse determination*.

When *we* receive an appeal, *we* will, within five working days from the receipt of the appeal, send the claimant 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, the acknowledgement letter will include 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 claimant 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.

Expedited internal appeal

A *covered person* or person acting on the *covered person's* behalf (claimant) may request an expedited internal appeal for:

- *Emergency care*;
- Denial of a continued stay for a hospitalized *covered person*;
- Denial of another service if the *health care practitioner* includes a written statement with supporting documentation that a service is necessary to treat a *life-threatening* condition or prevent serious harm to the *covered person*;
- Denial of *prescription* drugs or intravenous infusions for which the *covered person* is receiving benefits under the *master group contract*; or
- Denial of a *step therapy* exception request.

The time frame for resolution will be based on the medical or dental immediacy of the condition, procedure or treatment. The decision timeframe will be the earlier of one business day from the date all information necessary to complete the appeal is received or 72 hours after *we* receive the appeal request. 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 claimant'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 a particular type of specialty provider review the case, the appeal denial shall be reviewed by a *health care practitioner* 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 process" and "Internal appeal" provisions and who are dissatisfied with the resolution, may report an alleged violation to the Texas Department of Insurance, P.O. Box 12030, Austin, Texas 78711-2030.

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.

External appeal to an independent review organization (IRO)

Within four months after a *covered person* or person acting on the *covered person's* behalf (claimant) receives notice of an *adverse benefit determination*, involving medical necessity, experimental and investigational, medical judgment denials or a *rescission*, the claimant may request a review by an *independent review organization (IRO)*. For claims protected under the No Surprises Act, refer to *our* decision letter for the timeframe to submit the request. The request may be sent to the *IRO* as follows:

Online: Visit the *IRO's* secure website at externalappeal.cms.gov and click on the "Request a Review Online" heading.

Mail: MAXIMUS Federal Services
3750 Monroe Avenue, Suite 705
Pittsford, NY 14534

Fax: 1-888-866-6190

If the claimant has any questions or concerns during the external appeal process, they can call the toll-free number 1-888-866-6205. Additional written comments can be submitted to the *IRO's* mailing address above. Any additional information submitted will be shared with *us* for an opportunity to reconsider the denial.

When the *IRO* receives the external appeal request, the *IRO* will request from *us* all of the documents and any information considered in making the *adverse benefit determination*. The *IRO* will then conduct a preliminary review of the information *we* provided and may request additional information from *us*. If the *IRO* determines the claimant is not eligible for an external appeal, the *IRO* will notify the claimant and *us* in writing.

Review process

The *IRO* will review all of the information and documents that are timely received. In reaching a decision, the *IRO* will review the claim and not be bound by any decisions or conclusions reached during the internal appeal process.

The *IRO* will forward *us* all documents submitted directly to the *IRO* by the claimant. Upon receipt of this information, *we* may reconsider the *adverse benefit determination*. Reconsideration by *us* will not delay the external review. If *we* decide, upon completion of *our* reconsideration, to reverse the *adverse benefit determination* and provide coverage or payment, *we* will provide written notice of *our* decision to the claimant and the *IRO*. The *IRO* will terminate the external review upon receipt of the notice from *us*.

If *we* do not reverse *our* decision, the *IRO* will continue the review. The *IRO* will provide written notice of the final external review decision as expeditiously as possible, but no later than 45 days after the *IRO* receives the request for the external review. The *IRO* will deliver the notice of final external review decision to the claimant and to *us*.

Reversal of the adverse benefit determination

Upon receipt of a notice of a final external review decision reversing the *adverse benefit determination we* will immediately provide coverage or payment (including immediately authorizing care or immediately paying benefits) for the claim.

Expedited external appeal to an independent review organization (IRO)

A claimant may request an expedited external review by the *IRO* in writing, orally or online. For online external appeal requests, visit the *IRO's* secure website at externalappeal.com, click on "Request a Review Online" and select "expedited." Requests for an expedited external review can also be emailed to FERP@maximus.com, or by calling Federal External Review Process at 888-866-6205 ext. 3326.

The claimant is not required to comply with procedures for an internal review of an *adverse determination* in a circumstance involving a:

- *Life-threatening* condition;
- A medical condition that, in the opinion of a physician with knowledge of the *covered person's* medical condition, could seriously jeopardize the life or health of the *covered person* or the ability of the *covered person* to regain maximum function.
- Denial of *prescription* drugs or intravenous infusions for which the *covered person* is receiving benefits under the *master group contract*; or
- Review of a *step therapy* exception request for *urgent-care*.

When the *IRO* receives a request for an expedited external review, the *IRO* will contact *us*. Immediately upon receipt of request by the *IRO*, *we* will provide the *IRO* all documents and other information required under the standard external review. The *IRO* will conduct a preliminary review of the information from *us* and may request additional information that it deems necessary to the expedited external review. If the *IRO* determines that the claimant is not eligible for expedited external appeal, the *IRO* will notify the claimant and *us* as expeditiously as possible.

Review process

The *IRO* will review all of the information and documents received. Upon receipt of any information submitted by the claimant, the *IRO* will immediately forward the information to *us*. Upon receipt of any such information, *we* may reconsider *our adverse benefit determination*. Reconsideration by *us* will not delay the expedited external review. If *we* decide, upon completion of *our* reconsideration, to reverse the *adverse benefit determination* and provide full coverage or payment, *we* will immediately provide notice of *our* decision to the claimant and the *IRO*. The notice may be provided orally but will be followed up with written notice within 48 hours. The *IRO* will terminate the expedited external review upon receipt of the notice from *us*.

The *IRO* will provide notice of the final expedited external review decision as expeditiously as the *covered person's* medical conditions or circumstances require, but in no event more than 72 hours after the *IRO* receives a request for an expedited external review.

The *IRO* will deliver the notice of the final expedited external review decision to the claimant and *us*. The notice may be initially provided orally but will be followed by a written notice within 48 hours. Upon receipt of a notice of a final expedited external review decision reversing the *adverse benefit determination we* will immediately provide coverage or payment (including immediately authorizing care or immediately paying benefits) for the claim.

The appeal process does not prohibit the claimant 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 legal action to recover on the *master group contract* may be brought until 60 days after written proof of loss has been given in accordance with the "Proof of loss" provision of the *master group contract*.

No legal action to recover on the *master group contract* may be brought after three years from the date written proof of loss is required to be given.

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 services* 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 the 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 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
- Distributing and providing *covered persons* access to:

    - Benefit plan documents and the Summary of Benefits and Coverage (SBC);
    - Renewal notices and *master group contract* modification information;
    - Discontinuance notices; and
    - Information regarding continuation rights.

No *group plan sponsor* may change or waive any provision of the *master group contract*.

Evidence of coverage

An *evidence of coverage* setting forth the benefits available to the *employee* and the *employee's* covered *dependents* will be available at Humana.com or in writing when requested. The *employer* is responsible for providing *employees* access to the *evidence of coverage*.

No document inconsistent 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 by the administrator of a group plan subject to ERISA. If the terms of a summary plan description differ with the terms of this *evidence of 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 *master group contract* may be modified by *us*, upon renewal of the *master group contract*, as permitted by state and federal law. The *group plan sponsor* 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.

Corrections due to clerical errors or clarifications that do not change benefits are not modifications of the *master group contract* and may be made by *us* at any time without prior consent of, or notice to, the *group plan sponsor.*

Discontinuation of coverage

If *we* decide to discontinue offering a particular group health plan:

- The *group plan sponsor* and the *employees* 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 (or, in the case of a *large employer*, any) other group plans providing medical benefits that are being offered by *us* at such time.

If *we* cease doing business in the *small employer* or the *large employer* group market, the *group plan sponsors*, *covered persons*, and the Commissioner of Insurance will be notified of such discontinuation at least 180 days prior to the date of discontinuation of such coverage.

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*.

Emergency declarations

We may alter or waive the requirements of the *master group contract* as a result of a state or federal emergency declaration including, but not limited to:

- *Prior authorization* or *preauthorization* requirements;
- *Prescription* quantity limits; and

- *Your copayment*, *deductible* and/or *coinsurance*.

We have the sole authority to waive any *master group contract* requirements in response to an emergency declaration.

Communication preferences

You may elect how *you* receive written communication from *us*. Visit *our* website at Humana.com or call the customer service telephone number on *your* ID card to elect *your* communication preferences. *You* may withdraw or change *your* election at any time without consequence.

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*; and
- 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 mean 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.

Air ambulance means a professionally operated helicopter or airplane, 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 *air ambulance* must be *medically necessary.* When transporting the sick or injured person from one medical facility to another, the *air ambulance* must be ordered by a *health care practitioner*.

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, shiatsu, yoga, and chelation therapy.

Ambulance means a professionally operated ground 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.* When transporting the sick or injured person from one medical facility to another, the *ambulance* must be 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.

Ancillary services mean *covered health services* that are:

- Items or services related to emergency medicine, anesthesiology, pathology, radiology, or neonatology;
- Provided by *assistant surgeons*, hospitalists or intensivists;
- Diagnostic laboratory or radiology services; and
- Items or services provided by a *non-network provider* when a *network provider* is not available to provide the services at a *network facility.*

Assistant surgeon means a *health care practitioner* who assists at *surgery* and is a Doctor of Medicine (MD), Doctor of Osteopathic Medicine (DO), Doctor of Podiatric Medicine (DPM) or where state law requires a specific *health care practitioner* be treated and reimbursed the same as an MD, DO or DPM.

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 *serious mental illness* services, *mental health services* and *chemical dependency* services.

Birthing center means a *free-standing facility* that is specifically licensed to perform uncomplicated pregnancy care, delivery and immediate care after delivery for a *covered person*.

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*.

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*. 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, certified or approved as a chemical dependency treatment program or center by the state agency having the legal authority to 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 mean services that facilitate the continuum of care as an affected individual transitions into the community.

Companion plan means the health insurance coverage of this point-of-service product that is insured by Humana Insurance Company.

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 a registered bed patient as the result of a *health care practitioner's* recommendation. It does <u>not</u> 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.

Co-surgeon means one of two or more *health care practitioners* furnishing a single *surgery* which requires the skill of multiple surgeons each in a different specialty, performing parts of the same *surgery* simultaneously.

Covered health services means:

- *Medically necessary* services to treat an *illness* or *bodily injury*, such as:
  - Procedures;
  - *Surgeries*;
  - Consultations;
  - Advice;
  - Diagnosis;
  - Referrals;
  - Treatment;
  - Supplies;
  - Drugs, including *prescription* and *specialty drugs*;
  - Devices; or
  - Technologies;
- *Preventive services*.

To be considered a *covered health service*, services must be:

- Ordered by a *health care practitioner*;
- Authorized or prescribed by a *qualified provider*;
- Provided or furnished 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 insured 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, and 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;
- 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*. *Dependent* also means a grandchild or great grandchild if the child is dependent on the *employee* for Federal Income Tax purposes at the time of application, or the *employee* is responsible for the child under a qualified medical support order or court order;

- 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*.

Dependent does not mean a foster child, unless the *employee* is responsible for the foster child under a qualified medical support order or court order.

The limiting age means the end of the month 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*;
- Eligible for other coverage through employment; or
- Residing or working outside of the *service area.*

A covered *dependent* child, who attains the limiting age while covered under the *master group contract*, remains eligible if the covered *dependent* child is:

- Mentally or physically handicapped; and
- Incapable of self-sustaining employment.

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; non-prescriptive medications for controlling blood sugar levels; glucagon emergency kits; alcohol swabs; infusion sets; insulin cartridges; batteries; skin preparation items; adhesive supplies; and biohazard disposable containers.

Diagnostic imaging provider means a health care provider who performs a *diagnostic imaging service* on a patient for a fee or interprets imaging produced by a *diagnostic imaging service*.

Diagnostic imaging service means magnetic resonance imaging (MRI), computed tomography (CT), positron emission tomography (PET), or any hybrid technology that combines any of those imaging modalities.

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 <u>not</u> typically furnished by a *hospital* or *skilled nursing facility*; and
- It is provided in the most cost effective manner required by *your* condition, including, at *our* discretion, rental or purchase.

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, partner, corporate officer and independent contractor if the *employer* includes the sole proprietor, partner, corporate officer or an independent contractor as an *employee* under the health benefit plan of the *employer*. 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 benefit 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 an emergency facility, free-standing emergency medical care facility or a comparable emergency facility to evaluate and stabilize an *emergency medical condition. Emergency care* does not mean services for the convenience of the *covered person* or the provider of treatment or services.

Emergency medical condition means a recent onset of 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 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;
- 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.

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 the *master group contract*.

Employer means the sponsor of this *group* plan, or any subsidiary or affiliate described in the Employer Group Application. An *employer* must employ at least two *eligible employees* who enroll in the plan.

Endodontic services mean the following dental procedures, related tests or treatment and follow-up care:

- Root canal therapy and root canal fillings;
- Periradicular *surgery*;
- Apicoectomy;
- Partial pulpotomy; or
- Vital pulpotomy.

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

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

Evidence of coverage means this benefit plan document that describes the benefits, provisions and limitations of the *master group contract*. This *evidence of coverage* is part of the *master group contract* and is subject to the terms 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 & 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

Facility-based physician means a radiologist, anesthesiologist, pathologist, emergency department physician, neonatologist, hospitalist, intensivist, or *assistant surgeon*:

- To whom a facility has granted clinical privileges; and
- Who is a *facility-based provider*.

