INDIVIDUAL HMO MEDICAL CONTRACT
HUMANA HEALTH PLAN of TEXAS, INC.

Premium for this *contract* may increase upon the *contract* renewal date

Humana Health Plan of Texas, Inc.
121 S. Mopac, Suite 200
Austin, TX 78746
512-338-6100

Contractholder:	Policy Holder
Contract number:	Policyholder Na
Effective date:	99/99/99 as of 12:01 a.m.
Premium amount:	$9999.99 monthly

PLEASE READ THIS CONTRACT CAREFULLY

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 contracts in Texas. This standard health benefit plan may provide more affordable health *contract* for *you* although, at the same time, it may provide *you* with fewer health benefits than those normally included as state-mandated health benefits in Texas. Please consult with *your* agent, as applicable to discover which state-mandated health benefits are excluded in this *contract.*

This is not a contract of Workers' Compensation coverage. The Employer does not become a subscriber to the Workers' Compensation system by purchasing this contract, and if the Employer is a non-subscriber, the Employer loses those benefits which would otherwise accrue under the Workers' Compensation laws. The Employer must comply with the Workers' Compensation law as it pertains to non-subscribers and the required notifications that must be filed and posted.

THIS CONTRACT IS NOT A MEDICARE SUPPLEMENT CERTIFICATE. If *you* are eligible for Medicare, review the "Guide to Health Insurance for People with Medicare" available from the company.

We issue coverage on an equal access basis to *covered persons* without regard to health status, race, color, national origin, religion, disability, age, sex, gender identity, or sexual orientation.

Humana Health Plan of Texas, Inc. agrees to pay benefits for *services* rendered to *covered persons* who are named in the "Schedule of Benefits", subject to all the terms of this *contract*.

This *contract* is issued in consideration of the *contractholder's* application, a copy of which is attached and made a part of this *contract*, and the *contractholder's* payment of premium as provided under this *contract*. **Intentional omissions, fraud or misstatements of a material fact in the application may cause *your contract* to be voided, terminated or cancelled and claims to be denied.** Please check *your* application for errors and write to *us* if any information is not correct or is incomplete. If *you* purchased *your* coverage through the *marketplace*, please contact the *marketplace* for any information that is not correct or complete.

This *contract* and the coverage it provides become effective 12:01 a.m. (*your* time) on the *effective date* stated above. This *contract* and the coverage it provides terminate at 12:00 midnight (*your* time) on the date of termination. The provisions stated above and on the following pages are part of this *contract*.

Renewability

This *contract* remains in effect at the option of the *contractholder* except as provided in the "Renewability of Coverage and Termination" section of this *contract*.

Right to return contract

You have the right to return this *contract* within 10 calendar days after the day *we* mailed this *contract* to *you*. If *you* choose to return this *contract* to *us* within the 10 day period, *we* will refund any premium that *you* have paid. If *you* return this *contract* within the 10 day period, it will be void and *we* will have no liability under any of the terms or provisions of this *contract*. There will be no coverage for any claims incurred.

Bruce Broussard
President

Multi-Language Interpreter Services

English: ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call 1-877-320-1235 (TTY: 711).

Español (Spanish): ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-320-1235 (TTY: 711).

繁體中文 (Chinese): 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-877-320-1235 (TTY: 711)。

Tiếng Việt (Vietnamese): CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-877-320-1235 (TTY: 711).

한국어 (Korean): 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-877-320-1235 (TTY: 711)번으로 전화해 주십시오.

Tagalog (Tagalog – Filipino): PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-877-320-1235 (TTY: 711).

Русский (Russian): ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-877-320-1235 (телетайп: 711).

Kreyòl Ayisyen (French Creole): ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-877-320-1235 (TTY: 711).

Français (French): ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-877-320-1235 (ATS : 711).

Polski (Polish): UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-877-320-1235 (TTY: 711).

Português (Portuguese): ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-877-320-1235 (TTY: 711).

Italiano (Italian): ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-877-320-1235 (TTY: 711).

Deutsch (German): ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-877-320-1235 (TTY: 711).

العربية (Arabic):
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-877-320-1235 (رقم هاتف الصم والبكم: 711).

日本語 (Japanese): 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-877-320-1235 (TTY：711) まで、お電話にてご連絡ください。

فارسی (Farsi):
توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-877-320-1235 (TTY: 711) تماس بگیرید.

Diné Bizaad (Navajo): Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, koji' hódíílnih 1-877-320-1235 (TTY: 711).

Discrimination is Against the Law

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

Humana:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats

- Provides free language services to people whose primary language is not English when those services are necessary to provide meaningful access, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Dr. Michelle Griffin, PhD.

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

Dr. Michelle M. Griffin, PhD (FACHE)
Civil Rights/LEP/ADA/Section 1557
Compliance Officer: 500 W. Main Street -10th floor Louisville, Kentucky 40202
Phone: **1-877-320-1235** Fax: **1-877-320-1269**
Email: **Mgriffin5@humana.com** or **Accessibility@humana.com**

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Dr. Michelle Griffin PHD, Civil Rights/LEP/ADA/Section 1557 Compliance Officer is available to help you at the contact information listed above.

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

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

IMPORTANT NOTICE

To obtain information or make a complaint:

You may call Humana's toll free telephone number for information or to make a complaint at:

1-800-833-6917

You may also write to Humana at:

P.O. Box 14546
Lexington, KY 40512-4546

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

1-800-252-3439

You may write the Texas Department of Insurance:

P.O. BOX 149104
Austin, TX 78714-9104
FAX # (512) 490-1007
Web: www.tdi.texas.gov
E-mail: ConsumerProtection@tdi.texas.gov

PREMIUM OR CLAIM DISPUTES:

Should you have a dispute concerning your premium or about a claim you should contact the company first. If the dispute is not resolved, you may contact the Texas Department of Insurance.

ATTACH THIS NOTICE TO YOUR POLICY:

This notice is for information only and does not become a part or condition of the attached document.

AVISO IMPORTANTE

Para obtener informacion o para presentar una queja:

Usted puede llamar al numero de telefono gratuito de Humana para obtener informacion o para presentar una queja al:

1-800-833-6917

Usted también puede escribir a Humana:

P.O. Box 14546
Lexington, KY 40512-4546

Usted puede communicarse con el Departamento de Seguros de Texas para obtener informacion sobre companias, coberturas, derechos o quejas al:

1-800-252-3439

Usted puede escribir al Departamento de Seguros de Texas a:

P.O.BOX 149104
Austin, TX 78714-9104
FAX # (512) 490-1007
Sitio web: www.tdi.texas.gov
E-mail: ConsumerProtection@tdi.texas.gov

DISPUTAS POR PRIMAS DE SEGUROS O RECLAMACIONES:

Si tiene una disputa relacionada con su prima de seguro o con una reclamación, usted debe communicarse con la compañía primero. Si la disputa no es
resuelta, usted puede comunicarse con el Departamento de Seguros de Texas.

ADJUNTE ESTE AVISO A SU POLIZA:

Este aviso es solamente para propositos informativos y no se convierte en parte o en condicion del documento adjunto.

Humana

TEXAS NOTICE OF CERTAIN MANDATORY BENEFITS

This notice is to advise you of certain coverage and/or benefits provided by your contract with Humana Health Plan of Texas, Inc.

Mastectomy or Lymph Node Dissection

Minimum Inpatient Stay: If due to treatment of breast cancer, any person covered by this plan has either a mastectomy or a lymph node dissection, this plan will provide coverage for inpatient care for a minimum of:

1. 48 hours following a mastectomy; and
2. 24 hours following a lymph node dissection.

The minimum number of inpatient hours is not required if the covered person receiving the treatment and the attending physician determine that a shorter period of inpatient care is appropriate.

Prohibitions: We may not (a) deny any covered person eligibility or continued eligibility or fail to renew this plan solely to avoid providing the minimum inpatient hours; (b) provide money payments or rebates to encourage any covered person to accept less than the minimum inpatient hours; (c) reduce or limit the amount paid to the attending physician, or otherwise penalize the physician, because the physician required a covered person to receive the minimum inpatient hours; or (d) provide financial or other incentives to the attending physician to encourage the physician to provide care that is less than the minimum hours.

Coverage and/or Benefits for Reconstructive Surgery after Mastectomy

Coverage and/or benefits are provided to each covered person for reconstructive surgery after mastectomy, including:

1. All stages of the reconstruction of the breast on which mastectomy has been performed;
2. Surgery and reconstruction of the other breast to achieve a symmetrical appearance; and
3. Prosthesis and treatment of physical complications, including lymphedemas, at all stages of mastectomy.

The coverage and/or benefits must be provided in a manner determined to be appropriate in consultation with the covered person and the attending physician. Please refer to the schedule of benefits in the attached contract for any a specific deductible, copayment, or covered person's portion that may be applicable to these benefits.

Prohibitions: We may not (a) offer the covered person a financial incentive to forego breast reconstruction or waive the coverage and/or benefits referenced above; (b) condition, limit, or deny any covered person's eligibility or continued eligibility to enroll in the plan or fail to renew this plan solely to avoid providing the coverage and/or benefits referenced above; or (c) reduce or limit the amount paid to the physician or provider, nor otherwise penalize, or provide a financial incentive to induce the physician or provider to provide care to a covered person in a manner inconsistent with the coverage and/or benefits referenced above.

Examinations for Detection of Prostate Cancer

Benefits are provided for each covered male for an annual medically recognized diagnostic examination for the detection of prostate cancer. Benefits include:

1. A physical examination for the detection of prostate cancer; and
2. A prostate-specific antigen test for each covered male who is:
   a. At least 50 years of age; or
   b. At least 40 years of age with a family history of prostate cancer or other prostate cancer risk factor.

Inpatient Stay following Birth of a Child

For each person covered for maternity/childbirth benefits, we will provide inpatient care for the mother and her newborn child in a health care facility for a minimum of:

1. 48 hours following an uncomplicated vaginal delivery; and
2. 96 hours following an uncomplicated delivery by cesarean section.

This benefit does not require a covered female who is eligible for maternity/childbirth benefits to (a) give birth in a hospital or other health care facility; or (b) remain in a hospital or other health care facility for the minimum number of hours following birth of the child.

If a covered mother or her newborn child is discharged before the 48 or 96 hours have expired, we will provide coverage for post-delivery care. Post-delivery care includes parent education, assistance and training in breast-feeding and bottle-feeding and the performance of any necessary and appropriate clinical tests. A physician, registered nurse or other appropriate licensed health care provider will provide care, and the mother will have the option of receiving the care at her home, the health care provider's office or a health care facility.

Prohibitions: We may not (a) modify the terms of this coverage based on any covered person requesting less than the minimum coverage required; (b) offer the mother financial incentives or other compensation for waiver of the minimum number of hours required; (c) refuse to accept a physician's recommendation for a specified period of inpatient care made in consultation with the mother if the period recommended by the physician does not exceed guidelines for prenatal care developed by nationally recognized professional associations of obstetricians and gynecologists or pediatricians; (d) reduce payments or reimbursements below the usual and customary rate; or (e) penalize a physician for recommending inpatient care for the mother and/or the newborn child.

Coverage for Tests for Detection of Colorectal Cancer

Benefits are provided, for each person enrolled in the plan who is 50 years of age or older and at normal risk for developing colon cancer, for expenses incurred in conducting a medically recognized screening examination for the detection of colorectal cancer. Benefits include the covered person's choice of:

1. A fecal occult blood test performed annually and a flexible sigmoidoscopy performed every five years; or
2. A colonoscopy performed every 10 years.

Coverage of Tests for Detection of Human Papillomavirus and Cervical Cancer

Coverage is provided, for each woman enrolled in the plan who is 18 years of age or older, for expenses incurred for an annual medically recognized diagnostic examination for the early detection of cervical cancer. Coverage required under this section includes at a minimum a CA-125 blood test, a conventional Pap smear screening or a screening using liquid-based cytology methods, as approved by the United States Food and Drug Administration, alone or in combination with a test approved by the United States Food and Drug Administration for the detection of human papillomavirus.

Notice of Coverage for Acquired Brain Injury

Your health benefit plan coverage for an acquired brain injury includes the following services:

1. Cognitive rehabilitation therapy;
2. Cognitive communication therapy;
3. Neurocognitive therapy and rehabilitation;
4. Neurobehaviorial, neurophysiological, neuropsychological and psychophysiological testing and treatment;
5. Neurofeedback therapy and remediation;
6. Post-acute transition services and community reintegration services, including outpatient day treatment services or other post-acute care treatment services; and
7. Reasonable expenses related to periodic re-evaluation of the care of an individual covered under the plan who has incurred an acquired brain injury, has been unresponsive to treatment, and becomes responsive to treatment at a later date, at which time the cognitive rehabilitation services would be a covered benefit.

The fact that an acquired brain injury does not result in hospitalization or acute care treatment does not affect the right of the insured or the enrollee to receive the preceding treatments or services commensurate with their condition. Post-acute care treatment or services may be obtained in any facility where such services may legally be provided, including acute or post-acute rehabilitation hospitals and assisted living facilities regulated under the Health and Safety Code.

If any person covered by this plan has questions concerning the above coverages, please contact Humana at:

Humana Claims Office
PO Box 14635
Lexington, KY 40512-4635
1-800-833-6917

IMPORTANT INFORMATION ABOUT COVERAGE UNDER THE TEXAS LIFE, ACCIDENT, HEALTH AND HOSPITAL SERVICE INSURANCE GUARANTY ASSOCIATION

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

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

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

Eligibility for Protection by the Association

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

1. Residents of Texas (regardless of where the policyholder lived when the policy was issued); and
2. Residents of other states, ONLY if the following conditions are met:
   a. The policyholder has a policy with a company domiciled in Texas;
   b. The policyholder's state of residence has a similar guaranty association; and
   c. The policyholder is not eligible for coverage by the guaranty association of the policyholder's state of residence.

Limits of Protection by the Association

Accident, Accident and Health, or Health Insurance:

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

Life Insurance:

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

Individual Annuities:

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

Group Annuities:

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

Aggregate Limit:

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

These limits are applied for each insolvent insurance company.

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

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

Texas Department of Insurance
P.O. Box 149104
Austin, TX 78714-9104
800-252-3439 or www.tdi.texas.gov

GUIDE TO YOUR CONTRACT

Contents **Page number**

GUIDE TO YOUR CONTRACT

INTRODUCTION

As *you* read through this *contract, you* will notice that certain words and phrases are printed in *italics.* An *italicized* word may have a different meaning in the context of this *contract* than it does in general usage. Please check the "Definitions" section for the meanings of *italicized* words.

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

This *contract* should be read in its entirety. Since many of the provisions of this *contract* are related, *you* should read the entire *contract* to get a full understanding of *your* coverage.

Please note that provisions and conditions of this *contract* apply to *you* and to each of *your covered dependents.*

This *contract* overrides and replaces any health contract or certificate previously issued to *you* by *us.*

If *you* have any questions about this *contract*, please call the telephone number on *your ID card.*

This *contract* requires that each *covered person* select a *primary care physician* who will be responsible for providing primary medical care and helping to guide any care received from other medical care providers. This *contract* also requires that a referral be obtained from the *primary care physician* before receiving medical care from any medical care provider other than the *primary care physician,* an in-network *urgent care center* or an in-network *retail clinic.* If a referral is not obtained prior to receiving *services,* such *services* will not be a *covered expense.* See the "Access to Care" section for a description of these *contract* requirements.

SCHEDULE OF BENEFITS

This Schedule of Benefits outlines benefit information and the date these benefits take effect. As *your* needs change over time, *you* may change some of these benefits. See the "Eligibility" section.

In most cases, if a *covered person* receives *services* from an *in-network provider*, *we* will pay a higher percentage of benefits and the *covered person* will incur lower out-of-pocket costs.

Please read *your* entire *contract* to fully understand all terms, conditions, exclusions, and limitations that apply.

Coverage Information

Date benefits take effect:

Policy Holder	99/99/99
Dependent Name 1	99/99/99
Dependent Name 2	99/99/99
Dependent Name 3	99/99/99
Dependent Name 4	99/99/99
Dependent Name 5	99/99/99
Dependent Name 6	99/99/99
Dependent Name 7	99/99/99
Dependent Name 8	99/99/99
Dependent Name 9	99/99/99
Dependent Name 10	99/99/99

Contractholder: Policy Holder

Covered Person(s):

Policy Holder
Dependent Name 1
Dependent Name 2
Dependent Name 3
Dependent Name 4
Dependent Name 5
Dependent Name 6
Dependent Name 7
Dependent Name 8
Dependent Name 9
Dependent Name 10

SCHEDULE OF BENEFITS

Deductible - Each *deductible* is separate and does not apply toward satisfying any other *deductible.* *Copays* do not apply to the *deductible.* See the "Definitions" section for the definition of the *deductible.*

Medical Deductible

Individual deductible (per covered person per calendar year)

Services from in-network providers:	$3,000
Services from out-of-network providers:	not covered

Family deductible (per family per calendar year)

Services from in-network providers:	$6,000
Services from out-of-network providers:	not covered

Prescription Drug Deductible

Individual deductible (per covered person per calendar year)

Services from in-network providers:	$500
Services from out-of-network providers:	not covered

Family deductible (per family per calendar year)

Services from in-network providers:	$1,000
Services from out-of-network providers:	not covered

Out-of-Pocket Limit - Some *services* do not apply to the *out-of-pocket limit.* See the "Definitions" section for the definition of the *out-of-pocket limit*.

Individual maximum (per covered person per calendar year)

Services from in-network providers:	$5,700
Services from out-of-network providers:	not covered

Family maximum (per family per calendar year)

Services from in-network providers:	$11,400
Services from out-of-network providers:	not covered

Benefit Maximums for Covered Expenses

If *you* have family coverage, the individual *deductible* and *out-of-pocket limit* accumulates to the medical and *prescription* drug individual and family maximum. An individual covered family member will receive benefits once they have met their individual *deductible.* The rest of the covered family members will receive benefits once they have satisfied the earlier of their individual *deductible* or when the entire family *deductible* has been satisfied.

After the *out-of-pocket limit* is met, then this *contract* pays 100% of all *covered expenses* for the balance of that *calendar year.* See the "Definitions" section for the definitions of *covered person's portion* and *benefit maximum.*

All covered expenses except as noted below

Covered person pays for services from in-network providers:	20% after deductible
Covered person pays for services from out-of-network providers:	not covered

SCHEDULE OF BENEFITS

Medical Covered Expenses

Ambulance

Services from in-network providers:	20% after deductible
Services from out-of-network providers:	20% after deductible

Emergency Room Facility Services

Services from in-network providers:	$450 copay per visit and deductible
Services from out-of-network providers:	$450 copay per visit and deductible

Habilitative Services

Services from in-network providers:	20% after deductible
Services from out-of-network providers:	not covered

- **Benefit Maximum:** 35 visit limit per therapy for physical and occupational therapies per person per calendar year

  Speech therapy is not subject to the visit limit.

Healthcare Practitioner Services

Office visits for mental health

Services from in-network providers:	$10 copay per visit
Services from out-of-network providers:	not covered

Office visits for bodily injury and all other sickness

Services from in-network providers:	
PCP	$10 copay per visit
Specialist	$30 copay per visit
Retail Clinic	$25 copay per visit
Urgent Care	$30 copay per visit
Services from out-of-network providers:	not covered

Emergency room healthcare practitioner services

Services from in-network providers:	20% after deductible
Services from out-of-network providers:	20% after deductible

Therapeutic injections (includes allergy injections and administration fee; excludes routine injections)

Services from in-network providers:	$5 copay
Services from out-of-network providers:	not covered

SCHEDULE OF BENEFITS

Outpatient Therapies and Rehabilitative Services

Services from in-network providers:	20% after deductible
Services from out-of-network providers:	not covered

- **Benefit Maximum:** 35 combined visit limit for spinal manipulations, adjustments, modalities physical therapy, occupational therapy, cardiac and pulmonary rehabilitation per person per calendar year

  All other therapy and services for autism spectrum disorder are not subject to the visit limit.

Preventive Medical Services – Does not include drugs, medicines or medications and supplies on the Preventive Medication Coverage drug list. Refer to the "Prescription drugs" provision in the "Your Contract Benefits" section.

Services from in-network providers:	0%
Services from out-of-network providers:	not covered

Skilled Nursing and Rehabilitation Facility

Services from in-network providers:	20% after deductible
Services from out-of-network providers:	not covered

- **Benefit Maximum:** 25 days per person per calendar year

Specialty Medical Drug Benefit

Services from in-network providers:	20% after deductible
Services from out-of-network providers:	not covered

Transplants

Transplant services

Services from in-network providers:	20% after deductible
Services from out-of-network providers:	not covered

SCHEDULE OF BENEFITS

Prescription Drug Covered Expenses

Retail Pharmacy – Coverage for up to a 30-day supply

Level one drugs – Preferred, lowest cost generics

Services from in-network pharmacy:	$5 copay per prescription fill or refill
Services from out-of-network pharmacy:	not covered

Level two drugs – Low cost generic drugs

Services from in-network pharmacy:	$15 copay per prescription fill or refill
Services from out-of-network pharmacy:	not covered

Level three drugs – Preferred brand drugs and some higher cost generic drugs

Services from in-network pharmacy:	$45 copay after prescription drug deductible per prescription fill or refill
Services from out-of-network pharmacy:	not covered

Level four drugs – Non-preferred brand drugs and some non-preferred highest cost generic drugs

Services from in-network pharmacy:	50% covered person's portion after prescription drug deductible per prescription fill or refill
Services from out-of-network pharmacy:	not covered

Preventive Medication Coverage

Drugs, medicines or medications and supplies on the Preventive Medication Coverage *drug list* are covered with no *cost share* when obtained from an *in-network pharmacy*.

