Your Benefit Plan Document

HUMANA.
Guidance when you need it most

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

Certificate of Coverage
Humana Health Plan of Texas, Inc.

Group Plan Sponsor:

SAN ANTONIO INDEPENDENT SCHOOL DISTRICT

Group Plan Number: Q5259 **Plan:** 075 **Option:** 723

Effective Date: 11/01/08

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

Michael B McCallister
President

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

H200200TX 07/07

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

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

1-866-4ASSIST

3. You may also write Humana Health Plan of Texas Inc. at:

San Antonio Service Center
P.O. Box 14614
Lexington, KY 40512-4614

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

1-800-252-3439

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

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

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

H200300TX

AVISO IMPORTANTE
Para obtener informacion o para someter una queja:

Usted puede llamar al numero de telefono gratis de Humana Health Plan of Texas Inc. s para informacion o para someter una queja al:

1-866-4ASSIST

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

San Antonio Service Center
P.O. Box 14614
Lexington, KY 40512-4614

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

1-800-252-3439

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

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

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

IMPORTANT NOTICE

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

1-800-832-9623

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

H200301TX

AVISO IMPORTANTE

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

1-800-832-9623

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

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UNDERSTANDING YOUR COVERAGE

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

How to use your certificate

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

Please note the provisions and conditions of this *certificate* apply to *you* and to each of *your* covered *dependents.*
H202000 01/06

Covered and non-covered expenses

Benefits are subject to the specific conditions, limitations and applicable maximums of the *certificate* and are payable only if services are considered *covered health services.*

A *covered health service* is deemed to be obtained on the date a covered service is performed or a covered supply is furnished. The bill submitted by the provider, if any, will determine which benefit provision is applicable for payment of *covered health services.*

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

Please refer to the "Schedule of Benefits," the "Covered Health Services" and the "Limitations and Exclusions" sections of this *certificate* for more information about benefits. Also, be sure to check *your certificate* for any attached amendments or supplemental benefit riders that may modify *your* benefits.
H202100TX 05/05

How to find a network provider

An online directory of *network providers* will be made available to *you* and accessible via the Internet on *our* Website at www.humana.com at the time of *your* enrollment. This directory is subject to change. Due to the possibility of *network providers* changing status, please check the online directory of *network providers* prior to obtaining services. If *you* do not have access to the online directory, *you* may telephone *our* customer service center prior to services being rendered or to request a directory.
H202200 05/05

Use of network providers

In most instances, there are *network providers* available to provide *medically necessary* health care services. *Network providers* have agreed to accept discounted or negotiated fees. *You* will not be billed by *network providers* for charges in excess of the negotiated fees. *You* are responsible to pay the *network provider* for any applicable *deductible, coinsurance* and/or *copayment* for services received.

When receiving services from *network providers*, *you* should make sure the provider participates as a *network provider* for this plan. *We* offer many managed care plans, and a provider who participates in one plan may not necessarily be a *network provider* for this plan.

Not all *health care practitioners* who provide services at *network hospitals* are *network health care practitioners.* If services are provided to *you* by non-network pathologists, anesthesiologists, radiologists, and emergency room physicians at a *network hospital, we* will pay for those services at the *network provider* benefit level, subject to any applicable *deductible, coinsurance* and/or *copayment*.

We may designate *network providers* from which certain kinds of services must be obtained. *We* reserve the right, at *our* discretion, to make changes to the list of *network providers* at any time.

Please refer to the "Schedule of Benefits" sections in this *certificate* for a description of benefits available to *you*.
H202300TX 05/05

Use of non-network providers

Our authorization must be obtained before receiving services from a *non-network provider*, except for *emergency care*. In the event that medically necessary *covered health services* are not available through *network providers* under this *master group contract*, *you* and *your* provider must receive our authorization for non-network services before any procedure, treatment or supply is provided. We will, upon the request of a *network provider*, authorize medically necessary *covered health services* to be provided by a *non-network provider* and shall fully reimburse the *non-network provider* at the *usual and customary* or an agreed rate. Authorization for *non-network provider* services will be provided within the time appropriate to the circumstances relating to the delivery of the services and the condition of the patient. *Only* those services authorized by *us* to be provided by a *non-network provider* will be *covered health services.* We will further provide a review by a specialist of the same, or similar, specialty as the type of provider to which authorization of non-network services was requested before we may deny such request for authorization of non-network services.

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 calling *our* customer service center or accessing *your* network detail on *our* Website. *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. In other words, if *your* network *primary care physician*, *specialty care physician*, or other provider recommends that *you* receive care or services from another entity, it is *your* responsibility to verify the network participation status of that entity before receiving such care or services. If *you* do not, and the entity is not a *network provider* (regardless of what *your* referring provider may have told *you*), *you* will be responsible for all costs incurred, except as non-network services are otherwise authorized by *us* under this *certificate.*
H202350TX 06/06

Continuity of care

Provider termination

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

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

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

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

H202400TX

Master group contract termination

We extend limited coverage if:

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

H202425TX

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

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

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

H202450TX

Selecting your primary care physician

You may select a *primary care physician* for *yourself* and for each enrolled *dependent.* A *network provider* who practices in the areas of family medicine, general practice or internal medicine may be selected for each adult. *You* may choose a *network provider* who practices in the areas of pediatrics, family medicine, or general practice for each child. If *you* fail to select a *primary care physician*, one will be assigned to *you*.

You may change *your primary care physician* online or by calling *our* customer service center. *You* must notify *our* customer service center before receiving services from a new *primary care physician*. A new identification card will be issued to *you* with the new *primary care physician's* name. *You* must arrange to have *your* medical files transferred to *your* new *primary care physician*.
H202500

Role of the primary care physician

Your primary care physician is responsible for providing primary medical care and helping to guide any care *you* receive from other medical care providers, including *specialty care physicians*. Referrals to *specialty care physicians* are required by *us*.
H202600 09/04

When your primary care physician is not available

When *your primary care physician* is unavailable, *you* may need to obtain services from the back-up *network provider* designated by *your primary care physician*. Please be sure to discuss these back-up arrangements with *your primary care physician*.
H202700

Seeing a specialist

You should discuss all of *your* medical needs with *your primary care physician*. If *you* and *your primary care physician* determine *you* need to see a *specialty care physician*, *your primary care physician* may recommend one. Services received from a *specialty care physician* without the required *primary care physician* referral will not be considered *covered expenses.*
H202800

Seeking emergency care

When seeking *emergency care*, *you* should do the following:

- If *your* medical condition permits, proceed to the nearest *emergency care network provider* in this plan.

