Important

At Humana, it is important you are treated fairly.

Humana Inc. and its subsidiaries do not discriminate or exclude people because of their race, color, national origin, age, disability, sex, sexual orientation, gender, gender identity, ancestry, ethnicity, marital status, religion, or language. Discrimination is against the law. Humana and its subsidiaries comply with applicable Federal Civil Rights laws.

If you believe that you have been discriminated against by Humana or its subsidiaries, there are ways to get help.

- You may file a complaint, also known as a grievance:
  Discrimination Grievances, P.O. Box 14618, Lexington, KY 40512-4618
  If you need help filing a grievance, call **866-427-7478** or if you use a **TTY**, call **711**.
- You can also file a civil rights complaint with the **U.S. Department of Health and Human Services**, Office for Civil Rights electronically through their Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or at **U.S. Department of Health and Human Services**, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, DC 20201, **800-368-1019**, **800-537-7697 (TDD)**. Complaint forms are available at **https://www.hhs.gov/ocr/office/file/index.html**.
- **California residents**: You may also call California Department of Insurance toll-free hotline number: **800-927-HELP (4357)**, to file a grievance.

Auxiliary aids and services, free of charge, are available to you. 866-427-7478 (TTY: 711)

Humana provides free auxiliary aids and services, such as qualified sign language interpreters, video remote interpretation, and written information in other formats to people with disabilities when such auxiliary aids and services are necessary to ensure an equal opportunity to participate.

Language assistance services, free of charge, are available to you. 866-427-7478 (TTY: 711)

Español (Spanish): Llame al número arriba indicado para recibir servicios gratuitos de asistencia lingüística.
繁體中文 (Chinese): 撥打上面的電話號碼即可獲得免費語言援助服務。
Tiếng Việt (Vietnamese): Xin gọi số điện thoại trên đây để nhận được các dịch vụ hỗ trợ ngôn ngữ miễn phí.
한국어 (Korean): 무료 언어 지원 서비스를 받으려면 위의 번호로 전화하십시오 .
Tagalog (Tagalog – Filipino): Tawagan ang numero sa itaas upang makatanggap ng mga serbisyo ng tulong sa wika nang walang bayad.
Русский (Russian): Позвоните по номеру, указанному выше, чтобы получить бесплатные услуги перевода.
Kreyòl Ayisyen (French Creole): Rele nimewo ki pi wo la a, pou resevwa sèvis èd pou lang ki gratis.
Français (French): Appelez le numéro ci-dessus pour recevoir gratuitement des services d'aide linguistique.
Polski (Polish): Aby skorzystać z bezpłatnej pomocy językowej, proszę zadzwonić pod wyżej podany numer.
Português (Portuguese): Ligue para o número acima indicado para receber serviços linguísticos, grátis.
Italiano (Italian): Chiamare il numero sopra per ricevere servizi di assistenza linguistica gratuiti.
Deutsch (German): Wählen Sie die oben angegebene Nummer, um kostenlose sprachliche Hilfsdienstleistungen zu erhalten.
日本語 (Japanese): 無料の言語支援サービスをご要望の場合は、上記の番号までお電話ください。
فارسی (Farsi)
برای دریافت تسهیلات زبانی بصورت رایگان با شماره فوق تماس بگیرید.
Diné Bizaad (Navajo): Wódahí béésh bee hani'í bee wolta'ígíí bich'į' hódíílnih éí bee t'áá jiik'eh saad bee áká'ánída'áwo'dęę niká'adoowoł.
العربية (Arabic)
الرجاء الاتصال بالرقم المبين أعلاه للحصول على خدمات مجانية للمساعدة بلغتك

Texas Member Handbook

Humana Houston HMOx Network

Offered by Humana Health Plan of Texas, Inc.

Humana®

TXHLWHBEN 0123

Table of contents

Offering company statement 1

Important phone numbers 1

MyHumana 2

How to use your Humana plan 2

Provider relationships 3

Highlights of your plan 4
- Preventive care 4
- Physician services 5
- Hospital services 6
- Your Humana plan provides: 6
- Durable medical equipment 7
- Home health services 7
- Hospice services 7
- Physical, occupational, and speech therapies 7
- Skilled nursing facility services 7
- Urgent care 7
- Behavioral health services 8
- X-ray and laboratory 8
- Maternity services 8
- Transplants 8
- Prescription drugs 8
- Emergency care services 9
- Ambulance services 10

Facility-based physician disclosure 11

Your financial responsibilities 11

Limitations and exclusions 11

Preauthorization requirements 12

Utilization management 13

Continuity of care 13

Complaint and Appeals Procedures 14

Member coverage 17
- Open enrollment 17
- Dependent coverage 17

Loss of coverage 17
Effective date of coverage 17
Plan status change 17
Keep us up to date 17

Plan provisions 18
Continuation of benefits 18
Coordination of benefits 18
Filing a claim 18

Your rights and responsibilities 19
It's your responsibility to: 19

Provider Network Information 20
Attention Female Enrollees 20

Notice of rights 21

Service area (Humana Houston HMOx Network) 22

Member demographic information 23

This communication provides a general description of certain insurance benefits provided under one or more of our health benefit plans. Our health benefit plans have exclusions and limitations and terms under which the coverage may be continued in force or discontinued. Please note, the terms deductible and coinsurance within this document are applicable to Consumer Choice plans only.

For complete plan details, refer to the Evidence of Coverage or contact our Customer Care department. In the event of any disagreement between this communication and the Evidence of Coverage, the Evidence of Coverage will control. Prospective members can view a sample Evidence of Coverage on **Humana.com**. Plan specific information is also provided on the Summary of Benefits and Coverage (SBC). Prospective members can contact the benefits coordinator of their employer for a copy of the SBC. Members can access their plan specific SBC and Evidence of Coverage through MyHumana on **Humana.com**.