Specialty Pharmacy and Retail Pharmacy – Coverage for up to a 30-day supply from an in-network Specialty or Retail Pharmacy

Level five drugs – Specialty drugs

Specialty drugs and services from an in-network pharmacy designated by us as a preferred provider
40% covered person's portion after prescription drug deductible per prescription fill or refill

Specialty drugs and services from all other in-network pharmacy providers of specialty drugs
50% covered person's portion after prescription drug deductible per prescription fill or refill

Specialty drugs and services from an out-of-network pharmacy
not covered

Mail Order Pharmacy - Coverage for up to a 90-day supply from an in-network Mail Order Pharmacy

Prescription drugs (excludes specialty drugs)

Services from in-network pharmacy:	Applicable covered person's portion outlined above or 2.5 times the applicable level copay, if any, outlined above after prescription drug deductible per prescription fill or refill
Services from out-of-network pharmacy:	not covered

SCHEDULE OF BENEFITS

Pediatric Vision Covered Expenses

Comprehensive eye exam
Services from in-network providers: 50% after deductible
Services from out-of-network providers: not covered

- **Benefit Maximum:** one exam in any 12-month period

Prescription lenses (Single vision, bifocal, trifocal, and lenticular lenses)
Services from in-network providers: 50% after deductible
Services from out-of-network providers: not covered

- **Benefit Maximum:** one pair of covered prescription lenses in any 12-month period

Frames
Services from in-network providers: 50% after deductible
Services from out-of-network providers: not covered

- **Benefit Maximum:** one covered new frame per person in any 12-month period

Elective contact lenses (in lieu of all other benefits for frames and/or lenses)
Services from in-network providers: 50% after deductible
Services from out-of-network providers: not covered

- **Benefit Maximum:** a single purchase of up to a 3-month supply of daily disposables, or a 6-month supply of non-daily disposables, once per person in any 12-month period. Replacements are limited to once in any 12-month period.

Medically necessary contact lenses (in lieu of all other benefits for frames and/or lenses)
Services from in-network providers: 50% after deductible
Services from out-of-network providers: not covered

- **Benefit Maximum:** replacement is limited to once in any 12-month period

Contact lens fitting and follow up exam
Services from in-network providers: 50% after deductible
Services from out-of-network providers: not covered

Low vision services
Services from in-network providers: 50% after deductible
Services from out-of-network providers: not covered

- **Benefit Maximum:**
  - one comprehensive eye exam in any 5 year period
  - four follow up exams in any 5 year period
  - one low vision aid per person in any 36-month period except for video magnification which is limited to one in any 5 calendar years for aids

ACCESS TO CARE

How to find an in-network provider

An online directory of *in-network providers* is available to *you* via www.humana.com at the time *you* apply for coverage. This directory is subject to change at any time. Due to the possibility of *in-network providers* changing status, please check the online directory of *in-network providers* prior to obtaining *services*. If *you* do not have access to the online directory, call the telephone number on *your ID card* prior to *services* being rendered or to request a copy of a directory to be sent to *you* via e-mail or regular U.S. mail.

Use of in-network providers

In-network providers have agreed to provide *covered services* at lower costs. A *covered person* must pay any *copayment, deductible* or *portion* they owe to the *in-network provider.* The *in-network provider* will accept a *covered person's copayment, deductible* or *portion* and the amount *we* pay as the full payment for the *covered expenses* incurred. A *covered person* is not responsible for charges over the *usual and customary.* A *covered person* is responsible for payment of all non-covered *services*.

Be sure to determine if the provider is an *in-network provider* before receiving *services* from them. *We* offer many medical plans, and a provider who participates in one plan may not necessarily be an *in-network provider* for this *contract*.

Selecting a primary care physician

Each *covered person* on this *contract* must choose a *primary care physician* who will be responsible for providing primary medical care and helping to guide any care received from other medical care providers. If a *covered person* fails to select a *primary care physician,* one will be assigned by *us.* A *covered person* may choose an *in-network provider* who practices in the areas of family practice, general practice or internal medicine as their *primary care physician.* An in-network pediatrician, including a pediatric sub-specialist, may also be chosen as the *primary care physician* for each child.

Role of the primary care physician

A *covered person's primary care physician* is responsible for providing primary medical care and helping to guide any care they receive from other medical care providers, including *specialty care physicians.* Referrals to *specialty care physicians* are required by *us* and must be received prior to *services* being received.

When a primary care physician is not available

When a *covered person's primary care physician* is unavailable, a *covered person* may need to obtain *services* from the *in-network provider* designated by their *primary care physician* to provide patient care when the *primary care physician* is not available. Please be sure to discuss these arrangements with the *primary care physician*.

ACCESS TO CARE

Seeing a specialist

All medical needs should be discussed with the *primary care physician*. If a *covered person* and their *primary care physician* determine that there is a need to see a *specialty care physician*, *you* and *your primary care physician* should determine the most appropriate in-network *specialty care physician*. In order for *services* received from a *specialty care physician* to be considered *covered expenses* a referral is required. The referral must be approved by *us* prior to the *services* being rendered. *Your primary care physician* should initiate a request for a referral with *us* which includes the name of the *specialty care physician you* will be utilizing. *Services* received without the required *primary care physician* referral or received prior to *our* approval of the referral will not be considered *covered expenses* and no benefits will be payable.

Open access to specialists

We allow open access to certain in-network *specialty care physicians* without a referral from a *primary care physician* or *authorization* from *us*. These include obstetrical and gynecological *services* from an in-network *healthcare practitioner*. However, *you* must have a referral from *your primary care physician* and an *authorization* from *us* to see any other *in-network provider* or any *out-of-network provider*. In addition, *services* from an *out-of-network provider* must be *authorized* by *us* before receiving any *services* from the *out-of-network provider*. Refer to the "Use of out-of-network providers" provision in this section for information on *out-of-network provider services*.

We do require *preauthorization* for certain *services*. Visit *our* Website at www.humana.com or call the telephone number on *your ID card* for a list of *services* that require *preauthorization*. See the "Utilization Management" section for information on *preauthorization*.

Preauthorization of *services* does not necessarily mean that a provider is in the network. *You* can reduce *your* out-of-pocket expense by ensuring that all providers *you* receive *services* from are *in-network providers*.

Seeking emergency care services

If *you* need *emergency care*:

1. Go to the nearest in-network *hospital* emergency room; or
2. Find the nearest *hospital* emergency room if *your* condition does not allow time to locate an in-network *hospital*.

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

If *you* seek *emergency care* at an out-of-network *hospital*, arrangements will be made to transfer *you* to an in-network *hospital* after *your* condition is *medically stable*. *Medically stable* with respect to an emergency medical condition means that no material deterioration of the *covered person's* condition is likely to result from or occur during the transfer of the *covered person* from a facility.

If *we* deem a transfer is appropriate and the transfer does not take place, benefits will be denied for *your* continued *hospital confinement* at the out-of-network *hospital*. If *you* refuse to be transferred, benefits will be denied from the date *your* condition is *medically stable*.

ACCESS TO CARE

You must see an *in-network provider* for any follow-up care to receive benefits at the *in-network provider* medical payment level as shown on the "Schedule of Benefits". These *services* are subject to any applicable *copayment, deductible,* and *covered person's portion.* Follow up care from an *out-of-network provider* will not be covered. Please see the "Emergency care provision" in the "Your Contract Benefits" section.

We will approve or deny any post-stabilization care within the appropriate time frame based on the medical condition, but in no event will the approval or denial be reached greater than one hour from the time of the request.

Seeking urgent care services

The steps for seeking urgent care *services* are as follows:

1. Go to an *urgent care center* that is an *in-network provider*. *You* can obtain the names of *in-network provider urgent care centers* by accessing our online directory of *in-network providers* on *our* Website at www.humana.com or by calling *us.*
2. *You* must receive any follow-up *services* from the *primary care physician* or an *in-network provider.*
3. *You* must pay any applicable *deductible, copayment,* and the *covered person's portion* required for urgent care.

Services provided by an out-of-network *urgent care center* are not *covered expenses* under this *contract*.

Use of out-of-network providers

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

No benefits are available for *services* from an *out-of-network provider* that are not *authorized* in advance by *us* except as expressly provided in the "General Exclusions" section. This *authorization* must be obtained prior to seeking *services*. Only those *services authorized* by *us* to be provided by an *out-of-network provider* will be *covered expenses*.

Not all *healthcare practitioners* who provide *services* at in-network *hospitals* are in-network *healthcare practitioners.* If *services* are provided by out-of-network pathologists, anesthesiologists, radiologists, assistant surgeon, and emergency room physicians at an in-network *hospital, we* will pay for those *services* at the *in-network provider* benefit level. Out-of-network *healthcare practitioners* may require payment from *you* for any amount not paid by *us.* If possible, *you* may want to verify whether *services* are available from in-network *healthcare practitioners.*

ACCESS TO CARE

It is *your* responsibility to verify the network participation status of all providers prior to receiving all non-emergency *services*. *You* should verify network participation status, only from *us*, by either accessing *your* network information on *our* Website at www.humana.com or calling the telephone number on *your ID card*. *We* are not responsible for the accuracy or inaccuracy of network participation representations made by any *primary care physician*, *specialty care physician*, *hospital* or other provider whether contracted with *us* or not. This means that even if the in-network *primary care physician*, *specialty care physician* or other provider recommends that *services* be received from another provider or entity, it is *your* responsibility to verify the network participation status of that entity before receiving such *services*. If *you* do not, and the entity is not an *in-network provider* (regardless of what the referring provider may have told *you*), *you* will be responsible for all costs incurred.

In the event an *in-network provider* is unable to provide *medically necessary services*, a referral may be obtained from the provider and approved by *us* within the appropriate time frame for the circumstances relating to the delivery of *services* and the condition of the patient but in no event exceeding 5 business days after receipt of all necessary documentation, to seek the *services* of an *out-of-network provider.* Coverage will be fully reimbursed based upon *usual and customary amount* or an agreed upon rate.

UTILIZATION MANAGEMENT

Preauthorization for medical services and prior authorization for prescription drugs

***Preauthorization* for medical *services* is a determination of *medical necessity* only and is NOT a guarantee of coverage for or the payment of the medical *service*.**

***Prior authorization* for *prescription* drugs is a confirmation of the dosage, quantity, and duration as *medically necessary* for the *covered person* for the *prescription* drug reviewed.**

All benefits payable under this *contract* must be for medical *services* or *prescription* drugs that are *medically necessary* or for preventive *services* as stated in this *contract*. *Preauthorization* by *us* is required for certain medical *services* and *prior authorization* by *us* is required for certain *prescription* drugs, medicines or medications, including *specialty drugs*. Certain *prescription* drugs, medicines or medication, including *specialty drugs*, may also require *step therapy*. Visit *our* Website at www.humana.com or call the telephone number on *your ID card* to obtain a list of medical *services* that require *preauthorization* or a list of *prescription* drugs, medicines or medications, including *specialty drugs*, that require *prior authorization* and/or *step therapy*. These lists are subject to change based on state law and advanced written notice. These types of changes to *prescription* drug coverage will only be made by *us* at renewal of the *contract*. *We* will provide written notice no later than 60 days prior to the *effective date* of the change. Coverage provided in the past for medical *services* that did not receive or require *preauthorization* and coverage in the past for *prescription* drugs, medicines or medications, including *specialty drugs*, that did not receive or require *prior authorization* and/or *step therapy* is not a guarantee of future coverage of the same medical *service* or *prescription* drug, medicine, medication or *specialty drug*.

Your healthcare practitioner must contact *our* Clinical Pharmacy Review by calling the number on *your ID card* to request and receive *our* approval for *prescription* drugs, medicine or medication including *specialty drugs* that require *prior authorization* and/or *step therapy*. Benefits are payable only if approved by *us*.

You are responsible for informing *your healthcare practitioner* of the *preauthorization* and *prior authorization* requirements. *You* or *your healthcare practitioner* must contact *us* by telephone, *electronically* or in writing to request the appropriate authorization. *Your ID card* will show the *healthcare practitioner* the telephone number to call to request authorization. No benefits are payable for medical *services* or *prescription* drugs that are not *covered expenses*.

Reduction of payment

If *preauthorization* or *prior authorization* is not obtained from *us* prior to *services* being rendered the following penalties will apply:

1. Benefits will be reduced by 50% for:
   a. Any transplant *services* that are not authorized by *us* prior to the transplant evaluation, testing, preparative treatment or donor search;
   b. *Prescription* drugs, medicines, and medications, including *specialty drugs* as identified on the *drug list* on *our* Website at www.humana.com that require *prior authorization*; or
   c. *Services* provided by an *out-of-network provider* except as expressly provided in this *contract*.

UTILIZATION MANAGEMENT

2. Benefits will be reduced for otherwise *covered expenses* by the lesser of 50% or $500.00 if authorization is not obtained from *us* prior to *services* being rendered for:
   a. *Durable medical equipment*; or
   b. *Services* from:
      i. A *home healthcare provider*;
      ii. *Skilled nursing facility*;
      iii. *Hospice facility*; or
      iv. Other medical *services* listed in *our* Website at www.humana.com.

You will be financially responsible for medical *services* and *prescription* drugs, medicines, and medications, including *specialty drugs* that are not covered under this *contract* due to failure to obtain *preauthorization* or *prior authorization* from *us*. The reduced amount, or any portion thereof, will not count toward satisfying any applicable *copayment*, *deductible*, *covered person's portion* or *out-of-pocket limit*.

YOUR CONTRACT BENEFITS

Benefits are payable only if the *services* are *covered expenses*, and subject to specific conditions, exclusions and limitations, and applicable maximums of this *contract*. A *covered expense* is deemed to be incurred on the date a *covered service* is performed or furnished.

If *you* incur non-*covered expenses*, whether from an *in-network provider* or *out-of-network provider*, *you* are responsible for making the full payment to the healthcare provider. The fact that a *healthcare practitioner* has performed or prescribed a medically appropriate *service* or the fact that it may be the only available treatment for a *bodily injury* or *sickness* does not mean that the *service* is covered under this *contract*.

We will pay benefits for *covered expenses* as stated in the "Schedule of Benefits" and this *contract* section, and according to the "General Exclusions" and "Prescription Drug Exclusions" sections and any amendments that may modify *your* benefits which are part of *your contract*. All benefits *we* pay will be subject to the *usual and customary amount* and all conditions, exclusions and limitations, and applicable maximums of this *contract*.

Upon a *covered person* receiving a *service*, *we* will determine if such *service* qualifies as a *covered expense*. After determining that the *service* is a *covered expense*, *we* will pay benefits as follows:

1. *We* will determine the total *usual and customary amount* for eligible *covered expenses* incurred related to a particular *service.*
2. If *you* are required to pay a *copayment we* will subtract that amount from the *usual and customary amount* for eligible *covered expenses* incurred.
3. If *you* are required to meet a *deductible* and *you* have not met the *deductible* requirement, *we* will subtract any amounts *you* are required to pay as part of *your deductible* from the *usual and customary amount* for the eligible *covered expenses* incurred.
4. If *you* have not yet incurred enough *covered expenses*, if applicable, to equal the amount of the *out-of-pocket limit we* will subtract any portion *you* must pay from the *usual and customary amount* for eligible *covered expenses* incurred.
5. *We* will make payment for the remaining eligible *covered expenses* incurred to *you* or *your* servicing provider.

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

YOUR CONTRACT BENEFITS

Refer to the "General Exclusions" and "Prescription Drug Exclusions" sections in this contract. All terms and provisions of this contract, including the preauthorization and prior authorization requirements specified in this contract are applicable to covered expenses.

A *covered person* who has *special circumstances* is eligible for continuation of *services* from a terminated provider through continuity of care. A terminated provider is an *in-network provider* whose contract is terminated or not renewed.

Examples of *special circumstances* include:

1. A *covered person* with a disability;
2. A *covered person* with an acute condition;
3. A *covered person* with a *life-threatening disease*;
4. A *covered person* who is past the 24th week of pregnancy; or
5. Postpartum care and a follow-up checkup within six weeks after delivery for a covered person.

All terms and provisions of this *contract* are applicable to *covered expenses* provided during the period of continued care by the terminated provider.

Continuity of care is not available:

1. If the provider was terminated due to reason of medical competence or professional behavior;
2. After the 90th day after the effective date of the provider's termination; or
3. After the expiration of the nine month period after the effective date of the provider's termination if the *covered person* was diagnosed as having a terminal illness at the time of the termination.

Ambulance (licensed air and ground)

Licensed ambulance service as follows:

1. From the scene of a medical emergency to the nearest appropriate medical facility equipped to provide treatment for *emergency care*; and
2. When required by *us* to transfer a *covered person* to the nearest appropriate medical facility equipped to provide the *medically necessary services.*

Acquired brain injury (ABI)

Covered expenses are *expenses incurred* for *medically necessary services* as a result of and related to an *ABI*, including:

1. Cognitive rehabilitation therapy – *Services* designed to address therapeutic cognitive activities, based on an assessment and understanding of the *covered person's* brain-behavioral deficits;
2. Cognitive communication therapy – *Services* designed to address modalities of comprehension and expression, including understanding, reading, writing, and verbal expression of information;
3. Neurocognitive therapy – *Service*s designed to address neurological deficits in informational processing and to facilitate the development of higher level cognitive abilities;
4. Neurocognitive rehabilitation – *Services* designed to assist cognitively impaired *covered persons* to compensate for deficits in cognitive functioning by rebuilding cognitive skills and/or developing compensatory strategies and techniques;
5. Neurobehavioral testing – An evaluation of the history of neurological and psychiatric difficulty, current symptoms, current mental status, and pre-morbid history, including the identification of problematic behavior and the relationship between behavior and the variables that control behavior. This may include interviews of the *covered person,* family, or others;

6. Neurobehavioral treatment – Interventions that focus on behavior and the variables that control behavior;
7. Neurophysiological testing – An evaluation of the functions of the nervous system;
8. Neurophysiological treatment – Interventions that focus on the functions of the nervous system;
9. Neuropsychological testing – 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;
10. Neuropsychological treatment – Interventions designed to improve or minimize deficits in behavioral and cognitive processes;
11. Psychophysiological testing – An evaluation of the interrelationships between the nervous system and other bodily organs and behavior;
12. Psychophysiological treatment – Interventions designed to alleviate or decrease abnormal physiological responses of the nervous system due to behavioral or emotional factors;
13. Neurofeedback therapy – *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;
14. Remediation – The process(es) of restoring or improving a specific function;
15. Post-acute transition *services* – *Services* that facilitate the continuum of care beyond the initial neurological insult through rehabilitation and community reintegration;
16. Community reintegration services – *Services* that facilitate the continuum of care as an affected *covered person* transitions into the community;
17. Outpatient day treatment *services* – Structured *services* provided to address deficits in physiological, behavioral, and/or cognitive functions. Such *services* may be delivered in settings that include transitional residential, community integration, or non-residential treatment settings; and
18. Post-acute care treatment *services* – *Services* provided after acute care confinement and/or treatment that are based on an assessment of the *covered person's* physical, behavioral, or cognitive functional deficits, which include a treatment goal of achieving functional changes by reinforcing, strengthening, or re-establishing previously learned patterns of behavior and/or establishing new patterns of cognitive activity or compensatory mechanisms.

Covered expenses also include *expenses incurred* for *services* related to periodic re-evaluation for a *covered person* who incurred an *ABI,* has been un-responsive to treatment, or becomes responsive to treatment at a later date.

For this benefit only, therapy means the scheduled remedial treatment provided through direct interaction with the *covered person* to improve a pathological condition resulting from an *ABI*.

Autism spectrum disorder

Covered expenses are expenses incurred for a covered *dependent* child. *Covered services* include:

1. Evaluations and assessment *services*;
2. Applied behavioral analysis;
3. Behavior training and behavior management;
4. Speech, occupational and physical therapies; and
5. Medications or nutritional supplements used to treat symptoms of autism spectrum disorder.

YOUR CONTRACT BENEFITS

Clinical trial

The benefit outlined below is based on Federal law and may be applied in addition to what is provided by state law.

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

Routine costs include *services* that are otherwise a *covered expense* if the *covered person* was not participating in a clinical trial.

Routine costs do not include *services* that are:

1. *Experimental, investigational or for research purposes*;
2. Provided only for data collection and analysis that is not directly related to the clinical management of the *covered person*; or
3. 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 cancer and other *life threatening disease* or condition and:

1. Referred by a *healthcare practitioner*; or
2. Provide medical and scientific information supporting their participation in the clinical trial is appropriate.

This section shall not be construed to require *us* to provide benefits for routine patient care costs provided out-of-network unless out-of-network benefits are otherwise provided under the *contract*.

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:

1. Federally funded or approved by the appropriate Federal agency:
   a. The National Institutes of Health;
   b. The Centers for Disease Control and Prevention;
   c. The Agency for Health Care Research and Quality;
   d. The Centers for Medicare & Medicaid Services;
   e. Cooperative group or center of any of the entities described in a. through d.;
   f. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health;
   g. An institution review board of an institution in Texas that has an agreement with the Office of Human Research Protections of the United States Department of Health and Human Services;
   h. The Department of Veterans Affairs;
   i. The Department of Defense; or
   j. The Department of Energy;
2. A study or investigation that is conducted under an investigational new drug application reviewed by the Federal Food and Drug Administration; or
3. The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

YOUR CONTRACT BENEFITS

Dental services

1. Treatment for a *dental injury* to a *sound natural tooth.* Treatment must be completed within 24 months from the first date of *service* for treatment of the *dental injury. We* limit *covered expenses* to the least expensive *service* that *we* determine will produce professionally adequate results.
2. Certain oral surgical operations:
   a. 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;
   b. *Services* required to correct accidental injuries of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
   c. Reduction of fractures and dislocation of the jaw and injection of the temporomandibular joint;
   d. External incision and drainage of abscess;
   e. External incision of cellulites;
   f. Incision and closure of accessory sinuses, salivary glands or ducts; and
   g. Cutting of the tissue in the midline of the tongue (Frenectomy).

Services rendered by a dentist who is an *out-of-network provider* will be reimbursed at the *in-network provider* level.