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

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

- *You* must receive any follow-up services from a *network health care practitioner*.

In emergencies requiring *mental health services* or *chemical dependency* services, *you* should do the following:

- *Your* coverage includes 24-hour access to a phone line for crisis intervention, intake, and triage services. In an emergency requiring *mental health services* or *chemical dependency* services, *you* should call the mental health access telephone number found on the back of *your* member identification card. *You* will be given assistance, and any *emergency care* or treatment *you* require will be arranged at that time.

- If *your* medical condition does not permit *you* to call the 24-hour mental health access telephone number, *you* should proceed to the nearest *emergency care* facility at a *network hospital* in this plan. If *you* are admitted to a *non-network hospital* for *emergency care*, *you* (or someone acting for *you*) must call the mental health access telephone number found on *your* member identification card within forty-eight (48) hours of *your* admission. If this is not possible, a call to the mental health access telephone number should be made as soon as *your* medical condition permits.

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

- *You* must receive any follow-up *mental health services* or *chemical dependency* services from the provider designated by the mental health management organization's case manager.

H203000TX

Seeking urgent care

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

- Contact *your primary care physician* or his or her back up.
- If *your primary care physician* is unavailable, *you* may go to an *urgent care center* that is a *network provider* under this plan. (*You* can obtain the names of *network provider urgent care centers* by calling *our* customer service center or accessing *your* network detail on *our* website.)
- *You* must receive any follow-up services from *your primary care physician* or a *network health care practitioner*.
- *You* must pay the required *copayment* for *urgent care*.

H203100

Preauthorization

All benefits payable under the *master group contract* must be for services and supplies that are *medically necessary* or for *preventive services* as stated in this *certificate*. *Preauthorization* by *us* is required for certain services and supplies. Visit *our* Website at www.humana.com or call the customer service telephone number on *your* identification card to obtain a list of services and supplies that require *preauthorization*. The list of services and supplies that require *preauthorization* is subject to change. Coverage provided in the past for services or supplies that did not receive or require *preauthorization*, is not a guarantee of future coverage of the same services or supplies.

You or *your health care practitioner* must contact *us* by telephone, *electronic mail*, or in writing to obtain the appropriate authorization. *Your* identification card will show the *health care practitioner* the telephone number to call to request authorization. Benefits are not paid at all for services or supplies that are not *covered health services.*

H203300TX 05/05

Our relationship with providers

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

Nothing contained in the *master group 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. When requesting authorizations and ordering services, *health care practitioners* and other providers are acting on *your* behalf. All decisions related to patient care are the responsibility of the patient and the treating *health care practitioner*, regardless of any coverage determination(s) *we* have made or will make.

H203400TX

Our financial arrangements with providers

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

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

- Some health care providers may have capitation agreements. This means the provider is prepaid a set dollar amount each month to care for each *covered person* regardless of how few or how many services a particular *covered person* may receive, or in some cases, whether services are provided by the *primary care physician* or a *specialty care physician*. Stop-loss insurance protects some providers from financial loss in case the actual costs incurred in caring for patients exceed certain sums.

H203500TX

Privacy and confidentiality statement

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

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

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

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

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

- **Treatment -** *we* may disclose *your* PHI to a *health care practitioner*, a *hospital* or other entity which asks for it in order for *you* to receive medical treatment; and

- **Payment -** *we* may use and disclose *your* PHI to pay claims for *covered expenses* provided to *you* by *health care practitioners*, *hospitals* or other entities.

We may also use and disclose *your* PHI to conduct other health plan operational activities.

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

It has always been *our* goal to ensure the protection and integrity of *your* PHI. Therefore, *we* will notify *you* of any potential situations where *your* identification would be used for reasons other than treatment, payment and health plan operations.
H203600TX

A note about this certificate - "benefit plan document"

This *certificate* is part of the *master group contract* and describes the benefits, provisions and limitations of the *master group contract*. Nothing in this *certificate* waives or alters any of the terms or conditions of the *master group contract*. The final interpretation of any specific provision in this *certificate* is governed by the terms of the *master group contract*. In the event of conflict between the *master group contract* and this *certificate*, the provisions of the *master group contract* will prevail. The benefits outlined in this *certificate* are effective only if *you* are eligible for coverage, become covered and remain covered in accordance with the terms of the *master group contract*.
H203700

SCHEDULE OF BENEFITS

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

- The level of benefits generally paid for *covered health services*;
- The amounts of *copayments* and/or *coinsurance you* are required to pay;
- The services that require *you* to meet a *deductible*, if any, before benefits are paid; and
- *Preauthorization* requirements.

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

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

The benefits outlined under the "Schedule of Benefits - Behavioral Health", and "Schedule of Benefits - Transplant Services" sections are not payable under any other Schedule of Benefits of the *master group contract*. However, all other terms and provisions of the *master group contract*, including the *individual lifetime maximum benefit*, *preauthorization* requirements, and maximum *copayment limit(s)*, unless otherwise stated, are applicable.
HSCH1-1100TX

Network provider verification

This *certificate* contains multiple *network provider* benefit levels. The benefits are identified as "*primary care physician*" and "*specialty care physician*" in the Schedules of Benefits.

To know which benefit level is assigned to a *network provider*, please refer to the Online Physician Directory on *our* Website at www.humana.com. *You* may also contact *our* customer service department at the telephone number shown on *your* identification card. This list is subject to change.
HSCH1-1200

Individual lifetime maximum benefit

The total amount of benefits payable for all *covered health services* obtained by *you* will not exceed the *individual lifetime maximum benefit* as follows.