Offering company statement

This Humana HMO Plan is a Health Maintenance Organization (HMO) plan offered by Humana Health Plan of Texas, Inc.

Important phone numbers

As a Humana member, you can call our Customer Care department toll-free at the number on the back of your Humana member ID card when you have questions about your plan. We make every effort to answer your calls quickly. Our hours are 8 a.m. – 6 p.m., Monday – Friday. If you have comments on our service or ideas on how we can improve, please call 800-448-6262 (TTY: 711) or write to:

Humana Health Plan of Texas, Inc.
Claims Office
P.O. Box 14601
Lexington, KY 40512-4601

Humana ID card

You'll be issued a Humana member ID card to show that you're a member of the plan. Be sure to carry it with you at all times. You'll need to present the card anytime you receive medical care. If your Humana member ID card is lost or damaged, you can get a new one on MyHumana or by calling our Customer Care department at 800-448-6262 (TTY: 711).

Special needs

Humana strives to make it easy for all members to use the benefits provided by their plan. If you need help due to a disability or chronic medical problem that has affected your vision, hearing, speech or mobility, please call our Customer Care department at the number on the back of your Humana member ID card. If you use TTY, call 711.

MyHumana

MyHumana is your secure, personal online member account on **Humana.com**. It's one of the best ways to get information about your plan. With MyHumana, you can get answers to questions about your health plan when you want them. You can look up records 24 hours a day. Here are some of the things you can do on MyHumana:

- Find in-network providers
- Look at your health plan benefits
- See if a claim has been paid
- Compare costs of medical services
- Explore health and wellness information

It's easy to register. Have your Humana member ID card ready when you go to **Humana.com**. Select "Register now," then follow the brief directions.

How to use your Humana plan

With this Humana HMO Plan, you have the freedom to use any provider in your plan's network.

The Evidence of Coverage describes health coverage for covered healthcare services provided by in-network providers. We will cover services you receive from your primary care physician (PCP), or from an in-network provider with a primary care physician (PCP) referral. The Evidence of Coverage also describes health coverage for covered healthcare services provided by out-of-network providers in limited circumstances.

Get the most from your healthcare coverage by knowing your plan and following these simple guidelines:

- Always carry your Humana member ID card and show it when you receive medical care.
- Choose a primary care physician (PCP) from your plan’s network for yourself and each enrolled dependent.
- If you need specialized care, your primary care physician (PCP) will refer you to a network specialist.
- In an emergency, always go to the nearest emergency facility. Refer to your Evidence of Coverage for benefit information.
- Let us know immediately about changes that affect your coverage. You must tell us if you move, marry, divorce, or add a child. Call our Customer Care department for an enrollment change form. If you use a TTY, call 711.

Please read your Summary of Benefits and Coverage (SBC) and the Evidence of Coverage for details to help you get the most out of your plan.

Provider relationships

Our relationship with qualified providers

A qualified provider means a healthcare provider that is licensed by the appropriate state agency to provide preventive care, diagnose, or treat an illness or injury, provides such services within the scope of their license, and whose primary purpose is to provide healthcare services. Qualified providers are not our agents, employees, or partners. All providers are independent contractors. Qualified providers make their own clinical judgments or give their own treatment advice without coverage decisions made by us.

The master group contract will not change what is decided between you and qualified providers regarding your medical condition or treatment options.

Qualified providers act on your behalf when they order services. All decisions related to your care are the responsibility of you and the healthcare providers you choose to care for you, regardless of any coverage determination(s) we have made or will make. We are not responsible for anything said or written by a qualified provider about covered health services and/or what is not covered. If you have any questions, call our Customer Care department at the telephone number listed on your ID card. If you use TTY call, 711.

Our financial arrangements with in-network providers

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

- Many in-network providers are paid on a discounted fee-for-services basis, meaning they have agreed to be paid a set amount for each covered health service given to a covered person.
- Some in-network providers may have capitation agreements, meaning they are paid a set dollar amount each month to care for each covered person no matter how many services a covered person may receive from that in-network provider, such as a primary care physician (PCP) or a specialty care physician.
- In-network hospitals may be paid on a Diagnosis Related Group (DRG) basis or flat-fee-per-day basis for services provided to covered persons while confined in a hospital. In-network outpatient services are usually paid on a flat fee per service, or flat-fee-per-procedure or a discount from normal charges.

You are responsible to pay any deductible, coinsurance, and copayment to a provider for covered health services you receive. In-network providers have agreed to accept discounted or negotiated fees for covered health services and will not bill you for charges in excess of the negotiated fees.

Highlights of your plan

Your Humana HMO plan provides coverage for a wide range of services, including:

- Preventive care
- Physician services (PCP and Specialist)
- Hospital services
- Durable medical equipment
- Home health services
- Hospice services
- Physical, occupational, and speech therapy
- Skilled nursing facility services
- Urgent care
- Behavioral health services
- X-ray and laboratory
- Maternity services
- Transplants
- Prescription drugs
- Emergency care
- Ambulance services

A brief description of the above-listed benefits is provided below. This is not a complete list or description of all of your benefits. For complete details about covered health services, refer to your Evidence of Coverage. Prospective members can view a sample Evidence of Coverage on **Humana.com**.