Diabetes services

The following *services* for a *covered person* with diabetes:

1. Routine eye exams;
2. Routine foot care;
3. Podiatric appliances, including up to two pair of therapeutic footwear per *calendar year*; and
4. Outpatient self-management training and education, including medical nutritional therapy and diet counseling prescribed by a *healthcare practitioner* for the treatment of:
   a. Insulin-dependent diabetes;
   b. Insulin-using diabetes;
   c. Gestational diabetes; and
   d. Non-insulin using diabetes.

Prescription drugs for the treatment of diabetes are explained under the "Prescription drug" provision.

Durable medical equipment and medical supplies

The following equipment or devices specifically designed and intended for the care and treatment of a *bodily injury* or *sickness*:

1. Non-motorized wheelchair;
2. Hospital bed;
3. Ventilator;
4. Hospital type equipment;
5. Oxygen and rental of equipment for its administration;
6. Prosthetic devices or supplies, including, but not limited to, limbs and eyes. The prosthetic devices for a lost limb or absent limb must be necessary to provide or to restore their minimal basic function. Replacement, repair, and maintenance of prosthetic devices is a *covered expense* when due to pathological changes or growth. No coverage is provided if due to misuse;

7. Orthotics, including *medically necessary* foot orthotics, used to support, align, prevent or correct deformities. Replacement, repair, and maintenance of orthotics is a *covered expense* when due to pathological changes or growth. No coverage is provided if due to misuse. *Covered expense* does not include dental braces or oral and dental splints and appliances unless custom made for the treatment of documented obstructive sleep apnea;
8. Initial contact lenses or eyeglasses following cataract *surgery*;
9. Casts, splints (other than dental), trusses, braces (other than orthodontic), and crutches;
10. Wigs following cancer treatment (not to exceed one per lifetime);
11. The following special supplies up to a 30-day supply for the initial order or a subsequent refill, when prescribed by the *healthcare practitioner*:
    a. Surgical dressings;
    b. Catheters;
    c. Colostomy bags, rings, and belts;
    d. Flotation pads;
    e. Equipment prescribed by a *healthcare practitioner* for the treatment of diabetes; and
12. Other *durable medical equipment.* Visit *our* Website at www.humana.com or call the telephone number on *your ID card* to obtain a list of *durable medical equipment*.

If the equipment and device include comfort or convenience items or features that exceed what is *medically necessary* in the situation or needed to treat the condition, reimbursement will be based on the *usual and customary amount* for a standard item that is a *covered expense*, serves the same purpose and is *medically necessary.* Any expense that exceeds the *usual and customary amount* for the standard item that is a *covered service* is the *covered person's* responsibility. For example, the reimbursement for a motorized wheelchair will be limited to the reimbursement for a standard wheelchair, when a standard wheelchair adequately accommodates the condition.

If the *covered person* chooses to upgrade the equipment or device, they will be responsible for the price difference between the cost of the standard item and the cost of the upgraded item.

Costs for these items will be limited to the lesser of the rental cost or the purchase price, as decided by *us.* If *we* determine the lesser cost is the purchase option, any amount paid as rent for such *durable medical equipment* shall be credited toward the purchase price.

No benefits will be provided for, or on account of:

1. Repair or maintenance of the *durable medical equipment*; or
2. Duplicate or similar rentals of *durable medical equipment,* as determined by *us.*

Emergency care (True and non-emergency)

1. A *hospital* for the emergency room and ancillary *services* to evaluate an emergency medical condition;
2. A freestanding emergency medical care facility;
3. A comparable emergency facility; and
4. An emergency room *healthcare practitioner* for *outpatient services*.

Services include medical screening examinations or other required evaluations to determine whether an *emergency medical condition* exists, treatment and stabilization of an *emergency medical condition.*

YOUR CONTRACT BENEFITS

If *emergency care* is obtained through an *out-of-network provider,* benefits will be provided at the in-network medical payment level as shown on the "Schedule of Benefits", if the in-network level is more favorable than the *usual and customary amount*, subject to any applicable *copayment, deductible,* and *covered person's portion.* In addition, the *covered person* is responsible for the difference between the *usual and customary amount* and the amount the *out-of-network provider* bills the *covered person* for the *services.* Any amount the *covered person* pays to the *out-of-network provider* in excess of the *usual and customary amount* will not apply to the *covered person's out-of-pocket limit* or any applicable *deductible.*

If *you* need *emergency care*:

1. Go to the nearest in-network *hospital* emergency room; or
2. Find the nearest *hospital* emergency room if *your* condition does not allow time to locate an in-network *hospital*.

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

If *you* seek *emergency care* at an out-of-network *hospital*, arrangements will be made to transfer *you* to an in-network *hospital* after *your* condition is *medically stable*. *Medically stable* with respect to an emergency medical condition means that no material deterioration of the *covered person's* condition is likely to result from or occur during the transfer of the *covered person* from a facility.

If *we* deem a transfer is appropriate and the transfer does not take place, benefits will be denied for *your* continued *hospital confinement* at the out-of-network *hospital*. If *you* refuse to be transferred, benefits will be denied from the date *your* condition is *medically stable.*

We will approve or deny any post-stabilization care within the appropriate time frame based on the medical condition, but in no event will the approval or denial be reached greater than one hour from the time of the request.

You must see an *in-network provider* for any follow-up care to receive benefits at the *in-network provider* medical payment level as shown on the "Schedule of Benefits" subject to any applicable *copayment, deductible,* and the *covered person's portion.*

Foot care services

Foot care *services* for a *covered person* who has been diagnosed with diabetes, circulatory disorders of the lower extremities, peripheral vascular disease, peripheral neuropathy, or chronic arterial or venous insufficiency. *Covered expenses* include routine foot care, removal or warts, corns, or calluses, and trimming of toenails.

YOUR CONTRACT BENEFITS

Habilitative services

Habilitative services and devices ordered and performed by a *healthcare practitioner* for a *covered person* with a developmental delay or defect or congenital anomaly, to learn or improve skills and functioning for daily living for the following:

1. Physical therapy *services*;
2. Occupational therapy *services*; and
3. Speech therapy or speech pathology *services.*

No benefits will be provided for, or on account of group physical, occupational or speech therapy *services*.

Healthcare treatment facility services

1. Inpatient *hospital services* including, daily room and board up to the semi-private room rate for each day of *confinement*;
2. General nursing care and *medically necessary* special duty nursing;
3. Meals and special diets (when *medically necessary*);
4. *Confinement* in a critical care or intensive care unit;
5. Operating room;
6. Ancillary *services* (such as surgical dressings, supplies, casts, and splints);
7. Blood and blood plasma which is not replaced by donation;
8. Administration of blood and blood products including blood extracts or derivatives;
9. Other *healthcare treatment facility* charges;
10. Drugs, oxygen and medicines that are provided or administered to the *covered person* while *confined* in a *hospital* or *skilled nursing facility*;
11. Regularly scheduled treatment such as dialysis, chemotherapy, inhalation therapy or radiation therapy in a *healthcare treatment facility* as ordered by the *covered person's healthcare practitioner*;
12. Short-term rehabilitation therapy in the acute *hospital* setting;
13. *Inpatient services* in a *hospital* for 48 hours following a mastectomy and 24 hours following a lymph node dissection for the treatment of breast cancer, unless a shorter length of stay is determined to be appropriate by the *healthcare practitioner* and the *covered person*; and
14. *Outpatient services* in a *hospital* or *free standing surgical facility.* The *covered expense* will be limited to the average semi-private room rate when the *covered person* is in *observation status.*

Healthcare practitioner services

1. *Healthcare practitioner* visits;
2. Diagnostic laboratory and radiology tests;
3. Hearing loss screening test for a covered *dependent* child from birth through 30 days of age, including necessary diagnostic follow-up care related to the hearing loss screening test from birth to 24 months of age;
4. Second surgical opinions;

5. *Surgery*. If several *surgeries* are performed during one operation, *covered services* will be subject to the *usual and customary amount* for the most complex procedure. Subsequent procedures received from *in-network providers* will be paid according to the *provider contract*. For *out-of-network providers*, for each additional procedure *we* will allow:
   a. 50% of *usual and customary amount* for the secondary procedure; and
   b. 25% of *usual and customary amount* for the third and subsequent procedures.
   If two surgeons work together as primary surgeons performing distinct parts of a single reportable procedure, each surgeon will be paid according to the *provider contract* if they are *in-network providers*. For *out-of-network providers*, *we* will allow each surgeon 62.5% of the *usual and customary amount* for the procedure;
6. Surgical *services* rendered by a surgical assistant and/or assistant surgeon when *medically necessary*. The surgical assistants and/or assistant surgeon will be paid according to the *provider contract* if they are an *in-network provider*. For *out-of-network providers*, *we* will allow 20% of the *covered expense* for *surgery*;
7. Surgical *services rendered by* a physician assistant (P.A.), registered nurse (R.N.), or a certified operating room technician when *medically necessary*. Physician assistants (P.A.), registered nurses (R.N.), and certified operating room technicians will be paid according to the *provider contract* if they are an *in-network provider*. For *out-of-network providers*, *we* will allow 10% of the *covered expense* for the *surgery*;
8. Anesthesia administered by a *healthcare practitioner* or certified registered anesthetist attendant to a *surgery*;
9. *Services* of a pathologist;
10. *Services* of a radiologist;
11. Allergy injections, therapy, testing, and serum. Therapy and testing for treatment of allergies must be approved by the American Academy of Allergy and Immunology or the Department of Health and Human Services or any of its offices or agencies; and
12. Injections other than allergy.

For the purposes of this "Healthcare practitioner services" provision, *provider contract* means a written contract with an *in-network provider* that specifies reimbursement for a *covered expense*.

A *healthcare practitioner's* office visit includes only the following *services* performed on the same day or during the same encounter:

1. Taking a history;
2. Performing an examination;
3. Making a diagnosis or medical decision; and
4. Administering allergy shots.

Covered expense during a *healthcare practitioner's* office visit for charges incurred for *advanced imaging*, pulmonary function studies, cardiac catheterization, electrocardiogram (EKG), electroencephalogram (EEG) are not subject to the office visit *copayment*. Benefits will be provided at the medical payment level as shown on the "Schedule of Benefits" subject to any applicable *deductible* and the *covered person's portion*.

Services for *mental health* are explained under the "Mental health" provision.

Hearing aids

Coverage included for one hearing aid per hearing impaired ear every 36 months for a *covered person* to restore loss of or correct an impaired speech or hearing function.

YOUR CONTRACT BENEFITS

Home healthcare

Services provided by a *home healthcare agency*, including private duty nursing and home infusion therapy, at the *covered person's* home. All home healthcare *services* must be provided on a part-time or intermittent basis in conjunction with a *home healthcare plan.*

No benefits will be provided for, or on account of:

1. Charges for mileage or travel time to and from the *covered person's* home;
2. Wage or shift differentials for any representative of a *home healthcare agency*;
3. Charges for supervision of *home healthcare agencies*;
4. Charges for services of a home health aide;
5. *Custodial care*; and
6. Provision or administration of *self-administered injectable drugs*.

Hospice care

Covered expenses for *services* provided under a *hospice care program* furnished in a *hospice facility* or in the *covered person's* home by a *hospice care agency*. A *healthcare practitioner* must certify that the *covered person* is terminally ill with a life expectancy of six months or less:

1. Room and board in a *hospice facility*, when it is for management of acute pain or for an acute phase of chronic symptom management;
2. Other *services*;
3. Part-time nursing care provided by or supervised by a *nurse* for up to eight hours per day;
4. Counseling for the *hospice patient* and his/her *immediate family members* by a licensed clinical social worker or pastoral counselor;
5. Bereavement counseling;
6. Medical social services for the *hospice patient* or his/her *immediate family members* under the direction of a *healthcare practitioner* including:
   a. Assessment of social, emotional, and medical needs and the home and family situation; and
   b. Identification of the community resources available;
7. Psychological and dietary counseling;
8. Physical therapy, speech therapy, and respiratory therapy;
9. Private duty nursing;
10. Homemaker services routinely provided by a *hospice care agency*;
11. Part-time home health aide services for up to eight hours in any one day; and
12. Medical supplies, drugs, and medicines prescribed by a *healthcare practitioner* for *palliative care*.

YOUR CONTRACT BENEFITS

No benefits will be provided for, or on account of:

1. *Services* relating to a *confinement* that is not for management of acute pain control or other treatment for an acute phase of chronic symptom management;
2. Funeral arrangements;
3. Services by volunteers or persons who do not regularly charge for their services;
4. Financial or legal counseling, including estate planning or drafting of a will;
5. Homemaker or caretaker services, including:
   a. Sitter or companion services;
   b. Housecleaning;
   c. Household maintenance;
6. Services of a social worker other than a licensed clinical social worker; and
7. Services by a licensed pastoral counselor to a member of his/her congregation.

For this benefit only, *immediate family member* is considered to be the *covered person's* parent, *domestic partner*, spouse, and children or step-children.

Maternity services

1. Prenatal care;
2. A minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated caesarean section delivery. 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 *healthcare practitioner*, a post-discharge office visit to the *healthcare practitioner* or a *home healthcare visit* within the first 48 hours after discharge is also covered, subject to the terms of this *contract*;
3. *Complications of pregnancy*; and
4. Postpartum care.

No benefits will be provided for, or on account of, maternity *services* rendered to a *covered person* who becomes pregnant as a *surrogate* under the terms of, and in accordance with, a *surrogacy contract or arrangement.* This exclusion applies to all expenses for prenatal, intra-partial (care provided during delivery and childbirth), and post-partial (care for the mother following childbirth) maternity/obstetrical care, and healthcare *services* rendered to the *covered person* acting as a *surrogate.* This *contract* does not cover the newborn child(ren) of a *surrogate* because the newborn child(ren) do not qualify as a *dependent* child pursuant to this *contract*.

The *covered person* must provide *us* with a copy of the *surrogacy contract or arrangement* within 30 days of entering into the agreement to provide *surrogate* services. Notice must be given to *us* in writing or by *electronic* mail and sent to *us* at *our* mailing address shown on *your ID card* or on *our* Website at www.humana.com.

YOUR CONTRACT BENEFITS

Mental health

Covered expenses are charges made by a:

1. *Healthcare practitioner*;
2. *Partial hospitalization* program;
3. *Residential treatment center*;
4. *Hospital*; or
5. *Healthcare treatment facility.* A *healthcare treatment facility* does not include a halfway house.

Covered expenses include psychological testing. *Services* for neuropsychological testing are explained under the "Healthcare practitioner services" provision.

Inpatient care for mental health

Covered expenses are *expenses incurred* for:

1. *Inpatient services* including room and board; and
2. *Healthcare practitioner* visits.

Outpatient care and office services for mental health

Covered expenses while not *confined* in a *hospital* or *healthcare treatment facility* are *expenses incurred* for:

1. Office exams or consultations including laboratory tests and x-rays; and
2. Therapy.

No benefits will be provided for, or on account of:

1. A halfway house; or
2. *Court-ordered mental health services* unless *medically necessary.*

Newborn services

Covered expenses for a covered *dependent* newborn child include the following:

1. Routine well newborn care for the first 48 hours or 96 hours following birth for:
   a. *Hospital* charges for *routine nursery care*;
   b. *Healthcare practitioner's* charges for circumcision of the newborn child; and
   c. *Healthcare practitioner's* charges for routine examination of the newborn before release from the *hospital*;
2. *Bodily injury* or *sickness*;
3. Care and treatment for premature birth; and
4. Medically diagnosed birth defects and abnormalities.

Services provided by an *in-network provider* for routine well newborn care for the first 48 hours or 96 hours following birth that are the recommended preventive *services* identified on the Department of Health and Human Services (HHS) Website at www.healthcare.gov are explained under the "Preventive medical services" provision. All other well newborn care during the first 48 hours or 96 hours following birth is explained under this "Newborn services" provision.

YOUR CONTRACT BENEFITS

Occupational coverage

Services provided in connection with a *sickness* or *bodily injury* arising out of, or sustained in the course of any occupation, employment or activity for compensation, profit or gain.

Services are only covered when a *covered person* is not entitled to file a claim for Workers' Compensation and the *covered person* is recognized under state law as:

1. A sole proprietor in a proprietorship;
2. A partner in a partnership; or
3. An executive officer in a corporation.

Benefits will not be provided for, or on account of a *sickness* or *bodily injury* eligible for benefits under Workers' Compensation, Employers Liability or similar laws even when a claim for benefits is not filed.

Outpatient therapies and rehabilitative services

Outpatient services ordered and performed by a *healthcare practitioner* for the following:

1. *Services* for:
   a. Documented loss of physical function;
   b. Pain; or
   c. Developmental delay or defect;
2. Physical therapy *services*;
3. Occupational therapy *services*;
4. Spinal manipulations, adjustments, and modalities;
5. Speech therapy or speech pathology *services*;
6. Cognitive rehabilitation *services*;
7. Audiology therapy *services*;
8. Pulmonary rehabilitation *services*;
9. Therapeutic radiology *services*; and
10. Cardiac rehabilitation *services*.

The expectation must exist that the therapy will result in a measurable improvement in the level of functioning within a reasonable period of time and the therapy is not considered *maintenance care*, as determined by the treating *healthcare practitioner*. However, for a physically disabled *covered person*, the treatment goals include maintenance of, functioning or prevention of, or slowing of further deterioration.

No benefits will be provided for, or on account of group physical, occupational or speech therapy *services*.

These *services* are subject to an annual visit limit as shown on the "Schedule of Benefits". Limits do not apply due to the treatment of autism spectrum disorder.

YOUR CONTRACT BENEFITS

Prescription drugs

Benefits may be subject to *dispensing limits*, *prior authorization* or *step therapy* requirements, if any.

Covered *prescription* drugs that are included on the *drug list* are:

1. Drugs, medicines, medications or *specialty drugs* that under Federal or state law may be dispensed only by *prescription* from a *healthcare practitioner*;
2. Drugs, medicines, medications or *specialty drugs* that are included on the *drug list*;
3. Insulin and *diabetic supplies*;
4. Hypodermic needles or syringes or other methods of delivery when prescribed by a *healthcare practitioner* for use with insulin or *self-administered injectable drugs*. (Hypodermic needles, syringes, and other methods of delivery used in conjunction with covered drugs may be available at no cost to the *covered person*);
5. *Self administered injectable drugs* approved by *us*;
6. Drugs, medicines or medications on the Preventive Medication Coverage *drug list* with a *prescription* from a *healthcare practitioner*;
7. Enteral formulas and nutritional supplements for the treatment of phenylketonuria (PKU) or other inherited metabolic diseases, or as otherwise determined by *us*;
8. Orally administered anticancer medications;
9. Drug prescribed for intended use for off-label indications recognized through peer-reviewed medical literature or by a prescription drug reference compendium approved by the Commissioner;
10. Amino acid-based elemental formulas, regardless of delivery method, when prescribed or ordered by a *healthcare practitioner* as *medically necessary* for the treatment of:
    a. Immunoglobulin E and non-immunoglobulin E mediated allergies to multiple food proteins;
    b. Severe food protein-induced enterocolitis syndrome;
    c. Eosinophilic disorders, as evidenced by the results of a biopsy; or
    d. Impaired absorption of nutrients caused by disorders affecting the absorptive surface, functional length, and motility of the gastrointestinal tract; and
11. Spacers and/or peak flow meters for the treatment of asthma.

Regardless of any other provisions of this *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 *prescription* into the market.

If the dispensing *pharmacy's* charge is less than the *prescription* drug *copayment*, the *covered person* will be responsible for the dispensing *pharmacy* charge amount.

The amount paid by *us* to the dispensing *pharmacy* may not reflect the ultimate cost to *us* for the drug. A covered person's cost share is made on a per *prescription* fill or refill basis and will not be adjusted if *we* receive any retrospective volume discounts or *prescription* drug rebates.

Some retail *pharmacies* participate in *our* program which allows a *covered person* to receive a 90-day supply of a *prescription* fill or refill except for *specialty drugs* or *self-administered injectable drugs* which are limited to a maximum of a 30-day supply. The cost is three times the applicable *copayment* and/or the *covered person's portion* as shown on the "Schedule of Benefits", after any applicable *deductible* is met.

No benefits are available for prescriptions purchased at an *out-of-network pharmacy*.

YOUR CONTRACT BENEFITS

If a *covered person* requests a *brand-name drug* when a *generic drug* is available, the *covered person's cost share* is greater. The *covered person* is responsible for the applicable *brand-name drug copayment* or the *covered person's portion* and 100% of the difference between the amount *we* would have paid the dispensing *pharmacy* for the *brand-name drug* and the amount *we* would have paid the dispensing *pharmacy* for the *generic drug.* If the prescribing *healthcare practitioner* determines that the *brand-name drug* is *medically necessary,* the *covered person* is only responsible for the applicable *copayment* or the *covered person's portion* of the *brand-name drug limit.* If the *cost share* that is applicable to a *covered person's* claim is waived by the *pharmacy* or a provider, the *covered person* is required to inform *us.* Any amount thus waived and not paid by the *covered person* would not apply to any *out-of-pocket limit.*

Prescription drug coverage is subject to change. Based on state law, advanced written notice is required for the following modifications that affect *prescription* drug coverage:

1. Removal of a drug from the *drug list;*
2. Requirement that *you* receive *prior authorization* for a drug;
3. An imposed or altered a quantity limit;
4. An imposed *step-therapy* restriction;
5. 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 *contract. We* will provide written notice no later than 60 days prior to the *effective date* of the change.