Individual lifetime maximum benefit	Maximum benefit amount
Individual lifetime maximum benefit per *covered person*	UNLIMITED

HSCH1-1300TX

Preauthorization requirements

Preauthorization by *us* is required for certain services and supplies. Visit *our* Website at www.humana.com or call the customer service telephone number on your identification card to obtain a list of services and supplies that require *preauthorization*. The list of services and supplies that require *preauthorization* is subject to change. Coverage provided in the past for services or supplies that did not receive or require *preauthorization*, is not a guarantee of future coverage of the same services or supplies.

You or *your health care practitioner* must contact *us* by telephone, *electronic mail*, or in writing to request the appropriate authorization. *Your* identification card will show the *health care practitioner* the telephone number to call to request authorization.
HSCH1-1500TX

Copayment limit

The *copayment limit* is the amount of *copayment* that must be paid by *you*, either individually or combined as a covered family, per *year* before *copayments* are no longer required for the remainder of that *year*. *Copayments* for *chemical dependency* services and *mental health services* or for prescription drugs do not apply towards any *copayment limit*. A reasonable *copayment* option may not exceed 50% of the total cost of services provided. *Copayments* cannot exceed 200% of the average annual premium rate per *year*.

Copayment limit	**Copayment limit amount**
Individual *network provider copayment limit*	$2000
Family *network provider copayment limit*	$6000

HSCH1-1800TX

SCHEDULE OF BENEFITS (continued)

Preventive services

Preventive services office visits

Provider	Your copayment
Primary care physician	$15 PER VISIT
Specialty care physician	$30 PER VISIT

Hearing impairment screening (birth to 30 days old)

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

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

Preventive screenings and immunizations for covered persons under 18 years of age

Provider	Your copayment
Primary care physician	COVERED IN FULL
Specialty care physician	COVERED IN FULL

SCHEDULE OF BENEFITS (continued)

Preventive screenings for covered persons 18 years of age or over

Excludes preventive endoscopic services, including but not limited to colonoscopy, proctosigmoidoscopy and sigmoidoscopy.

Provider	Your copayment
Primary care physician	COVERED IN FULL
Specialty care physician	COVERED IN FULL

Preventive endoscopic services

Includes colonoscopy, proctosigmoidoscopy and sigmoidoscopy.

Provider	Your copayment
Primary care physician	COVERED IN FULL
Specialty care physician	COVERED IN FULL

Routine mammogram

Primary care physician	COVERED IN FULL
Specialty care physician	COVERED IN FULL

SCHEDULE OF BENEFITS (continued)

Routine pap smear

Primary care physician	COVERED IN FULL
Specialty care physician	COVERED IN FULL

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

Primary care physician	COVERED IN FULL
Specialty care physician	COVERED IN FULL

Immunizations against influenza (flu shots) and pneumonia

Provider	**Your copayment**
Primary care physician	COVERED IN FULL
Specialty care physician	COVERED IN FULL

SCHEDULE OF BENEFITS (continued)

Health care practitioner office visit services

Health care practitioner office visit

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

Provider	Your copayment
Primary care physician	$15 PER VISIT
Specialty care physician	$30 PER VISIT

Diagnostic laboratory and radiology services

Excludes *advanced imaging*.

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

Provider	Your copayment
Primary care physician	COVERED IN FULL
Specialty care physician	COVERED IN FULL

Advanced imaging

Provider	Your copayment
Primary care physician	COVERED IN FULL
Specialty care physician	COVERED IN FULL

SCHEDULE OF BENEFITS (continued)

Allergy serum

Provider	Your copayment
Primary care physician	COVERED IN FULL
Specialty care physician	COVERED IN FULL

Allergy injections

Provider	Your copayment
Primary care physician	$5 PER VISIT
Specialty care physician	$5 PER VISIT

Surgery

Provider	Your copayment
Primary care physician	$15 PER VISIT
Specialty care physician	$30 PER VISIT

SCHEDULE OF BENEFITS (continued)

Hospital services

Hospital inpatient care

Provider	Your copayment
Network hospital	$100 PER DAY, LIMITED TO THE FIRST FIVE DAYS PER ADMISSION

Health care practitioner inpatient services when provided in a hospital

Provider	Your copayment
Primary care physician	COVERED IN FULL
Specialty care physician	COVERED IN FULL

Hospital outpatient surgical services

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

Provider	Your copayment
Network hospital	$50 PER VISIT

Health care practitioner outpatient services when provided in a hospital

Includes *outpatient surgery*.

Provider	Your copayment
Primary care physician	COVERED IN FULL
Specialty care physician	COVERED IN FULL

SCHEDULE OF BENEFITS (continued)

Hospital outpatient non-surgical services

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

Provider	Your copayment
Network hospital	COVERED IN FULL

Hospital outpatient advanced imaging

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

Provider	Your copayment
Network hospital	COVERED IN FULL

Pregnancy and newborn benefit

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

Emergency services

Hospital emergency room services

Provider	Your copayment
Network hospital	$75 *copayment* per visit. *Copayment* waived if admitted.

Hospital emergency room health care practitioner services

Provider	Your copayment
Primary care physician	COVERED IN FULL
Specialty care physician	COVERED IN FULL

Ambulance

Provider	Your copayment
Network provider	COVERED IN FULL

Ambulatory surgical center services

Ambulatory surgical center for outpatient surgery

Provider	Your copayment
Network provider	$50 PER VISIT

Health care practitioner outpatient services provided in an ambulatory surgical center

Includes *outpatient surgery*.

Provider	Your copayment
Primary care physician	COVERED IN FULL
Specialty care physician	COVERED IN FULL

SCHEDULE OF BENEFITS (continued)

Autism Spectrum Disorders

Autism Spectrum Disorders, as required by law, for a *dependent* child from age 2 to age 6 is subject to the *deductible requirement*, if any.

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

Durable medical equipment

Provider	Your copayment
Network provider	COVERED IN FULL

Diabetes equipment

Provider	Your copayment
Network provider	COVERED IN FULL

Free-standing facility services

Free-standing facility outpatient non-surgical services

(Excludes *advanced imaging*.)