Facility-based provider means a *health care practitioner* or provider who provides *covered health services* to a *covered person* who is a patient of a *health care treatment facility*.

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

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

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 mean 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 is not 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, or institution, duly licensed by the appropriate state agency to provide medical services, *behavioral health* services or *serious mental illness* 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.

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 or less 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 requiring clinical laboratory services, diagnostic x-ray services, treatment facilities including *surgery* or obstetrical care, or both, and other medical or surgical treatment of similar extent 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, for patients requiring diagnosis, treatment or care for *illness*, *bodily injury*, deformity abnormality, or pregnancy;

- 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;
  - Facility providing custodial, educational or rehabilitative care;
  - *Chemical dependency treatment center*;
  - *Crisis stabilization unit*; or
  - *Psychiatric day treatment facility*.

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*.

Immune effector cell therapy means immune cells or other blood products that are engineered outside of the body and infused into a patient. *Immune effector cell therapy* may include acquisition, integral chemotherapy components and engineered immune cell infusion.

Infertility services mean any 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; 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

Laboratory service provider means an accredited facility in which a specimen taken from a human body is interpreted and pathological diagnoses are made or a *health care practitioner* who makes an interpretation of or diagnosis based on a specimen or information provided by a laboratory based on a specimen.

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 two *employees* on the first day of the plan *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 legal agreement between *us* and the *group plan sponsor*, including the Employer Group Application and *evidence of coverage*, together with any riders, amendments and endorsements.

Medicaid means a state program of medical care, 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 generally accepted 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*;
- Neither sourced from a location, nor provided primarily for the convenience of the patient, physician or other health care provider;
- Not more costly than an alternative source, 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*; and
- Performed in the least costly site or sourced from, or provided by the least costly *qualified provider*.

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 mean those diagnoses and treatments related to the care of a *covered person* who exhibits a mental, nervous or emotional condition or disorders 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 facility means a *hospital*, *hospital outpatient* department or *ambulatory surgical center* that has been designated as such or has signed an agreement with *us* as an independent contractor, or has been designated by *us* to provide services to all *covered persons*. *Network facility* designation by *us* may be limited to specified services.

Network health care practitioner means a *health care practitioner*, who has been designated as such or has signed an agreement with *us* as an independent contractor, or who has been designated by *us* 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 been designated as such or has signed an agreement with *us* as an independent contractor, or has been designated by *us* 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*, *health care practitioner*, or other health services provider who is designated as such or has signed an agreement with *us* as an independent contractor, or who has been designated by *us* 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 by *us* as a *network health care practitioner*.

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

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

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 *you* are receiving *hospital outpatient* services to help the *health care practitioner* decide if *you* need to be admitted as an *inpatient*.

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.

Out-of-pocket limit means the amount of *copayments*, *deductibles* and *coinsurance you* must pay for *covered health services*, as specified in the "Out-of-pocket limit" provision in the "Schedule of Benefits" section, either individually or combined as a covered family, per *year* before a benefit percentage is increased.

Covered health services 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 day treatment services mean structured services provided to address deficits in physiological, behavioral, and/or cognitive functions as related to an *acquired brain injury*. Such services may be delivered in settings that include transitional residential, community integration, or nonresidential treatment settings.

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

- Has a comprehensive and intensive interdisciplinary psychiatric treatment under the supervision of a psychiatrist for *mental health services* or a psychiatrist or addictionologist for *chemical dependency*, and patients are seen by a psychiatrist or addictionologist, as applicable, at least once a week;

- 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

- 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 *master group contract*. 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.

Personal care services means assistance with meals, dressing, movement, bathing or other personal needs or maintenance, including the administration of medication by a person licensed to administer medication or the assistance with or supervision of medication; or general supervision or oversight of the physical and mental well-being of a person who needs assistance to maintain a private and independent residence in an *assisted living facility* or who needs assistance to manage the person's personal life, regardless of whether a guardian has been appointed to the person.

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

Post-acute-care treatment services mean services provided after acute-care confinement and/or treatment that are based on an assessment of the individual's physical, behavioral, or cognitive functional deficits, which include a treatment goal of achieving functional changes by reinforcing, strengthening, or reestablishing previously learned patterns of behavior and/or establishing new patterns of cognitive activity or compensatory mechanisms as related to an *acquired brain injury*.

Post-acute transition services mean services that facilitate the continuum of care beyond the initial neurological insult through rehabilitation and community reintegration.

Post-stabilization services means services *you* receive in *observation status* or during an *inpatient* or *outpatient* stay in a *network facility* related to an *emergency medical condition* after *you* are stabilized.

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*.

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 an *illness* 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*.

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 USPSTF or as otherwise required by state law.
- Immunizations recommended by the Advisory Committee on Immunization Practices of the CDC.
- Preventive care for infants, children and adolescents provided in the comprehensive guidelines supported by the HRSA.
- Preventive care for women provided in the comprehensive guidelines supported by the 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* ID card. Refer to the "Preventive services" provision in the "Covered Health Services" section which includes *preventive services* covered by the *master group contract*.

Primary care physician means a *network health care practitioner* 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.

A *primary care physician* is a *health care practitioner* in one of the following specialties:

- Family medicine/General practice;
- Internal medicine; and
- Pediatrics.

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 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 payment amount means the lesser of:

- Billed charges; or
- The median of the contracted rates negotiated by *us* with one or more *network providers* in the same geographic area for the same or similar services.

If sufficient information is not available for *us* to calculate the median of the contracted rates, the rate established by *us* through use of any database that does not have any conflict of interest and has sufficient information reflecting allowed amounts paid to a *qualified provider* for relevant services furnished in the applicable geographic region.

The *qualified payment amount* applies to *covered health services* when *you* receive the following services from a *non-network provider*:

- *Air ambulance* services;
- *Emergency care* outside the state of Texas;
- *Ancillary services* when *you* are at a *network facility* outside of Texas;
- *Ancillary services*, other than those provided by a *facility based physician*, when *you* are at a *network facility* in the state of Texas;
- Services that are not considered *ancillary services* when *you* are at a *network facility*, and *you* did not consent to the *non-network provider* to obtain such services; or
- *Post-stabilization services* provided outside the state of Texas when:
  - The attending *qualified provider* determines *you* are not able to travel by non-medical transportation to obtain services from a *network provider*; and
  - *You* do not consent to the *non-network provider* to obtain such services.

Qualified provider means a person, facility, supplier, or any other health care provider:

- That is licensed by the appropriate state agency to:
  - Diagnose, prevent or treat an *illness* or *bodily injury*; or
  - Provide *preventive services*;

A *qualified provider* must provide services within the scope of their license and their primary purpose must be 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 an institution that:

- Provides residential care and treatment for emotionally disturbed children and adolescents 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.

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, or *congenital anomaly* 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);
- Schizoaffective 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*. Refer to "Appendix A – Service Area" for a map of the *service area*. A description of the *service area* is also 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 or a home for the care of the aged.

Small employer means an *employer* who employed an average of at least two *employees* but not more than 50 *employees* on business days during the preceding calendar year and who employs at least two *employees* on the first day of the plan *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. For the purpose of this definition, a partnership is the *employer* of a partner.

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.

Specialty drug means a drug, medicine, medication, or biological used as a specialized therapy developed for chronic, complex *illnesses* 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.

Stem cell 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 *stem cell* transplant includes the harvesting, integral chemotherapy components and the *stem cell* infusion. A *stem cell* transplant is commonly referred to as a bone marrow transplant.

Surgery means procedures categorized as Surgery in either the:

- Current Procedural Terminology (CPT) manuals published by the American Medical Association; or
- Healthcare Common Procedure Coding System (HCPCS) Level II manual published by the Centers for Medicare & Medicaid Services (CMS).

The term *surgery* includes, but is not limited to:

- Excision or incision of the skin or mucosal tissues;
- 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;
- Treatment of fractures;
- Procedures to repair, remove or replace any body part or foreign object in or on the body; and

- Endoscopic procedures.

Surgical assistant means a *health care practitioner* who assists at *surgery* and is not a Doctor of Medicine (MD), Doctor of Osteopathic Medicine (DO) or Doctor of Podiatric Medic state law does not require that specific *health care practitioners* be treated and reimb MD, DO or DPM.

IM Kathy to check this as wrong plural for dentist is dentists. same for CR CNPOS form

T

Teledentistry dental service means a health care service delivered by a dentist or a health professional acting under the delegation and supervision of a dentist and acting within the scope of the dentists's or health care professional's license or certification to a *covered person* at a different physical location than the dentist or health professional using telecommunications or information technology.

Telehealth service means a health service, other than a *telemedicine medical service* or *teledentistry dental service*, delivered by a health professional licensed, certified or otherwise entitled to practice in Texas and acting within the scope of their license, certification, or entitlement to a patient at a different physical location than the health professional using telecommunications or information technology.

Telemedicine medical service means a health care service delivered by a *health care practitioner* licensed in Texas, or a health professional acting under the delegation and supervision of a *health care practitioner* licensed in Texas and acting within the scope of their license to a patient at a different physical location than the *health care practitioner* or health professional using telecommunications or information technology.

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 health care services provided on an *outpatient* basis for an unforeseen condition that usually requires attention without delay but 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.

Usual and customary fee for a *covered health service* 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 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 & 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.

When *you* obtain services from a *network provider* the *usual and customary fee* for *covered health services* will not be lower than the negotiated rate in the *network provider's* contract.

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 the *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

Coinsurance means the amount expressed as a percentage of the *covered health service* that *you* must pay toward the cost of each separate *prescription* fill or refill dispensed by a *pharmacy*.

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 applicable *prescription drug deductible*, *copayment* 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*.

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

Level 1 drugs mean a category of *prescription* drugs, medicines or medications within the *drug list* that are designated by *us* as level 1. The *prescription* drugs in this category are low-cost *generic drugs* and *brand-name drugs*.

Level 2 drugs mean a category of *prescription* drugs, medicines or medications within the *drug list* that are designated by *us* as level 2. The *prescription* drugs in this category are higher-cost *generic drugs* and *brand-name drugs*.

Level 3 drugs mean a category of *prescription* drugs, medicines or medications within the *drug list* that are designated by *us* as level 3. The *prescription* drugs in this category have a higher *copayment* than Level 2 for high cost, mostly *brand-name drugs* that may have *generic drug* or *brand-name drug* alternatives on Levels 1 or 2.

Level 4 drugs mean a category of *prescription* drugs, medicines or medications within the *drug list* that are designated by *us* as level 4. The *prescription* drugs in this category are highest-cost drugs that have a *coinsurance* amount higher than the level 3 *copayment*. This category includes mostly *brand-name drugs*. *Specialty drugs* are not categorized as *level 4 drugs*.

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* 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* 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 drug deductible means the specified dollar amount for *prescription* drug *covered health services* which *you*, either individually or combined as a covered family, must pay per *year* before *we* pay *prescription* drug benefits under the *master group contract*. These expenses do not apply toward any other *deductible*, if any, stated in the *master group contract*.

Prescription drug *covered health services* applied to the *prescription drug deductible* listed in the "Schedule of Benefits - Pharmacy Services" section of this *evidence of coverage* will be applied to the

prescription drug deductible, if any, listed in the "Schedule of Benefits - Pharmacy Services" section of the "Certificate of Insurance."

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 *medically necessary* for the *covered person*.

Q

R

S

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

Step therapy means a protocol that requires *you* to first use a *prescription* drug or sequence of *prescription* drugs other than the drug the *health care practitioner* recommends for *your* treatment before *we* will cover the drug recommended by the *health care practitioner*.

T

U

V

W

X

Y

Z

Humana.

(512) 338-6100
1221 S. Mopac, Suite 200
Austin, Texas 78746

OFFERED BY
Humana Health Plan of Texas, Inc.

Humana.

Administrative Office:
1100 Employers Boulevard
Green Bay, Wisconsin 54344

Humana.com

Certificate of Insurance
Humana Insurance Company

Policyholder:

Policy Number:

Effective Date:

Product Name:

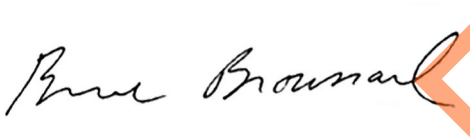
In accordance with the terms of the *policy* issued to the *policyholder*, Humana Insurance Company certifies that a *covered person* is insured for the benefits described in this *certificate*. This *certificate* becomes the Certificate of Insurance and replaces any and all certificates and certificate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

This *certificate* is the *companion plan* to the "Evidence of Coverage" issued to *you* by Humana Health Plan of Texas, Inc. (the *HMO*). The *HMO* "Evidence of Coverage" and this *certificate*, describe the coverage for this point-of-service product and the manner in which the *health insurance coverage* may be used. The *HMO* "Evidence of Coverage" describes *health insurance coverage* for covered health services provided by *network providers* and provided by *non-network providers* in limited circumstances. This *certificate* describes *health insurance coverage* for *covered expenses* provided by *network providers* and *non-network providers*.

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

THIS POLICY 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 the company.

This is not a policy of Long Term Care insurance.



Bruce Broussard
President

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

200400TX 01/23

Have a complaint or need help?

If you have a problem with a claim or your premium, call your insurance company or HMO first. If you can't work out the issue, the Texas Department of Insurance may be able to help.