Preventive medical services

Services for well child and adult care preventive medical *services*. Preventive medical *services* under this *contract* are the recommended preventive *services* identified on the Department of Health and Human Services (HHS) Website at www.healthcare.gov on the date a *covered person* receives *services*. The recommended preventive medical *services* are subject to change. A *covered person* may obtain the current list of preventive *services* at www.healthcare.gov or by calling the telephone number on *your ID card* prior to receiving a preventive medical *service.*

Covered expenses for preventive medical *services* include the following:

1. Evidence-based items or *services* that have in effect a rating of A or B in the current recommendations of the U.S. Preventive Services Task Force (USPSTF);
2. Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control (CDC) and prevention that are listed on the Immunization Schedules of the CDC and those required by the state of Texas;
3. Evidence-informed preventive care and screenings provided for in the Health Resources and Services Administration (HRSA) guidelines for infants, children, adolescents, and women;
4. 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 processionals recognized by the Commissioner. Minimum requirements for the diagnostic examination to detect the human papillomavirus include a CA 125 blood test and conventional Pap smear screening, or screening using liquid-based cytology methods;
5. An annual prostate cancer detection exam, including a Prostate Antigen test (PSA) for a male *covered person* age 40 or older;
6. Routine hearing screenings to determine the need for hearing correction for a *covered person* to age 18;

7. Routine eye screenings (not including refractions) to determine the need for vision correction for a *covered person* to age 18; A hearing impairment screening for a *dependent* child from birth through 30 days of age;
8. Current recommendations of the USPSTF regarding breast cancer screening, mammography, and prevention (does not include recommendations issued in or around November 2009);
9. An annual low-dose mammogram for a female *covered person* age 35 years of age or older;
10. A computed tomography (CT) scan or ultrasonography every five year for early detection of cardiovascular disease for a *covered person* who is diabetic or at risk of developing coronary heart disease, based on a score derived using the Framingham Heart Study coronary prediction algorithm that is intermediate or higher for qualified *covered persons*; and
11. Colorectal cancer screening for a *covered person* age 50 or older who is at normal risk for developing colon cancer:
    a. Annual fecal occult blood test;
    b. Stool DNA test;
    c. One flexible sigmoidoscopy every five years;
    d. One colonoscopy every 10 years; or
    e. One computed tomographic colonography every five years.

Reconstructive surgery

Reconstructive surgery is payable only if the *sickness* or *bodily injury* necessitating the *reconstructive surgery* procedure would have been a *covered expense* under this *contract*.

We will provide benefits for *covered expenses incurred* for the following:

1. To restore function for conditions resulting from a *bodily injury*;
2. That is incidental to or follows a covered *surgery* resulting from *sickness* or a *bodily injury* of the involved part if trauma, infection or other disease occurred;
3. Following a *medically necessary* mastectomy. *Reconstructive surgery* includes all stages and revisions of reconstruction of the breast on which the mastectomy has been performed, reconstruction of the other breast to establish symmetry, and prosthesis and treatment of physical complications in all stages of mastectomy, including lymphedemas; and
4. Because of a congenital *sickness* or anomaly of a *dependent* child that resulted in a functional defect to improve the function of or attempt to create a normal appearance of the abnormal body structure.

No benefits are available for *surgery* or treatment to change the texture or appearance of the skin or to change the size, shape or appearance of facial or body features (including but not limited to a *covered person's* nose, eyes, ears, cheeks, chin, chest or breasts).

Cosmetic services and *services* for complications from *cosmetic services* are not covered regardless of whether the initial *surgery* occurred while the *covered person* was covered under this *contract* or under any prior coverage.

YOUR CONTRACT BENEFITS

Skilled nursing facility and rehabilitation services

Covered expenses include those *incurred* for daily room and board, general nursing *services* for each day of *confinement*, private duty nursing, and *rehabilitation services*, rendered while *confined* in a *sub-acute rehabilitation facility* or *skilled nursing facility*, provided the *covered person* is under the regular care of a *healthcare practitioner* who has reviewed and approved the *confinement*.

Services in a *sub-acute rehabilitation facility* or *skilled nursing facility* must be:

1. Provided in lieu of care in a *hospital*; or
2. For the same condition that required *confinement* in a *hospital*. The *covered person* must enter the *sub-acute rehabilitation facility* or *skilled nursing facility* within 14 days after discharge from the *hospital*.

Coverage for *sub-acute rehabilitation facility* or *skilled nursing facility* will cease when measurable and significant progress toward expected and reasonable outcomes has been achieved or has plateaued as determined by *us*.

Rehabilitation services include but are not limited to:

1. Treatment of complications of the condition that required an inpatient *hospital* stay;
2. Physical therapy, occupational therapy, respiratory therapy, and speech therapy; and
3. The evaluation of the need for the *services* listed above.

Confinement in a *skilled nursing facility* is limited to an annual maximum as shown on the "Schedule of Benefits".

Specialty drug medical benefit

Benefits may be subject to *dispensing limits*, *prior authorization* or *step therapy* requirements, if any.

Covered *specialty drugs* included on *our specialty drug list* when given during a:

1. *Healthcare practitioner's* office visit;
2. *Home healthcare visit*;
3. *Hospital*;
4. *Free-standing surgical facility* visit;
5. *Urgent care center* visit;
6. *Skilled nursing facility*;
7. Emergency room; or
8. Ambulance.

No benefits will be provided for, or on account of:

1. Any amount exceeding the *default rate* for *specialty drugs*; or
2. *Specialty drugs* for which coverage is not approved by *us*.

YOUR CONTRACT BENEFITS

Telehealth and telemedicine services

Covered expenses are expenses incurred for *medically necessary telehealth* and *telemedicine services* provided to a *covered person* which are:

1. For the purpose of diagnosis, consultation or treatment; and
2. Delivered through the use of a two-way telephonic and/or video-enabled, *electronic* communication between the *covered person* and *healthcare practitioner.*

Benefits are available for *telehealth* and *telemedicine services,* provided both of the following conditions are met:

1. The *services* would be covered under this *contract* if they were delivered during an in person consultation between the *covered person* and a *healthcare practitioner* instead of by *telehealth* or *telemedicine*; and
2. The *distant site* at which the *healthcare practitioner* is providing the *service* cannot be the same site as the *originating site* where the *covered person* is located at the time the *service* is being furnished.

Services provided through *telehealth* or *telemedicine* or that result from a *telehealth* or *telemedicine* consultation must comply with the following as applicable:

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

No benefits will be provided for internet only *services* that lack a video component unless coverage for such *services* is mandated by state or Federal law.

Transplant services

We will pay benefits for *covered expenses* incurred by a *covered person* for a transplant that is preauthorized and approved by *us. We* must be notified of the initial transplant evaluation and given a reasonable opportunity to review the clinical results to determine if the transplant will be covered. A *covered person* or their *healthcare practitioner* must contact *our* Transplant Management Department by calling the telephone number on the *ID card* when in need of a transplant. *We* will advise the *healthcare practitioner* once coverage of the requested transplant is approved by *us.* Benefits will be reduced if the transplant is not preauthorized and approved by *us.*

YOUR CONTRACT BENEFITS

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

1. Heart;
2. Lung(s);
3. Liver;
4. Kidney;
5. *Bone marrow*;
6. Pancreas;
7. Auto-islet cell;
8. Intestine;
9. Multivisceral;
10. Any combination of the above listed transplants; and
11. Any transplant not listed above required by state or Federal law.

Multiple transplantations performed simultaneously are considered one transplant *surgery.*

Corneal transplants and porcine heart valve implants are tissues which are considered part of regular *contract* benefits and are subject to other applicable provisions of this *contract*.

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

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

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

No benefits will be provided for, or on account of:

1. Transplants which are *experimental, investigational or for research purposes*;
2. Expenses related to the donation or acquisition of an organ for a recipient who is not covered by *us*;
3. Expenses that 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;
4. Expenses related to a transplant for which *we* do not approve coverage based on *our* established criteria;
5. Expenses related to the transplantation of any non-human organ or tissue except as expressly provided in this *contract*;
6. Expenses related to donor costs that are payable in whole or in part by any other medical plan, insurance company, organization or person other than the donor's family or estate;
7. Expenses related to the storage of cord blood and stem cells unless it is an integral part of a transplant approved by *us*; or
8. Expenses related to a transplant performed outside of the United States and any care resulting from that transplant.

YOUR CONTRACT BENEFITS

Urgent care services

Services in an *urgent care center* ore *retail clinic* for a *sickness* or *bodily injury* that develops suddenly and unexpectedly outside of a *healthcare practitioner's* normal business hours and requires immediate treatment but that does not endanger the *covered person's* life or pose serious bodily impairment to a *covered person.*

If a *covered person* needs urgent care, they should go to the nearest in-network *urgent care center* or in-network *retail clinic* to receive the *in-network provider* benefit level. If *services* are received at an *out-of-network provider,* no benefits will be provided except as expressly stated in this *contract.*

You must see an *in-network provider* for any follow-up care to receive benefits at the *in-network provider* medical payment level as shown on the "Schedule of Benefits" subject to any applicable *copayment, deductible,* and the *covered person's portion.*

To find the nearest in-network *urgent care center* or in-network *retail clinic,* visit *our* Website at www.humana.com or call the telephone number on *your ID card.*

GENERAL EXCLUSIONS

Below is a list of limitations and exclusions on *contract* benefits. Please review the entire document, as there may be multiple limitations applying to a particular *service.* These limitations and exclusions apply even if a *healthcare practitioner* has performed or prescribed a medically appropriate *service.* This does not prevent *your healthcare practitioner* from providing or performing the *service,* however, the *service* will not be a *covered expense.*

For the current recommended preventive *services* please see the Health and Human Services (HHS) Website at www.healthcare.gov and the "Preventive medical services" provision of this *contract*.

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

1. *Services* which require a *primary care physician* referral if the referral was not approved by *us* prior to the *service* being rendered or a referral was not obtained;
2. *Services* provided by an *out-of-network provider,* except when:
   a. *Authorized* by *us*;
   b. A referral is obtained from a *primary care physician* and *we* have approved the referral prior to the *service* being rendered; or
   c. The following *services* are *medically necessary* to render *emergency care*;
      i. Licensed ambulance service; or
      ii. *Services* in a *hospital* emergency room;
3. *Services* for care and treatment of non-covered procedures or *services*;
4. *Services* incurred before the *effective date* or after the termination date of this *contract*;
5. *Services* not *medically necessary* for diagnosis and treatment of *a bodily injury* or *sickness* or do not meet *our* medical and *pharmacy* coverage policies, claim payment policies or benefit contract guidelines, except for the specified routine preventive medical *services*;
6. *Services* performed in association with a *service* that is not covered under this *contract*;
7. Expenses for prophylactic *services* performed to prevent a disease process from becoming evident in the organ tissue at a later date;
8. *Services* which *are experimental, investigational or for research purposes*, or related to such, whether incurred prior to, in connection with, or subsequent to the *service* which is *experimental, investigational or for research purposes* as determined by *us.* The fact that a *service* is the only available treatment for a condition does not make it eligible for coverage if *we* deem it to be *experimental, investigational or for research purposes*;
9. Complications directly related to a *service* that is not a *covered expense* under this *contract* because it was determined by *us* to be *experimental, investigational or for research purposes* or not *medically necessary.* Directly related means that the complication occurred as a direct result of the *service* that was *experimental, investigational or for research purposes* or not *medically necessary* and the complication would not have taken place in the absence of the *service* that was *experimental, investigational or for research purposes* or not a *medically necessary service*;
10. Expenses in excess of the *usual and customary amount* for the *service*;
11. *Services* exceeding the amount of benefits available for a particular *service*;
12. *Services* provided when this *contract* is past the premium due date and the required premium is not received within 31 days (90 days if *you* are receiving an Advanced Premium Tax Credit (APTC)) after the premium is due and the *contract* is terminated;
13. *Services* for treatment of complications of non-covered procedures or *services*;
14. *Services* relating to a *sickness* or *bodily injury* incurred as a result of the *covered person* operating a motorized vehicle while intoxicated, as defined by applicable law in the state in which the loss occurred;

GENERAL EXCLUSIONS

15. *Services* where *sickness* or *bodily injury* was contributed to by the *covered person* being under the influence of illegal narcotics or a controlled substance unless administered by or used as prescribed by a *healthcare* practitioner;
16. *Services* relating to a *sickness* or *bodily injury* as a result of:
    a. War or an act of war, whether declared or not;
    b. Taking part in a riot;
    c. Engaging in an illegal profession or occupation;
    d. Any act of armed conflict, or any conflict involving armed forces or any authority; or
    e. Commission of or an attempt to commit a criminal act;
17. *Services*:
    a. For expenses which are not authorized, furnished or prescribed by a *healthcare practitioner* or *healthcare treatment facility*;
    b. For which no charge is made, or for which the *covered person* would not be required to pay if he/she did not have this coverage, unless expenses are received from and reimbursable to the United States government or any of its agencies as required by law;
    c. Furnished by or payable under any plan or law through a government or any political subdivision, unless prohibited by law;
    d. Furnished while a *covered person* is *confined* in a *hospital* or institution owned or operated by the United States government or any of its agencies for any service-connected *sickness* or *bodily injury*;
    e. For expenses received from a *healthcare practitioner* over the *usual and customary amount we* would pay for the least costly provider;
    f. Which are not rendered by the billing provider;
    g. Which are not substantiated in the medical records by the billing provider;
    h. Provided by a *family member* or person who resides with the *covered person*; or
    i. Rendered by a standby *health*care *practitioner*, surgical assistant, assistant surgeon, physician's assistant, *nurse* or certified operating room technician unless *medically necessary*;
18. Weekend non-emergency *hospital* admissions, specifically admissions to a *hospital* on a Friday or Saturday at the convenience of the *covered person* or his/her *healthcare practitioner* when there is no cause for an emergency admission and the *covered person* receives no *surgery* or therapeutic treatment until the following Monday; *Hospital inpatient services* when the *covered person* is in *observation status*;
19. *Cosmetic services*, or any complication therefrom;
20. *Custodial care* and *maintenance care*;
21. Ambulance services for routine transportation to, from or between medical facilities and/or a *healthcare practitioner's* office except as expressly provided in this *contract*;
22. Medical or surgical procedures that are not *medically necessary* except elective tubal ligation and vasectomy;
23. Elective medical or surgical abortion unless:
    a. The pregnancy would endanger the life of the mother; or
    b. The pregnancy is a result of rape or incest;
24. Reversal of sterilization;
25. *Infertility services*;
26. Sexual dysfunction;
27. Vision examinations or testing for the purposes of prescribing corrective lenses except for routine eye screenings that are covered under preventive medical *services*; radial keratotomy; refractive keratoplasty; or any other *surgery* or procedure to correct myopia, hyperopia or stigmatic error; orthoptic treatment (eye exercises); or the purchase or fitting of eyeglasses or contact lenses, unless specified in this *contract*;

GENERAL EXCLUSIONS

28. Dental *services*, appliances or supplies for treatment of the teeth, gums, jaws or alveolar processes including, but not limited to, excision of partially or completely unerupted impacted teeth, surgical preparation of soft tissue and excision of bone or bone tissue performed with or without extraction or excision of erupted, partially erupted, or completely un-erupted impacted teeth, surgical procedures related to repositioning of teeth, tooth transplantation or re-implantation, any oral *surgery*, *endodontic services* or *periodontics*, preoperative and post operative care, implants and related procedures, orthodontic procedures, orthognathic *surgery*, and any dental *services* related to a *bodily injury* or *sickness* except as expressly provided in this *contract*;
29. *Pre-surgical/procedural testing* duplicated during a *hospital confinement*;
30. Any treatment for obesity, which includes *morbid obesity*, regardless of any potential benefits for co-morbid conditions, including but not limited to:
    a. Surgical procedures for *morbid obesity*; or
    b. *Services* or procedures for the purpose of treating a *sickness* or *bodily injury* caused by, complicated by or exacerbated by the obesity;
31. Surgical procedures for the removal of excess skin and/or fat in conjunction with or resulting from weight loss or a weight loss *surgery*;
32. Treatment of nicotine habit or addiction, including but not limited to, nicotine patches, hypnosis, smoking cessation classes, tapes or *electronic* media;
33. Educational or vocational training or therapy, *services*, and schools including but not limited to videos and books;
34. Nutritional therapy except for treatment of diabetes;
35. Except as expressly provided in this *contract*, foot care *services* including but not limited to:
    a. Shock wave therapy of the feet;
    b. Treatment of weak, strained, flat, unstable or unbalanced feet;
    c. Hygienic care, and the treatment of superficial lesions of the feet, such as corns, calluses or hyperkeratosis;
    d. Tarsalgia, metatarsalgia or bunion treatment, except *surgery* which involves exposure of bones, tendons or ligaments;
    e. Cutting of toenails, except removal of nail matrix; and
    f. Arch supports, heel wedges, lifts, shoe inserts, the fitting or provision of foot orthotics or orthopedic shoes, unless *medically necessary* because of diabetes or hammertoe;
36. Hair prosthesis except as expressly provided in this *contract*, hair transplants or implants;
37. Hearing care that is routine, including but not limited to exams and tests except for routine hearing screenings that are covered under preventive medical *services*, any artificial hearing device, cochlear implant, auditory prostheses or other electrical, digital, mechanical or surgical means of enhancing, creating or restoring auditory comprehension;
38. *Services* rendered in a premenstrual syndrome clinic or holistic medicine clinic;
39. Transplant *services* except as expressly provided in this *contract*;
40. Charges for growth hormones except as expressly provided in this *contract*;
41. Over-the-counter medical items or supplies that can be provided or prescribed by a *healthcare practitioner* but are also available without a written order or *prescription* except for drugs prescribed for use for a covered preventive medical *service*;
42. Immunizations including those required for foreign travel for *covered persons* of any age except as expressly provided in this *contract*;
43. Any non-surgical (dental restorations, orthodontics, or physical therapy) or non-diagnostic services or supplies (oral appliances, oral splints, oral orthotics, devices, or prosthetics) provided for the treatment of the temporomandibular joint and all adjacent or related muscles and nerves;
44. Genetic testing, counseling or *services* except for BRCA screening, counseling, and appropriate testing as recommended by the Health Resources and Services Association (HRSA);

GENERAL EXCLUSIONS

45. Expense for employment, school, sports or camp physical examinations or for the purpose of obtaining coverage, or premarital tests or examinations;
46. *Services* received during an inpatient stay when the stay is primarily related to behavioral, social maladjustment, lack of discipline or other antisocial actions which are not specifically the result of *mental health*;
47. *Services* and supplies which are:
    a. Rendered in connection with *mental illnesses* not classified in the International Classification of Diseases of the U.S. Department of Health and Human Services;
    b. Extended beyond the period necessary for evaluation and diagnosis of learning and behavioral disabilities or for mental retardation; and
    c. Rendered in connection with marriage counseling;
48. *Services* rendered for:
    a. Immunotherapy for recurrent abortion;
    b. Chemonucleolysis (non-surgical treatment for a bulging disc that involves the injection of an enzyme in an intervertebral disc with the goal of dissolving the inner part of the disc);
    c. Biliary lithotripsy (procedure using high energy shock waves to fragment gall stones);
    d. Home uterine activity monitoring;
    e. Sleep therapy;
    f. Light treatment for Seasonal Affective Disorder (S.A.D.);
    g. Immunotherapy for food allergy;
    h. Prolotherapy (injection of an irritant solution);
    i. Hyperhidrosis (excessive sweating); and
    j. Sensory integration therapy;
49. *Services* or supplies provided in connection with a *sickness* or *bodily injury* arising out of, or sustained in the course of, any occupation, employment or activity for compensation, profit or gain, whether or not benefits are available under Workers' Compensation except as expressly provided in this *contract*. This applies whether or not a *covered person* has Workers' Compensation coverage;
50. *Court-ordered mental health services* unless *medically necessary*;
51. *Services* of a midwife, unless the midwife is licensed;
52. Expenses for alternative medicine, including medical diagnosis, treatment, and therapy. Alternative medicine *services* includes, but is not limited to:
    a. Acupressure;
    b. Acupuncture;
    c. Aromatherapy;
    d. Ayurveda;
    e. Biofeedback;
    f. Faith healing;
    g. Guided mental imagery;
    h. Herbal medicine and supplements;
    i. Holistic medicine;
    j. Homeopathy;
    k. Hypnosis;
    l. Macrobiotic;
    m. Massage therapy;
    n. Naturopathy;
    o. Ozone therapy;
    p. Reflexotherapy;
    q. Relaxation response;

GENERAL EXCLUSIONS

r. Rolfing;
s. Shiatsu;
t. Yoga;
u. Herbs, nutritional supplements, and alternative medicines; and
v. Chelation therapy, except for treatment of acute metal poisioning;

53. Private-duty nursing except as expressly provided in this *contract*;
54. Living expenses, travel, transportation, except as expressly provided in the "Ambulance services" provision or "Transplant services" provision in the "Your Contract Benefits" section of this *contract*; and
55. Expenses for *services* (whether or not prescribed by a *healthcare practitioner*) that are primarily and customarily used for a non-medical purpose or used for environmental control or enhancement and certain medical devices including but not limited to:
    a. Common household items such as air conditioners, air purifiers, water purifiers, vacuum cleaners, waterbeds, hypoallergenic mattresses or pillows or exercise equipment;
    b. Scooters or motorized transportation equipment, escalators, elevators, ramps, modifications or additions to living/working quarters or transportation vehicles;
    c. Personal hygiene equipment including bath/shower chairs, transfer equipment or supplies or bed side commodes;
    d. Personal comfort items including cervical pillows, gravity lumbar reduction chairs, swimming pools, whirlpools or spas or saunas;
    e. Medical equipment including PUVA lights and stethoscopes;
    f. Expenses for any membership fees or program fees paid by a *covered person*, including but not limited to:
        i. Health clubs;
        ii. Health spas;
        iii. Aerobic and strength conditioning;
        iv. Work-hardening programs and weight loss or similar programs; and
        v. Any related material or products related to these programs;
    g. Communication system, telephone, television or computer systems and related equipment or similar items or equipment; and
    h. Communication devices except after surgical removal of the larynx or a diagnosis of permanent lack of function of the larynx.

PRESCRIPTION DRUG EXCLUSIONS

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

For the current recommended preventive *services* please see the Health and Human Services (HHS) Website at www.healthcare.gov and the "Preventive medical services" provision of this *contract*.