Provider	Your copayment
Network provider	COVERED IN FULL

Free-standing facility outpatient advanced imaging

Provider	Your copayment
Network provider	COVERED IN FULL

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

Provider	Your copayment
Primary care physician	COVERED IN FULL
Specialty care physician	COVERED IN FULL

Home health care

Provider	Your copayment
Network provider	COVERED IN FULL

Hospice

Provider	Your copayment
Network provider	COVERED IN FULL

Infertility services

Network provider	50% *coinsurance*

Jaw joint benefit

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

SCHEDULE OF BENEFITS (continued)

Physical medicine and rehabilitative services

Provider	Your copayment
Network provider	$30 PER VISIT

Audiology and cognitive rehabilitation services

Provider	Your copayment
Network provider	$30 PER VISIT

Spinal manipulations, adjustments and modalities are limited to a combined maximum of 20 visits per *year*.

Provider	Your copayment
Primary care physician	$30 PER VISIT
Specialty care physician	$30 PER VISIT

Other therapy

Provider	Your copayment
Primary care physician	COVERED IN FULL
Specialty care physician	COVERED IN FULL

SCHEDULE OF BENEFITS (continued)

Skilled nursing facility

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

Provider	Your copayment
Network provider	COVERED IN FULL

Urgent care services

Urgent care facility services

Provider	Your copayment
Network provider	$30 PER VISIT

Urgent care facility health care practitioner services

Provider	Your copayment
Network provider	COVERED IN FULL

Additional covered expenses

Same as any other *illness* based upon location of services and the type of provider.
HSCH2TX 09/07

SCHEDULE OF BENEFITS - BEHAVIORAL HEALTH

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

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

The benefits outlined in this "Schedule of Benefits - Behavioral Health" are a summary of coverage and limitations provided under the *master group contract*. A more detailed explanation of *your* coverage and its limitations and exclusions for these benefits are provided in the "Covered Health Services - Behavioral Health" and "Limitations and Exclusions" sections of this *certificate*. Please refer to this *certificate* and any applicable riders for additional coverage and/or limitations.

All services are subject to all the terms and provisions, limitations and exclusions of the *master group contract*. This schedule does not include services for *serious mental illness.*

Mental Health Services

Inpatient services

All *inpatient services* for *mental health services* are limited to a maximum of 10 days per *year*.

Inpatient services

Provider	Your copayment
Network provider	$100 PER DAY, LIMITED TO THE FIRST FIVE DAYS P ER ADMISSION

Health care practitioner inpatient services

Provider	Your copayment
Network health care practitioner	COVERED IN FULL

Outpatient care and office therapy

Outpatient care and office therapy sessions for *mental health services* are limited to a maximum of 20 visits per *year*.

Provider	Your copayment
Network provider	$30 PER VISIT

SCHEDULE OF BENEFITS - BEHAVIORAL HEALTH (continued)

Chemical Dependency

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

Chemical dependency services are limited to a lifetime maximum of three separate *series of treatments* for each *covered person*. All *inpatient* care, and *outpatient* care, including *outpatient* services provided as part of an *intensive outpatient program*, and office therapy sessions for *chemical dependency* services are limited to a combined maximum of three separate *series of treatments*. Two days of *partial hospitalization* or treatment in a *chemical dependency treatment center, crisis stabilization unit, psychiatric day treatment facility, or residential treatment center for children and adolescents* is equal to one day of *inpatient* care.
SCH-BHTX 07/07

SCHEDULE OF BENEFITS - SERIOUS MENTAL ILLNESS

Reading this "Schedule of Benefits - Serious Mental Illness" section will help *you* understand:

- The level of benefits generally paid for the treatment of *serious mental illness* covered under the *master group contract*;
- The amounts of *copayments* and/or *coinsurance you* are required to pay; and
- The services that require *you* to meet a *deductible*, if any, before benefits are paid.

The benefits outlined in this "Schedule of Benefits - Serious Mental Illness" section is a summary of coverage and limitations provided under the *master group contract*. A more detailed explanation of *your* coverage and its limitations and exclusions for these benefits are provided in the "Covered Health Services - Serious Mental Illness" and "Limitations and Exclusions" sections of this *certificate*. Please refer to this *certificate* and any applicable riders for additional coverage and/or limitations.

Inpatient services

Inpatient facility services

Serious mental illness inpatient care is limited to a maximum of 45 days per *year*. Two days of *partial hospitalization*, treatment in a *psychiatric day treatment facility, crisis stabilization unit,* or *residential treatment center for children or adolescents* is equal to one day of *inpatient* care. A *health care practitioner* must certify that the treatment being provided in a *psychiatric day treatment facility, crisis stabilization unit, or residential treatment center for children or adolescents* is in lieu of hospitalization.

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

Health care practitioner inpatient services

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

Outpatient services

Serious mental illness outpatient care is limited to a maximum of 60 days per *year*. *Outpatient* visits for medication management are payable to the same extent as coverage for any other *illness* under the *master group contract,* but will not apply toward the *year* limit for *serious mental illness*.

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

SCHEDULE OF BENEFITS - TRANSPLANT SERVICES

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

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

The benefits outlined in this "Schedule of Benefits - Transplant Services" are a summary of coverage and limitations provided under the *master group contract*. A more detailed explanation of *your* coverage and its limitations and exclusions for these benefits are provided in the "Covered Expenses - Transplant Services" and "Limitations and Exclusions" sections of this *certificate*. Please refer to this *certificate* and any applicable riders for additional coverage and/or limitations.