Even if you file a complaint with the Texas Department of Insurance, you should also file a complaint or appeal through your insurance company or HMO. If you don't, you may lose your right to appeal.

Humana Insurance Company

To get information or file a complaint with your insurance company or HMO:

Call: Customer Care at **1-800-448-6262 / TTY Number: 711**
Toll-free: **1-800-448-6262 / TTY Number: 711**

Email: HumanaResolution@Humana.com

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

The Texas Department of Insurance
To get help with an insurance question or file a complaint with the state:
Call with a question: 1-800-252-3439
File a complaint: www.tdi.texas.gov
Email: ConsumerProtection@tdi.texas.gov
Mail: MC 111-1A, P.O. Box 12030, Austin, TX 78711-2030

¿Tiene una queja o necesita ayuda?

Si tiene un problema con una reclamación o con su prima de seguro, llame primero a su compañía de seguros o HMO. Si no puede resolver el problema, es posible que el Departamento de Seguros de Texas (Texas Department of Insurance, por su nombre en inglés) pueda ayudar.

Aun si usted presenta una queja ante el Departamento de Seguros de Texas, también debe presentar una queja a través del proceso de quejas o de apelaciones de su compañía de seguros o HMO. Si no lo hace, podría perder su derecho para apelar.

Humana Insurance Company

Para obtener información o para presentar una queja ante su compañía de seguros o HMO:

Llame a: Atención al cliente al **1-800-448-6262 / TTY Number: 711**
Teléfono gratuito: **1-800-448-6262 / TTY Number: 711**

Correo electrónico: HumanaResolution@Humana.com

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

El Departamento de Seguros de Texas
Para obtener ayuda con una pregunta relacionada con los seguros o para presentar una queja ante el estado:
Llame con sus preguntas al: 1-800-252-3439
Presente una queja en: www.tdi.texas.gov
Correo electrónico: ConsumerProtection@tdi.texas.gov
Dirección postal: MC 111-1A, P.O. Box 12030, Austin, TX 78711-2030

200500TX 01/23

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. Please check 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.

Essential health benefits

This *certificate* does not apply annual dollar limits or lifetime dollar limits to *covered expenses* that are *essential health benefits*.

Covered and non-covered expenses

We will provide coverage for services, equipment and supplies that are *covered expenses*. All requirements of the *certificate* 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.

Not all services and supplies are a *covered expense*, even when ordered by a *health care practitioner*. *You* must pay the health care provider for any service that is not a *covered expense*.

Refer to the "Schedule of Benefits," the "Covered Expenses" and the "Limitations and Exclusions" sections and any amendment attached to the *certificate* to see when services or supplies are *covered expenses* or are non-covered expenses.

How your policy works

We may apply a *copayment* or *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 a *copayment*, *deductible* and/or *coinsurance* may apply.

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.

Covered expenses are subject to the *maximum allowable fee*. *We* will apply the applicable *network provider* or *non-network provider* benefit level to 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*; or
- Those in excess of the *maximum allowable fee*; and

- Adjustments related to *our* claims processing procedures. Refer to the "Claims" section of this *certificate* for more information on *our* claims processing procedures.

Unless stated otherwise in this *certificate*, *you* will be responsible to pay:

- The applicable *network provider* or *non-network provider copayment*, *deductible* and/or *coinsurance*;
- Any amount over the *maximum allowable fee* to a *non-network provider*; and
- Any amount not paid by *us*.

However, *we* will apply the *network provider* benefit level and *you* will only be responsible to pay the *network provider copayment*, *deductible* and/or *coinsurance* for *covered expenses*, based on *maximum allowable fee* when *you* receive the following services from a *non-network provider* in the state of Texas:

- *Emergency care*;
- *Post-stabilization services* until *you* can reasonably be expected to transfer to a *network provider*;
- Services from a *facility-based physician* at a *network facility*;
- Services from a *diagnostic imaging provider* or *laboratory service provider* who are *non-network providers* if the services are associated with a *covered expense* performed by a *network provider*.

We will apply the *network provider* benefit level and *you* will only be responsible to pay the *network provider copayment*, *deductible* and/or *coinsurance*, based on the *qualified payment amount*, for *covered expenses* when *you* receive the following services from a *non-network provider*:

- *Air ambulance* services;

- *Emergency care* outside the state of Texas;

- *Ancillary services* when *you* are at a *network facility* outside the state of Texas;

- *Ancillary services*, other than those provided by a *facility based physician*, when *you* are at a *network facility* in the state of Texas;

- Services that are not considered *ancillary services* when *you* are at a *network facility*, and *you* did not consent to the *non-network provider* to obtain such services; or

- *Post-stabilization services* provided outside the state of Texas when:

  - The attending *qualified provider* determines *you* are not able to travel by non-medical transportation to obtain services from a *network provider*; and
  - *You* do not consent to the *non-network provider* to obtain such services.

Any *network provider copayment*, *deductible* and/or *coinsurance you* pay a *non-network* provider for the specific services listed above will be applied to the *network provider out-of-pocket limit*.

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 any maximum benefit and all other terms, provisions, limitations, and exclusions of the *policy*.

Point-of-Service (POS) plan description

Point-of-service (POS) plan means an arrangement under which a *covered person* can choose *covered health services* through the *HMO* "Evidence of Coverage" or *covered expenses* through this *companion plan* "Certificate of Insurance."

The *HMO* "Evidence of Coverage" describes *health coverage* for *covered health services* provided by *network providers*. *We* will cover services when received by *you* from a *network provider* with or without a referral from *your* primary care physician. The *HMO* "Evidence of Coverage" also describes *health coverage* for *covered health services* provided by *non-network providers* in limited circumstances. Please refer to the "Your choice of providers affects your benefits" provision in the "Understanding Your Coverage" section of the *HMO* "Evidence of Coverage" for more information.

This *companion plan* "Certificate of Insurance" describes *health insurance coverage* for *covered expenses* provided by *network providers* and *non-network providers*. Please refer to the "Your choice of providers affects your benefits" provision in this "Understanding Your Coverage" section of this *companion plan* "Certificate of Insurance" for more information.

Your choice of providers affects your benefits

We will pay benefits for *covered expenses* at a higher percentage most of the time if *you* see a *network provider*, so the amount *you* pay will be lower. Be sure to check if *your qualified provider* is a *network provider* before *you* receive services from them.

We may designate certain *network providers* as preferred providers for specific services. If *you* do not see the *network provider* designated by *us* as a preferred provider for these services, *we* may pay less.

Network providers have a signed agreement with *us* to provide *covered expenses* at an agreed rate and will accept *your* payment of any applicable *copayment*, *deductible* and/or *coinsurance* and the amount *we* pay for *covered expenses* as the full payment.

Unless stated otherwise in this *certificate*, *we* will pay a lower percentage if *you* choose to see a *non-network provider*, so the amount *you* pay will be higher. *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*, unless balance billing is prohibited by applicable law. If the *non-network provider* bills *you* any amount over the *maximum allowable fee*, *you* will have to pay that amount and any *copayment*, *deductible* and/or *coinsurance* to the *non-network provider*. Any amount *you* pay over the *maximum allowable fee* will not apply to *your deductible* or any *out-of-pocket limit*.

NOTICE: "Although *covered expenses* may be or have been provided to *you* at a *network facility*, other professional services may be or have been provided at or through the *network facility* by physicians and other *health care practitioners* who are *non-network providers*. *You* may be responsible for payment of all or part of the fees for those professional services that are not paid or covered by *your* health benefit plan unless balance billing for those services is prohibited."

We will apply the *network provider* benefit level and *you* will only be responsible to pay the *network provider copayment*, *deductible* and/or *coinsurance* for *covered expenses* when *you* receive the following services from a *non-network provider*:

- Services from a *facility-based physician* at a *network facility* in the state of Texas;
- *Ancillary services*, other than those provided by a *facility based physician*, when *you* are at a *network facility* in the state of Texas;
- *Ancillary services* when *you* are at a *network facility* outside the state of Texas;
- Services that are not considered *ancillary services* when *you* are at a *network facility*, and *you* did not consent to the *non-network provider* to obtain such services;
- *Post-stabilization services*, provided in the state of Texas, until *you* can reasonably be expected to transfer to a *network provider*;
- *Post-stabilization services* provided outside the state of Texas when:
  - The attending *qualified provider* determines *you* are not able to travel by non-medical transportation to obtain services from a *network provider*; and
  - *You* do not consent to the *non-network provider* to obtain such services; and
- Services from a *diagnostic imaging provider* or *laboratory service provider*, in the state of Texas, who is a *non-network provider* if the services are associated with a *covered expense* performed by a *network provider*.

If a *network provider* is not reasonably available for services other than those listed above, *we* will apply the *network provider copayment, deductible* and/or *coinsurance* to *covered expenses* for services received from a *non-network provider* when authorized by *us*, subject to the *maximum allowable fee*. The *non-network provider* may bill *you* any amount over the *maximum allowable fee*, unless balance billing is prohibited by applicable law. *You* may have to pay that amount and any *copayment*, *deductible* and/or *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*.

For all other services, *you* receive from a *non-network provider*, *you* will be responsible to pay the *non-network provider copayment*, *deductible* and/or *coinsurance* and *you* may also be responsible to pay any amount over the *maximum allowable fee* for *covered expenses* including:

- Services that are not considered *ancillary services* when *you* are at a *network facility* and *you* consent to the *non-network provider* to obtain such services;
- *Post-stabilization services* in the state of Texas when *you* do not transfer to a *network provider*; and
- *Post-stabilization services* provided outside the state of Texas when:
  - The attending *qualified provider* determines *you* are able to travel by non-medical transportation to obtain services from a *network provider*; and
  - *You* consent to the *non-network provider* to obtain such services.

Refer to the "Schedule of Benefits" sections to see what *your network provider* and *non-network provider* benefits are.

How to find a network provider

You may find a list of *network providers* at 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*.

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.

Continuity of care

You may be eligible to elect continuity of care if *you* are a continuing care patient as of the date the following events occur:

- *Your qualified provider* terminates as a *network provider*;
- The terms of a *network provider's* participation in the network changes in a manner that terminates a benefit for a service *you* are receiving as a continuing care patient; or
- The *policy* terminates.

If *you* elect continuity of care, *we* will apply the *network provider* benefit level to *covered expenses* related to *your* treatment as a continuing care patient. *You* will be responsible for the *network provider copayment*, *deductible* and/or *coinsurance* until the earlier of:

- 90 days from the date *we* notify *you* the *qualified provider* is no longer a *network provider*;
- 90 days from the date *we* notify *you* the terms of a *network provider's* participation in the network changes in a manner that terminates a benefit for a service *you* are receiving as a continuing care patient;
- 90 days from the date *we* notify *you* this *policy* terminates;
- In the case of a pregnancy, 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 terminal illness, nine months from the date *we* notify *you* the *qualified provider* is no longer a *network provider* or nine months from the date *we* notify *you* the terms of a *network*

provider's participation in the network changes in a manner that terminates a benefit for a service *you* are receiving as a continuing care patient; or

- The date *you* are no longer a continuing care patient.

For the purposes of this "Continuity of care" provision, continuing care patient means at the time continuity of care becomes available, *you* are undergoing treatment from the *network provider* for:

- A disability;
- An acute *sickness* or *bodily injury*;
- A *life-threatening* or complex *sickness* or *bodily injury*;
- *Inpatient* care;
- A scheduled non-elective *surgery* and any related post-surgical care;
- A pregnancy; or
- A terminal illness.

Continuity of care is not available if:

- The *qualified provider's* participation in *our* network is terminated due to failure to meet applicable quality standards, medical competence, professional behavior, or fraud;
- *You* transition to another *qualified provider*;
- The services *you* receive are not related to *your* treatment as a continuing care patient;
- This "Continuity of care" provision is exhausted; or
- *Your* coverage terminates, however the *policy* remains in effect.

All terms and provisions of the *policy* are applicable to this "Continuity of care" provision.

Seeking emergency care

If *you* need *emergency care*, go to the nearest *hospital* emergency facility, free-standing emergency medical care facility, or comparable emergency facility.

You, or someone on *your* behalf, must call *us* within 48 hours after *your admission* to a *hospital* for *emergency care*.

Seeking urgent care

If *you* need *urgent care*, go to the nearest *urgent care center* or call an *urgent care qualified provider*. *You* must receive *urgent care* services from a *network provider* 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 *network providers* may have capitation agreements. This means the *network 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 *network 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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COVERED EXPENSES

This "Covered Expenses" section describes the services that will be considered *covered expenses* under the *policy* for *preventive services* and medical services for a *bodily injury* or *sickness*. Benefits will be paid as specified in the "How your policy works" provision in the "Understanding Your Coverage" section and as shown on the "Schedules of Benefits," subject to any applicable:

- *Preauthorization* requirements;
- *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* apply.

Preventive services

Covered expenses include the *preventive services* appropriate for *you* as 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 United States Preventive Services Task Force (USPSTF).
- 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* ID card.

Covered expenses include the following *preventive services* as required by state law:

- Childhood immunizations for a *dependent* from birth through the date of the child's sixth birthday:
    - Diphtheria;
    - Haemophilus influenzae type b;
    - Hepatitis B;
    - Measles;
    - Mumps;
    - Pertussis;
    - Polio, rubella, tetanus;
    - Varicella;
    - Rotovirus; and
    - Any other immunization that is required for a covered *dependent* by state or federal law.