Unless specifically stated otherwise, no benefits will be provided for, or on account of, the following items obtained from a *pharmacy*:

1. 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*;
2. Drugs which are not included on the *drug lists*;
3. Dietary supplements except enteral formulas and nutritional supplements for the treatment of phenylketonuria (PKU) or other inherited metabolic disease and amino acid-based elemental formulas;
4. Nutritional products;
5. Drugs and/or ingredients not approved by the FDA, including bulk compounding ingredients;
6. Minerals;
7. 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 an *in-network pharmacy* with a *prescription* from a *healthcare practitioner*;
8. *Legend drugs* which are not deemed *medically necessary* by *us*;
9. Any drug prescribed for a *sickness* or *bodily injury* not covered under this *contract*;
10. Any drug prescribed for intended use other than for:
    a. Indications approved by the FDA;
    b. Off-label indications recognized through peer-reviewed medical literature;
11. Any amount exceeding the *default rate*;
12. Any drug, medicine or medication that is either:
    a. Labeled "Caution-limited by Federal law to investigational use"; or
    b. *Experimental, investigational or for research purposes*, even though a charge is made to the *covered person*;
13. Allergen extracts;
14. The administration of covered medication(s);
15. *Specialty drugs* for which coverage is not approved by *us*;
16. Therapeutic devices or appliances, including but not limited to:
    a. Hypodermic needles and syringes except when prescribed by a *healthcare practitioner* for use with insulin, and *self-administered injectable drugs* whose coverage is approved by *us*;
    b. Support garments;
    c. Test reagents;
    d. Mechanical pumps for delivery of medication; and
    e. Other non-medical substances;
17. Anorectic or any drug used for the purpose of weight control;
18. Abortifacients (drugs used to induce abortions);
19. Any drug used for cosmetic purposes, including but not limited to:
    a. Dermatologicals or hair growth stimulants; or
    b. Pigmenting or de-pigmenting agents;

PRESCRIPTION DRUG EXCLUSIONS

20. Any drug or medicine that is lawfully obtainable without a *prescription* (over-the-counter) except:
    a. Drugs or medicines or medication and supplies on the Preventive Medication Coverage *drug list* when obtained from an *in-network pharmacy* with a *prescription* from a *healthcare practitioner*; or
    b. Any drug or medicine that is available in *prescription* strength without a *prescription*;
21. Compounded drugs in any dosage form except when prescribed for chemotherapy or pediatric use for children up to 19 years of age or as otherwise determined by *us*;
22. *Infertility services* including medications;
23. Any drug prescribed for impotence and/or sexual dysfunction;
24. Any drug, medicine or medication that is consumed or injected at the place where the *prescription* is given or dispensed by the *healthcare practitioner* (these drugs are covered under the "Healthcare practitioner services" provision);
25. *Prescriptions* that are to be taken by or administered to the *covered person*, in whole or in part, while he/she is a patient in a facility where drugs are ordinarily provided by the facility on an inpatient basis by the facility. Inpatient facilities include, but are not limited to:
    a. *Hospital*;
    b. *Skilled nursing facility*; or
    c. *Hospice facility*;
26. Injectable drugs, including but not limited to:
    a. Immunizing agents unless otherwise determined by *us*;
    b. Biological sera;
    c. Blood;
    d. Blood plasma; or
    e. *Self-administered injectable drugs* or *specialty drugs* for which *prior authorization* has not been obtained from *us*;
27. *Prescription* fills or refills:
    a. In excess of the number specified by the *healthcare practitioner*; or
    b. Dispensed more than one year from the date of the original order;
28. 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 a *covered person* to receive a 90-day supply of a *prescription* fill or refill;
29. 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 a *covered person* to receive a 30-day supply of a *prescription* fill or refill;
30. Any portion of a *specialty drug prescription* fill or refill that exceeds a 30-day supply, unless otherwise determined by *us*;
31. Any drug for which *we* require *prior authorization* or *step therapy* and it is not obtained;
32. Any portion of a drug for which a charge is customarily not made;
33. Any portion of a *prescription* fill or refill that:
    a. Exceeds *our* drug specific *dispensing limit*;
    b. Is dispensed to a *covered person* whose age is outside the drug specific age limits defined by *us*;
    c. Is refilled early, as defined by *us*; or
    d. Exceeds the duration-specific *dispensing limit*;
34. Any drug, medicine or medication received by the *covered person*:
    a. Before becoming covered under this *contract*; or
    b. After the date the *covered person's* coverage under this *contract* has ended;
35. Any costs related to the mailing, sending or delivery of *prescription* drugs;
36. Any intentional misuse of this benefit, including *prescriptions* purchased for consumption by someone other than the *covered person*;

PRESCRIPTION DRUG EXCLUSIONS

37. Any *prescription* fill or refill for drugs, medicines or medications that are lost, stolen, spilled, spoiled or damaged;
38. Allergy serum and allergy testing materials;
39. Any amount the *covered person* paid for a *prescription* that has been filled, regardless of whether the *prescription* is revoked or changed due to adverse reaction or change in dosage or *prescription*; and
40. *Prescription drugs* filled or refilled at an *out-of-network pharmacy*.

PEDIATRIC VISION CARE BENEFIT

This section describes the *services* that will be considered *covered expenses* for pediatric vision care *services* under this *contract*. Benefits we pay for pediatric vision care *services* will be based on the *reimbursement limit* and as shown in the "Schedule of Benefits–Pediatric Vision Covered Expenses" section of this *contract* subject to:

1. The *deductible*, if applicable;
2. Any *copayment*, if applicable;
3. Any *covered person's portion*;
4. Any *out-of-pocket limit*; and
5. Any *benefit maximum*.

Refer to the "Pediatric vision care exclusions" provision below, the "General Exclusions" and the "Prescription Drug Exclusions" sections in this *contract*. All terms and provisions of this *contract*, including *preauthorization* requirements specified in this *contract*, are applicable to the pediatric vision care *covered expenses*.

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

Pediatric vision care covered expenses

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

1. *Comprehensive eye exam*;
2. Prescription lenses including fashion gradient tinting, ultraviolet protective coating, oversized glass-grey #3 prescription sunglass lenses and polycarbonate prescription lenses with scratch resistant coating;
3. Frames available from a selection of covered frames. The *in-network provider* will show the *covered person* the selection of frames covered by this *contract*. If a *covered person* selects a frame that is not included in the frame selection this *contract* covers, the *covered person* is responsible for the difference in cost between the *in-network provider* reimbursement amount for covered frames and the retail price of the frame selected;
4. Elective contact lenses available from a selection of covered contact lenses, *contact lens fitting and follow-up*. The *in-network provider* will inform the *covered person* of the contact lens selection covered by this *contract*. If a *covered person* selects a contact lens that is not part of the contact lens selection this *contract* covers, the *covered person* is responsible for the difference in cost between the lowest cost contact lens available from the contact lens selection covered by this *contract* and the cost of the contact lens selected;

PEDIATRIC VISION CARE BENEFIT

5. *Medically necessary* contact lenses under the following circumstances when *preauthorization* is obtained:
   a. Visual acuity cannot be corrected to 20/70 in the better eye except by use of contact lenses;
   b. Anisometropia greater than 3.50 diopters and aesthenopia or diplopia, with glasses;
   c. Keratoconus;
   d. Monocular aphakia or binocular aphakia where the doctor certifies contact lenses are *medically necessary* for safety and rehabilitation to a productive life;
   e. High ametropia of either +10D or -10D in any meridian;
   f. Pathological myopia;
   g. Aniseikonia;
   h. Aniridia;
   i. Corneal disorders;
   j. Post-traumatic disorders; or
   k. Irregular astigmatism;
6. *Low vision services* includes the following when *preauthorization* is obtained:
   a. Comprehensive low vision evaluation;
   b. Low vision follow-up care; or
   c. Low vision aids include only the following:
      i. Spectacle-mounted magnifiers;
      ii. Hand-held and stand magnifiers;
      iii. Hand held or spectacle-mounted telescopes; or
      iv. Video magnification.

Pediatric vision care exclusions

In addition to the "General Exclusions" section and the "Prescription Drug Exclusion" section of this *contract* and any limitations specified in the "Schedule of Benefits – Pediatric Vision Covered Expenses" section of this *contract*, benefits for *pediatric vision care* are limited as follows:

1. In no event will benefits exceed the lesser of the limits shown in the "Schedule of Benefits – Pediatric Vision Covered Expenses" section of this *contract.*
2. *Materials* covered by this *contract* that are lost, or stolen. Broken or damaged *materials* will only be replaced at normal intervals as specified in the "Schedule of Benefits – Pediatric Vision Covered Expenses" section of this *contract*.
3. Basic cost for lenses and frames covered by the *contract*.

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

1. Orthoptic or vision training and any associated supplemental testing;
2. Two or more multiple pair of glasses, in lieu of bifocals or trifocals;
3. Medical or surgical treatment of the eye, eyes or supporting structure;
4. Any *services* and/or *materials* required by an *employer* as a condition of employment;
5. Safety lenses and frames;
6. Contact lenses, when benefits for frames and lenses are received;
7. Cosmetic items;
8. Any *services* or *materials* not listed in this *contract* as a *covered expense* or in the "Schedule of Benefits – Pediatric Vision Covered Expenses" section of this *contract*;
9. Expenses for missed appointments;
10. Any charge from a providers' office to complete and submit claim forms;
11. Treatment relating to or caused by disease;

PEDIATRIC VISION CARE BENEFIT

12. Non-prescription *materials* or vision devices;
13. Costs associated with securing *materials*;
14. Pre- and post-operative *services*;
15. Orthokeratology;
16. Routine maintenance of *materials*;
17. Refitting or change in lens design after initial fitting;
18. Artistically painted lenses;
19. *Pediatric vision care* not obtained from an *in-network provider* designated by *us*; or
20. *Services* provided by an *out-of-network provider.*

PEDIATRIC VISION CARE BENEFIT

Definitions

The following terms are specific to *pediatric vision care* benefits:

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

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

Covered person under this section means a person who is eligible and enrolled for benefits provided under this *contract* through the age of 19.

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

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

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

Reimbursement limit is the maximum fee allowed for a *covered expense.* It is the lesser of:

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

PEDIATRIC VISION CARE BENEFIT

Severe vision problems mean the best-corrected acuity is:

1. 20/200 or less in the better eye with best conventional spectacle or contact lens prescription;
2. A demonstrated constriction of the peripheral fields in the better eye to 10 degrees or less from the fixation point; or
3. The widest diameter subtends an angle less than 20 degrees in the better eye.

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 govern 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

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.

1. *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; limited benefit coverage that is not issued to supplement individual or group in-force policies; uninsured arrangements of group or group-type coverage; the medical benefits coverage in automobile insurance contracts; and Medicare or other governmental benefits, as permitted by law;
2. *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; hospital confinement indemnity coverage or 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*.

COORDINATION OF BENEFITS

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 healthcare 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:*

1. 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.
2. 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 amount*s, 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.*
3. 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.*
4. 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 amount*s, 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.
5. 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, prior authorization of admissions, and preferred healthcare 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 healthcare 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.

COORDINATION OF BENEFITS

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:

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

2. 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.

3. 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.

4. 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*.

5. 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 healthcare provider or physician, except for emergency services or authorized referrals that are paid or provided by the primary *plan*.

6. 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.

7. If a person is covered by more than one secondary *plan*, the order of benefit determination rules of this subchapter 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*.

COORDINATION OF BENEFITS

8. Each *plan* determines its order of benefits using the first of the following rules that apply:
   a. 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.
   b. 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:
      i. For a dependent child whose parents are married or are living together, whether or not they have ever been married:
         a) The *plan* of the parent whose birthday falls earlier in the calendar year is the primary *plan*; or
         b) If both parents have the same birthday, the *plan* that has covered the parent the longest is the primary *plan.*
      ii. For a dependent child whose parents are divorced, separated, or not living together, whether or not they have ever been married:
         a) If a court order states that one of the parents 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.
         b) 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.
         c) 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.
         d) 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.*
      iii. 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.

iv. 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.
v. 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.

9. Active, Retired, or Laid-off Employee: The *plan* that covers a person as an active employee, that is, an 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.

10. 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.

11. 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*.

12. 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

1. 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.

2. 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*.

COORDINATION OF BENEFITS

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.

CLAIMS

Claims processing edits

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

1. The intensity and complexity of a *service*;
2. Whether a *service* is one of multiple *services* performed during the same *service* session such that the cost of the *service* to the provider is less than if the *service* had been provided in a separate *service* session. For example:
   a. Two or more *surgeries* occurring during the same *service* session; or
   b. Two or more radiologic imaging views performed during the same session;
3. Whether an assistant surgeon, physician assistant, registered nurse, certified operating room technician or any other provider who is billing independently is involved;
4. 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;
5. If the *service* is reasonably expected to be provided for the diagnosis reported;
6. Whether a *service* was performed specifically for *you*; or
7. Whether *services* can be billed as a complete set of *services* under one billing code.

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

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

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

CLAIMS

Subject to applicable law, providers who are *out-of-network providers* may bill *you* for any amount *we* do not pay even if such amount exceeds the allowed amount after these claims processing edits. Any such amount paid by *you* will not apply to *your deductible* or any *out-of-pocket limit. You* will also be responsible for any applicable *deductible, copayment* or *covered person's portion. Services* provided by an *in-network provider* are not subject to a *deductible.*

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

Completing the claim form

We do not require completion of a standard claim form to process benefits. After *we* receive notice informing *us* of the claim, *we* will notify the *covered person* of any additional information *we* need to process the claim.

Duplicating provisions

If any charge is described as covered under two or more benefit provisions, *we* will pay only under the provision allowing the greater benefit. This may require *us* to make a recalculation based upon both the amounts already paid and the amounts due to be paid. *We* have no obligation to pay for benefits other than those this *contract* provides.

Non-duplication of Medicare benefits

We will not duplicate benefits for expenses that are paid by Medicare.

If the *covered person* is enrolled in Medicare, the benefits available under this *contract* will be coordinated with Medicare, in the case where Medicare is the primary payer. Before filing a claim with *us*, the *covered person* or the provider must first file a claim with Medicare. After filing the claim with Medicare, the *covered person* or the provider must send a copy of the itemized bill and a copy of the Explanation of Medicare Benefits to *us*.

If the *covered person* is eligible for Medicare Part B benefits but not enrolled, benefits under this *contract* will be coordinated to the extent benefits otherwise would have been payable under Medicare.

In all cases, coordination of benefits with Medicare Part B and the provisions of Title XVIII of the Social Security Act as amended will conform with Federal Statutes and Regulations.

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

Medicare means Title XVIII, Parts A, B, C, and D of the Social Security Act, as enacted or amended.

CLAIMS

Notice of claim

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

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

1. Name of the *covered person* who incurred the *covered expenses*;
2. Name and address of the provider;
3. Diagnosis;
4. Procedure or nature of the treatment;
5. Place of *service*;
6. Date of *service*; and
7. Billed amount.

For *services* received from a foreign provider, the information to be submitted by a *covered person* along with their complete claim includes but is not limited to:

1. Proof of payment to the foreign provider for the *services* provided;
2. Complete medical information and/or records;
3. Proof of travel to the foreign country such as airline tickets or passport stamps; and
4. The foreign provider's fee schedule if the provider uses a billing agency.

Proof of loss **(Information we need to process your claim)**

The *covered person* must complete and submit all claim information that *we* request in order for *us* to pay the claim within 90 days after the date of loss. This information must be given *electronically* or in writing. *We* may need to obtain additional information to determine if the *expense incurred* is a *covered expense.* The information *we* may need includes but is not limited to:

1. Authorizations for the release of medical information including the names of all providers from whom the *covered person* received *services*;
2. Medical information and/or records from any provider;
3. Information about other coverage; and
4. Any information *we* need to administer the terms of this *contract*.

If *you* fail to provide the necessary information, *we* may recover payments made by *us* and deny any pending or subsequent claims for which the information is requested. *We* also have the right to terminate this *contract.*

However, *your* claims will not be reduced or denied nor will this *contract* be terminated if it was not reasonably possible to give such proof within 90 days after the date of loss. In no event, except in the absence of legal capacity, can written or *electronic* notice be given later than one year after the date written or *electronic* proof of loss is otherwise required under this *contract*.

CLAIMS

Right to request overpayments

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

1. Made in error;
2. Made to *you* and/or any party on *your* behalf, where *we* determine that such payment made is greater than the amount payable under this *contract*;
3. Made to *you* and/or any party on *your* behalf, based on fraudulent or misrepresented information; or
4. 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 any *deductible* or *out-of-pocket limit*.

Right to require medical examinations

We have the right to have the *covered person* examined or autopsied, while the claim is pending unless prohibited by law. These procedures will be conducted as often as *we* deem reasonably necessary to determine *contract* benefits, at *our* expense.

State public medical assistance

Payments due under this *contract* will be paid immediately after *our* receipt of complete written or *electronic* proof of loss.

If a *covered person* received medical assistance from the Texas Department of Human Services while insured under this *contract, 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 expense* for which benefits are payable under this *contract*, and if *we* received 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 the claim to *you* or to the provider.

If the Texas Department of Human Services is paying financial and medical assistance for a child and *you* are a parent who purchased this *contract* or a parent covered by this *contract* and have possession or access to the child, or 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 this *contract* must be paid to the Texas Department of Human Services.

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

Time of payment of claims

Payments due under this *contract* will be paid after *our* receipt of complete written or *electronic* proof of loss and within the time required by applicable Federal or state law.

CLAIMS

To whom benefits are payable

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

All benefit payments for *services* rendered by an *out-of-network provider* are payable to the *covered person.* Assignment of benefits is prohibited; however, *you* may request that *we* direct a payment of selected medical benefits to the healthcare provider on whose charge the claim is based. If *we* consent to this request, *we* will pay the healthcare provider directly. Such payments will not constitute the assignment of any legal obligation to the *out-of-network provider.* If *we* decline this request, *we* will pay *you* directly, and *you* are then responsible for all payments to the *out-of-network provider*(*s*).

If any *covered person* to whom benefits are payable is a minor or, in *our* opinion, not able to give a valid receipt for any payment due him/her, such payment will be made to his/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/her custody and support.

If the *covered person* is deceased, payment will be made, at *our* option, to any one of the following:

1. *You* in the case of a covered *dependent*;
2. *Your* spouse;
3. A provider; or
4. *Your* estate.

Any payment made by *us* in good faith will fully discharge *us* of any liability to the extent of such payment.

Unpaid premium

If any premium is due or unpaid and a payment of a claim is made under this *contract*, the due or unpaid premium may be deducted from the payment due on the claim.

APPEAL RIGHTS

Appeal and external review rights

If a *covered person* disagrees with *our* decision on payment of a particular claim, the *covered person* may request a second review of the claim, also known as an appeal. To request this review, the *covered person* must appeal orally or in writing to the address given on the denial letter received from *us.* The *covered person* may also send any documents or information which is relevant to *our* decision of how to pay the claim.

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

A covered person also has the right to request an external review of an adverse claim determination.

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

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

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

Definitions

Adverse determination means a determination by *us* or a utilization review agent that the healthcare *services* furnished or proposed to be furnished to a *covered person* are not *medically necessary* or are experimental or investigational.

For *prescription* drug coverage, an *adverse determination* includes a denial to provide benefits for a *prescription* drug if the *prescription* drug is not included on *our drug list,* and *your healthcare practitioner* has determined the *prescription* drug is *medically necessary* or *prescription* drugs and intravenous infusions that a *covered person* is currently receiving.

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

APPEAL RIGHTS

Complaint process

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

After receipt of the written *complaint we* will investigate and send a letter with *our* resolution to the *covered person. We* will notify *you* of *our* determination within 30 calendar days after the date *we* received the *complaint.*

Appeals to the plan

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

1. *We* shall send an acknowledgment letter to the *covered person* not later than the fifth business day after the date of receipt of the request for appeal.
2. *We* shall appoint members to the complaint appeal panel, which shall advise *us* on the resolution of the dispute. The complaint appeal panel shall be composed of an equal number of *our* staff, *healthcare practitioners,* and other persons covered under a health plan provided by *us.* A member of the complaint appeal panel may not have been previously involved in the disputed decision.
3. Not later than the fifth business day before the scheduled meeting of the panel, unless the *covered person* agrees otherwise, *we* shall provide to the *covered person* or *covered person's* designated representative:
   a. Any documentation to be presented to the panel by *our* staff;
   b. The specialization of any *healthcare practitioner* consulted during the investigation; and
   c. The name and affiliation of each of *our* representatives on the panel.
4. The *covered person* or the *covered person's* designated representative if the *covered person* is a minor or disabled, are entitled to:
   a. Appear in person before the complaint appeal panel;
   b. Present alternative expert testimony; and
   c. Request the presence of and question any person responsible for making prior determination that resulted in the appeal.

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

APPEAL RIGHTS

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

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

Notification of adverse determination

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

In the case of an adverse determination of a retrospective utilization review, notification will be provided in writing to *you* and the treating healthcare provider 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 healthcare provider before the expiration of the initial 30 day period.

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

Appeals of adverse determination

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

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

After review of the appeal of an *adverse determination*, *we* will issue a response letter to the *covered person*, a person acting on behalf of the *covered person*, and the *covered person's healthcare practitioner* explaining the resolution of the appeal as soon as practical, but in no case later than the 30th calendar day after the date *we* receive the appeal. If the appeal is for *emergency care*, denial of a continued stay for hospitalized *covered person*, or denial of prescription drugs or intravenous infusions for which a *covered person* is receiving benefits for, the time frame for resolution will be based on the medical or dental immediacy of the condition, procedure or treatment, but may not exceed one working day from the date the request is received. The resolution letter will contain a statement of the specific medical, dental, or contractual reasons for the resolution, the clinical basis for the appeal's denial, a description of or the source of the screening criteria that were utilized in making the determination, the specialty of the *healthcare practitioner* making the denial, and notice of the appealing party's right to seek review of the denial by an Independent Review Organization (IRO), notice of the independent review process, a copy of a request for a review by an IRO form, and procedures for filing a complaint.