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

Organ transplant benefit

Medical Services

- *Hospital* services

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

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

- *Health care practitioner* services

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

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

SCHEDULE OF BENEFITS - TRANSPLANT SERVICES (continued)

Direct, non-medical costs

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

- Transportation

Provider	Your copayment
Network hospital designated by *us* as an approved transplant facility	Covered in full

- Temporary lodging

Provider	Your copayment
Network hospital designated by *us* as an approved transplant facility	Covered in full

HSCH-OTTX 03/07

COVERED HEALTH SERVICES

The "Covered Health Services" section describes the services that will be considered *covered health services* under the *master group contract*. Benefits will be paid, as prescribed by *your primary care physician*, for covered medical services for a *bodily injury* or *illness*, or for specified *preventive services*, on a *maximum allowable fee* basis and as shown on the Schedules of Benefits subject to any applicable:

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

Refer to the "Limitations and Exclusions" section listed in this *certificate*. All terms and provisions of the *master group contract*, including the *preauthorization* and referral requirements specified in this *certificate*, are applicable to *covered health services*.
H204000TX

Preventive services

Preventive services office visit

Covered health services include charges incurred for an office visit made to a *health care practitioner* for examinations and physicals to detect or prevent *illness*, annually or as recommended by the U.S. Preventive Services Task Force.

Preventive screenings and immunizations

Covered expenses include charges incurred by *you* for the following *preventive services* as recommended by the United States Preventive Services Task Force:

- Laboratory, radiology and/or endoscopic services to detect or prevent *illness*.
- A hearing impairment screening for a *dependent* child from birth through 30 days old.
- A baseline mammogram for a female *covered person* between the ages of 35 years of age or older.
- A bone mass measurement for a *qualified individual* to detect low bone mass and determine the risk of osteoporosis and fractures associated with osteoporosis.
- An annual medically recognized diagnostic examination for a female *covered person* 18 years of age or older for the early detection of cervical cancer in accordance with guidelines adopted by the American College of Obstetricians and Gynecologists or another similar national organization of medical professionals recognized by the Commissioner. Minimum requirements for the diagnostic examination to detect the human papillomavirus include a conventional pap smear screening, alone or in combination with a test approved by the United States Food and Drug Administration.
- An annual prostate cancer detection exam, including a prostate specific antigen (PSA) test for a male *covered person* 40 years of age or older.

- A medically recognized screening examination for the detection of colorectal cancer for *covered persons* 50 years of age or older and at normal risk for developing colon cancer. Benefits include:
  - An annual fecal occult blood test; and
  - A flexible sigmoidoscopy every five years; or
  - A colonoscopy every 10 years.
- Routine immunizations. TB tine tests and allergy desensitization injections are not considered routine immunizations.
- Immunizations against influenza and pneumonia, as determined by *us*.
- Routine hearing screening.
- Routine vision screening (not including refractions).

H204200TX 07/07

Health care practitioner office services

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

Health care practitioner office visit

Covered health services include:

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

Covered health services for *health care practitioner* office visit services do not include *advanced imaging*.
H204400TX 07/07

Hospital services

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

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

Hospital inpatient services

Covered health services include:

- Daily semi-private, ward, intensive care or coronary care *room and board* charges for each day of *confinement*. Benefits for a private or single-bed room are limited to the charge for a semi-private room in the *hospital* while a registered bed patient.
- Services and supplies, other than *room and board*, provided by a *hospital* to a registered bed patient.

Health care practitioner inpatient services

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

Covered health services include:

- Medical services furnished by an attending *health care practitioner* to *you* while *you* are *hospital confined*.
- *Surgery* performed on an *inpatient* basis. If several *surgeries* are performed during one operation, *we* will pay the *maximum allowable fee* for the most complex procedure.
- Services of a surgical assistant and/or assistant surgeon when *medically necessary*.
- Services of a physician assistant (P.A.), registered nurse (R.N.) or a certified operating room technician when *medically necessary*.
- Anesthesia administered by a *health care practitioner* or certified registered anesthetist attendant for a *surgery*.
- Consultation charges requested by the attending *health care practitioner* during a *hospital confinement*. The benefit is limited to one consultation by any one consultant per specialty during a *hospital confinement*.
- Services of a pathologist.
- Services of a radiologist.
- Services performed on an emergency basis in a *hospital* if the *illness* or *bodily injury* being treated results in a *hospital confinement*.

Hospital outpatient services

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

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

Hospital outpatient surgical services

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

Health care practitioner outpatient services

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

Covered health services include:

- Surgery performed on an *outpatient* basis. If several *surgeries* are performed during one operation, *we* will pay the *maximum allowable fee* for the most complex procedure.
- Services of a surgical assistant and/or assistant surgeon when *medically necessary*.
- Services of a physician assistant (P.A.), registered nurse (R.N.) or a certified operating room technician when *medically necessary*.
- Anesthesia administered by a *health care practitioner* or certified registered anesthetist attendant for a *surgery*.
- Services of a pathologist.
- Services of a radiologist.

Hospital outpatient non-surgical services

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

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

Hospital outpatient advanced imaging

We will pay benefits for *covered health services* incurred by *you* for *outpatient advanced imaging* in a *hospital's outpatient* department.
H205400TX 07/07

Pregnancy and newborn benefit

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

covered health services include:

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

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

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

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

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

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

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

The newborn will not be required to satisfy a separate *deductible* and/or *copayment* for *hospital* facility charges for the *confinement* period immediately following birth. A *deductible* and/or *copayment*, if applicable, will be required for any subsequent *hospital admission*.
H205500TX

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

COVERED HEALTH SERVICES (continued)

Emergency services

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

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

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

Emergency care provided by a *non-network hospital* or a *non-network health care practitioner* will be covered at the *network provider* benefit percentage.

Covered health services also include *health care practitioner* services for *emergency care*, including the treatment and stabilization of an emergency medical condition, provided in a *hospital* emergency facility or comparable facility. These services are subject to the terms, conditions, limitations, and exclusions of the *master group contract*.
H205700TX 07/07

Ambulance

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

Ambulance service for *emergency care* provided by a *non-network provider* will be covered at the *network provider* benefit percentage.
H205800TX 05/05

Ambulatory surgical center

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

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

Services which are payable as an *ambulatory surgical center* charge are not payable as a *health care practitioner* charge.

Covered health services include:

- *Surgery* performed on an *outpatient* basis. If several *surgeries* are performed during one operation, *we* will pay the *maximum allowable fee* for the most complex procedure.
- Services of a surgical assistant and/or assistant surgeon when *medically necessary*.
- Services of a physician assistant (P.A.), registered nurse (R.N.) or a certified operating room technician when *medically necessary*.
- Anesthesia administered by a *health care practitioner* or certified registered anesthetist attendant for a *surgery*.
- Services of a pathologist.
- Services of a radiologist.