Preventive care

Your plan includes coverage for preventive care, such as:

- A health risk assessment
- Routine physical exams
- Well-child care
- Necessary immunizations - It's important for you and your family to get all of your immunizations because they help the body fight disease. Children may need certain immunizations before they can start school. Your child's physician will tell you when immunizations are required.
- An annual well-woman exam
- Prostate cancer detection exam

Physician services

- **Choosing or changing your primary care physician (PCP)**

Your Humana HMO Plan requires you to select a primary care physician (PCP) for yourself and each enrolled dependent. If you do not choose a primary care physician (PCP), we will assign you one. The primary care physician (PCP) is your personal doctor who can get to know you and your medical history and is responsible for coordinating all of your healthcare, except emergency care or services from an obstetrician/gynecologist. You can change your primary care physician (PCP) anytime. This physician can get to know you and your medical history and give you health advice. Typically, this is a physician who is a family practitioner, pediatrician or who specializes in internal medicine. This physician can:

- Provide most of your medical care
- Keep your medical records
- Guide you when you need special care

There is a "Find a doctor" tool on **Humana.com** and on your personal MyHumana page that you can use to choose a primary care physician (PCP) in your plan's network. You may also request a printed copy of a physician list or get help finding an in-network physician, by calling our Customer Care department at 800-448-6262 (TTY: 711). The physician list for your network includes service areas, by county or ZIP code, and listings of facilities and PCPs along with their addresses and contact information. The physician list is subject to change. Due to the possibility of in-network providers changing status, be sure to check the physician list online or call our Customer Care department prior to obtaining services.

- **Visiting your primary care physician (PCP)**

Whenever you need to see your PCP, simply call the PCP's office and make an appointment. If you're going to be late for an appointment, call the office and tell them. If you can't keep an appointment, call the office as soon as possible to reschedule. Please try to give notice at least 24 hours in advance or you may be billed by a provider based on their cancellation rules. You should make an appointment to meet your PCP to review your general health. This gives your PCP the chance to get to know you and your medical history. After your first visit, your PCP may recommend a checkup or a routine appointment. Your PCP may determine if you need specialist services.

- **Specialized care**

Your plan covers a wide range of specialized medical services. When you need specialized care, your primary care physician (PCP) will refer you to an in-network specialist. Remember: depending on your plan, you may have to pay all or a greater portion of the bill if you receive specialized care without your primary care physician (PCP) authorization (except for emergency care or services received from an in-network obstetrician or gynecologist), or if such care is not a covered service.

- **Telehealth and Telemedicine services**

This plan covers telehealth and telemedicine services for the diagnosis and treatment of an illness or bodily injury. Telehealth and telemedicine services must be for services that would otherwise be a covered health service if provided during a face-to-face consultation between you and healthcare provider.

- **Access to services after hours**

If you have medical questions or concerns, you can call your physician's office 24 hours a day, seven days a week.

- **Outpatient care**

Covered healthcare services are subject to the limitations and exclusions in your plan. Office visits, diagnostic lab tests and X-rays, and outpatient surgery are included in plan coverage.

- **Network changes**

To get the most from your health plan coverage, make sure the physician you choose currently participates in your plan's network and will accept new patients. Visit **Humana.com** and select "Find a doctor." Complete the required information on the "Find a doctor" page to perform a search for in-network providers. If you prefer, call our Customer Care department at the number on the back of your Humana member ID card, if you use TTY, call 711.

Hospital services

If you need hospital care, you must have a referral from your primary care physician (PCP) prior to seeking care from any in-network hospital. A physician other than your primary care physician (PCP) may direct and oversee your hospital care. Additionally, your plan may require, as a condition of coverage, that certain medical conditions be treated at specific facilities.

Your Humana plan provides:

- **In-network inpatient care**

- As many days as medically necessary, in a semi-private room (private room when authorized by your physician due to medical necessity).
- Preadmission testing.
- Services and supplies.
- Services from a healthcare provider, who directs your care while you're in an inpatient facility.

- **In-network outpatient care**

- Outpatient surgery
- Outpatient diagnostic services

Durable medical equipment

Durable medical equipment means equipment that meets all of the criteria listed in your Evidence of Coverage. Coverage may be provided for rental or purchase of durable medical equipment. If the cost of renting the equipment is more than its purchase price, only the cost of the purchase will be covered. However, certain items aren't covered, including tub chairs, elastic supports and environmental control items. You may obtain the preauthorization list online at **Humana.com/pa**l or call our Customer Care department at 800-448-6262 (TTY: 711) to confirm coverage and preauthorization requirements.

Home health services

Humana's Utilization Management department or our contracted utilization review agent, along with your physician, arranges:

- Home nursing care
- Medical social work
- Nutrition services
- Physical, occupational, respiratory, and speech therapies

Your healthcare providers and Humana will help you to determine what home healthcare needs are medically necessary and covered under your plan.

Nursing care must be by or under the supervision of a registered nurse or licensed practical nurse. Medically necessary appliances and equipment and laboratory services also may be covered. Review your Evidence of Coverage for applicable limitations of this benefit.

Hospice services

Inpatient and outpatient hospice services are a covered benefit. Refer to your Evidence of Coverage for more information.

Physical, occupational, and speech therapies

Your plan covers rehabilitative services including physical, occupational, and speech therapies. Preauthorization may be required. Therapy is covered only if that treatment, in the judgment of your physician, will significantly improve your condition. Review your Evidence of Coverage for applicable limitations of this benefit.

Skilled nursing facility services

For details and limitations on care in a skilled nursing facility, including physician visits during your stay, refer to your Evidence of Coverage. Custodial care isn't covered.

Urgent care

If you have an illness or bodily injury requiring prompt medical attention, but it isn't an emergency or a life-threatening situation, you may want to see your primary care physician (PCP) or go to an urgent care facility near you.