APPEAL RIGHTS

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

Filing complaints with the Texas Department of Insurance

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

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

1. Additional information is needed;
2. A on-site review is necessary;
3. *We,* the *healthcare practitioner* or the *covered person* does not provide all documentation necessary to complete the investigation; or
4. Other circumstances beyond the control of the department occur.

Appeals process to Independent Review Organization (IRO)

In a circumstance, involving a *life-threatening disease or prescription* drugs or intravenous infusions that a *covered person* is currently receiving being removed from the *drug list,* the *covered person* is entitled to an immediate appeal to an IRO and is not required to comply with procedures for an internal review of *our adverse determination.* The procedure for filing an immediate appeal to an IRO is included in *our* initial denial notice.

We shall permit any party whose appeal of an *adverse determination* is denied by *us* to seek review of that determination by an IRO assigned to the appeal. The procedure for requesting an IRO review is included in *our* appeal resolution letter.

The appeal process does not prohibit the *covered person* from pursuing other appropriate remedies, including injunctive relief, a declaratory judgment, or relief available under law, if the requirement of exhausting the process for appeal and review places the *covered person's* health in serious jeopardy.

Exhaustion of remedies

All levels of the appeal process applicable to *you* and any regulatory/statutory review process available to *you* under state or federal law must 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 this *contract*.

RECOVERY RIGHTS

Your obligation to assist in the recovery process

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

1. Promptly notifying *us* that *you* have asked anyone other than *us* to make payment for *your* injuries;
2. Obtaining *our* consent before releasing any party from liability for payment of medical expenses;
3. 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;
4. Taking all action to assist *our* enforcement of recovery rights and doing nothing after loss to prejudice *our* recovery rights; and
5. Agreeing to not attempt to avoid *our* recovery rights by designating all (or any disproportionate part) of any recovery as exclusively for "pain and suffering".

For information on the process of obtaining *our* consent, *you* may contact *us* at the phone number on *your ID card.* If the *covered person* fails to cooperate with *us, we* shall be entitled to recover from *you* any payments made by *us* from *you.*

Other coverage/non-duplication of benefits

We will not provide duplicate coverage for benefits under this *contract* when a person is covered by *us* and has, or is entitled to:

1. Receive benefits;
2. Recovery for damages; or
3. Settlement proceeds, as a result of their *bodily injuries* from any other coverage including, but not limited to:
   a. The medical benefits coverage in automobile contracts;
   b. Other group coverage (including student plans); or
   c. 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" provision.

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

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

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

RECOVERY RIGHTS

Right to request information

The *covered person* must cooperate with *us* and when asked, assist *us* by:

1. Authorizing the release of medical information including the names of all providers from whom medical attention was received;
2. Obtaining medical information/or records from any provider as requested by *us*;
3. Providing information regarding the circumstances of the *sickness*, *bodily injury* or accident;
4. Providing information about other coverage benefits, including information related to any *bodily injury* or *sickness* for which another party may be liable to pay compensation or benefits;
5. Providing information *we* request to administer the *contract*;
6. Providing copies of claims and settlement demands submitted to third parties in relation to a *bodily injury* or *sickness*; and
7. Disclosing details of liability settlement agreements reached with third parties in relation to a *bodily injury* or *sickness*.

If the *covered person* fails 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.

Our 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*, the *covered person* agrees to transfer to *us* any rights they may have to make a claim, take legal action or recover any expenses paid for benefits covered under this *contract. We* will be subrogated to the *covered person's* rights to recover from any funds paid or payable as a result of a personal injury claim or any reimbursement of expenses by:

1. Any legally liable person or their carrier including self-insured entities;
2. 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 person covered under this plan or an immediate family member of a person covered under this plan;
3. Uninsured or underinsured motorist coverage if premiums for that coverage were not paid by a person covered under this plan or an immediate family member of a person covered under this plan; or
4. 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 carrier, *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 as a result of any *sickness* or *bodily injury*.

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

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

RECOVERY RIGHTS

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

1. One-half of total amount recoverable by *you,* after a reduction for the amount of fees costs owed by *you* to the attorney; or
2. 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 *sickness* or *bodily injury.* If *we* are precluded from exercising *our* right of subrogation, *we* may exercise *our* right of reimbursement.

Right of reimbursement

If *we* pay benefits and later any *covered person* recovers from any legally responsible person or carrier described above under "Our right of subrogation", *we* have the right to recover from *you* or *the covered person* the amount *we* paid.

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

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

Workers' compensation

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

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

We will 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 *sickness or bodily injury. We* are not required to contribute to attorney fees or recovery expenses under a Common Fund or similar doctrine.

RECOVERY RIGHTS

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

1. The Workers' Compensation carrier does not accept responsibility to provide benefits;
2. There is no final determination that *bodily injury* or *sickness* was sustained in the course of or resulted from the *covered person's* employment;
3. The amount of Workers' Compensation due to medical or health care is not agreed upon or defined by the *covered person* or the Workers' Compensation carrier; or
4. Medical or health care benefits are specifically excluded from the Worker' Compensation settlement or compromise.

As a condition to receiving benefits from *us*, *you* and the *covered person* hereby agree that, in consideration for the coverage provided by this *contract*, *we* will be notified of any Workers' Compensation claim the *covered person* makes, and that *you* or the *covered person* 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 the *covered person.*

PREMIUM PAYMENT

Your duty to pay premium

You must pay the required premium to *us* as it becomes due. If *you* don't pay *your* premium on time, *we* will terminate coverage.

The first premium is due on the date specified by *us.* Subsequent premiums are due on the date *we* assign. All premiums are payable to *us.*

Grace period

You have 31 days from the premium due date to remit the required funds. If premium is not paid *we* will terminate the coverage after the grace period and the *covered person* is responsible for the costs of *services* received within the grace period. Coverage will remain in force during the 31-day grace period.

If coverage was purchased through a *marketplace* and *you* are receiving an Advanced Premium Tax Credit (APTC), *you* have 90 days from the premium due date to remit the required fund. If premium is not paid *we* will terminate the coverage on the last day of the first month of the grace period.

Changes to your premium

Premium may change when:

1. *Dependents* are added or deleted;
2. Benefits and/or coverage is increased or decreased;
3. The *covered person* moves to a different zip code or county;
4. An intentional material misstatement or omission is made on the application resulting in the proper amount due not being charged;
5. A new set of rates applies to this *contract*;
6. Any *covered person's* age increases; or
7. Any *covered person's* rating classification changes.

We will notify *you* of any premium change. A 60 day advanced notice will be provided prior to premium rate changes due to items 5 through 7 above.

Your payment of premium will stand as proof of *your* agreement to the change.

Return of premium

In no event, except for the following reasons will premium be returned:

1. The *contractholder* returns the *contract* as described in the "Right to return contract" provision on the cover of this *contract*;
2. *Rescission* of coverage as described in the "Incontestability" provision in the "General Provisions" section; or
3. The *contractholder* requests coverage to end and premium has been paid past the date in which the termination is being requested.

In the event that *you* cancel this *contract,* the earned premium shall be computed by the use of the short-rate table last filed with the Texas Department of Insurance where *you* resided when the *contract* was issued.

Cancellation of this *contract* will not affect claims incurred prior to the cancellation.

ELIGIBILITY

Eligibility

In order to be eligible for coverage under this *contract*, the *contractholder* must live, reside, or work in the *service area* or area in which *we* are authorized to do business. In addition, the legal residence of the *contractholders dependents* must be the same as the *contractholder's* except in the following situations:

1. A *dependent* in the *service area* with a person having temporary or permanent conservatorship or guardianship, including children who are subject to a suit for adoption, when the *contractholder* has a legal responsibility to provide healthcare coverage;
2. In the *service area* under other circumstances where the *contractholder* has a legal responsibility to provide healthcare coverage;
3. In the *service area* with the *contractholder's* spouse;
4. Anywhere in the United States whose coverage is required due to a medical support order.

Your rights to make changes to the contract

You have several rights to make changes to *your contract*. *You* may be required to complete an application to request a change to *your contract*.

Changes in benefits

You may make a change in benefits during an *open enrollment period* or when qualifying for a special enrollment.

If *you* purchased *your* coverage through the *marketplace you* will need to contact the *marketplace* to request a change in benefits.

Change in residence

We must be notified of any change in *your* resident address. If *you* purchased *your* coverage through the *marketplace*, please also notify the *marketplace* of the change in *your* resident address.

At least 14 days prior to *your* move, call or write *us* informing *us* of *your* new address and phone number. When *we* receive this information, *we* will inform *you* of any changes to *your contract* on such topics as new networks, benefits, and premium. If *you* move outside of this *contract's* service area *we* will terminate this *contract*. See the "Renewability of Coverage and Termination" section for the events that will cause this *contract* to end. Such change will be effective on the date *we* assign.

We have the right to change *your* resident address in *our* records upon *our* receipt of an address change from *your* agent.

Changes to covered persons

You may request a change to the persons covered under *your contract* due to certain changes in *your* family.

1. Removing dependents

If *you* purchased *your* coverage through the *marketplace you* will need to contact the *marketplace* and request to have *your dependent* removed from this *contract*.

If *you* did not purchase *your* coverage through the *marketplace* and wish to remove a *covered person* from *your contract*, simply call the telephone number on *your ID card.*

ELIGIBILITY

2. Adding dependents

If *you* purchased *your* coverage through the *marketplace you* will need to contact the *marketplace* and request to have *your dependent* added to this *contract*.

If *you* did not purchase *your* coverage through the *marketplace* and a child is born to a *contractholder,* or any *covered person,* a *contractholder* adopts a child, or date the *contractholder* is a party in a suit in which adoption of a child is sought, or a child is placed with the *contractholder* for the purpose of adoption or foster care *we* must be notified of the event in writing and receive any required premium within 60 days.

If *we* do not receive notice and premium for the first 60 days and forward, the child must wait to enroll for coverage during the next *open enrollment period* unless such child becomes eligible for a *special enrollment* as specified in the "Special enrollment" provision.

For a *dependent* not falling under the previous paragraphs the *dependent* must wait to enroll for coverage during the next *open enrollment period,* unless the *dependent* becomes eligible for a *special enrollment* as specified in the "Special enrollment" provision.

Upon *our* receipt of the completed application and premium, an *effective date* will be assigned. A *dependent* child is eligible to apply if they are under age 26.

3. Effective date of dependent changes

a. Coverage for a newborn will be effective on the date of the birth. *We* must receive verbal notification or a completed application and premium in order for coverage to continue beyond 31 days from the date of birth.
b. Coverage for a foster child or adopted child will be effective on the date of the placement, adoption or date the *contractholder* is a party in a suit in which adoption of a child is sought, provided *you* complete an application and remit the premium within 60 days of the child's date of birth, placement or adoption.
c. Coverage for a *dependent* child who is the subject of a medical support order will be effective for the first 31 days after receipt of the medical support order or notice of the medical support order.
d. If *we* receive the application and any required premium more than 60 days after the newborn's date of birth or the child's adoption, date the *contractholder* is a party in a suit in which adoption of a child is sought or placement for adoption or foster care, such child will not be eligible for coverage until the next *open enrollment period*.
e. For changes for other *dependents,* the *dependent* will not be eligible for coverage until the next *open enrollment period* or until qualifying for a special enrollment.

ELIGIBILITY

Special enrollment

A *special enrollment period* is available if the following apply:

1. A *covered person* has a change in family status due to:
   a. Marriage;
   b. Divorce;
   c. Separation;
   d. The birth of a natural born child;
   e. The adoption of a child or placement of a child with the *contractholder* for the purpose of adoption;
   f. Placement of a foster child with the *contractholder*;
   g. Death of the *contractholder*; or
   h. For a *covered person* who purchased coverage through a *marketplace*, any other event as determined by the *marketplace*.

   In the event of the death of the *contractholder*, the spouse of the *contractholder*, if covered under this *contract* becomes the *contractholder.*

   The *covered person* must furnish proof of the event that is satisfactory to *us* and enroll within 60 days of the date of the special enrollment event.

2. Coverage under this *contract* terminates due to:
   a. A *dependent* child ceasing to be eligible due to attaining the *limiting age*;
   b. The *contractholder* moves outside of the service area for this *contract*; or
   c. For a *covered person* who purchased coverage through a *marketplace*, any other event as determined by the *marketplace*.

   The *covered person* must furnish proof of the event that is satisfactory to *us* and enroll within 60 days of the date of the special enrollment event.

3. A *dependent* did not enroll for coverage under this *contract* when first eligible due to:
   a. Being covered under an employer sponsored health plan and coverage under that plan terminates;
   b. Not a citizen of the United States, lawfully present, and subsequently gaining such lawful status;
   c. Was incarcerated and is no longer incarcerated; or
   d. Any other event as determined by the *marketplace*, for a *covered person* who purchased coverage through a *marketplace*.

   The *dependent* must furnish proof of the event that is satisfactory to *us* and enroll within 60 days of the date of the special enrollment event.

4. For a *covered person* who purchased coverage through a *marketplace*, any other event as determined by the *marketplace*. The *covered person* must enroll within 60 days of the special enrollment event date.

The *effective date* of coverage for a *covered person* who requests coverage due to a special enrollment event will be assigned, except in the case of a change in marital status. If a *covered person* loses coverage due to a change in marital status, a new *contract* with like coverage will be issued to that person without proof of insurability and with the same effective and termination dates as the prior coverage.

A *special enrollment period* is not available if coverage terminated due to non-payment of premium or coverage is *rescinded.*

ELIGIBILITY

Open enrollment

An *open enrollment period* is the opportunity for a *dependent* who did not enroll under this *contract* when first eligible to enroll for coverage. The *open enrollment period* is also the opportunity for a *covered person* to change to a different health plan.

The request to enroll must be received by *us* during the *open enrollment period*. If enrollment is requested after the *open enrollment period*, the *covered person* and/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.

The *effective date* of coverage when enrolling during an *open enrollment period* will be assigned.

Our rights to make changes to the contract

We have the right to make certain changes to *your contract* in accordance with the "Renewability of Coverage and Termination" provision of this *contract.*

Changes we will make without notice to you

Changes to this *contract* can be made by *us* at any time without prior consent of, or notice to *you,* when the changes are corrections due to clerical errors or clarifications that do not change benefits.

Changes where we will notify you

1. A 60-day notice will be provided for:
   a. An increase in benefits without any increase in premium; or
   b. Clarifications that do not reduce benefits but modify material content.

2. If *we* determine that *you* or a *covered person* have misrepresented any material information, *we* shall have the right to:
   a. Reform *your contract* and reissue the correct form of coverage *you* would have received had the misrepresentation not been made; or
   b. Continue *your* present coverage and collect the difference in premium which would have been assessed had the misrepresentation not been made.

   We will notify *you* with a 60-day notice of this change in coverage and/or premium and request *your* acceptance of the change(s). *We* will apply all premium paid to the new coverage and shall collect any difference in the premium due to the change(s). Intentional omissions, fraud or misstatements of a material fact in the application may cause *your policy* to be voided, terminated or cancelled and claims to be denied. *Your* payment of premium will stand as proof of *your* agreement to the change.

We can also make changes to *your contract* on the premium due date or upon separate notice, provided *we* send *you* a written explanation of the change. All such changes will be made in accordance with state law. *Your* payment of premium will stand as proof of *your* agreement to the change.

RENEWABILITY OF COVERAGE AND TERMINATION

Reasons we will terminate your contract

This *contract* is renewable at the option of the *contractholder*, except for the conditions stated below. *We* will terminate *your contract* at the end of the billing period in which the following events occur unless stated otherwise:

1. The required premium was due to *us* and not received by *us.* Termination is subject to the "Grace period" provision in the "Premium Payment" section;
2. *You* or a *covered person* commit fraud or make an intentional material misrepresentation of a material fact. Termination will be effective at 12:01 a.m. local time at the *contractholder's* state of residence on the date the misrepresentation occurred. A 30-day advance written notice of the termination will be provided;
3. *You* cease to reside, live, or work in the *service area*, or area in which *we* are authorized to do business, as determined by *us*. Call the telephone number on *your ID card* for this *contract's service area*;
4. *You* cease to be a resident in the state in which this *contract* was issued;
5. *You* request termination of the *contract*. The request may be given verbally, *electronically*, or in writing. Termination will be effective on the last day of the billing period in which the requested termination date occurs;
6. *We* cease to offer a type of contract or cease to do business in the individual medical market, as allowed or required by state or Federal law:
   a. If *we* decide to discontinue offering a type of contract, the *contractholder* will be notified of such discontinuation at least 90 days prior to the date of discontinuation of such coverage and given the option to purchase any other individual hospital, medical or surgical contract providing medical benefits that are being offered by *us* at such time; or
   b. If *we* decide to cease doing business in the individual hospital, medical or surgical market, the *contractholders* covered by such contracts and the Commissioner of Insurance will be notified of such discontinuation at least 180 days prior to the date of discontinuation of such coverage; or
7. If coverage was purchased through a *marketplace*:
   a. *You* cease to be eligible for coverage through a *marketplace*; or
   b. This *contract* ceases to be a *qualified health plan* and is decertified by a *marketplace*.

   The *marketplace* will initiate the termination and notify *us* of the event. The termination date will be assigned.

Reasons we will terminate coverage for a covered person

We will terminate coverage for a *covered person* at the end of the billing period in which the following events occur unless stated otherwise:

1. When the *covered person* no longer qualifies as a *dependent* or meets eligibility criteria;
2. The *covered person* commits fraud or makes an intentional material misrepresentation of a material fact. Termination will be effective at 12:01 a.m. local time at the *covered person's* state of residence on the date the misrepresentation occurred. A 30-day advance written notice of the termination will be provided;
3. When the *contractholder's* coverage under this *contract* terminates; or
4. If coverage was purchased through a *marketplace*, the *covered person* ceases to be eligible for coverage through a *marketplace*. The *marketplace* will initiate the termination and notify *us* of the event. The termination date will be assigned.

RENEWABILITY OF COVERAGE AND TERMINATION

Coverage for a child subject to a medical support order will not be terminated due to the child not living, working, or residing in the *service area.*

You must notify *us* as soon as possible if *your dependent* no longer meets the eligibility requirements of this *contract.* Notice should be provided to *us* within 31 days of the change. If there is an overpayment of *your* premium prior to the change to *your dependent* eligibility, *we* will apply any overpayments as a credit to *your* next premium payment unless *you* request a refund by providing written notice to *us.*

Your duty to notify us

You are responsible to notify *us* of any of the events stated above in "Reasons we will terminate your contract" and "Reasons we will terminate coverage for a covered person" provisions which would result in termination of this *contract* or a *covered person.*

If *we* accept premium for any *covered person* extending beyond the date, age or event specified in this section as a reason for termination, then coverage for that *covered person* will continue during the period for which an identifiable premium was accepted.

Fraud

You or a *covered person* commit fraud against *us* when *you* or a *covered person* make an intentional material misrepresentation of a material fact by not telling *us* the correct facts or withholding information which is necessary for *us* to administer this *contract*.

Health coverage 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 is committing coverage fraud.

If *you* or the *covered person* commits fraud against *us,* as determined by *us, we* reserve the right to rescind coverage under this *contract* as of the date fraud is committed or as of the date otherwise determined by *us. We* will provide a 30-day advance written notice that coverage will be *rescinded. You* have the right to appeal the *rescission. We* will also provide information to the proper authorities and support any criminal charges which may be brought. Further, *we* reserve the right to seek any civil remedies which may be available to *us.*

Extension of benefits for total disability and pregnancy

If this *contract* is terminated or non-renewed by *us* for a reason other than fraud or non-payment of premium, while any *covered person* is *totally disabled, we* will continue to provide medical benefits for the *bodily injury* or *sickness* which caused the disabling condition, to the extent benefits would have been paid if the *contract* had remained in force.

Benefits for the disabling condition will continue until the earlier of the following:

1. The date the *covered person* is no longer *totally disabled*; or
2. The end of 90 consecutive days immediately following the date coverage terminated. The 90-day period begins on the day coverage terminated and ends 90 days later on the same calendar day.
3. For a pregnancy that began while the *contract* was in force and for which benefits would have been payable.

GENERAL PROVISIONS

Assignment

This *contract* and its benefits may not be assigned by the *contractholder* or any *covered person.*

Conformity with state statutes

Any provisions which are in conflict with the laws of the state in which this *contract* is issued are amended to conform to the minimum requirements of those laws.

Entire contract

The rules governing *our* agreement to provide *you* with health coverage in exchange for *your* premium payment are based upon several written documents: this *contract,* riders, amendments, endorsements, and the application. All statements made by *you* or a *covered person* are considered to be representations, not warranties. This means that the statements are made in good faith. No statement or omission will void this *contract,* reduce the benefits it provides or be used in defense to a claim unless it is contained in a written or *electronic* application and a copy is furnished to the person making such statement or his/her beneficiary. If coverage was purchased through a *marketplace, your contract* may not include a copy of *your* application.

No modification or amendment to this *contract* will be valid unless approved by the President, Secretary or a Vice-President of *our* Company. The approval must be endorsed on or attached to this *contract*. No agent has authority to modify this *contract,* waive any of the *contract* provisions, extend the time for premium payment, or bind *us* by making any promise or representation.

Incontestability

No misstatement made by the *contractholder*, except for fraud or an intentional misrepresentation of a material fact made in the application, may be used to void this *contract.*

After a *covered person* is insured without interruption for two years, *we* cannot contest the validity of their coverage except for:

1. Nonpayment of premium; or
2. Any fraud or intentional misrepresentation of a material fact made by the *covered person.*

At any time, *we* may assert defenses based upon provisions in this *contract* which relate to a *covered person's* eligibility for coverage under this *contract*.

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

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

Legal action

No lawsuit with respect to benefits under this *contract* may be brought:

1. Before the 61st day after the date on which *we* first received the *service* or claim; or
2. After the expiration of three years after the time written proof of loss is required to be provided.