H206000TX 07/07

Autism Spectrum Disorders

We will pay benefits for *covered expenses* incurred by covered *dependents* age 2 to age 6 for *autism spectrum disorder* (ASD) services provided by a *health care practitioner*.

Covered expenses include:

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

H2060025TX

Durable medical equipment and diabetes equipment

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

We do not pay for equipment or devices not specifically designed and intended for the care and treatment of a *sickness* or *bodily injury*.

The following are not considered *covered health services:*

- Repair or maintenance of the *durable medical equipment* or *diabetes equipment*; or
- Duplicate or similar rentals or purchases of *durable medical equipment* or *diabetes equipment* as determined by *us*.

H206100TX 05/05

Free-standing facility services

Free-standing outpatient non-surgical services

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

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

Health care practitioner services provided in a free-standing facility

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

Free-standing outpatient advanced imaging

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

H206400TX 07/07

Home health care

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

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

Home health care *covered health services* include:

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

Home health care *covered health services* do not include:

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

H206700TX 05/05

Hospice

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

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

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

- *Room and board* at a hospice, when it is for management of acute pain or for an acute phase of chronic symptom management;

- Part-time nursing care provided by or supervised by a registered nurse (R.N.) for up to eight hours in any one day;

- Counseling for the terminally ill *covered person* and his/her immediate covered family members by a licensed:

  - Clinical social worker; or
  - Pastoral counselor.

- Medical social services provided to the terminally ill *covered person* or his/her immediate covered family members under the direction of a *health care practitioner*, including:

  - Assessment of social, emotional and medical needs, and the home and family situation; and
  - Identification of the community resources available;

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

Hospice care *covered health services* do not include:

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

H206800TX 05/05

Jaw joint benefit

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

The following are *covered health services*:

- A single examination including a history, physical examination, muscle testing, range of motion measurements, and psychological evaluation;
- Diagnostic x-rays;
- Physical therapy of necessary frequency and duration, limited to a multiple modality benefit when more than one therapeutic treatment is rendered on the same date of service;
- Therapeutic injections;

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

- Surgical procedures.

Covered health services do not include charges for:

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

H206900TX

Physical medicine and rehabilitative services benefit

We will pay benefits for *covered health services* incurred by *you* for the following physical medicine and/or rehabilitative services for a documented loss of physical function, or pain, as ordered by a *health care practitioner* and performed by a *health care practitioner*:

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

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

H207000TX

Skilled nursing facility

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

The "Schedule of Benefits" shows the maximum length of time for which *we* will pay benefits for charges made by a *skilled nursing facility*, if any.
H207100TX 05/05

Urgent care center

We will pay benefits for *covered health services* incurred by *you* for charges made by an *urgent care center* for *urgent care* services. *Covered health services* also include *health care practitioner* services for *urgent care* provided at and billed by an *urgent care center*.
H207200TX

Additional covered health services

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

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

- Oxygen and rental of equipment for its administration.

- Initial prosthetic devices or supplies, including but not limited to limbs and eyes. Coverage will be provided for prosthetic devices necessary to restore the minimal basic function of a lost limb or eye. Replacement is a *covered health service* if due to pathological changes or growth.

- Casts, splints, trusses, crutches, orthotics and braces. Orthotics must be custom made of rigid or semi-rigid material.

  Regardless of indication, no coverage is provided for:

  - Fabric supports;
  - Replacement orthotics and braces;
  - Oral splints and appliances; or
  - Dental splints and dental braces.

- *Diabetes self-management training.*

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

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

- *Medically necessary services* received by a *covered person* as a result from or related to an *acquired brain injury* provided in a *hospital*, an acute or post-acute *rehabilitation facility* or an *assisted living facility*:

  - *Cognitive rehabilitation therapy;*
  - *Cognitive communication therapy;*
  - *Neurocognitive therapy and rehabilitation;*
  - *Neurobehavioral testing or treatment;*
  - *Neurophysiological testing or treatment;*
  - *Neuropsychological testing or treatment;*
  - *Psychophysiological testing or treatment;*
  - *neurofeedback therapy;*
  - *Remediation;*
  - *Post-acute transition services;* or
  - *Community reintegration services.*

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

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

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

- Dental treatment only if:

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

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

COVERED HEALTH SERVICES (continued)

- Certain oral surgical operations as follows:

  - Excision of partially or completely impacted teeth;
  - Excisions of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth when such conditions require pathological examinations;
  - Surgical procedures required to correct accidental injuries of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
  - Reduction of fractures and dislocation of the jaw;
  - External incision and drainage of cellulitis;
  - Incision of accessory sinuses, salivary glands or ducts; and
  - Frenectomy (the cutting of the tissue in the midline of the tongue).

- Elective vasectomy or tubal ligation.

- Reconstructive *surgery*:

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

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

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

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

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

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

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

- Enteral formulas for use at home by a *covered person* that are prescribed or ordered by a *health care practitioner* and are for the treatment of an inherited metabolic disease, e.g. phenylketonuria (PKU), unless otherwise covered in the Prescription Drug Benefit Rider, if any, attached to this *master group contract*.

COVERED HEALTH SERVICES (continued)

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

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

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

- *Telehealth service.*

- *Telemedicine medical service.*

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

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

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

H207470TX 07/07

COVERED HEALTH SERVICES - BEHAVIORAL HEALTH

The "Covered Health Services - Behavioral Health" section describes the services that will be considered *covered health services* for *mental health services* and *chemical dependency* services under the *master group contract*. Benefits for *mental health services* and *chemical dependency* services will be paid as shown in the "Schedule of Benefits - Behavioral Health" subject to any applicable:

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

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

This "Covered Health Services - Behavioral Health" section does not include services for *serious mental illness.*
H208000TX

Inpatient services

We will pay benefits for *covered health services* incurred by *you* for *inpatient* care for *mental health services* and *chemical dependency* services provided in a *hospital, health care treatment facility, chemical dependency treatment center, crisis stabilization unit, psychiatric day treatment facility, or residential treatment center for children or adolescents*. Two days of *partial hospitalization* is equal to one day of *inpatient* care. A *health care practitioner* must certify that the *partial hospitalization* being provided is in lieu of hospitalization.