Behavioral health services

Your plan covers services for inpatient and outpatient mental healthcare, serious mental illness and chemical dependency. Refer to your Evidence of Coverage for more information.

X-ray and laboratory

Your plan covers:

- Diagnostic X-ray exams and imaging
- Lab tests and analysis for diagnosis or treatment
- Radiation therapy

Some X-ray and lab services may require preauthorization. Call our Customer Care number at 800-448-6262 (TTY: 711) to verify.

Maternity services

Hospital room and board (semi-private accommodation), services and supplies while confined in the hospital, and physician care are covered under the plan. This includes the cost and administration of anesthetics. Coverage also includes prenatal and postnatal care and medically necessary testing in a physician's office.

HumanaBeginnings® is dedicated to helping Humana members make healthy decisions throughout pregnancy. The program combines personal contact with a registered nurse and informative mailings. Members can:

- Find out more about their pregnancy
- Follow their baby's development
- Receive guidance about healthy habits to practice along the way

If you'd like more information about HumanaBeginnings®, or if you're a Humana member who's expecting a baby, call us toll-free at 888-847-9960 (TTY: 711).

Transplants

You or your physician must call Humana's Transplant Management Department at 866-421-5663 (TTY: 711) as soon as you, or a covered dependent, make the decision to proceed with a covered transplant. The Transplant Management Department will provide assistance and coordinate all of your covered transplant services with an approved Transplant facility. This will maximize the benefits of your health plan. Review your Evidence of Coverage for applicable limitations of this benefit.

Prescription drugs

To have a prescription filled, simply go to any in-network pharmacy and show your Humana member ID card. You are required to pay a copayment or a portion of the drug cost for each prescription based on the assigned level of the drug as specified on the drug list. You can obtain a copy of the drug list at **Humana.com/druglist** or call our Customer Care department at the number on the back of your Humana member ID card, if you use TTY, call 711. Information on the drug list may change at the renewal of the

group plan. We will provide written notice no later than 60 days prior to the effective date of the change.

Descriptions of the various prescription drug benefits are provided below. To determine which prescription drug benefit is applicable to your plan, please review the plan materials provided to you, including your Evidence of Coverage. As a member, you can also visit **Humana.com** and sign in to MyHumana to view your cost-share for prescription drug benefits.

- **Rx3 Prescription Drug Benefit**

Covered prescription drugs are assigned to one of three different levels with corresponding copayment or coinsurance amounts. Specialty drugs are also indicated. The levels are organized as follows:

- **Level One**: Includes generic drugs
- **Level Two**: Includes preferred brand-name drugs
- **Level Three**: Includes higher-cost brand-name drugs
- **Specialty Drugs**: High-cost/high-technology drugs that often require special dispensing conditions.

- **Rx4 Prescription Drug Benefit**

Covered prescription drugs are assigned to one of four different levels with corresponding copayment or coinsurance amounts. Specialty drugs are also indicated. The levels are organized as follows:

- **Level One**: Includes low-cost generic drugs and brand-name drugs
- **Level Two**: Includes higher-cost generic drugs and brand-name drugs
- **Level Three**: Includes high-cost, mostly brand-name drugs. These drugs may have generic drug or brand-name drug alternatives in Levels One or Two.
- **Level Four**: Includes highest-cost drugs
- **Specialty Drugs**: High-cost/high-technology drugs that often require special dispensing conditions.

DISPENSE AS WRITTEN: If you request a brand-name drug when an equivalent generic drug is available, your cost may be greater. Refer to the Evidence of Coverage for specific benefit information.

Emergency care services

- **What is emergency care?**

Emergency care means services provided in an emergency facility, free-standing emergency medical care facility or a comparable emergency facility to evaluate and stabilize an emergency medical condition. Emergency care does not mean services for the convenience of the covered person or the provider of treatment or services.

Emergency medical condition means a recent onset of a bodily injury or illness manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

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

- **Seeking emergency care**

When seeking emergency care, you should:

- Go to the nearest emergency facility, free-standing emergency medical care facility, or comparable emergency facility.
- If you're admitted to an out-of-network hospital after emergency care, you or someone acting on your behalf must contact us within 48 hours of your admission.

- **Out-of-area coverage**

- The service area is the area where the plan provides coverage. You and your eligible dependents must live or work in the service area to be eligible for coverage.
- Your Humana plan covers emergency care in and out of the service area. If you have an emergency, you should go to the nearest emergency facility or call 911 for help.
- Care for problems that aren't emergencies are not covered outside of the service area.

For details about emergency care coverage, refer to your Evidence of Coverage. After receiving emergency care, It's a good idea to notify your physician and Humana within 48 hours, or as soon as possible. Call Humana at 800-448-6262 (TTY: 711).

Ambulance services

- Ambulance service means transportation to, from, or between medical facilities for an emergency medical condition. For details about Ambulance services, refer to your Evidence of Coverage.

The information above is not a complete list or description of all of your benefits. Not all services or supplies your physician may order or suggest are covered benefits under your plan. This is the case even when your physician refers you to other in-network providers for services. For complete details about covered health services, refer to your Evidence of Coverage. Prospective members can view a sample Evidence of Coverage on **Humana.com**.

Facility-based physician disclosure

Although covered health services may be provided to you at an in-network healthcare treatment facility, such services may be provided by a facility-based physician or other healthcare practitioner who is not an in-network provider. Covered health services provided by a facility-based physician or other healthcare practitioner may include emergency medicine, anesthesiology, pathology, radiology, neonatology, diagnostic laboratory and radiology services. If you receive a bill from an out-of-network facility-based physician or other out-of-network healthcare practitioner for amounts not paid by the plan, contact us by calling our Customer Care department at 800-448-6262 (TTY: 711).