GENERAL PROVISIONS

Misstatement of age or gender

If *you* or the *covered person* has provided *us* with information in error, and after *we* investigate the matter *we* also determine it was an error, *we* will not end *contract* coverage. However, *we* will adjust premium or claim payment based on this new information.

Our relationship with providers

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

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

Reinstatement

If this *contract* is terminated due to lack of premium payment, other than *your* initial premium payment, *you* may request reinstatement. *We* will reinstate *your contract* provided all of the following are met:

1. A new application is submitted by *you*;
2. Coverage has not been terminated for more than 90 days; and
3. *We* approve the reinstatement.

If *your* request for reinstatement is approved, coverage will be reinstated on the date *we* approve the reinstatement.

No benefits will be paid for any condition that occurs during the time between the termination date and the reinstatement date if:

1. A *covered person* received medical treatment, diagnosis, consultation, *service* or took *prescription* drugs; or
2. *We* inquire about the condition on the application for reinstatement and it is not disclosed.

This limitation will be for 12 months from the reinstatement date, unless the condition has been specifically excluded from coverage.

GENERAL PROVISIONS

Shared savings program

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

As a *covered person under* this *contract*, *you* are free to obtain *services* from *in-network providers or out-of-network providers*. **If *you* chose to receive *services* from an *out-of-network provider* there is no coverage for any *services* received except when authorized by *us*.**

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

In most cases, to maximize *your* benefit design and reduce your non-covered expenses, please access *in-network providers* associated with this *contract*.

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

However, if *you* would like to inquire in advance to determine if an *out-of-network provider* participates in the Shared Savings Program, please call the telephone number on *your ID card.* Please note provider arrangements in the Shared Savings Program are subject to change without notice. *We* cannot guarantee that the provider from whom *you* received treatment is still participating in the Shared Savings Program at the time treatment is received. Discounts are dependent upon availability and cannot be guaranteed.

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

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 a *covered person's* health. These programs may be accessed by registering at *our* Website at Humana.com. Participation in these programs may include:

1. Completing certain health related activities that can be tracked, such as taking wellness classes, exercising and getting regular medical check-ups and screenings;
2. Completing a health risk assessment. A personalized health program will be developed for a *covered person* based on this assessment. This health program may be educational, preventive, fitness related or informational; or
3. Achieving certain health standards or reaching certain goals developed for a *covered person,* such as lowering blood pressure or becoming smoke free.

Please call the telephone number listed on the *ID card* or in the marketing literature for a possible alternative activity if:

1. It is unreasonably difficult for a *covered person* to reach certain goals due to their medical condition; or
2. The *covered person's health care practitioner* advises them not to take part in the activities needed to reach certain goals.

GENERAL PROVISIONS

We may require proof in writing from the *covered person's health care practitioner* that their medical condition prevents them from taking part in the available activities.

By participating in these health related activities a *covered person* may earn rewards. For additional information on how the program works, please go to *our* Website at Humana.com. From time to time *we* may enter into agreements with third parties who provide rewards for participating in certain wellness programs. These rewards may include items such as merchandise, gift cards, and merchandise discounts. In the event *our* agreement with a third party terminates, other reward options will be made available as a substitute.

The rewards may be taxable income. A *covered person* may consult a tax advisor for further guidance.

The wellness program may be terminated in accordance with the termination provision of the *contract*.

The wellness programs are included in a *covered person's* health plan however it is a *covered person's* decision to participate in the activities to earn points toward the rewards. A *covered person* may participate anytime during the year. If this *contract* terminates, a *covered person* will no longer be eligible for the program. To resolve a complaint or issue, a *covered person* may call the customer service telephone number on the *ID card*.

Workers' compensation

This *contract* does not cover *sickness* or *bodily injury* arising out of, or sustained in the course of, any occupation, employment or activity for compensation, profit or gain and is not issued as a substitute for Workers' Compensation or occupational disease coverage except as provided for under the "Occupational coverage" provision.

DEFINITIONS

The following are definitions of terms as they are used in this *contract*. Defined terms are printed in *italic* type wherever found in this *contract*.

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), Computed Tomography (CT) imaging, and *nuclear medicine*.

Authorize/authorization means *we* have given permission to receive *services* from an *out-of-network provider* prior to the *services* being rendered.

Benefit maximum means the limit set on the amount of *covered expenses* that *we* will pay on behalf of a *covered person* for some *services*. *We* will not make benefit payments in excess of the *benefit maximum* for the *covered expenses* and time periods shown on the "Schedule of Benefits".

Bodily injury means bodily damage other than *sickness*, including all related conditions and recurrent symptoms, resulting from sudden, violent, external physical trauma which could not be avoided or predicted in advance. The *bodily injury* must be the direct cause of the loss, independent of disease, bodily infirmity or any other cause. Bodily damage resulting from infection or muscle strain due to athletic or physical activity is considered a *sickness* and not a *bodily injury*.

Bone marrow means the transplant of human blood precursor cells. Such cells may be derived from *bone marrow*, circulating blood, or a combination of *bone marrow* and circulating blood obtained from the patient in an autologous transplant or from a matched related or unrelated donor or cord blood. The term *bone marrow* includes the harvesting, the transplantation and the integral chemotherapy components.

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*.

Calendar year means the period of time beginning on any January 1st and ending on the following December 31st. The first *calendar year* begins for a *covered person* on the date benefits under this *contract* first become effective for that *covered person* and ends on the following December 31st.

Chemical dependency means the abuse of, or psychological or physical dependence on, or addiction to alcohol or a controlled substance as classified in the Diagnostic and Statistical Manual of Mental Disorders.

Covered person's portion means the amount of *covered expense*, expressed as a percentage, a *covered person* must pay toward the cost *incurred* for each separate *prescription* fill or refill dispensed by a *pharmacy* and for all other medical *services*, in addition to any applicable *copayments* and *deductibles*. This percentage is shown in the "Schedule of Benefits". Charges paid as *covered person's portion* do not apply to any responsibility for *copayments* or *deductibles*.

DEFINITIONS

Complications of pregnancy means conditions requiring *hospital confinement* (when the pregnancy is not terminated) whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy, including:

1. Acute nephritis;
2. Nephrosis;
3. Cardiac decompensation;
4. Missed or threatened abortion;
5. Similar medical and surgical conditions of comparable severity;
6. Non-elective cesarean section;
7. Termination of an ectopic pregnancy; and
8. Spontaneous termination of pregnancy occurring during a period of gestation in which a viable birth is not possible.

Complications of pregnancy does not mean:

1. False labor;
2. Occasional spotting;
3. Rest prescribed during the period of pregnancy;
4. Morning sickness;
5. Hyperemesis gravidarum;
6. Pre-eclampsis; and
7. Similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy.

Confined/confinement means the status of being a resident patient in a *hospital* or *healthcare treatment facility* receiving *inpatient services*. *Confinement* does not mean detainment in *observation status.* Successive *confinements* are considered to be one *confinement* if they are:

1. Due to the same *bodily injury* or *sickness*; and
2. Separated by fewer than 30 consecutive days when the *covered person* is not *confined*.

Contract means this document, together with any amendments, riders, and endorsements which describe the agreement between *you* and *us.*

Contractholder means the person to whom this *contract* is issued and whose name is shown on the cover of this *contract* and the "Schedule of Benefits".

Copayment/Copay means a specified dollar amount shown on the "Schedule of Benefits", to be paid by a *covered person* toward the cost of each separate *prescription* fill or refill dispensed by a *pharmacy* and for certain medical benefits specified in this *contract* each time a *covered service* is received, regardless of any amounts that may be paid by *us. Copayments*, if any, do not apply toward any applicable *deductible.*

Cosmetic means *surgery*, procedure, injection, medication or treatment primarily designed to improve appearance, self-esteem or body image and/or to relieve or prevent social, emotional or psychological distress.

DEFINITIONS

Cost share means any applicable *copayment, deductible,* and/or *covered person's portion* that must be paid by the *covered person* per *prescription* drug fill or refill. Any expense that exceeds the *default rate* will not apply to any *covered person's cost share* responsibility.

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

Covered expense means a *medically necessary* expense, based on the *usual and customary amount* for *services* incurred by a *covered person* which were ordered by a *healthcare practitioner.* To be a *covered expense,* the *service* must not be *experimental, investigational or for research purposes* or otherwise excluded or limited by this *contract* or by any amendment.

Covered person means anyone eligible to receive *contract* benefits as a *covered person.* Refer to the "Schedule of Benefits" for a complete list.

Custodial care means *services* given to a *covered person* if:

1. The *covered person* needs *services* that include, but are 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; or
2. The *services* are required to primarily maintain and not likely to improve the *covered person's* condition.

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

1. The *covered person* is under the care of a *healthcare practitioner*;
2. The *services* are prescribed by a *healthcare practitioner* to support or maintain the *covered person's* condition;
3. *Services* are being provided by a *nurse*; or
4. The *services* involve the use of skills which can be taught to a layperson and do not require the technical skills of a *nurse*.

Deductible means the amount of *covered expense* that a *covered person,* either individually or combined as a covered family, must pay in a *calendar year* and is responsible to pay in addition to any applicable *copayments* or *covered person's portion* before *we* pay medical or *prescription* drug benefits under this *contract*. This amount will be applied on a *calendar year* basis and will vary for medical *services, prescription* drug *services,* and for *services* obtained by *in-network providers* and *out-of-network providers.* The *deductible* is shown on the "Schedule of Benefits".

One or more of the following *deductibles* may apply to *covered expenses* as shown on the "Schedule of Benefits":

1. **Family medical deductible.** The amount of medical *covered expense* that a *covered person,* either individually or combined as a covered family, must pay each *calendar year* in addition to any applicable *copayment* and/or *covered person's portion* before *we* pay medical benefits under this *contract.* These expenses do not apply toward any other *deductible* stated in this *contract*.
2. **Family prescription drug deductible.** The amount of *prescription* drug *covered expense* that a *covered person,* either individually or combined as a covered family, must pay each *calendar year* in addition to any applicable *copayment* and/or *covered person's portion* before *we* pay *prescription* drug benefits under this *contract*. These expenses do not apply toward any other *deductible* stated in this *contract*.

DEFINITIONS

Default rate means the fee based on rates negotiated by *us* or other payers with one or more *in-network providers* in a geographic area determined by *us* for the same or similar *prescription* fill or refill.

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.

Dependent means *your domestic partner* or legally recognized spouse, *your* natural born child, step-child, legally adopted child, foster child upon placement in the home whose age is less than the *limiting age* or a child placed for adoption or a child for whom *you* are a party in a suit in which adoption of the child is sought by you whose age is less than the *limiting age*, a child whose age is less than the *limiting age* and for whom *you* have received a court or administrative order to provide coverage until such court or administrative order is no longer in effect, the child is enrolled for comparable health coverage or will be enrolled in comparable coverage that will take effect no later than the effective date of the cancellation or non-renewal, or *your* adult child who meets the following conditions:

1. Is beyond the *limiting age* of a child;
2. Is unmarried;
3. Is permanently mentally or physically handicapped; and
4. Incapable of self-sustaining employment.

Each child, other than the child who qualifies because of a court or administrative order, must meet all of the qualifications of a *dependent* as determined by *us*.

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 condition as defined in the 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.

Dependent does not mean a:

1. Grandchild, unless such child is *your* unmarried *dependent* for Federal income tax purposes at the time application for coverage of the grandchild is made and whose age is less than the *limiting age*; or
2. Great grandchild.

Diabetic equipment and supplies means:

1. Blood glucose monitors, including non-invasive glucose monitors and glucose monitors used by blind individuals;
2. Test strips for blood glucose monitors;
3. Visual reading strips and urine test strips and tablets which test for glucose, ketones and protein;
4. Lancets and lancet devices;
5. Insulin and insulin analogs;
6. Injection aids;
7. Syringes;
8. Prescriptive and non-prescription oral agents for controlling blood sugar levels;
9. Insulin pumps and associated appurtenances;
10. Insulin infusion devices;

DEFINITIONS

11. Podiatric appliances (up to 2 pair of therapeutic footwear per year) for the prevention of complications associated with diabetes;
12. Biohazard disposable containers;
13. Prescriptive non-insulin injectable agents for controlling blood sugar levels;
14. Glucagon emergency kits;
15. Alcohol swabs; and
16. Any *medically necessary* new or improved equipment and supplies approved by the Food and Drug Administration (FDA).

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.*

Distant site means the site at which the *healthcare practitioner* delivering the *services* is located at the time the *service* is provided via a telecommunications system.

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

Drug list means a list of covered *prescription* drugs, medicines, medications, and supplies specified by *us*. The *drug list* identifies categories of drugs, medicines or medications and supplies by applicable levels, if any, and indicates applicable *dispensing limits*, *specialty drug* designation and/or any *prior authorization* or *step therapy* requirements. Visit *our* Website at www.humana.com or call the telephone number on *your ID card* to obtain the *drug lists.* The *drug lists* are subject to change based on state law and advanced written notice.

These types of changes to *prescription* drug coverage will only be made by *us* at renewal of the *contract. We* will provide written notice no later than 60 days prior to the *effective date* of the change

Durable medical equipment means equipment which meets the following criteria:

1. It can withstand repeated use;
2. It is primarily and customarily used to serve a medical purpose rather than being primarily for comfort or convenience;
3. It is usually not useful to a person except to treat a *bodily injury* or *sickness*;
4. It is *medically necessary* and necessitated by the *covered person's bodily injury* or *sickness*;
5. It is not typically furnished by a *hospital* or *skilled nursing facility*; and
6. It is prescribed by a *healthcare practitioner* as appropriate for use in the home.

Effective date means the first date all the terms and provisions of this *contract* apply. It is the date that appears on the cover of this *contract* or on the date of any amendment or endorsement.

DEFINITIONS

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

Emergency care means healthcare s*ervices* provided in a *hospital* emergency facility, freestanding emergency medical care facility, or comparable emergency facility to evaluate and stabilize medical conditions of a recent onset and severity, including severe pain, that would lead a prudent layperson possessing an average knowledge of medicine and health to believe that the individual's condition, *sickness*, or injury is of such a nature that failure to get immediate medical care could:

1. Place the *covered person's* health in serious jeopardy;
2. Result in serious bodily impairment to bodily functions;
3. Result in serious dysfunction of a bodily organ or part;
4. Result in serious disfigurement; or
5. For a pregnant woman, result in serious jeopardy to the health of the fetus.

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

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

1. Root canal therapy and root canal fillings;
2. Periradicular *surgery* (around the root of the tooth);
3. Apicoectomy;
4. Partial pulpotomy; or
5. Vital pulpotomy.

Expense incurred means the *usual and customary amount* charged for *services* which are *medically necessary* to treat the condition. The date a *service* is rendered is the *expense incurred* date.

Experimental, investigational or for research purposes means any procedure, treatment, supply, device, equipment, facility or drug (all *services*) determined by *our* Medical Director or his/her designee to:

1. Not be a benefit for diagnosis or treatment of a *sickness* or a *bodily injury*;
2. Not be as beneficial as any established alternative; or
3. Not show improvement outside the investigational setting.

A drug, biological product, device, treatment or procedure that meets any one of the following criteria, as determined by *us*, will be considered *experimental, investigational or for research purposes*:

1. Cannot be lawfully marketed without the final approval of the United States Food and Drug Administration (FDA) for the particular *sickness* or *bodily injury* and which lacks such final FDA approval for the use or proposed use, unless:
    a. Found to be accepted for that use in the most recently published edition of the United States Pharmacopoedia-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 Federal or state law;

DEFINITIONS

2. Is a device required to receive Premarket Approval (PMA) or 510K approval by the FDA, but has not received a PMA or 510K approval;
3. 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;
4. Is the subject of a National Cancer Institute (NCI) Phase I, II or III trial, or any trial not recognized by NCI regardless of the Phase except as expressly provided in this *contract*;
5. Is identified as not covered by the Centers for Medicare and Medicaid Services (CMS) Medicare Coverage Issues Manual, a CMS Operational Policy Letter or a CMS National Coverage Decision except as required by state or Federal law;
6. The FDA has determined the device to be contraindicated for the particular *sickness* or *bodily injury* for which the device has been prescribed; or
7. The treatment, *services* or supplies are:
   a. Not as effective in improving health outcomes and not as cost effective as established technology; or
   b. Not usable in appropriate clinical contexts in which established technology is not employable.

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

Free-standing surgical facility means any licensed public or private establishment which has permanent facilities that are equipped and operated primarily for the purpose of performing outpatient *surgery*.

Generic drug means a drug, medicine or medication that is manufactured, distributed, and available from a pharmaceutical manufacturer and identified by a chemical name, or any drug product that has been designated as generic by an industry-recognized source used by *us*.

Habilitative services means *services* and devices that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These *services* may include physical and occupational therapy, speech-language pathology, dietary or nutritional evaluations, and other *services* for people with disabilities in a variety of inpatient and/or outpatient settings.

Healthcare practitioner means a practitioner, professionally licensed by the appropriate state agency, to provide preventive medical *services* or diagnose or treat a *bodily injury* or *sickness*, and who provides *services* within the scope of that license. A *healthcare practitioner's services* are not covered if the practitioner resides in the *covered person's* home or is a *family member*.

Healthcare treatment facility means only a facility, institution or clinic duly licensed by the appropriate state agency, and is primarily established and operating within the scope of its license. *Healthcare treatment facility* does not include a halfway house.

HMO means Humana Health Plan of Texas, Inc., a licensed health maintenance organization.

Home healthcare agency means a *home healthcare agency* which provides home health *services* and is licensed by the Texas Department of Human Services.

DEFINITIONS

Home healthcare plan means a plan of healthcare established with a home healthcare provider. The *home healthcare plan* must consist of:

1. Care by or under the supervision of a *healthcare practitioner* and not for *custodial care*;
2. Physical, speech, occupational, and respiratory therapy;
3. Medical social work and nutrition *services*; or
4. Medical appliances, equipment, and laboratory *services*, if *expenses incurred* for such supplies would have been *covered expenses* during a *confinement*.

A *healthcare practitioner* must:

1. Review and approve the *home healthcare plan*;
2. Certify and verify that the *home healthcare plan* is required in lieu of *confinement* or a continued *confinement*; and
3. Not be related to the *home healthcare agency* by ownership or contract.

Home healthcare visit means home healthcare *services* provided by any one *healthcare practitioner* for four consecutive hours or any portion thereof.

Hospice care agency means an agency which:

1. Has the primary purpose of providing hospice *services* to *hospice patients*;
2. Is licensed and operated according to the laws of the state in which it is located; and
3. Meets the following requirements:
   a. Has obtained any required certificate of need;
   b. Provides 24-hour-a-day, seven-day-a-week service, supervised by a *healthcare practitioner*;
   c. Has a full-time administrator;
   d. Keeps written records of *services* provided to each patient; and
   e. Has a coordinator who:
      i. Is a *nurse*; and
      ii. Has four years of full-time clinical experience, of which at least two were involved in caring for terminally ill patients; and
4. Has a licensed social service coordinator.

Hospice care program means a coordinated, interdisciplinary program provided by a hospice designed to meet the special physical, psychological, spiritual, and social needs of a terminally ill *covered person* and his/her *immediate family members*, by providing *palliative care* and supportive medical, nursing, and other *services* through at-home or *inpatient* care. A hospice must:

1. Be licensed by the laws of the jurisdiction where it is located and run as a hospice as defined by those laws; and
2. Provide a program of treatment for a least two unrelated individuals who have been medically diagnosed as having no reasonable prospect for cure for their *sickness* or *bodily injury*, and as estimated by their *healthcare practitioners*, are expected to live less than six months as a result of that *sickness* or *bodily injury*.

For purposes of the Hospice Care benefit only, *immediate family member* is considered to be the *covered person's* parent, spouse, *domestic partner*, and children or step-children.

DEFINITIONS

Hospice facility means a licensed facility or part of a facility which:

1. Principally provides hospice care;
2. Keeps medical records of each patient;
3. Has an ongoing quality assurance program;
4. Has a *healthcare practitioner* on call at all times;
5. Provides 24-hour-a-day skilled nursing *services* under the direction of a registered nurse; and
6. Has a full-time administrator.

Hospice patient means a terminally ill or injured person who has six months or less to live, as certified by a *healthcare practitioner*.

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

1. It must be licensed as a *hospital* and operate according to law;
2. It must provide or operate, either on its premises or in facilities available to the *hospital* on a pre-arranged basis and under the supervision of a staff of one or more duly licensed *healthcare practitioners*, medical, diagnostic, and surgical facilities for the care and treatment of sick or injured persons on an inpatient basis for which a charge is made;
3. It must have x-ray and laboratory facilities either on its premises or in facilities available to the *hospital* on a pre-arranged basis;
4. It must maintain and operate a minimum of five beds;
5. It must maintain permanent medical records; or
6. Nursing *services* must be provided on a 24-hour basis and must be given by or supervised by registered nurses.

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

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

ID cards mean cards each *covered person* receives which contain *our* address, telephone number, group number and other coverage information.

DEFINITIONS

Infertility services mean any treatment, supply, medication or *service* given to achieve pregnancy or to achieve or maintain ovulation. This includes, but is not limited to:

1. Artificial insemination;
2. In vitro fertilization;
3. GIFT;
4. ZIFT;
5. Tubal ovum transfer;
6. Embryo freezing or transfer;
7. Sperm storage or banking;
8. Ovum storage or banking;
9. Embryo or zygote banking;
10. Diagnostic and/or therapeutic laparoscopy;
11. Hysterosalpingography;
12. Ultrasonography;
13. Endometrial biopsy; and
14. Any other assisted reproductive techniques or cloning methods.

In-network pharmacy means a *pharmacy* that has signed a direct agreement with *us* or has been designated by *us* to provide covered *pharmacy services*, covered *specialty pharmacy services* or covered *mail-order pharmacy services* as defined by *us*, to *covered persons* including covered *prescription* fills or refills delivered to a *covered person's* home or healthcare provider.

In-network provider means a *hospital*, *healthcare treatment facility*, *healthcare practitioner* or other 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 *covered persons* for this *contract* and for the *services* received.