The "Schedule of Benefits - Behavioral Health" reflects benefit limitations for *inpatient* care for *mental health services* and *chemical dependency* services.
H208100TX

Health care practitioner inpatient

We will pay benefits for *covered health services* incurred by *you* for *mental health services* and *chemical dependency* services provided by a *health care practitioner* in a *hospital, health care treatment facility, chemical dependency treatment center, psychiatric day treatment facility, crisis stabilization unit, or residential treatment center for children or adolescents.*
H208300TX

COVERED HEALTH SERVICES - BEHAVIORAL HEALTH (continued)

Outpatient care and office therapy services

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

The "Schedule of Benefits - Behavioral Health" reflects the benefit limitations for *outpatient* care, including *outpatient* services provided as part of an *intensive outpatient program*, for *mental health services* and *chemical dependency* services, if any.
H208500TX

COVERED HEALTH SERVICES - SERIOUS MENTAL ILLNESS

The "Covered Health Services - Serious Mental Illness" section describes the services that will be considered *covered health services* for *serious mental illness* under the *master group contract*. Benefits for *serious mental illness* will be paid as any other *illness* subject to any applicable:

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

Refer to the "Limitations and Exclusions" section listed in this *certificate*. All terms and provisions of the *master group contract*, including *preathorization* requirements specified in this *certificate*, are applicable to *covered health services*.
H209000TX

Inpatient services

We will pay benefits for *inpatient* care for the treatment of *serious mental illness* provided in a *hospital, health care treatment facility, psychiatric day treatment facility, crisis stabilization unit,* or *residential treatment center for children or adolescents*.

The "Schedule of Benefits - Serious Mental Illness" reflects the benefit limitations for *inpatient* care of *serious mental illness*, if any.
H209100TX

Inpatient facility services

We will pay benefits for *covered health services* incurred by *you* while *confined* in a *hospital, health care treatment facility, psychiatric day treatment facility, crisis stabilization unit,* or *residential treatment center for children or adolescents* for the treatment of *serious mental illness*.
H209200TX

Health care practitioner inpatient services

We will pay benefits for *covered health services* incurred by *you* for the treatment of *serious mental illness* provided by a *health care practitioner* in a *hospital, health care treatment facility, psychiatric day treatment facility, crisis stabilization unit,* or *residential treatment center for children or adolescents*.
H209300TX

Outpatient services

We will pay benefits for *covered health services* incurred by *you* for the treatment of *serious mental illness* while not *confined* in a *hospital, health care treatment facility, psychiatric day treatment facility, crisis stabilization unit,* or *residential treatment center for children or adolescents* for *outpatient* services.

The "Schedule of Benefits - Serious Mental Illness" reflects the benefit limitations for *outpatient* care of *serious mental illness*, if any.
H209400TX

COVERED HEALTH SERVICES - TRANSPLANT SERVICES

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

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

Refer to the "Exclusions" provision in this section and the "Limitations and Exclusions" section listed in this *certificate* for transplant services not covered by the *master group contract*. All terms and provisions of the *master group contract*, including the *preauthorization* and referral requirements specified in this *certificate*, are applicable to *covered health services*.
H210000TX

Organ transplant benefit

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

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

Once coverage for the *organ transplant* is approved, *we* will advise *your health care practitioner*. Benefits are payable only if the pre-transplant services, the *organ transplant* and post-discharge services are approved by *us*. Coverage for post-discharge services and treatment of complications after transplantation are limited to the *organ transplant treatment period*.

Corneal transplants and porcine heart valve implants, which are tissues rather than organs, are considered part of regular plan benefits and are subject to other applicable provisions of the *master group contract*.
H210100TX 10/06

COVERED HEALTH SERVICES - TRANSPLANT SERVICES (continued)

Covered health services

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

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

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

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

- Organ acquisition and donor costs, including pre-transplant services, the acquisition procedure, and any complications resulting from the acquisition. Donor costs will not exceed the *organ transplant treatment period* and are not payable under the *master group contract* if they are payable in whole or in part by any other group plan, insurance company organization or person other than the donor's family or estate.

- Direct, non-medical costs for:

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

  Direct, non-medical costs include:

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

All direct, non-medical costs for the *covered person* receiving the *organ transplant* and the designated caregiver(s) or support person(s) are limited to a combined maximum coverage per *organ transplant*, as specified in the "Schedule of Benefits - Transplant Services" section in this *certificate*.
H210200 10/06

COVERED HEALTH SERVICES - TRANSPLANT SERVICES (continued)

Exclusions

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

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

H210300 10/06

LIMITATIONS AND EXCLUSIONS

Limitations and exclusions

Unless specifically stated otherwise, no benefits will be provided for or on account of the following items:
H211200

- Treatments, services, supplies or *surgeries* that are not *medically necessary*, except for the specified *preventive services* as outlined in the "Schedule of Benefits" and described in the "Covered Expenses" section of this *certificate*.

- An *illness* or *bodily injury* arising out of, or in the course of, any employment for wage, gain or profit.

- 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.

H211600TX 07/07

- Any service furnished while *you* are *confined* in a *hospital* or institution owned or operated by the United States government or any of its agencies for any military service-connected *illness* or *bodily injury*.

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

- *Illness* or *bodily injury* for which *you* are in any way paid or entitled to payment or care and treatment by or through a government program.

- Any service not ordered by a *health care practitioner*.

H212000TX 07/07

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

  - Received in an emergency room, unless required because of *emergency care;*

  - Which require *preauthorization* if *preauthorization* was not obtained.

  - Which require a *primary care physician* referral if a referral was not obtained.

- Services rendered by a standby physician, surgical assistant, assistant surgeon, physician assistant, registered nurse or certified operating room technician unless *medically necessary*.