Your financial responsibilities

- **Covered health services**

You are responsible to pay any deductible, coinsurance, and copayment to a provider for covered health services you receive. In-network providers have agreed to accept discounted or negotiated fees for covered health services and will not bill you for charges in excess of the negotiated fees. Plan specific deductibles, coinsurance and copayments are provided in the Summary of Benefits and Coverage (SBC) for prospective members and on the Schedule of Benefits in the members' Evidence of Coverage. Prospective members can obtain the SBC from the benefits coordinator of their employer or insurance agent. Members can view their plan specific Evidence of Coverage by accessing MyHumana on **Humana.com**.

- **Non-covered health services**

If you obtain non-covered health services, whether from an in-network provider or an out-of-network provider, you're responsible for making the full payment to the healthcare provider. Covered health services provided by an out-of-network providers are non-covered health services, except for emergency care services or as otherwise required by applicable law. Refer to your Evidence of Coverage for complete information. Prospective members can view a sample Evidence of Coverage on **Humana.com**.

Limitations and exclusions

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

- Treatments, services, supplies, or surgeries that are not medically necessary, except for preventive services.
- An illness or bodily injury that is covered under any Workers' Compensation or similar law. This limitation also applies to a covered person who is not covered by Workers' Compensation and lawfully chose not to be.
- Care and treatment given in a hospital owned or run by any government entity, unless you are legally required to pay for such care and treatment. However, care and treatment provided by military hospitals to covered persons who are

armed services retirees and their dependents are not excluded.

- Any service you receive while you are confined in a hospital or institution owned or operated by the United States government or any of its agencies for any illness or bodily injury connected to military service.
- Services, or any portion of a service, you would not be required to pay for, or would not have been charged for, in the absence of this coverage.
- Illness or bodily injury for which you are paid or entitled to payment or care and treatment by or through a government program.
- Any service not ordered by a healthcare practitioner.
- Any drug, biological product, device, medical treatment, or procedure which is experimental or investigational or for research purposes except for clinical trials.
- Legend drugs, which are not deemed medically necessary by Humana.
- Prescription drugs not included on the drug list.

- Drugs not approved by the FDA.
  - Any drug prescribed for intended use other than for indications approved by the FDA or off-label indications recognized through peer-reviewed medical literature.
  - Any drug prescribed for an illness or bodily injury not covered under the plan.
  - Any drug, medicine, or medication that is either labeled "Caution-limited by federal law to investigational use" or experimental, investigational or for research purposes, even though a charge is made to you.
  - Any prescription fill or refill for drugs, medicines, or medications that are lost stolen, spilled, spoiled, or damaged.

This is not a complete list of the plan's Limitations and Exclusions. For a complete listing, refer to your Evidence of Coverage. Prospective members can view a sample Evidence of Coverage on **Humana.com**.

Preauthorization requirements

Humana requires preauthorization for some services, supplies and procedures your physician or healthcare provider may recommend for you. Visit **Humana.com/pal** to receive a list of services that require preauthorization or call our Customer Care department number on the back of your ID card, If you use TTY, call 711. This list is subject to change and notification of changes are provided as required by state law. Benefits are not paid at all for services or supplies that are not covered health services. Preauthorization is not required for emergency care or any other services not permitted to be preauthorized by law.

Preauthorization means your in-network provider will contact Humana before you receive services. Humana does this to determine whether the service or procedure qualifies for payment under your benefit plan. Some network providers may qualify for

an exemption from the preauthorization requirements as required by state law. You and your healthcare provider decide whether you should have the services or procedures. If any required preauthorization is not obtained by the network provider payment for the services or supplies may be reduced or denied. An in-network provider cannot bill you for services or supplies that are reduced or denied when preauthorization is required and not obtained.

Renewal of an existing preauthorization may be requested up to sixty days prior to the expiration of the existing preauthorization.

Utilization management

The Humana call center or a utilization review agent contracted with Humana manages calls from healthcare providers to fulfill the requirements of notification and preauthorization of members' inpatient admissions. Certain procedure or durable medical equipment (DME) requests may require review to determine coverage.

Humana contracts with various utilization review companies (utilization review agents) to assist with preauthorization reviews, concurrent reviews or retrospective reviews. Concurrent review is the process that determines coverage during the length of stay in the hospital/acute rehab/skilled nursing facility. Retrospective review is the process to determine coverage of inpatient services when prospective preadmission notification and other reviews aren't obtained. When this occurs, the claim information for an inpatient stay that is not preauthorized is directed to the Utilization Management Department or to one of Humana's contracted utilization review agents. If we deny services based on an adverse determination of medical necessity, you can appeal the decision. Refer to the "Complaint and Appeals Procedures" section within this handbook.

If you have questions or concerns or wish to contact the utilization review agent conducting your review you may contact Humana at 800-448-6262 (TTY: 711) to obtain information on how to contact either the Utilization Review Department at Humana or the agent assigned by Humana to conduct your specific utilization review or preauthorization. You can find an updated preauthorization list on **Humana.com/pal**.

Continuity of care

If special circumstances apply, you may be eligible to elect continuity of care as of the date the following events occur:

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

If you elect continuity of care, we will apply the network provider benefit level to covered health services related to your treatment as a continuing care patient. You will only be responsible for the network provider copayment, deductible and/or coinsurance for services related to a special circumstance while continuity of care is in effect. Continuity of care will end upon the earlier of:

- 90 days from the date we notify you the qualified provider is no longer a network provider.
- 90 days from the date we notify you the terms of a network provider's participation in the network changes in a manner that terminates a benefit for a service you are receiving as a continuing care patient.
- 90 days from the date we notify you this master group contract terminates.
- In the case of a pregnancy, through the delivery of a child, including immediate post-partum care and follow-up visit within the first six weeks of delivery.
- In the case of a terminal illness, nine months from the date we notify you the qualified provider is no longer a network provider, or nine months from the date we notify you the terms of a network provider's participation in the network changes in a manner that terminates a benefit for a service you are receiving as a continuing care patient; or
- The date you are no longer a continuing care patient.