Inpatient services are *services* rendered to a *covered person* during their *confinement*.

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 one drug means a category of *prescription* drugs, medicines or medications within the *drug list* that are designated by *us* as level one. Visit *our* Website at www.humana.com or call the telephone number on *your ID card* for a description of the drugs in this category.

Level two drug means a category of *prescription* drugs, medicines or medications within the *drug list* that are designed by *us* as level two. Visit *our* Website at www.humana.com or call the telephone number on *your ID card* for a description of the drugs in this category.

Level three drug means a category of *prescription* drugs, medicines or medications within the *drug list* that are designated by *us* as level three. Visit *our* Website at www.humana.com or call the telephone number on *your ID card* for a description of the drugs in this category.

Level four drug means a category of *prescription* drugs, medicines or medications within the *drug list* that are designated by *us* as level four. Visit *our* Website at www.humana.com or call the telephone number on *your ID card* for a description of the drugs in this category.

DEFINITIONS

Level five drug means a category of *prescription* drugs, medicines or medications within the *drug list* that are designated by *us* as level five. Visit *our* Website at www.humana.com or call the telephone number on *your ID card* for a description of the drugs in this category.

Life-threatening disease means a disease or condition from which the likelihood of death is probable unless the course of the disease is interrupted.

Limiting age means a covered *dependent* child's 31st birthday (26th birthday if coverage was purchased through a *marketplace*).

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.*

Maintenance care means *services* furnished mainly to:

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

Marketplace (or Exchange) means a governmental agency or nonprofit entity that meets the applicable Federal or state standards and makes *qualified health plans* available to qualified individuals. This term includes an *exchange* serving the individual market regardless of whether the *exchange* is established and operated by a state (including a regional *exchange* or subsidiary *exchange*) or by the Federal government.

Medically necessary or medical necessity means healthcare *services* that a *healthcare practitioner* exercising prudent clinical judgment would provide to his/her patient for the purpose of preventing, evaluating, diagnosing, or treating a *sickness* or *bodily injury* or its symptoms. The fact that a *healthcare practitioner* may prescribe, authorize or direct a *service* does not of itself make it *medically necessary* or covered under this *contract*. Such healthcare *service*, treatment or procedure must be:

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

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 *healthcare practitioners* practicing in relevant clinical areas, and any other relevant factors.

DEFINITIONS

Mental health means *mental illness* and *chemical dependency*.

Mental illness means a mental, nervous or emotional condition of any type as classified in the Diagnostic and Statistical Manual of Mental Disorders. This is true regardless of the original cause of the disorder.

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

1. 40 kilograms or greater per meter squared (kg/m^2); or
2. 35 kilograms or greater per meter squared (kg/m^2) with an associated co-morbid condition such as hypertension, type II diabetes, or joint disease that is treatable, if not for the obesity.

Nuclear medicine means radiology in which radioisotopes (compounds containing radioactive forms of atoms) are introduced into the body for the purpose of imaging, evaluating organ function or localizing disease or tumors.

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

Observation status means a stay in a *hospital* or *healthcare treatment facility* if the *covered person*:

1. Has not been admitted as a resident inpatient;
2. Is physically detained in an emergency room, treatment room, observation room or other such area; or
3. Is being observed to determine whether a *confinement* will be required.

Open enrollment period means the period during which:

1. A *dependent* who did not enroll for coverage under this *contract* when first eligible or during a *special enrollment period* can enroll for coverage; or
2. A *covered person* has an opportunity to enroll in another health plan.

Visit *our* Website at www.humana.com for information on the *open enrollment period*.

Originating site means the location of the *covered person* at the time the *service* is being furnished via a telecommunications system.

Out-of-network pharmacy means a *pharmacy* that has not signed a direct agreement with *us* or has not been designated by *us* to provide covered *pharmacy services*, covered *specialty pharmacy services* or covered *mail-order pharmacy services* as defined by *us*, to *covered persons* including covered *prescription* fills or refills delivered to a *covered person's* home or healthcare provider.

Out-of-network provider means a *hospital*, *healthcare treatment facility*, *healthcare practitioner*, or other provider who has not been designated by *us* as an *in-network provider* for this *contract* and for the *services* received.

DEFINITIONS

Out-of-pocket limit means the amount of *covered expense* a *covered person,* either individually or combined as a covered family, must pay each *calendar year* for medical *services* or *prescription* drugs covered under this *contract*. This amount does not include:

1. Amounts over the *usual and customary amount*;
2. Transplant *services* from a *out-of-network provider*;
3. Amounts over the *default rate*;
4. Utilization management or *prescription* drug penalties;
5. Non-covered *services*; or
6. Other *contract* limits.

There may be separate individual and family medical, *prescription* drug, *in-network provider* and *out-of-network provider out-of-pocket limits*. **See the "Schedule of Benefits" for the specific amounts.**

Outpatient services means *services* that are rendered to a *covered person* while they are not *confined* as a registered inpatient. *Outpatient services* include, but are not limited to, *services* provided in:

1. A *healthcare practitioner's* office;
2. A *hospital* outpatient setting;
3. A *free-standing surgical facility*;
4. A licensed birthing center; or
5. An independent laboratory or clinic.

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

Partial hospitalization means *services* provided in an outpatient program by a *hospital* or *healthcare treatment facility* in which patients do not reside for a full 24-hour period.

1. For a comprehensive and intensive interdisciplinary psychiatric treatment for a minimum of five hours a day, five days per week;
2. That provides for social, psychological, and rehabilitative training programs with a focus on reintegration back into the community and admits children and adolescents who must have a treatment program designed to meet the special needs of that age range; and
3. That has *healthcare 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:

1. *Custodial care*; or
2. Day care.

DEFINITIONS

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:

1. Periodontal maintenance;
2. Scaling and tooth planning;
3. Gingivectomy;
4. Gingivoplasty; or
5. Osseous *surgery.*

Pharmacist means a person who is licensed to prepare, compound, and dispense medication and who is practicing within the scope of his/her license.

Pharmacy means a licensed establishment where *prescription* drugs, medicines or medications are dispensed by a *pharmacist.*

Preauthorization means the determination by *us,* or *our* designee, of the *medical necessity* of a *service* prior to it being provided. *Preauthorization* is not a determination that a *service* is a *covered expense* and does not guarantee coverage for or the payment of *services* reviewed.

Prescription means a direct order written by a *healthcare practitioner* for the preparation and use of a drug, medicine, or medication. The *prescription* must be given to a *pharmacist* for a *covered person's* benefit and used for the treatment of a *bodily injury* or *sickness* which is covered under this *contract* or for drugs, medicines or medications on the *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 *healthcare practitioner*.

The *prescription* must include at least:

1. The name of the *covered person*;
2. The type and quantity of the drug, medicine or medication prescribed and the directions for its use;
3. The date the *prescription* was prescribed; and
4. The name and address of the prescribing *healthcare practitioner*.

Pre-surgical/procedural testing means:

1. 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 procedures; and
2. The tests must be for the same *bodily injury* or *sickness* causing the *covered person* to be *confined* to a *hospital* or to have the outpatient *surgery* or procedure.

Primary care physician means an in-network *healthcare 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 *healthcare practitioner* in one of the following specialties:

1. Family Medicine;
2. Internal Medicine; and
3. Pediatrics.

DEFINITIONS

An Obstetrician/Gynecologist, Nurse Practitioner, and pediatric sub-specialist will be considered as *primary care physicians* if the following conditions are met:

1. The *healthcare practitioners* have signed an agreement with *us* as a *primary care physician*; and
2. A *covered person* has selected the Obstetrician/Gynecologist, Nurse Practitioner, or pediatric sub-specialist as their *primary care physician*.

Review the "Provider Directory" on *our* Website at www.humana.com or call the telephone number on *your ID card* to obtain a list of Obstetrician/Gynecologists and Nurse Practitioners who are considered *primary care physicians.*

Prior authorization means the required prior approval from *us* for the coverage of *prescription* drugs, medicines, or medications or *specialty drugs*, including the dosage, quantity, and duration, as *medically necessary* for a *covered person.* Certain *prescription* drugs, medicines, medications or *specialty drugs* may require *prior authorization* and/or *step therapy.* Visit *our* Website at www.humana.com or call the telephone number on *your ID card* to obtain a list of *prescription* drugs, medicines, medications, and *specialty drugs* that require *prior authorization* and/or *step therapy.*

Qualified health plan means a health plan that is certified and meets the standards issued or recognized by each *marketplace* through which the plan is offered.

Reconstructive surgery means *surgery* performed on an abnormal body structure caused by congenital defects, developmental abnormalities, trauma, infection, tumor or disease in order to improve function or create a normal appearance.

Rehabilitation services means specialized treatment for *sickness* or a *bodily injury* which meets all of the following requirements:

1. Is a program of *services* provided by one or more members of a multi-disciplinary team;
2. Is designed to improve the patient's function and independence;
3. Is under the direction of a qualified *healthcare practitioner*;
4. Includes a formal written treatment plan with specific attainable and measurable goals and objectives; and
5. May be provided in either an inpatient or outpatient setting.

Rescission/rescinded means a cancellation or discontinuance of coverage that has a retroactive effect. Coverage under this *contract* will be *rescinded* due to fraud or intentional misrepresentation of material fact made on the application.

Residential treatment center means an institution which:

1. Is licensed as a 24-hour residential, intensive, inpatient facility, although NOT licensed as a *hospital*;
2. Provides a multidisciplinary treatment plan in a controlled environment, with periodic supervision of a licensed *healthcare practitioner* or Ph.D. psychologist; and
3. Provides programs such as social, psychological, and rehabilitative training, age appropriate for the special needs of the age group of patients, with a focus on reintegration back into the community.

Residential treatment is utilized to provide structure, support, and reinforcement of the treatment required to reverse the course of behavioral deterioration.

DEFINITIONS

Retail clinic means a *healthcare 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).

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. *Healthcare practitioner* visits are not considered *routine nursery care.* Treatment of *bodily injury, sickness,* birth abnormality or congenital defect following birth and care resulting from prematurity are not considered *routine nursery care*.

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

Service area means the geographic area designated by *us* and approved by the Department of Insurance of the state in which this *contract* is issued, if such approval is required.

If *you* purchased *your contract* in Waco, *your service area* is:

- McLennan

If *you* purchased *your contract* in San Antonio, *your service area* is:

- Bexar and Comal

If *you* purchased *your contract* in Corpus Christi or Beaumont/Port Arthur, *your service area* is:

- Aransas, Bee, Jim Wells, Kleberg, Nueces, Refugio, and San Patricio.

Services mean procedures, *surgeries*, consultations, advice, diagnosis, referrals, treatment, supplies, drugs, devices or technologies.

Sickness means disturbance in function or structure of the *covered person's* body which causes physical signs or symptoms which, if left untreated, will result in a deterioration of the health state of the structure or system(s) of the *covered person's* body.

Skilled nursing facility means a facility that provides continuous skilled nursing *services* on an inpatient basis for persons recovering from a *sickness* or a *bodily injury.* The facility must meet all of the following requirements:

1. Be licensed by the state to provide skilled nursing *services*;
2. Be staffed by an on call *healthcare practitioner* 24 hours per day;
3. Provide skilled nursing *services* supervised by an on duty registered nurse 24 hours per day;
4. Maintain full and complete daily medical records for each patient; and
5. Not primarily a place for rest, for the aged, for *custodial care* or to provide care for *mental health* although these *services* may be provided in a distinct section of the same physical facility. The facility may also provide extended care which would not be covered under this *contract.*

DEFINITIONS

Sound natural tooth means a tooth that:

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

Special circumstances means a condition for which the treating *healthcare practitioner* or healthcare provider reasonably believes that discontinuing care by the treating *healthcare practitioner* or healthcare provider could cause harm to the *covered person.* Examples of *special circumstances* include:

1. A *covered person* with a disability;
2. A *covered person* with an acute condition;
3. A *covered person* with a *life-threatening disease*; or
4. A *covered person* who is past the 24th week of pregnancy.

Special enrollment period means a 60-day period of time during which a *covered person* or *dependent* who has a qualifying event may enroll for coverage outside of an *open enrollment period*.

Specialty care physician means an in-network *healthcare practitioner* who has received training in a specific medical field and is not a *primary care physician.*

Specialty drug means a drug, medicine, or medication, or biological used as a specialized therapy developed for chronic, complex *sicknesses* or *bodily injuries. Specialty drugs* may:

1. Be injected, infused or require close monitoring by a *healthcare practitioner* or clinically trained individual;
2. Require nursing *services* or special programs to support patient compliance;
3. Require disease-specific treatment programs;
4. Have limited distribution requirements; or
5. Have special handling, storage or shipping requirements.

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

Step therapy means a type of *prior authorization. We* may require a *covered person* to follow certain steps prior to *our* coverage of some medications including *specialty drugs. We* may also require a *covered person* to try similar drugs, medicines or medications, including *specialty drugs* that have been determined to be safe, effective, and more cost effective for most people that have the same condition as the *covered person.* Alternatives may include over-the-counter drugs, *generic drugs,* and *brand-name drugs.*

DEFINITIONS

Sub-acute medical care means a short-term comprehensive inpatient program of care for a *covered person* who has a *sickness* or a *bodily injury* that:

1. Does not require the *covered person* to have a prior admission as an inpatient in a *healthcare treatment facility*;
2. Does not require intensive diagnostic and/or invasive procedures; and
3. Requires *healthcare practitioner* direction, intensive nursing care, significant use of ancillaries, and an outcome-focused, interdisciplinary approach using a professional medical team to deliver complex clinical interventions.

Sub-acute rehabilitation facility means a facility that provides *sub-acute medical care* for *rehabilitation services* for *sickness* or a *bodily injury* on an inpatient basis. This type of facility must meet all of the following requirements:

1. Be licensed by the state in which the *services* are rendered to provide *sub-acute medical care* for *rehabilitation services*;
2. Be staffed by an on call *healthcare practitioner* 24 hours per day;
3. Provide nursing *services* supervised by an on duty registered nurse 24 hours per day;
4. Maintain full and complete daily medical records for each patient; and
5. Not primarily provide care for *mental health* although these *services* may be provided in a distinct section of the same physical facility. The facility may also provide extended care or *custodial care* which would not be covered under this *contract*.

Surgery means surgical procedures as categorized in the Current Procedural Terminology (CPT) Manuals published by the American Medical Association. The term *surgery* includes, but is not limited to:

1. Excision or incision of the skin or mucosal tissues;
2. Insertion of instruments for exploratory purposes into a natural body opening;
3. Insertion of instruments into any body opening, natural or otherwise, done for diagnostic or other therapeutic purposes;
4. Treatment of fractures; and
5. Procedures to repair, remove or replace any body part or foreign object in/on the body.

Surrogacy contract or arrangement means an oral or written agreement, regardless of the state or jurisdiction where executed, between the *surrogate* and the intended parent or parents.

Surrogate means a woman, regardless of age, who contracts, orally or in writing, to become pregnant by means of assisted reproductive technology for the benefit of a third party.

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

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

DEFINITIONS

Telemedicine means *services* provided by a *healthcare practitioner* for purposes of patient assessment, diagnosis, consultation, treatment or the transfer of medical data, that requires the use of advanced telecommunications technology other than by telephone or facsimile, including:

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

Totally disabled or total disability means a *covered person* who, as a result of a covered *bodily injury* or illness:

1. Is unable to engage in any employment or occupation for which he/she is or becomes qualified by reason of education, training or experience, and is not engaged in any employment or occupation for wage or profit; and
2. Requires the regular care of a *healthcare practitioner.*

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

Usual and customary amount for a *covered expense,* other than *emergency care services* provided by *out-of-network providers* in a *hospital's* emergency department, is the lesser of:

1. The fee charged by the provider for the *service*;
2. The fee that has been negotiated with the provider whether directly or through one or more intermediaries or shared savings contracts for the *services*;
3. 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 geographic area determined by *us*;
4. The fee based on rates negotiated by *us* or other payers with one or more *in-network providers* in a geographic area determined by *us* for the same or similar *services*;
5. The fee based upon the provider's costs for providing the same or similar *services* as reported by such provider in its most recent publicly available Medicare cost report submitted to the Centers for Medicare and Medicaid Services (CMS) annually; or
6. The fee based on a percentage determined by *us* of the fee Medicare allows for the same or similar *services* provided in the same geographic area.

Usual and customary amount for a covered expense for emergency care services provided by *out-of-network providers* in an emergency department is an amount equal to the greatest of:

1. The fee negotiated with *in-network providers*;
2. The fee calculated using the same method to determine payments for *out-of-network provider services*; or
3. The fee paid by Medicare for the same *services*.

The bill *you* receive for *services* from *out-of-network providers* may be significantly higher than the *usual and customary amount.* In addition to any applicable *deductible, copayments, covered person's portion* or *out-of-pocket limit, you* are responsible for the difference between the *usual and customary amount* and the amount the *out-of-network provider* bills *you* for the *services.* Any amount *you* pay to the *out-of-network provider* in excess of the *usual and customary amount* will not apply to *your out-of-pocket limit* or any applicable *deductible.*

DEFINITIONS

We, us or **our** means or otherwise refers to the insurer as shown on the cover page of this *contract*.

You/your means the *contractholder*.

Humana.

OFFERED BY
Humana Health Plan of Texas, Inc.

FEDERAL NOTICES

The following pages contain important information about certain federal laws. There may also be differences between this notice packet and state law.
This section includes notices about:

Federal Legislation

Women's Health and Cancer Rights Act

Statement of Rights under the Newborns' and Mothers' Health Protection Act

Patient Protection Act

Pharmacy Exception Requests

FEDERAL NOTICES

Federal Legislation

Women's health and cancer rights act of 1998
Required coverage for reconstructive surgery following mastectomies

Under federal law, health insurance issuers offering health insurance providing medical and surgical benefits with respect to mastectomy shall provide, in a case of a participant or beneficiary who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with such mastectomy, coverage for:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce symmetrical appearance; and
- Prostheses and physical complications of all stages of mastectomy, including lymphedemas;

in a manner determined in consultation with the attending physician and the patient. Such coverage may be subject to annual deductibles and coinsurance provisions as may be deemed appropriate and as are consistent with those established for other benefits under the plan.

Statement of rights under the newborns' and mothers' health protection act (NMHPA)

If your plan covers normal pregnancy benefits, the following notice applies to you.

Under federal law, health insurance issuers offering health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, health insurance issuers may not set the level of benefits or out-of-pocket costs so any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a health insurance issuer may not, under federal law, require a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain pre-authorization. For information on pre-authorization, contact your plan administrator

FEDERAL NOTICES

Patient Protection Act

Humana generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, Humana designates one for you. For children, you may designate a pediatrician or a pediatric subspecialist as the primary care provider. For information on how to select a primary care provider, and for a list of the participating primary care providers, visit our Website at www.humana.com or call the customer service telephone number on your identification card.

If you plan provides coverage for obstetric or gynecological care and requires you to designate a primary care provider, you do not need prior authorization from us or from any other person (including a primary care provider) in order to obtain access to this care from a health care professional in our network who specialize in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, visit our Website at www.humana.com or call the customer service telephone number on your identification card.

Pharmacy Exception Requests

About our drug list

Prescription drugs, medicines, and medications, including specialty drugs and self-administered injectable drugs prescribed by healthcare practitioners and covered by us are specified on our printable drug list. The drug list identifies categories of drugs, medicines or medications by levels. It also indicates dispensing limits, specialty drug designation, and any applicable prior authorization or step therapy requirements. This information is reviewed on a regular basis by a Pharmacy and Therapeutics committee made up of physicians and pharmacists. Placement on the drug list does not guarantee your healthcare practitioner will prescribe that prescription drug, medicine, or medication for a particular medical condition. A covered person can obtain a copy of our drug list by visiting our Website at www.humana.com or calling the telephone number on the ID card.

Access to non-formulary drugs

A drug not included on our drug list is a non-formulary drug. If a healthcare practitioner prescribed a clinically appropriate non-formulary drug, a request for coverage of the non-formulary drug can be made through a standard exception request or an expedited exception request. If a covered person is dissatisfied with our decision of an exception request, they have the right to the non-formulary drug appeal procedures.

FEDERAL NOTICES

Pharmacy standard exception requests

A standard exception request for coverage of a clinically appropriate non-formulary drug may be initiated by a covered person, their appointed representative, or the prescribing healthcare practitioner by calling the telephone number on the ID card, in writing or electronically by visiting our Website at www.humana.com. We will respond to the standard exception request no later than 72 hours after the receipt date of the request.

As part of the standard exception request, the prescribing healthcare 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:

1. Will be or have been ineffective;
2. Would not be as effective as the non-formulary drug; or
3. 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, a covered person has the right to appeal our decision as outlined in the "Non-formulary drug appeal procedures" provision in this section.

Pharmacy expedited exception request

An expedited exception request for coverage of a clinically appropriate non-formulary drug based on exigent circumstances may be initiated by a covered person, their appointed representative, or their prescribing healthcare practitioner by calling the telephone number on the ID card, in writing or electronically by visiting our Website at www.humana.com. We will respond to the expedited exception request within 24 hours of receipt of the request. An exigent circumstance exists when a covered person is:

1. Suffering from a health condition that may seriously jeopardize their life, health, or ability to regain maximum function; or
2. Undergoing a current course of treatment using a non-formulary drug.

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

1. 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
2. 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:
   a. Will be or have been ineffective;
   b. Would not be as effective as the non-formulary drug; or
   c. Would have adverse effects.

FEDERAL NOTICES

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:

1. Without unreasonable delay; and
2. For the duration of the exigent circumstances.

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

If we deny an expedited exception request, a covered person has the right to appeal our decision as outlined in the "Non-formulary drug appeal procedures" provision in this section.

Non-formulary drug appeal procedures

If we deny an exception request to cover a non-formulary drug, a covered person, their appointed representative or their prescribing healthcare practitioner have the right to appeal our decision to an external independent review organization. Refer to the exception request decision letter for instructions or call the telephone number on the ID card.