- A hearing impairment screening test for a *dependent* child from birth through 30 days old and

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

- Mammograms as follows:

  - An annual screening by all forms of low-dose mammogram for the presence of occult breast cancer provided for a female *covered person* 35 years of age or older. Low-dose mammography includes digital mammography and breast tomosynthesis (three-dimensional images).

  - A diagnostic imaging, using mammography, ultrasound imaging or magnetic resonance if the *covered person* has a personal history of breast cancer, dense breast tissue or an abnormality of the breast is:

    - Detected by a physician or *covered person*;
    - Seen by a physician on a screening mammogram;
    - Previously identified by a physician as probably benign in a breast for which follow-up imaging is recommended by a physician.

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

- 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.

- 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 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;
  - A screening using liquid-based cytology methods; or
  - Any other test or screening approved by the FDA for the detection of ovarian cancer.

- 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* 45 years of age or older and at normal risk for developing colon cancer. Benefits include:

  - Services with an A or B rating in the current recommendations by the USPSTF, and those assigned with an A or B rating in future recommendations; and

- A follow-up colonoscopy if the results of the initial colonoscopy, test or procedure were abnormal.

- 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 hearing screenings.

- Routine vision screenings (not including refractions).

Health care practitioner office services

We will pay the following benefits for *covered expenses* incurred by *you* for *health care practitioner* home and 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:

- Home and office visits for the diagnosis and treatment of a *sickness* or *bodily injury*.
- Home and office visits for prenatal care.
- Home and office visits for diabetes.
- 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*.

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, 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.

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.
- Services of an *assistant surgeon*.
- Services of a *surgical assistant*.
- 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 *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.

Covered expenses include:

- *Surgery* performed on an *outpatient* basis.
- Services of an *assistant surgeon*.
- Services of a *surgical assistant*.
- 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 in a *hospital* for 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 timely post-delivery care as 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, 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* or *birthing center* facility charges for the *confinement* period immediately following birth. A *deductible* and/or *copayment*, if applicable, will be required for any subsequent *hospital admission*.

If determined by the *covered person* and *your health care practitioner*, coverage is available in a *birthing center*. *Covered expenses* in a *birthing center* include:

- An uncomplicated, vaginal delivery; and
- Immediate care after delivery for the *covered person* and the newborn.

Emergency services

We will pay benefits for *covered expenses* incurred by *you* for an *emergency medical condition*, including:

- A medical screening examination or other evaluation required by state or federal law to be provided in the emergency facility of a *hospital* or comparable facility that is necessary to determine if an *emergency medical condition* exists;

- Treatment and stabilization of an *emergency medical condition*; and

- Supplies related to a service described in this "Emergency services" provision.

Emergency care provided by a *non-network provider* will be covered at the *network provider* benefit level, specified in the "Emergency services" benefit in the "Schedule of Benefits." However, *you* will only be responsible to pay the *network provider copayment*, *deductible* and/or *coinsurance* to the *non-network provider* for *emergency care*.

Benefits under this "Emergency services" provision must be for an *emergency medical condition* as defined in the "Glossary" section.

Ambulance services

We will pay benefits for *covered expenses* incurred by *you* for licensed *ambulance* and *air ambulance* services to, from or between medical facilities for *emergency care*.

Ambulance and *air ambulance* services for *emergency care* provided by a *non-network provider* will be covered at the *network provider* benefit level, as specified in the "Ambulance services" benefit in the "Schedule of Benefits" section. *You* may be required to pay any amount not paid by *us*, as follows:

- For *ambulance* services, *you* will be responsible to pay the *network provider copayment*, *deductible* and/or *coinsurance*. *You* may also be responsible to pay any amount over the *maximum allowable fee* to a *non-network provider*. *Non-network providers* have not agreed to accept discounted or negotiated fees, and may bill *you* for charges over of the *maximum allowable fee*; and

- For *air ambulance* services, *you* will only be responsible to pay the *network provider copayment*, *deductible* and/or *coinsurance* based on the *qualified payment amount*.

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.

Covered expenses include:

- *Surgery* performed on an *outpatient* basis.
- Services of an *assistant surgeon*.
- Services of a *surgical assistant*.
- Anesthesia administered by a *health care practitioner* or certified registered anesthetist attendant for a *surgery*.
- Services of a pathologist.
- Services of a radiologist.

Durable medical equipment and diabetes equipment

We will pay benefits for *covered expenses* incurred by *you* for *durable medical equipment* and *diabetes equipment*. New or improved *diabetes equipment* approved by the FDA may be a *covered expense* if determined to be *medically necessary* and appropriate by the treating *health care practitioner* or other provider. *Diabetes equipment* will be dispensed as written unless a substitution is approved by the *health care practitioner* who issues the written order for the equipment.

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 purchase price is considered 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; and
- Repair or maintenance is not a result of misuse or abuse; 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; and
- 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 facility diagnostic laboratory and radiology services

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

Health care practitioner 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 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* provided by a *home health care agency*. All home health care services and supplies must be provided on a part-time 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. Each additional four hours or less is considered an additional visit.

Home health care *covered expenses* are limited to:

- Care provided by a *nurse*;
- Physical, occupational, respiratory or speech therapy;

- Home infusion therapy. Refer to the *specialty drugs* benefit in the *specialty drug* provision in the "Schedule of Benefits – Pharmacy Services" section to determine how benefits for infusion therapy are paid;
- Medical social work and nutrition services;
- Medical supplies, except for *durable medical 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 in 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 aide services for up to eight hours in any one day; and

- Medical supplies, drugs, and medicines 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 the *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 therapy 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; and
- Services of a radiologist.

Specialty drug medical benefit

We will pay benefits for *covered expenses* incurred by *you* for *specialty drugs* provided by or obtained from a *qualified provider* in the following locations:

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

Specialty drugs may be subject to *preauthorization* requirements. Refer to the "Schedule of Benefits" in this *certificate* for *preauthorization* requirements and contact *us* prior to receiving *specialty drugs*. Coverage for certain *specialty drugs* administered to *you* by a *qualified provider* in a *hospital's outpatient* department may only be granted as described in the "Access to non-formulary drugs" provision in the "Covered Expenses – Pharmacy Services" section in this *certificate*.

Specialty drug benefits do not include the charge for the actual administration of the *specialty drug*. Benefits for the administration of *specialty drugs* are based on the location of the service and type of provider.

Transplant services and immune effector cell therapy

We will pay benefits for *covered expenses* incurred by *you* for covered transplants and *immune effector cell therapies* approved by the FDA, including but not limited to Chimeric Antigen Receptor Therapy (CAR-T). The transplant services and *immune effector cell therapy* must be preauthorized and approved by *us*.

You or *your health care practitioner* must call *our* Transplant Department at 866-421-5663 to request and obtain *preauthorization* from *us* for covered transplants and *immune effector cell therapies*. *We* must be notified of the initial evaluation and given a reasonable opportunity to review the clinical results to determine if the requested transplant or *immune effector cell therapy* will be covered. *We* will advise *your health care practitioner* once coverage is approved by *us*. Benefits are payable only if the transplant or *immune effector cell therapy* is approved by *us*.

Covered expenses for a transplant include 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;
- *Stem cell*;
- 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 solid organ transplants performed simultaneously are considered one transplant *surgery*. Multiple *stem cell* or *immune effector cell therapy* infusions occurring as part of one treatment plan is considered one event.

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*.

The following are *covered expenses* for an approved transplant or *immune effector cell therapy* and all related complications:

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

- Acquisition of cell therapy products for *immune effector cell therapy*, acquisition of *stem cells* or solid organs for transplants and associated donor costs, or an FDA approved artificial device, including pre-transplant or *immune effector cell therapy* services, the acquisition procedure, and any complications resulting from the harvest and/or acquisition. Donor costs for post-discharge services and treatment of complications will not exceed the treatment period of 365 days from the date of discharge following harvest and/or acquisition.

- Non-medical travel and lodging costs for:

  - The *covered person* receiving the transplant or *immune effector cell therapy*, if the *covered person* lives more than 100 miles from the transplant or *immune effector cell therapy* facility designated by *us*; and

  - One caregiver or support person (two, when the *covered person* receiving the transplant or *immune effector cell therapy* is under 18 years of age), if the caregiver or support person lives more than 100 miles from the transplant or *immune effector cell therapy* facility designated by *us*.

  Non-medical travel and lodging costs include:

  - Transportation to and from the designated transplant or *immune effector cell therapy* facility where the transplant or *immune effector cell therapy* is performed; and
  - Temporary lodging at a prearranged location when requested by the designated transplant or *immune effector cell therapy* facility and approved by *us*.

  All non-medical travel and lodging costs for transplant and *immune effector cell therapy* are payable as specified in the "Schedule of Benefits" section in this *certificate*.

Covered expenses for post-discharge services and treatment of complications for or in connection with an approved transplant or *immune effector cell therapy* are limited to the treatment period of 365 days from the date of 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.

Urgent care services

We will pay benefits for *urgent care covered expenses* incurred by *you* for charges made by an *urgent care center* or an *urgent care qualified provider*.

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, blood plasma and blood plasma expanders, 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 and supplies, including but not limited to limbs, eyes and professional services related to the fitting and use of the devices. *Covered expense* includes the same prosthetic devices covered by *Medicare*, limited to the most appropriate model of prosthetic device that adequately meets the medical needs of the *covered person*, as determined by the treating *health care practitioner*.

  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.

- Cochlear implants and external components, including an external speech processor and controller for a *covered person* when *medically necessary*.

  Replacement or upgrade of a cochlear implant and its external components may be a *covered expense* when *medically necessary* and audiologically necessary. Replacement of the external speech processor and controller may occur once every 36 months.

Coverage also includes habilitation and rehabilitation as necessary for educational gain.

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

  Covered expenses include:

  - The same orthotic devices covered by *Medicare*, limited to the most appropriate model of orthotic device that adequately meets the medical needs of the *covered person*, as determined by the treating *health care practitioner*;

  - Professional services related to the fitting and use of the orthotic; and

  - Repair and replacement of an orthotic except when due to misuse or loss.

  Covered expenses do not include:

  - Repair or replacement of 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*, *neurophysiological*, *neuropsychological*, and *psychophysiological testing* or *treatment*;
  - *Neurofeedback therapy*;
  - *Remediation*; or
  - *Post-acute transition services* and *community reintegration services*, including *outpatient day treatment services* or other *post-acute-care treatment services*.

  To ensure appropriate *post-acute-care treatment* is provided, *covered expenses* include reasonable expenses related to periodic re-evaluation 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.*

  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*.

- *Teledentistry dental services*. *Covered expenses* provided as *teledentistry dental services* are payable the same as when the *covered person* and dentist are in the same physical location.

- 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 lymphedemas.

- Reconstructive *surgery* resulting from:

  - A *bodily injury*, infection or other disease of the involved part, when a *functional impairment* is present;

  - A *congenital anomaly* that resulted in a *functional impairment*; or

  - *Craniofacial abnormalities* to improve the function of or attempt to create a normal appearance of an abnormal structure caused by congenital defects, developmental deformities, trauma, tumor, infections or disease.

  Expenses for reconstructive *surgery* due to a psychological condition are not considered a *covered expense*, unless the condition(s) described above are also met.

- 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).

- *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 prevention, detection, or 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 prevention, detection or treatment of cancer or other *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 FDA; or

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

- 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*.

- *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*; and
  - Provided to a *covered person* at a different physical location than the *health care practitioner*.

Covered health services do not include a *telehealth service* or *telemedicine medical service* provided by only synchronous or asynchronous audio interaction, including:

- An audio-only telephone consultation;
- A text-only e-mail message; or
- A facsimile transmission.

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. Coverage includes:

  - The purchase, fitting or advice on the care of hearing aids for *covered persons* 18 years of age or younger, including the provision of ear molds; or
  - Implantable hearing devices; and
  - Habilitation and rehabilitation as necessary for educational gain.

  Coverage for hearing aids and implantable hearing devices is limited to 1 per ear every 36 months.

- *Palliative care*.

- Newborn screening tests required by the Health and Safety Code, including the cost of a newborn screening test kit and administration provided by the Department of State Health Services.

- 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.

  Rehabilitative and habilitative therapies provided under this provision are not subject to any visit limit applicable to other rehabilitative or habilitative services specified in this *certificate*.

- Injections of drugs or medicines.

- Orally administered cancer treatment medications.

- Private duty nursing while *you* are *hospital confined*.

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COVERED EXPENSES - BEHAVIORAL HEALTH AND SERIOUS MENTAL ILLNESS

This "Covered Expenses – Behavioral Health and Serious Mental Illness" section describes the services that will be considered *covered expenses* for *mental health services*, *chemical dependency* and *serious mental illness* under the *policy*. Benefits will be paid as specified in the "How your policy works" provision of the "Understanding Your Coverage" section and as shown in the "Schedule of Benefits – Behavioral Health and Serious Mental Illness." Refer to the "Schedule of Benefits" for any service not specifically listed in the "Schedule of Benefits – Behavioral Health and Serious Mental Illness." Benefits are subject to any applicable:

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

Benefits and services under this section are provided under the same terms and conditions, meaning without any quantitative or non-quantitative treatment limitations that are more restrictive than are applied to medical and surgical treatment.

Refer to the "Limitations and Exclusions" section listed in this *certificate*. All terms and provisions of the *policy* apply.