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

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

Continuity of care is not available if:

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

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

Complaint and Appeals Procedures

If you have a complaint

We want you to be happy with your Humana plan. If you aren't satisfied with the healthcare or services you receive, please call our Customer Care department at 800-448-6262 (TTY: 711). If you're not satisfied with the results of your call, you can file a formal complaint by writing to:

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

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

Please refer to the information below when filing a formal complaint.

Complaint procedures

"Complaint" means any dissatisfaction you express orally or in writing to us about any aspect of our operation. This includes, but isn't limited to:

- Dissatisfaction with plan administration
- How we provide a service
- Disenrollment decisions
- Procedures related to the review or appeal of an adverse determination
- Procedures related to the denial, reduction or termination of a service for reasons not related to medical necessity.

A complaint isn't a misunderstanding or a problem of misinformation that's resolved by supplying appropriate information to your satisfaction. It also doesn't include adverse determinations.

If you notify us of a complaint, we will send you a letter acknowledging the date we received the complaint within five business days of the receipt of the complaint. The letter will include Humana's complaint procedures and time frames for resolution.

If the complaint was received by phone, we will send you a one-page complaint form clearly stating the form must be returned to us for prompt resolution of the complaint. After receipt of the written complaint or one-page complaint form from you, we will investigate and send you a letter with our resolution within 30 days of our receipt of the complaint.

If the complaint is not resolved to your satisfaction, you have the right to appear in person or address a written appeal to a complaint appeal panel. Notice of our final decision will be provided within 30 calendar days from receipt of the request for a complaint appeal panel.

Internal appeal of adverse determination

"Adverse determination" means a determination by Humana or a utilization review agent that healthcare services provided or proposed to be provided to a member are:

- Not medically necessary
- Not Appropriate
- Experimental or investigational, or
- Are protected under the Federal No Surprises Act.

Adverse determination does not include a denial of healthcare services due to the failure to request prospective or concurrent utilization review.

The member, anyone acting on the member's behalf or provider has the right to appeal an adverse determination. When we receive an appeal, we will, within five business days from the receipt of the appeal, send a letter to the appealing party 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 verbally, a one-page appeal form will be included with an acknowledgment letter to the appealing party.

After review of the appeal of the adverse determination, we'll issue a response letter to the member or a person acting on behalf of the member and the member's physician or healthcare provider.

This letter will explain the resolution of the appeal as soon as is practical. This will take place before the 30th calendar day from when we receive the appeal.

If the appeal is for emergency care, denial of a continued stay for hospitalized patients, or denial of prescriptions drugs or intravenous infusions, we'll base the time frame for resolution on the medical or dental immediacy of the condition, procedure or treatment. This won't exceed one working day from the date we receive all information necessary to complete the appeal. The resolution letter will contain the clinical basis for the appeal's denial, the specialty of the healthcare practitioner making the denial, and notice of the claimant's right to seek review of the denial by an Independent Review Organization.

Filing complaints with the Texas Department of Insurance

Any person, including persons who have attempted to resolve complaints through our complaint and appeal process and who aren't satisfied with the resolution, can get help with a question or file a complaint with the state:

Call with a question: 800-252-3439
File a complaint: **www.tdi.texas.gov**
Email: **ConsumerProtection@tdi.texas.gov**
Mail: Texas Department of Insurance
Consumer Protection Section
MC: CO-CP
P.O. Box 12030
Austin, TX 78711-2030

The Texas Department of Insurance will investigate a complaint against us to determine compliance. This will happen within 60 days of the Texas Department of Insurance's receipt of the complaint and all information necessary for the department to determine compliance. The commissioner may extend the time necessary to complete an investigation if:

- Additional information is necessary
- We, the provider or the member doesn’t provide all documentation necessary to complete the investigation
- An on-site review is necessary
- Other circumstances beyond the control of the department occur

External appeal to an Independent Review Organization (IRO)

An Independent Review Organization (IRO) process is available to you. Refer to your Evidence of Coverage for the IRO process.

Member coverage

Open enrollment

Employers usually set aside time for changing from one healthcare plan to another or for making changes in coverage. At other times, changes in your enrollment can generally be made if:

- You lose your group health plan coverage
- Your family size changes due to marriage, divorce, or birth or adoption of a child

Enrollment changes for these reasons must generally be made within 31 days of the event. Check with your employer for group-specific provisions.

Dependent coverage

Eligible dependents generally include your spouse and children up to a specified age. Check your Evidence of Coverage for more information.

Loss of coverage

With some Humana plans, you may lose your coverage if you move from the plan service area. Humana can remove you from the plan if you:

- Fail to pay plan premiums
- Commit fraud or make an intentional misrepresentation of a material fact

Effective date of coverage

Your effective date of coverage, and when you are first eligible to receive plan benefits, is determined by your employer. Ask your personnel office or benefits administrator for information about your effective date.

Plan status change

If you have individual coverage with your employer and want to change to the family plan, you must notify your employer of the new change within the number of days specified in your Evidence of Coverage. Please ask your employer about changes in coverage.

Keep us up to date

Please notify our Customer Care department whenever there's a change in your name, address, or telephone number.