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* and *serious mental illness* 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.

Acute inpatient health care practitioner services

We will pay benefits for *covered expenses* incurred by *you* for *mental health services*, *chemical dependency* and *serious mental illness* provided by a *health care practitioner*, including *telehealth* or *telemedicine*, in a *hospital*, *health care treatment facility*, *chemical dependency treatment center*, *crisis stabilization unit*, *psychiatric day treatment facility*, *residential treatment center for children and adolescents*, or *residential treatment facility for adults*.

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* for *mental health services*, *chemical dependency* and *serious mental illness* services. This includes:

- A medical screening examination or other evaluation required by state or federal law to be provided in the emergency facility of a *hospital* or comparable facility that is necessary to determine if an *emergency medical condition* exists;

- Treatment and stabilization of an *emergency medical condition* for *mental health services*, *chemical dependency* and *serious mental illness*; and

- Supplies related to a service described in this "Emergency services" provision.

Emergency care provided by a *non-network provider* will be covered at the *network provider* benefit level, specified in the "Emergency services" benefit in the "Schedule of Benefits" or "Schedule of Benefits – Behavioral Health and Serious Mental Illness" sections of this *certificate*. However, *you* will only be responsible to pay the *network provider copayment*, *deductible* and/or *coinsurance* to the *non-network provider* for *emergency care*.

Benefits under this "Emergency services" provision are not available if the services provided are not for an *emergency medical condition*.

Urgent care services

We will pay benefits for *urgent care covered expenses* incurred by *you* for charges made by an *urgent care center* or an *urgent care qualified provider* for *mental health services*, *chemical dependency* and *serious mental illness*.

Outpatient services

We will pay benefits for *covered expense* incurred by *you* for *mental health services*, *chemical dependency* and *serious mental illness*, including services in a *health care practitioner* office, or *retail clinic*, or *health care treatment facility*. Coverage includes *outpatient* therapy, *intensive outpatient programs*, *partial hospitalization* in a *hospital* or *health care treatment facility*, *crisis stabilization unit*, *telehealth* and *telemedicine*, and other *outpatient* services.

Skilled nursing facility services

We will pay benefits for *covered expenses* incurred by *you* in a *skilled nursing facility* for *mental health services*, *chemical dependency* and *serious mental illness*. *Your confinement* to a *skilled nursing facility* must be based upon a written recommendation of a *health care practitioner*.

Covered expenses also include *health care practitioner* services for *behavioral health* and *serious mental illness* during *your confinement* in a *skilled nursing facility*.

Home health care services

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

Home health care *covered expenses* include services provided by a *health care practitioner* who is a *behavioral health* professional, such as a counselor, psychologist or psychiatrist.

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*.

Specialty drug benefit

We will pay benefits for *covered expenses* incurred by *you* for *behavioral health specialty drugs* provided by or obtained from a *qualified provider* in the following locations:

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

Specialty drugs may be subject to *preauthorization* requirements. Refer to the "Schedule of Benefits" in this *certificate* for *preauthorization* requirements and contact *us* prior to receiving *specialty drugs*. Coverage for certain *specialty drugs* administered to *you* by a *qualified provider* in a *hospital's outpatient* department may only be granted as described in the "Access to non-formulary drugs" provision in the "Covered Expenses – Pharmacy Services" section in this *certificate*.

Specialty drug benefits do not include the charge for the actual administration of the *specialty drug*. Benefits for the administration of *specialty drugs* are based on the location of the service and type of provider.

Residential treatment facility services

We will pay benefits for *covered expenses* incurred by *you* for *mental health services*, *chemical dependency* and *serious mental illness* provided while *inpatient* or *outpatient* in a *residential treatment facility*.

Autism spectrum disorders

We will pay benefits for *covered expenses* incurred by *covered persons* for:

- Screening a *dependent* for *autism spectrum disorder* at the ages of 18 and 24 months; and
- All generally recognized services prescribed in relation to *autism spectrum disorder* 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* 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;
  - 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 *autism spectrum disorders*.

Autism spectrum disorder benefits are payable for *covered expenses* as recommended in the treatment plan by the *health care practitioner*.
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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* apply, including *prior authorization* requirements specified in the "Schedule of Benefits – Pharmacy Services" of this *certificate*.

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*.
- Drugs prescribed to treat a chronic, disabling, or *life-threatening illness* if the intended use of the drug is for off-label indications recognized through peer-reviewed medical literature.
- Insulin and *diabetes supplies*. New or improved *diabetes supplies* approved by the United States Food and Drug Administration, including improved insulin or another *prescription* drug, may be a *covered expense* if determined to be *medically necessary* and appropriate by the treating *health care practitioner* or other provider. Insulin and *diabetes supplies* will be dispensed as written unless a substitution is approved by the *health care practitioner* who issues the written order for the supplies or medication.
- Emergency refills of insulin or the following insulin-related equipment or supplies:

  - Needles;
  - Syringes;
  - Cartridge systems;
  - Prefilled pen systems;
  - Glucose meters;
  - Continuous glucose monitor supplies; and
  - Test strips.

  An emergency refill of insulin is limited to a 30-day supply. An emergency refill of insulin-related equipment or supplies is limited to the lesser of a 30-day supply or the smallest available package.

- Contraceptive drugs and contraceptive drug delivery implants approved by the FDA.

- Eye drops included on *our drug list* that are *prescribed* by a *health care practitioner* to treat a chronic eye disease or condition.

- *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 prescribed or ordered by a *health care practitioner* 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 *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.

Prescription drug coverage restrictions

If *we* determine *you* are using *prescription* drugs in a potentially abusive, excessive, or harmful manner, *your* coverage of *pharmacy* services may be limited in one or more of the following ways:

- By restricting *your pharmacy* services to a single *network pharmacy* store or physical location of *your* choice;

- By restricting *your specialty pharmacy* services to a specific *specialty pharmacy* of *your* choice, if the *network pharmacy* store or physical location for *pharmacy* services is unable to provide or is not contracted with *us* to provide covered *specialty pharmacy* services; and

- By restricting all of *your prescriptions* to be prescribed by a specific *network health care practitioner* of *your* choice.

When *we* determine it is necessary to restrict *your pharmacy* services, only *prescriptions* obtained from the specific *network pharmacy* store or physical location or *specialty pharmacy* will be eligible to be considered *covered expenses*. Additionally, only *prescriptions* prescribed by the specific *network health care practitioner* will be eligible to be considered *covered expenses*.

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 and indicates *dispensing limits*, *specialty drug* designation, any applicable *prior authorization* and/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 Humana.com or calling the customer service telephone number on *your* ID 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 *policy*. *We* will provide written notice no later than 60 days prior to the *effective date* of the change.

Access to medically necessary contraceptives

In addition to *preventive services*, contraceptives on *our drug list* and non-formulary contraceptives may be covered at no *cost share* when *your health care practitioner* contacts *us*. *We* will defer to the *health care practitioner's* recommendation that a particular method of contraception or FDA-approved contraceptive is determined to be *medically necessary*. The *medically necessary* determination made by *your health care practitioner* may include severity of side effects, differences in permanence and

reversibility of contraceptives, and ability to adhere to the appropriate use of the contraceptive item or service.

Access to non-formulary drugs

A drug not included on *our drug list* is a non-formulary drug. If a *health care practitioner* prescribes a clinically appropriate non-formulary drug, *you* can request coverage of the non-formulary drug through a standard exception request or an expedited exception request. If *you* are dissatisfied with *our* decision of an exception request, *you* have the right to an external review as described in the "Non-formulary drug exception request external review" provision of this section.

Non-formulary drug standard exception request

A standard exception request for coverage of a clinically appropriate non-formulary drug may be initiated by *you*, *your* appointed representative, or the prescribing *health care practitioner* by calling the customer service number on *your* ID card, in writing, or *electronically* by visiting *our* website at 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 non-formulary drug 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 non-formulary drug; or
- Would have adverse effects.

If *we* grant a standard exception request to cover a prescribed, clinically appropriate non-formulary drug, *we* will cover the prescribed non-formulary 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 external review as described in the "Non-formulary drug exception request external review" provision of this section.

Non-formulary drug expedited exception request

An expedited exception request for coverage of a clinically appropriate non-formulary drug 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* ID card, in writing or *electronically* by visiting *our* website at 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 non-formulary drug.

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 non-formulary drug is not provided within the timeframes of the standard exception request; and

- Justification supporting the need for the prescribed non-formulary drug 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 non-formulary drug; or
  - Would have adverse effects.

If *we* grant an expedited exception request to cover a prescribed, clinically appropriate non-formulary drug based on exigent circumstances, *we* will provide access to the prescribed non-formulary 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 external review as described in the "Non-formulary drug exception request external review" provision of this section.

Non-formulary drug exception request external review

You, *your* appointed representative, or *your* prescribing *health care practitioner* have the right to an external review by an independent review organization if *we* deny a non-formulary drug standard or expedited exception request. To request an external review, refer to the exception request decision letter for instructions or call the customer service number on *your* ID card for assistance.

Step therapy exception request

Your health care practitioner may submit to *us* a written request for an exception to *step therapy* for a clinically appropriate *prescription* drug. The *health care practitioner* should submit the written *step therapy* exception request using the *prior authorization* form. The *health care practitioner* can obtain the *prior authorization* form on *our* website at Humana.com or by calling customer service at the phone number provided on the back of *your* ID card.

A covered *prescription* drug for the treatment of *stage four advanced*, *metastatic cancer* and *associated conditions* will not be subject to *step therapy* when the *prescription* drug is:

- Consistent with best practices for the treatment of *stage four advanced*, *metastatic cancer* or an *associated condition*;
- Supported by peer-reviewed, evidence-based medical literature; and
- Approved by the United States Food and Drug Administration.

We will approve *your health care practitioner's* written step therapy exception request when the request includes the prescribing *health care practitioner's* written statement and supporting documentation that:

- The *prescription* drug requiring *step therapy*;
  - Is contraindicated;
  - Will likely cause an adverse reaction in or physical or mental harm to *you*;
  - Is expected to be ineffective based on *your* known clinical characteristics and the known characteristics of the *prescription* drug regimen;
- *You* previously discontinued taking the *prescription* drug required under *step therapy*, or another *prescription* drug in the same pharmacologic class or with the same mechanism of action as the required drug, while under the health benefit plan currently in force or while covered under another health benefit plan because the *prescription* drug was not effective or had a diminished effect, or because of an adverse event;
- The *prescription* drug requiring step therapy is not in *your* best interest, based on clinical appropriateness, because use of the drug is expected to:
  - Cause a significant barrier to *your* adherence to or compliance with *your* plan of care;
  - Worsen a comorbid condition; or
  - Decrease *your* ability to achieve or maintain reasonable functional ability in performing daily activities; or
- The *prescription* drug subject to *step therapy* was prescribed for *your* condition and:
  - *You* received benefits for the *prescription* drug under this health benefit plan or a prior health benefit plan;
  - *You* are stable on a *prescription* drug selected by *your health care practitioner* for the medical condition under consideration; and
  - The change in *your prescription* drug regimen required by *step therapy* is expected to be ineffective or cause harm to *you* based on the treatment of *your* disease or medical condition and the known characteristics of the required *prescription* drug regimen.

A *step therapy* exception request will be considered granted if *we* do not deny a *step therapy* exception request before:

- 72 hours after *we* receive the request; or
- 24 hours after *we* receive the request that the prescribing *health care practitioner* reasonably believes denial of the *step therapy* exception request could cause death or serious harm to *you*.

If *we* deny an exception request, *we* will provide *your* prescribing *health care practitioner* the reason for the denial, an alternative covered medication, and *your* right to appeal *our* decision as outlined in the "Complaint and Appeals Procedures" section.
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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 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* which is covered under any Workers' Compensation or similar law. This limitation also applies to a *covered person* who is not covered by Workers' Compensation and lawfully chose not to be.
- Care and treatment given in a *hospital* owned or run by any government entity, unless *you* are legally required to pay for such care and treatment. However, care and treatment provided by military *hospitals* to *covered persons* who are armed services retirees and their *dependents* are not excluded.
- 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*.
- Services, or any portion of a service, for which no charge is made.
- Services, or any portion of a service, *you* would not be required to pay for, or would not have been charged for, in the absence of this insurance.
- Any portion of the amount *we* determine *you* owe for a service that the provider waives, rebates or discounts, including *your copayment*, *deductible* or *coinsurance*.
- *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, unless *medically necessary* while *you* are *hospital confined*.
- Services rendered by a standby physician, *surgical assistant* or *assistant surgeon*, unless *medically necessary*.
- Any service not rendered by the billing provider.
- Any service not substantiated in the medical records of the billing provider.
- Any amount billed for a professional component of an automated:
  - Laboratory service; or
  - Pathology service.

- 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 the *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 the *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*, except as allowed by state law for *covered health services* provided by a dentist.

- *Ambulance* and *air 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*.

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

- *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*, *residential treatment facility for adults*, *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*.

- For a *covered person* 19 years of age or older, hearing aids, the fitting of hearing aids or advice on their care; implantable hearing devices, except for cochlear implants as otherwise stated in this *certificate.*

- Certain *specialty drugs* administered by a *qualified provider* in a *hospital's outpatient* department, except as specified in the "Access to non-formulary drugs" provision in the "Covered Expenses - Pharmacy Services" section of this *certificate*.

- Services received in an emergency room, unless required because of *emergency care*.

- *Hospital inpatient* services when *you* are in *observation status*.

- *Infertility services*; or reversal of elective sterilization.

- In vitro fertilization regardless of the reason for treatment.

- Services for or in connection with a transplant or *immune effector cell therapy* if:

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

  - Not approved by *us*, 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 or tissue for a recipient who is not covered by *us*.

  - The expense relates to a transplant or *immune effector cell therapy* performed outside of the United States and any care resulting from that transplant or *immune effector cell therapy*. This exclusion applies even if the *employee* and *dependents* live outside the United States and the *employee* is in *active status* with the *employer* sponsoring the *policy*.

- Services provided for:

  - Immunotherapy for recurrent abortion;
  - Chemonucleolysis;
  - 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* 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 hyperkeratosis;
  - The treatment of tarsalgia, metatarsalgia or bunion, except surgically;
  - The cutting of toenails, except the removal of the nail matrix;
  - Shoe inserts, except as covered by *Medicare*;
  - Heel wedges or lifts; and
  - Arch supports (foot orthotics) or orthopedic shoes, except as covered by *Medicare*.

- *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.

- Services relating to a *sickness* or *bodily injury* as a result of:

- Engagement in an illegal profession or 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, aerobic and strength conditioning, work-hardening programs, and weight loss or surgical programs, and any materials or products related to these programs.

- Surgical procedures for the removal of excess skin and/or fat in conjunction with or resulting from weight loss or a weight loss *surgery*.

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

  - 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, unless prescribed by a *health care practitioner* for *preventive services* and ambulatory blood pressure monitoring is not available to confirm diagnosis of hypertension;

    - 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*, except insulin pumps.

- 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.

- 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 a *health care practitioner* certifies that the pregnancy endangers the life of the mother or places the mother in serious risk of substantial impairment of a major bodily function.

- *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.

- 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*.

- 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.

LIMITATIONS AND EXCLUSIONS (continued)

- Expenses for:

  - Employment;
  - School;
  - Sport;
  - Camp;
  - Travel; or
  - 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.*

216880TX 01/23

LIMITATIONS AND EXCLUSIONS – PHARMACY SERVICES

This "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 not approved by the FDA.
- 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 and nutritional products, 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.

- Non-prescription, over-the-counter minerals, except as specified on the Preventive Medication Coverage *drug list* when obtained from a *network pharmacy* with a *prescription* from a *health care practitioner*.

- 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* when obtained from a *network pharmacy* with a *prescription* from a *health care practitioner*.

- Anabolic steroids.

- Any drug used for the purpose of weight loss.

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

- Compounded drugs that:

  - Are prescribed for a use or route of administration that is not FDA approved or compendia supported;
  - Are prescribed without a documented medical need for specialized dosing or administration;
  - Only contain ingredients that are available over-the-counter;
  - Only contain non-commercially available ingredients; or
  - Contain ingredients that are not FDA approved, including bulk compounding powders.

- Abortifacients (drugs used to induce abortions).

- *Infertility services* including medications.

- Any drug prescribed for impotence and/or sexual dysfunction.

LIMITATIONS AND EXCLUSIONS – PHARMACY SERVICES (continued)

- Any drug, medicine or medication that is consumed or injected at the place where the *prescription* is given, or dispensed by the *health care practitioner*.

- The administration of covered medication(s).

- *Prescriptions* that are to be taken by or administered to *you*, in whole or in part, while *you* are a patient in a facility where drugs are ordinarily provided 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*;
  - *Residential treatment facility for adults*;
  - *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*;

- Exceeds the duration-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*, except for refills of *prescription* eye drops when:
    - The product is written for additional fills;
    - The refill does not exceed the total quantity of dosage units authorized by the prescribing provider on the original *prescription*; and
    - The eye drop refill is dispensed on or before the last day of the prescribed dosage period and not earlier than the:
        - 21st day after the date a 30-day supply is dispensed;
        - 42nd day after the date a 60-day supply is dispensed; or
        - 63rd day after the date a 90-day supply is dispensed.

- 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.
- Treatment for onychomycosis (nail fungus).
- 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*.

1807955TX 01/23

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."

220600TX 01/19

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* were covered under the *employer's* Prior Plan on the day before the *effective date* of the *policy*; and
- *You* are insured for medical coverage on 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* under the *policy* if the medical expense was:

- Incurred in the same calendar year the *policy* first becomes effective; and
- Applied to the network deductible amount under the Prior Plan.

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 medical expense amount applied to the Prior Plan's *network out-of-pocket limit* or stop-loss limit will be credited to *your network provider out-of-pocket limit* under the *policy* if the medical expense was incurred in the same calendar year the *policy* first becomes effective.
221400TX 01/22

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.
222450TX 01/22

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.
223100TX 01/22

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.

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.

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*; or
- The date on which the *covered person* is covered for similar benefits under another group or Individual policy.

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*.

State continuation of coverage for certain dependents

Continuation of coverage is available for *dependents* that 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.

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.

CONTINUATION (continued)

The option to continue coverage is not 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 01/19

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 *plans* 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 *plans* and exclusive provider benefit *plans*;
- 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*.

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 *plans* provides coverage for private hospital room expenses.

- If a person is covered by two or more *plans* 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 *plans* 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 *plans*. 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 *plans*, 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 *plans* 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 *plans*' benefits are determined in relation to each other. Each secondary *plan* must take into consideration the benefits of the primary *plan* or *plans* and the benefits of any other *plan* that, under the rules of this contract, has its benefits determined before those of that secondary *plan*.

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, *plans* 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' *plans* 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' *plans*, 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 *plans* 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 *plans* 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 *plans* meeting the definition of *plan*. In addition, *this plan* will not pay more than it would have paid had it been the primary *plan*.

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 *plans* 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 *plans* 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 *plans* and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one *closed panel plan*, COB must not apply between that *plan* and other closed panel *plans*.

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 *plans*. *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 *plans* 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.

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.
COBTX 01/23

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* may have to 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* ID card or *our* website at 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 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 *you* incur such loss. *Your* claims will not be reduced or denied if it was not reasonably possible to give such proof within that time period.

Your claims may be reduced or denied if written or *electronic* proof of loss is not provided to *us* within one year after the date proof of loss is required, unless *your* failure to timely provide that proof of loss is due to *your* legal incapacity as determined by an appropriate court of law.

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.

Claims processing procedures

Qualified provider services are subject to *our* claims processing procedures. *We* use *our* claims processing procedures to determine payment of *covered expenses*. *Our* claims processing procedures include, but are not limited to, claims processing edits and claims payment policies. *Your qualified provider* may access *our* claims processing edits and claims payment policies on *our* website at Humana.com by clicking on "For Providers" and "Claims Resources."

Claims processing procedures include the interaction of a number of factors. The amount determined to be payable for a *covered expense* may be different for each claim because the mix of factors may vary. Accordingly, it is not feasible to provide an exhaustive description of the claims processing procedures, but examples of the most commonly used factors are:

- The complexity of a service;
- Whether a service is one of multiple same day services such that the cost of the service to the *qualified provider* is less than if the service had been provided on a different day. For example:
  - Two or more *surgeries* performed the same day;
  - Two or more endoscopic procedures performed during the same day; or
  - Two or more therapy services performed the same day;
- Whether a *co-surgeon*, *assistant surgeon*, *surgical assistant*, 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;
- Whether 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 procedures based on *our* review of correct coding initiatives, national benchmarks, industry standards, and industry sources such as the following, including any successors of the same:

- *Medicare* laws, regulations, manuals, and other related guidance;
- Federal and state laws, rules and regulations, including instructions published in the Federal Register;

- National Uniform Billing Committee (NUBC) guidance including the UB-04 Data Specifications Manual;
- American Medical Association's (AMA) Current Procedural Terminology (CPT®) and associated AMA publications and services;
- Centers for Medicare & Medicaid Services' (CMS) Healthcare Common Procedure Coding System (HCPCS) and associated CMS publications and services;
- International Classification of Diseases (ICD);
- American Hospital Association's Coding Clinic Guidelines;
- Uniform Billing Editor;
- American Psychiatric Association's (APA) Diagnostic and Statistical Manual of Mental Disorders (DSM) and associated APA publications and services;
- Food and Drug Administration guidance;
- Medical and surgical specialty societies and associations;
- Industry-standard utilization management criteria and/or care guidelines;
- *Our* medical and pharmacy coverage policies; and
- Generally accepted standards of medical, behavioral health and dental practice based on credible scientific evidence recognized in published peer reviewed literature.

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

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 *we* apply claims processing procedures. 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*.

You should discuss *our* claims processing edits, claims payment policies and medical or pharmacy coverage policies and their availability with any *qualified provider*, who is a *non-network provider*, prior to receiving any services. *You* or *your qualified provider* may access *our* claims processing edits and claims payment policies on *our* website at Humana.com by clicking "For Providers" and "Claims resources." *Our* medical and pharmacy coverage policies may be accessed on *our* website at Humana.com under "Medical Resources" by clicking "Coverage Policies." *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 claims processing edit, claims payment policy or coverage policy.

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* will not require a medical examination for a *covered person* whose coverage has terminated and elects continuation of coverage. *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 expenses*. *You* will not have to submit a claim for payment.

Benefit payments for *covered expenses* rendered by a *non-network provider* are due and owing solely to *you* or *your* assignee. *You* or *your* assignee are responsible for all payments to the *non-network provider*. However, *we* will pay the *non-network provider* directly for the amount *we* owe if:

- *You* or *your* assignee request *we* direct a payment of selected medical benefits to the health care provider on whose charge the claim is based and *we* consent to this request; or

- The services are for the *covered expenses we* apply the *network provider copayment, deductible* and/or *coinsurance* to, as specified in the "How your policy works" provision in the "Understanding Your Coverage" section of this *certificate*.

Any payment made directly to the *non-network provider* will not constitute the assignment of any legal obligation to the *non-network provider*.

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 Health and Human Services Commission 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 Health and Human Services Commission 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 Health and Human Services Commission.

We must receive written notice, affixed to the claim when first submitted, that benefits must be paid directly to the Texas Health and Human Services Commission.

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 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.

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

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. Written notice must be received by us at least 10 days before releasing any party from liability for payment of medical expenses. Notice shall be sent to *us* at *our* mailing address shown on *your* identification card;

- 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; and

- Taking all action to assist *our* enforcement of recovery rights and doing nothing after loss to prejudice *our* recovery rights.

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 *policy* when a *covered person*:

- Has received or is entitled to receive covered benefits under any other plan or policy;
- Has received recovery for damages; or
- Has received 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.

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 *policy* excludes coverage for *sickness* or *bodily injury* for which Workers' Compensation or similar coverage is available.

If benefits are paid by *us*, and 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, in consideration for the coverage provided by the *policy*, *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 *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 third party or their carrier including self-insured entities;

- Medical payments/expense or no-fault 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 expenses* and benefits provided under a managed care agreement from any funds that are paid or payable as a result of any *bodily injury.*

If *you* pursue recovery against another party or 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 *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 *policy* 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*, subject to the recovery limits under Chapter 140 of the Texas Civil Practice and Remedies Code.

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 *policy*, 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 *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 *bodily injury*. This right, however, shall apply only to the extent of such payment.

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 *bodily injury*.
229700TX 01/23

COMPLAINT AND APPEAL PROCEDURES

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 benefit determination* by an *independent review organization (IRO)*.

For questions on appeal and external review rights, a *covered person* can call the telephone number on the back of their ID card.

You may contact the Texas Department of Insurance (TDI) Consumer Protection for assistance with complaints, appeals or the external review process. Call the TDI at 1-800-252-3439. *You* can file a complaint at www.tdi.texas.gov or send an email to ConsumerProtection@tdi.texas.gov. Written requests may be sent to:

Texas Department of Insurance
Consumer Protection Section
Mail Code 111-1A
P.O. Box 12030
Austin, TX 78711-2030

We will not retaliate in any way if *you* or any person acting on *your* behalf files an appeal or *complaint* against *us*.

Definitions

Adverse determination means a determination by *us* or a utilization review agent that health care services provided or proposed to be provided to a *covered person* are not *medically necessary* or are not appropriate, or are experimental or investigational, or are protected under the Federal No Surprises Act. Adverse determination 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:

- Of a *step therapy* exception request; and
- 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.*

Adverse benefit determination, for the purpose of external review, means a determination by *us* that involves:

- Medical judgment (including, but not limited to *medically necessary* services, appropriateness, health care setting, level of care, or effectiveness of a *covered expense*;
- *Our* determination the treatment is experimental or investigational;
- *Our* determination whether *you* are entitled to a reasonable alternative standard for a reward under a wellness program;
- *Our* determination whether *we* are complying with the non-quantitative treatment limitation provisions under Federal MHPAEA; or
- Any *rescission* of coverage.

An *adverse benefit determination* also includes claims protected under the Federal No Surprises Act.

For *prescription drug* coverage, an *adverse benefit determination* includes a denial:

- Of a *step therapy* exception request; and
- 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.*

External review is not available to resolve disputes about eligibility to participate in the *group* health plan, other than those disputes that are related to *rescissions*.

Complaint means any dissatisfaction expressed 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* or person acting on the *covered person's* behalf and does not include *adverse determinations*.

Independent review organization (IRO) means MAXIMUS Federal Services, a Federal contractor that conducts independent external reviews of *adverse benefit determinations*.