Plan provisions

Continuation of benefits

If your group coverage ends, you may be allowed to continue coverage through your employer. Ask your company's benefits administrator or refer to your Evidence of Coverage.

Coordination of benefits

If you or your family members are covered by more than one healthcare plan, you can't collect full benefits from both plans. In this case, Humana will work with the other plan to decide which plan will have primary responsibility for paying for your medical care. To help us do this, we may ask you for information about other coverage you may have.

Remember that each healthcare plan may require you to follow certain rules or use specific physicians and hospitals. It may be impossible to comply with both plans at the same time. Be sure to read and understand the rules for any healthcare plan that covers you or your family.

Filing a claim

In-network providers will submit claims to us on your behalf. If you receive emergency care outside the service area, you may be asked to pay the out-of-network provider directly and submit a notice of claim to Humana. In that case, you should obtain a receipt, an itemized statement and any medical records associated with your care. The forms necessary for filing these claims are available on **Humana.com**.

Submit copies of these to the Humana Claims department at:

Humana Claims Office
P.O. Box 14601
Lexington, KY 40512-4601

Within 15 business days of receiving satisfactory proof-of-loss, we will provide you with a written notice of our decision to accept or reject a claim or provide reasons why additional time is needed to make a decision. A decision will be made within 45 days of the date of our letter. If the claim is accepted, it will be paid in whole or in part within five days of the written approval notice you receive.

If your claim is denied and you aren't reimbursed, you may ask to have the claim reviewed. If you have any questions about the review procedure, call our Customer Care department.

Your rights and responsibilities

As a Humana member, you have certain rights and responsibilities.

You have the right to:

- Be provided with information about your Humana plan, its services and benefits, its providers and your member rights and responsibilities.
- Choose or change a physician from Humana's provider network.
- Privacy and confidentiality regarding your medical care and records. Records pertaining to your healthcare will not be released without your, or your authorized representative's, written permission, except as permitted or required by law.
- Discuss your medical record with your physician and receive, upon request, a summary copy of that record.
- Be informed of your diagnosis, treatment choices including non-treatment and prognosis in terms you can reasonably expect to understand and to participate in decision-making about your healthcare and treatment plan.
- Have a candid discussion with your physician about appropriate or medically necessary treatment options for your conditions, regardless of cost or benefit coverage.
- Expect reasonable access to medically necessary healthcare services regardless of race, national origin, religion, physical abilities or source of payment.
- File a formal complaint, as outlined in the plan's appeal procedure, and to expect a response to that complaint within a reasonable period of time.
- Be treated with courtesy and respect with appreciation for your dignity and protection of your right to privacy.
- Participate in wellness programs.
- Receive assistance from Humana's Customer Care specialists to address your concerns and questions.

It's your responsibility to:

- Give Humana and your healthcare provider complete and accurate information as needed to arrange care for you.
- Read and be aware of all material distributed by Humana about the plan explaining policies and procedures regarding services and benefits.
- Obtain and carefully consider all information you may need or desire to give informed consent for a procedure or treatment.
- Follow the treatment plan agreed on with your healthcare provider and to weigh the potential consequences of any refusal to observe those instructions

or recommendations.

- Be considerate and cooperative in dealing with the plan providers and to respect the rights of other plan members.
- Schedule appointments, arrive on time for scheduled visits and notify your healthcare provider if you must cancel or be late for a scheduled appointment.
- Express opinions, concerns or complaints in a constructive manner.
- Tell us in writing if you move or change your address or phone number, even if these changes are only temporary.
- Pay all applicable copayments, deductibles, and/or premiums by the date when they are due.
- Be honest and open with your physician and report unexpected changes in your condition in a timely fashion.
- Follow healthcare facility rules and regulations affecting patient care and conduct.
- Carry your Humana member ID card with you at all times and use it while enrolled in the Humana plan.

Provider Network Information

A current list of in-network providers, including behavioral health and substance abuse providers can be found online at **Humana.com** with the "Find a doctor" tool. You also may request a printed copy of the physician list by calling our Customer Care department at 800-448-6262 TTY (711). We offer many healthcare plans. A provider that is an in-network provider for one plan may not be an in-network provider for your plan. It is important for you to ensure the physician list is specific for the provider network listed on your ID card. The physician list includes names, locations and contact information for all physicians and providers in your network, the physicians and providers that may require a referral (certain specialists, for example), and whether new patients are being accepted. Please note, the in-network physician list is subject to change. Due to the possibility of in-network providers changing status, be sure to check the online physician list of in-network providers or call Customer Care department prior to obtaining services.

Attention Female Enrollees

Right to designate an obstetrician or gynecologist

This notice is being provided to advise the member of rights under Texas Insurance Code, Chapter 1451 Subchapter F:

You have direct access to receive gynecological and obstetrical care from an in-network obstetrician or gynecologist (OB/GYN). You may elect to receive your OB/GYN services from your primary care physician (PCP).