MAXIMUS Federal Services,
3750 Monroe Avenue, Suite 705, Pittsford, NY 14534.
Fax: 1-888-866-6190
Expedited review phone number: 1-888-866-6205, ext. 3326
Expedited review email address: FERP@maximus.com
Secure website: externalappeal.com. Refer to the "Request a Review Online" heading on the website

Urgent-care means care in which the timeframe 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 treatment.

Humana will make a determination of whether treatment is *urgent-care*. However, any claim a physician, with knowledge of a *covered person's* medical condition, determines is *urgent-care* will be treated as *urgent-care*.

Complaint process

If a *covered person* or person acting on the *covered person's* behalf (claimant) 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 the claimant 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 o*ur* resolution to the claimant. The total time for acknowledging, investigating and resolving the *complaint* will not exceed 30 calendar days after the date *we* receive the *complaint*.

Complaints concerning an emergency or a denial of a continued 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 *we* receive the *complaint*.

Notification of adverse determinations

The *adverse determination* notification must be provided:

- For a *covered person* who is hospitalized at the time of the *adverse determination*:
    - Within one working day, notice will be sent by telephone or *electronically* to the *covered person's* provider;
    - Within 3 working days, *we* will follow-up with a letter to the *covered person* or person acting on the *covered person's* behalf (claimant) and the *covered person's* provider;

- For a *covered person* who is not hospitalized at the time of the *adverse determination*, notice will be provided in writing to the *covered person's* provider within three working days;

- 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*;

- If *we* seek to discontinue coverage of *prescription drugs* or intravenous infusions for which *you* are receiving benefits under this *certificate, you* will be notified no later than the 30th day before the date on which coverage will be discontinued.

- In the case of an *adverse determination* of a retrospective utilization review, notification will be provided in writing to *you* and the treating *health care practitioner* not later than 30 days after the claim is received. An extension of 15 days may be granted if necessary due to matters beyond *our* control and notice is provided to *you* and the treating *health care practitioner* before the expiration of the initial 30 day period.

Internal appeal

A *covered person* or a person acting on the *covered person's* behalf (claimant) has the right to appeal an *adverse determination* orally or in writing. The appeal must be made within 180 days from receipt of the *adverse determination*.

When *we* receive an appeal, *we* will, within five working days from the receipt of the appeal, send the claimant 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, the acknowledgement letter will include 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 claimant 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.

Expedited internal appeal

A *covered person* or person acting on the *covered person's* behalf (claimant) may request an expedited internal appeal for:

- *Emergency care*;

- Denial of a continued stay for a hospitalized *covered person*;

- Denial of another service if the *health care practitioner* includes a written statement with supporting documentation that a service is necessary to treat a *life-threatening* condition or prevent serious harm to the *covered person*;

- Denial of *prescription* drugs or intravenous infusions for which the *covered person* is receiving benefits under the *policy*; or

- Denial of a *step therapy* exception request.

The time frame for resolution will be based on the medical or dental immediacy of the condition, procedure or treatment. The decision timeframe will be the earlier of one business day from the date all information necessary to complete the appeal is received or 72 hours after *we* receive the appeal request. 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 claimant'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 a particular type of specialty provider review the case, the appeal denial shall be reviewed by a *health care practitioner* 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 process" and "Internal appeal" provisions and who are dissatisfied with the resolution, may report an alleged violation to the Texas Department of Insurance, P.O. Box 12030, Austin, Texas 78711-2030.

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.

External appeal to an independent review organization (IRO)

Within four months after a *covered person* or person acting on the *covered person's* behalf (claimant) receives notice of an *adverse benefit determination*, involving medical necessity, experimental and investigational, medical judgment denials or a *rescission*, the claimant may request a review by an *independent review organization (IRO)*. For claims protected under the No Surprises Act, refer to *our* decision letter for the timeframe to submit the request. The request may be sent to the *IRO* as follows:

Online: Visit the *IRO's* secure website at externalappeal.cms.gov and click on the "Request a Review Online" heading.

Mail: MAXIMUS Federal Services
3750 Monroe Avenue, Suite 705
Pittsford, NY 14534

Fax: 1-888-866-6190

If the claimant has any questions or concerns during the external appeal process, they can call the toll-free number 1-888-866-6205. Additional written comments can be submitted to the *IRO's* mailing address above. Any additional information submitted will be shared with *us* for an opportunity to reconsider the denial.

When the *IRO* receives the external appeal request, the *IRO* will request from *us* all of the documents and any information considered in making the *adverse benefit determination*. The *IRO* will then conduct a preliminary review of the information *we* provided and may request additional information from *us*. If the *IRO* determines the claimant is not eligible for an external appeal, the *IRO* will notify the claimant and *us* in writing.

Review process

The *IRO* will review all of the information and documents that are timely received. In reaching a decision, the *IRO* will review the claim and not be bound by any decisions or conclusions reached during the internal appeal process.

The *IRO* will forward *us* all documents submitted directly to the *IRO* by the claimant. Upon receipt of this information, *we* may reconsider the *adverse benefit determination*. Reconsideration by *us* will not delay the external review. If *we* decide, upon completion of *our* reconsideration, to reverse the *adverse benefit determination* and provide coverage or payment, *we* will provide written notice of *our* decision to the claimant and the *IRO*. The *IRO* will terminate the external review upon receipt of the notice from *us*.

If *we* do not reverse our decision, the *IRO* will continue the review. The *IRO* will provide written notice of the final external review decision as expeditiously as possible, but no later than 45 days after the *IRO* receives the request for the external review. The *IRO* will deliver the notice of final external review decision to the claimant and to *us*.

Reversal of the adverse benefit determination

Upon receipt of a notice of a final external review decision reversing the *adverse benefit determination* *we* will immediately provide coverage or payment (including immediately authorizing care or immediately paying benefits) for the claim.

Expedited external appeal to an independent review organization (IRO)

A claimant may request an expedited external review by the *IRO* in writing, orally or online. For online external appeal requests, visit the *IRO's* secure website at externalappeal.com, click on "Request a Review Online" and select "expedited." Requests for an expedited external review can also be emailed to FERP@maximus.com, or by calling Federal External Review Process at 888-866-6205 ext. 3326.

The claimant is not required to comply with procedures for an internal review of an *adverse determination* in a circumstance involving a:

- *Life-threatening* condition;
- A medical condition that, in the opinion of a physician with knowledge of the *covered person's* medical condition, could seriously jeopardize the life or health of the *covered person* or the ability of the *covered person* to regain maximum function.
- Denial of *prescription* drugs or intravenous infusions for which the *covered person* is receiving benefits under the *policy*; or
- Review of a *step therapy* exception request for *urgent-care*.

When the *IRO* receives a request for an expedited external review, the *IRO* will contact *us*. Immediately upon receipt of request by the *IRO*, *we* will provide the *IRO* all documents and other information required under the standard external review. The *IRO* will conduct a preliminary review of the information from *us* and may request additional information that it deems necessary to the expedited external review. If the *IRO* determines that the claimant is not eligible for expedited external appeal, the *IRO* will notify the claimant and *us* as expeditiously as possible.

Review process

The *IRO* will review all of the information and documents received. Upon receipt of any information submitted by the claimant, the IRO will immediately forward the information to us. Upon receipt of any such information, we may reconsider our *adverse benefit determination*. Reconsideration by *us* will not delay the expedited external review. If *we* decide, upon completion of *our* reconsideration, to reverse the *adverse benefit determination* and provide full coverage or payment, *we* will immediately provide notice of *our* decision to the claimant and the *IRO*. The notice may be provided orally but will be followed up with written notice within 48 hours. The *IRO* will terminate the expedited external review upon receipt of the notice from *us*.

The *IRO* will provide notice of the final expedited external review decision as expeditiously as the *covered person's* medical conditions or circumstances require, but in no event more than 72 hours after the *IRO* receives a request for an expedited external review.

The *IRO* will deliver the notice of the final expedited external review decision to the claimant and *us*. The notice may be initially provided orally but will be followed by a written notice within 48 hours. Upon receipt of a notice of a final expedited external review decision reversing the *adverse benefit determination we* will immediately provide coverage or payment (including immediately authorizing care or immediately paying benefits) for the claim.

The appeal process does not prohibit the claimant 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 *policy*.

Legal actions and limitations

No legal action to recover on the *policy* may be brought until 60 days after written proof of loss has been given in accordance with the "Proof of loss" provision of the *policy*.

No legal action to recover on the *policy* may be brought after three years from the date written proof of loss is required to be given.
TX Appeal NonGF 01/23

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 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 the 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 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* may obtain services from *network providers* who participate in the Preferred Provider Organization network, or *non-network providers* who do not participate in the Preferred Provider Organization network. If *you* choose a *network provider*, *your* out-of-pocket expenses are normally lower than if *you* choose a *non-network provider*.

If *you* choose to obtain services from a *non-network provider*, the services may be eligible for a discount to *you* under the Shared Savings Program. It is not necessary for *you* to inquire in advance about services that may be discounted. When processing *your* claim, *we* will automatically determine if the services are subject to the Shared Savings Program and calculate *your deductible* and *coinsurance* on the discounted amount. Whether the services are subject to the Shared Savings Program is at *our* discretion, and *we* apply the discounts in a non-discriminatory manner. *Your* Explanation of Benefits statement will reflect any savings with a remark code that the services have been discounted. *We* cannot guarantee that services rendered by *non-network providers* will be discounted. The *non-network provider* discounts in the Shared Savings Program may not be as favorable as *network provider* discounts.

If *you* would like to inquire in advance to determine if services rendered by a *non-network provider* may be subject to 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 services *you* receive from a *non-network provider* are still subject to the Shared Savings Program at the time services are 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.
231100TX 01/18

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
- Distributing and providing *covered persons* access to:

    - Benefit plan documents and the Summary of Benefits and Coverage (SBC);
    - Renewal notices and *policy* modification information;
    - Discontinuance notices; and
    - Information regarding continuation rights.

No *policyholder* may change or waive any provision of the *policy*.

Certificates of insurance

A *certificate* setting forth the benefits available to the *employee* and the *employee's* covered *dependents* will be available at Humana.com or in writing when requested. The *policyholder* is responsible for providing *employees* access to the *certificate*.

No document inconsistent 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 by the administrator of a group health plan subject to ERISA. If the terms of a summary plan description differ with the terms of this *certificate*, 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*.

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.

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* and the *employees* 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 (or, in the case of a *large employer*, any) other group health plans providing medical benefits that are being offered by *us* at such time.

If *we* cease doing business in the *small employer* or the *large employer* group market, the *policyholders*, *covered persons*, and the Commissioner of Insurance will be notified of such discontinuation at least 180 days prior to the date of discontinuation of such coverage.

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*.

Communication preferences

You may elect how *you* receive written communication from *us*. Visit *our* website at Humana.com or call the customer service telephone number on *your* ID card to elect *your* communication preferences. *You* may withdraw or change *your* election at any time without consequence.

Emergency declarations

We may alter or waive the requirements of the *policy* as a result of a state or federal emergency declaration including, but not limited to:

- *Prior authorization* or *preauthorization* requirements;
- *Prescription* quantity limits; and
- *Your copayment*, *deductible* and/or *coinsurance*.

We have the sole authority to waive any *policy* requirements in response to an emergency declaration.

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).
233300TX 01/23

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.

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 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*.

Acute inpatient services mean 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.

Air ambulance means a professionally operated helicopter or airplane, 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 *air ambulance* must be *medically necessary*. When transporting the sick or injured person from one medical facility to another, the *air ambulance* must be ordered by a *health care practitioner*.

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, shiatsu, yoga, and chelation therapy.

Ambulance means a professionally operated ground 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*. When transporting the sick or injured person from one medical facility to another, the *ambulance* must be 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.

Ancillary services mean *covered expenses* that are:

- Items or services related to emergency medicine, anesthesiology, pathology,~~,~~ radiology,~~,~~ or neonatology;
- Provided by *assistant surgeons*, hospitalists or intensivists;
- Diagnostic laboratory or radiology services; and
- Items or services provided by a *non-network provider* when a *network provider* is not available to provide the services at a *network facility*.

Assistant surgeon means a *health care practitioner* who assists at *surgery* and is a Doctor of Medicine (MD), Doctor of Osteopathic Medicine (DO), Doctor of Podiatric Medicine (DPM) or where state law requires a specific *health care practitioner* be treated and reimbursed the same as an MD, DO or DPM.

Autism spectrum disorder means a neurobiological disorder that includes autism, asperger's syndrome or pervasive developmental disorder, not otherwise specified.

B

Behavioral health means *serious mental illness* services, *mental health services* and *chemical dependency* services.

Birthing center means a *free-standing facility* that is specifically licensed to perform uncomplicated pregnancy care, delivery and immediate care after delivery for a *covered person*.

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*.

C

Certificate means this benefit plan document that describes the benefits, provisions and limitations of the *policy*. This *certificate* is part of the *policy* and is subject to the terms 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*. The facility must also be:

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

Companion plan means the *health insurance coverage* of this point-of-service product that is insured by Humana Insurance Company.

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;

- 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 a registered bed patient as the result of a *health care practitioner's* recommendation. It does <u>not</u> 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.

Co-surgeon means one of two or more *health care practitioners* furnishing a single *surgery* which requires the skill of multiple surgeons, each in a different specialty, performing parts of the same *surgery* simultaneously.