Notice of rights

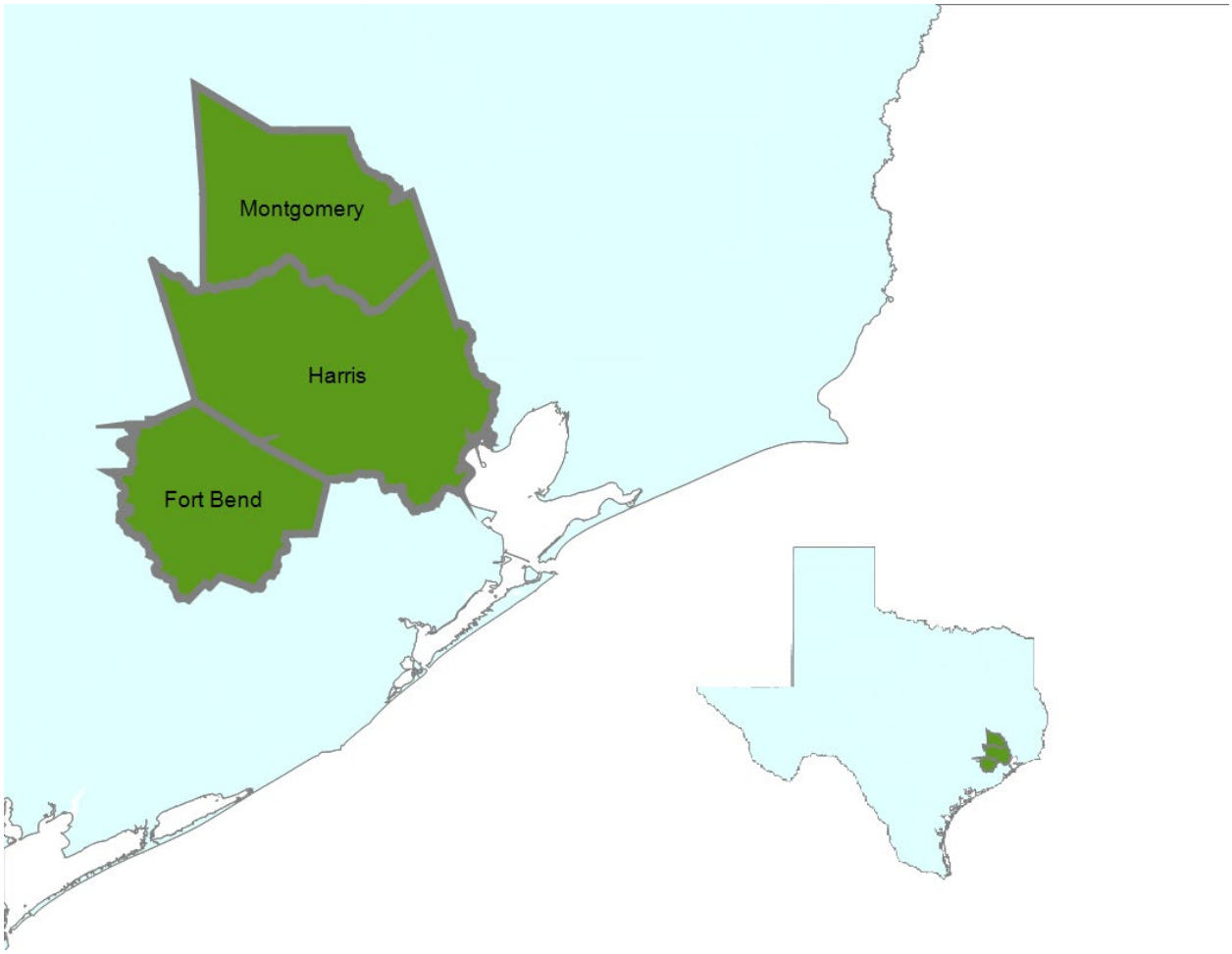
A health maintenance organization (HMO) plan provides no benefits for services you receive from out-of-network healthcare practitioners or out-of-network providers, with specific exceptions as described in your Evidence of Coverage and below:

- You have the right to an adequate network of in-network physicians and providers (known as in-network healthcare practitioners and in-network providers).
- If you believe that the network is inadequate, you may file a complaint with the Texas Department of Insurance at **tdi.texas.gov/consumer/complfrm.html.**
- If your HMO approves a referral for out-of-network services because no in-network healthcare practitioner or in-network provider is available, or if you have received out-of-network emergency care, the HMO must, in most cases, resolve the out-of-network healthcare practitioner's or out-of-network provider's bill so that you only have to pay any applicable in-network copayment, coinsurance, and deductible amounts.
- You may obtain a current directory of in-network healthcare practitioners or in-network providers at **Humana.com** or by calling our Customer care department at the telephone number shown on your ID card, if you use TTY, call 711 for assistance in finding available in-network healthcare practitioners or out-of-network providers. If you relied on materially inaccurate directory information, you may be entitled to have a claim by an out-of-network healthcare practitioner or out-of-network provider paid as if it were from an in-network healthcare practitioner or in-network provider, if you present a copy of the inaccurate directory information to the HMO, dated not more than 30 days before you received the service.

Service area (Humana Houston HMOx Network)

Service area means the geographic area designated by us and approved by the Department of Insurance of the state in which the master group contract is issued and in-network provider services are available to covered persons. The Humana Houston HMOx Network service area in Texas includes the county in the following Region:

Region 6 - Gulf Coast: Fort Bend; Harris; Montgomery



Member demographic information

Provider network demographic information (Humana Houston HMOx Network)

Number of insureds by geographic region

- Region 6: 158

Number of in-network providers for the following areas of practice by geographic region

Region 6:

- Internal medicine practitioners: 307
- Family/General practitioners: 613
- Pediatricians: 529
- Obstetricians and Gynecologists: 375
- Anesthesiologists: 982
- Psychiatrists: 474
- General Surgeons: 242

Number of in-network hospitals by geographic region

- Region 6: 26 Refer to access plan

Waivers or local market access plans (Humana Houston HMOx Network)

If the "Provider network demographic information" states "Refer to access plan" for an in-network provider or hospital in a region, the access plan can be viewed on our website **Humana.com** under "Find a doctor" page and selecting "View printed directories." For assistance in obtaining a copy of an access plan, call our Customer Care department phone number on the back of your Humana ID card, if you use TTY, call 711.