Covered expense means:

- *Medically necessary* services to treat a *sickness* or *bodily injury*, such as:
  - Procedures;
  - *Surgeries*;
  - Consultations;
  - Advice;
  - Diagnosis;
  - Referrals;
  - Treatment;
  - Supplies;
  - Drugs, including *prescription* and *specialty drugs*;
  - Devices; or
  - Technologies;
- *Preventive services*.

To be considered a *covered expense*, services must be:

- Ordered by a *health care practitioner*;
- Authorized or prescribed by a *qualified provider*;
- Provided or furnished 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, and 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*. Any amount *you* pay exceeding the *maximum allowable fee* is not applied to the individual or family *deductibles*.

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;
- 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*. *Dependent* also means a grandchild or great grandchild if the child is dependent on the *employee* for Federal Income Tax purposes at the time of application, or the *employee* is responsible for the child under a qualified medical support order or court order;

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

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

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

Dependent does not mean a foster child, unless the *employee* is responsible for the foster child under a qualified medical support order or court order.

The limiting age means the end of the month 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 or working outside of the network area;
- 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:

- Mentally or physically handicapped; and
- Incapable of self-sustaining employment.

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.

Diagnostic imaging provider means a health care provider who performs a *diagnostic imaging service* on a patient for a fee or interprets imaging produced by a *diagnostic imaging service*.

Diagnostic imaging service means magnetic resonance imaging (MRI), computed tomography (CT), positron emission tomography (PET), or any hybrid technology that combines any of those imaging modalities.

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 <u>not</u> 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, partner, corporate officer and an independent contractor if the *employer* includes the sole proprietor, partner, corporate officer or an independent contractor as an *employee* under the health benefit plan of the *employer*. 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 benefit 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 an *emergency medical condition*. *Emergency care* does not mean services for the convenience of the *covered person* or the provider of treatment or services.

Emergency medical condition means a recent onset of 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;
- 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.

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 the *policy*.

Employer means the sponsor of this *group* insurance plan, or any subsidiary or affiliate described in the Employer Group Application. An *employer* must employ at least two *eligible employee*s who enroll in the plan.

Endodontic services mean the following dental procedures, related tests or treatment and follow-up care:

- Root canal therapy and root canal fillings;
- Periradicular *surgery*;

- Apicoectomy;
- Partial pulpotomy; or
- Vital pulpotomy.

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

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

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

- 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 & 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

Facility-based physician means a radiologist, anesthesiologist, pathologist, emergency department physician, neonatologist, hospitalist, intensivist, or *assistant surgeon*:

- To whom a facility has granted clinical privileges; and
- Who is a *facility-based provider*.

Facility-based provider means a *health care practitioner* or provider who provides *covered expenses* to a *covered person* who is a patient of a *health care treatment facility* or *network facility*.

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

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

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 mean 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 is not 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 or institution, duly licensed by the appropriate state agency to provide medical services, *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 medical professionals, including *health care practitioners* 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 *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;
  - Facility providing custodial, educational or rehabilitative care;
  - *Chemical dependency treatment center*;
  - *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

Immune effector cell therapy means immune cells or other blood products that are engineered outside of the body and infused into a patient. *Immune effector cell therapy* may include acquisition, integral chemotherapy components and engineered immune cell infusion.

Infertility services mean any 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; 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

Laboratory service provider means an accredited facility in which a specimen taken from a human body is interpreted and pathological diagnoses are made or a *health care practitioner* who makes an interpretation of or diagnosis based on a specimen or information provided by a laboratory based on a specimen.

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 two *employees* on the first day of the plan *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* 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 based on the provider's costs for providing the same or similar services as reported by such provider in its most recent publicly available *Medicare* cost report submitted to the Centers for Medicare & 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.

Medicaid means a state program of medical care, 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 generally accepted 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*;
- Neither sourced from a location, nor provided primarily for the convenience of the patient, physician or other health care provider;

- Not more costly than an alternative source, 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*; and

- Performed in the least costly site or sourced from, or provided by the least costly *qualified provider*.

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 mean 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 facility means a *hospital*, *hospital outpatient* department or *ambulatory surgical center* that has been designated as such or has signed an agreement with *us* as an independent contractor, or has been designated by *us* to provide services to all *covered persons*. *Network facility* designation by *us* may be limited to specified services.

Network health care practitioner means a *health care practitioner*, who has been designated as such or has signed an agreement with *us* as an independent contractor, or who has been designated by *us* 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 been designated as such or has signed an agreement with *us* as an independent contractor, or has been designated by *us* 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*, *health care practitioner*, or other health services provider who is designated as such or has signed an agreement with *us* as an independent

contractor or who has been designated by *us* 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 by *us* as a *network health care practitioner*.

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

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

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 *hospital outpatient* services provided to *you* to help the *health care practitioner* decide if *you* need to be admitted as an *inpatient*.

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.

Out-of-pocket limit means the amount of *copayments*, *deductibles* or *coinsurance you* must pay for *covered expenses*, as specified in the "Out-of-pocket limit" provision in the "Schedule of Benefits" section, either individually or combined as a covered family, per *year* before a benefit percentage is increased. Any amount *you* pay a *non-network provider* exceeding the *maximum allowable fee* is not applied to the *out-of-pocket limits*.

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 day treatment services means structured services provided to address deficits in physiological, behavioral, and/or cognitive functions as related to an *acquired brain injury*. Such services may be delivered in settings that include transitional residential, community integration, or nonresidential treatment settings.

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

- Has a comprehensive and intensive interdisciplinary psychiatric treatment under the supervision of a psychiatrist for *mental health services* or a psychiatrist or addictionologist for *chemical dependency*, and patients are seen by a psychiatrist or addictionologist, as applicable, at least once a week;

- 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

- 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.

Policy means the legal agreement between *us* and the *policyholder*, including the Employer Group Application and *certificate*, together with any riders, amendments and endorsements.

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-care treatment services mean services provided after acute-care confinement and/or treatment that are based on an assessment of the individual's physical, behavioral, or cognitive functional deficits, which include a treatment goal of achieving functional changes by reinforcing, strengthening, or reestablishing previously learned patterns of behavior and/or establishing new patterns of cognitive activity or compensatory mechanisms as related to an *acquired brain injury*.

Post-acute -transition services means services that facilitate the continuum of care beyond the initial neurological insult through rehabilitation and community reintegration.

Post-stabilization services means services *you* receive in *observation status* or during an *inpatient* or *outpatient* stay in a *network facility* related to an *emergency medical condition* after *you* are stabilized.

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*.

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*.

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 USPSTF.
- Immunizations recommended by the Advisory Committee on Immunization Practices of the CDC.
- Preventive care for infants, children and adolescents provided in the comprehensive guidelines supported by the HRSA.
- Preventive care for women provided in the comprehensive guidelines supported by the 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* ID card. Refer to the "Preventive services" provision in the "Covered Expenses" section which includes *preventive services* covered by the *policy*.

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 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 payment amount means the lesser of:

- Billed charges; or
- The median of the contracted rates negotiated by *us* with one or more *network providers* in the same geographic area for the same or similar services.

If sufficient information is not available for *us* to calculate the median of the contracted rates, the rate established by *us* through use of any database that does not have any conflict of interest and has sufficient information reflecting allowed amounts paid to a *qualified provider* for relevant services furnished in the applicable geographic region.

The *qualified payment amount* applies to *covered expenses* when *you* receive the following services from a *non-network provider*:

- *Air ambulance* services;
- *Emergency care* outside the state of Texas;
- *Ancillary services* when *you* are at a *network facility* outside the state of Texas;
- *Ancillary services*, other than those provided by a *facility based physician*, when *you* are at a *network facility* in the state of Texas;
- Services that are not considered *ancillary services* when *you* are at a *network facility*, and *you* did not consent to the *non-network provider* to obtain such services; and
- *Post-stabilization services* provided outside the state of Texas when:
  - The attending *qualified provider* determines *you* are not able to travel by non-medical transportation to obtain services from a *network provider*; and
  - *You* do not consent to the *non-network provider* to obtain such services.

Qualified provider means a person, facility, supplier, or any other health care provider:

- That is licensed by the appropriate state agency to:
  - Diagnose, prevent or treat a *sickness* or *bodily injury*; or
  - Provide *preventive services*;

A *qualified provider* must provide services within the scope of their license and their primary purpose must be 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 that:

- Provides residential care and treatment for emotionally disturbed children and adolescents 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.

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, or *congenital anomaly* 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);
- Schizoaffective 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 or a home for the care of the aged.

Small employer means an *employer* who employed an average of at least two *employees* but not more than 50 *employees* on business days during the preceding calendar year and who employs at least two *employees* on the first day of the plan *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. For the purpose of this definition, a partnership is the *employer* of a partner.

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*.

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.

Stem cell 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 *stem cell* transplant includes the harvesting, integral chemotherapy components and the *stem cell* infusion. A *stem cell* transplant is commonly referred to as a bone marrow transplant.

Surgery means procedures categorized as Surgery in either the:

- Current Procedural Terminology (CPT) manuals published by the American Medical Association; or
- Healthcare Common Procedure Coding System (HCPCS) Level II manual published by the Centers for Medicare & Medicaid Services (CMS).

The term *surgery* includes, but is not limited to:

- Excision or incision of the skin or mucosal tissues;
- 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;
- Treatment of fractures;
- Procedures to repair, remove or replace any body part or foreign object in or on the body; and
- Endoscopic procedures.

Surgical assistant means a *health care practitioner* who assists at *surgery* and is not a Doctor of Medicine (MD), Doctor of Osteopathic Medicine (DO) or Doctor of Podiatric Medicine (DPM), or where state law does not require that specific *health care practitioners* be treated and reimbursed the same as an MD, DO or DPM.

T

Teledentistry dental service means a health care service delivered by a dentist or a health professional acting under the delegation and supervision of a dentist and acting within the scope of the dentist's or health care professional's license or certification to a *covered person* at a different physical location than the dentist or health professional using telecommunications or information technology.

Telehealth service means a health service, other than a *telemedicine medical service* or *teledentistry dental services*, delivered by a health professional licensed, certified, or otherwise entitled to practice in Texas and acting within the scope of their license, certification, or entitlement to a patient at a different physical location than the health professional using telecommunications or information technology.

Telemedicine medical service means a health care service delivered by a *health care practitioner* licensed in Texas, or a health professional acting under the delegation and supervision of a *health care practitioner* licensed in Texas and acting within the scope of their license to a patient at a different physical location than the *health care practitioner* or health professional using telecommunications or information technology.

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 health care services provided on an *outpatient* basis for an unforeseen condition that usually requires attention without delay but 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.

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

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

Associated conditions means the symptoms or side effects associated with *stage-four advanced, metastatic cancer* or its treatment and which, in the judgment of the *health care practitioner*, further jeopardize the health of a patient if left untreated.

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

Coinsurance means the amount expressed as a percentage of the *covered expense* that *you* must pay toward the cost of each separate *prescription* fill or refill dispensed by a *pharmacy*.

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 applicable *prescription drug deductible*, *copayment* 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.

Drug list means a list of covered *prescription* drugs, medicines or medications and supplies specified by *us*.

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."

Level 1 drugs mean a category of *prescription* drugs, medicines or medications within the *drug list* that are designated by *us* as level 1. The *prescription* drugs in this category are low-cost *generic drugs* and *brand-name drugs*.

Level 2 drugs mean a category of *prescription* drugs, medicines or medications within the *drug list* that are designated by *us* as level 2. The *prescription* drugs in this category are higher-cost *generic drugs* and *brand-name drugs*.

Level 3 drugs mean a category of *prescription* drugs, medicines or medications within the *drug list* that are designated by *us* as level 3. The *prescription* drugs in this category have a higher *copayment* than Level 2 for high cost, mostly *brand-name drugs* that may have *generic drug* or *brand-name drug* alternatives on Levels 1 or 2.

Level 4 drugs mean a category of *prescription* drugs, medicines or medications within the *drug list* that are designated by *us* as level 4. The *prescription* drugs in this category are highest-cost drugs that have a *coinsurance* amount higher than the level 3 *copayment*. This category includes mostly *brand-name drugs*. *Specialty drugs* are not categorized as *level 4 drugs*.

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* 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* 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 drug deductible means the specified dollar amount for *prescription* drug *covered expenses* which *you*, either individually or combined as a covered family, must pay per *year* before *we* pay *prescription* drug benefits under the *policy*. These expenses do not apply toward any other *deductible*, if any, stated in the *policy*.

Prescription drug *covered expenses* applied to the *prescription drug deductible* listed in the "Schedule of Benefits - Pharmacy Services" section of this *certificate* will be applied to the *prescription drug deductible*, if any, listed in the "Schedule of Benefits - Pharmacy Services" section of the "Evidence of Coverage."

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 *medically necessary* for the *covered person*.

Q

R

S

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

Stage-four advanced, metastatic cancer means cancer that has spread from the primary or original site of the cancer to nearby tissues, lymph nodes, or other areas or parts of the body.

Step therapy means a protocol that requires *you* to first use a *prescription* drug or sequence of *prescription* drugs other than the drug the *health care practitioner* recommends for *your* treatment before *we* will cover the drug recommended by the *health care practitioner*.

T

U

V

W

X

Y

Z

RX GLOSS 01/23

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Toll Free: 800-558-4444
1100 Employers Blvd.
Green Bay,WI 54344
www.humana.com

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