LIMITATIONS AND EXCLUSIONS (continued)

- Any service that is not rendered or not substantiated in the medical records.

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

- Educational or vocational, therapy, testing, services or schools, including therapeutic boarding schools and other therapeutic environments. Educational or vocational videos, tapes, books and similar materials are also excluded.

H212600 07/07

- Medical services provided by a *covered person's family member*.

- *Ambulance* services for routine transportation to, from or between medical facilities and/or a *health care practitioner's* office.

- Any drug, biological product, device, medical treatment, or procedure which is *experimental* or *investigational* or *for research purposes*.

- Vitamins, dietary supplements, and dietary formulas (except enteral formulas for the treatment of genetic metabolic diseases, e.g. phenylketonuria (PKU)), unless otherwise covered by a Prescription Drug Benefit Rider attached to the *master group contract*.

- Over the counter, non-prescription medications.

H213100 07/07

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

- Growth hormones (medication, drugs or hormones to stimulate growth) unless there is a laboratory confirmed diagnosis of growth hormone deficiency, or as otherwise determined by *us*.

- Treatment of nicotine habit or addiction, including, but not limited to, nicotine patches, hypnosis, smoking cessation classes or tapes.

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

  - While an *inpatient* in a *hospital*, *skilled nursing facility*, or *health care treatment facility, chemical dependency treatment center, crisis stabilization unit, psychiatric day treatment facility*, or *residential treatment center for children or adolescents*;
  - By a *health care practitioner* during an office visit; or
  - By a *home health care agency* as part of a covered *home health care plan* when approved by *us*.

H213600TX 07/07

- Hearing aids, the fitting of hearing aids or advice on their care; implantable hearing devices.

LIMITATIONS AND EXCLUSIONS (continued)

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

- Weekend non-emergency *hospital admissions*, specifically *admissions* to a *hospital* on a Friday or Saturday at the convenience of the *covered person* or his or her *health care practitioner* when there is no cause for an emergency *admission* and the *covered person* receives no *surgery* or therapeutic treatment until the following Monday.

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

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

H214000 07/07

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

- No benefits will be provided for:
  - Immunotherapy for recurrent abortion;
  - Chemonucleolysis;
  - Biliary lithotripsy;
  - Home uterine activity monitoring;
  - Sleep therapy;
  - Light treatments for Seasonal Affective Disorder (S.A.D.);
  - Immunotherapy for food allergy;
  - Prolotherapy;
  - Cranial banding, unless otherwise determined by *us*;
  - Hyperhydrosis surgery;
  - Lactation therapy; or
  - Sensory integration therapy.

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

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

H214300TX 07/07

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

- The following types of care of the feet:

  - Shock wave therapy of the feet;
  - The treatment of weak, strained, flat, unstable or unbalanced feet;
  - Hygienic care, and the treatment of superficial lesions of the feet, such as corns, calluses, or hyperkeratoses;
  - The treatment of tarsalgia, metatarsalgia, or bunion, except surgically;

- The cutting of toenails, except the removal of the nail matrix;
- The provision of heel wedges, lifts, or shoe inserts; and
- The provision of arch supports or orthopedic shoes, unless *medically necessary* because of diabetes or hammer toe.

- *Custodial care* and *maintenance care*.

- Any loss contributed to, caused by:

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

- *Illness* or *bodily injury* caused by the *covered person's*:

  - Engaging in an illegal occupation; or
  - Commission of or an attempt to commit a criminal act.

H214800TX 07/07

- Expenses for any membership fees or program fees paid by *you*, including but not limited to, health clubs, health spas, aerobic and strength conditioning, work-hardening programs, and weight loss or surgical programs, and any materials or products related to these programs.

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

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

  - Common household items including air conditioners, air purifiers, water purifiers, vacuum cleaners, waterbeds, hypoallergenic mattresses or pillows or exercise equipment;
  - Motorized transportation equipment (e.g. scooters), escalators, elevators, ramps or modifications or additions to living/working quarters or transportation vehicles;
  - Personal hygiene equipment including bath/shower chairs, transfer equipment or supplies or bed side commodes;
  - Personal comfort items including cervical pillows, gravity lumbar reduction chairs, swimming pools, whirlpools, spas or saunas;
  - Medical equipment including blood pressure monitoring devices, breast pumps, PUVA lights and stethoscopes;
  - Communication systems, telephone, television or computer systems and related equipment or similar items or equipment;
  - Communication devices, except after surgical removal of the larynx or a diagnosis of permanent lack of function of the larynx.

LIMITATIONS AND EXCLUSIONS (continued)

- Therapy and testing for treatment of allergies including, but not limited to, services related to clinical ecology, environmental allergy and allergic immune system dysregulation and sublingual antigen(s), extracts, neutralization tests and/or treatment unless such therapy or testing is approved by:

  - The American Academy of Allergy and Immunology; or
  - The Department of Health and Human Services or any of its offices or agencies.

- Lodging accommodations or transportation, except as otherwise specified in the "Covered Health Services - Transplant Services" section.

H215200TX 07/07

- Communications or travel time.

- Any treatment, including but not limited to surgical procedures:

  - For obesity, which includes *morbid obesity*; or
  - For obesity, which includes *morbid obesity*, for the purpose of treating an *illness* or *bodily injury* caused by, complicated by, or exacerbated by the obesity.

- *Illness* or *bodily injury* for which medical payment or expense coverage benefits are paid or payable under any homeowners, premises or any other similar coverage.

- Elective medical or surgical abortion unless:

  - The pregnancy would endanger the life of the mother; or
  - The pregnancy is a result of rape or incest; or
  - The fetus has been diagnosed with a lethal or otherwise significant abnormality.

- *Alternative medicine.*

H215700TX 07/07

- Acupuncture, unless:

  - The treatment is *medically necessary* and appropriate and is provided within the scope of the acupuncturist's license;
  - *You* are directed to the acupuncturist for treatment by a licensed physician; and
  - The acupuncture is performed in lieu of generally accepted anesthesia practices.

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

- Chiropractic services or spinal manipulations.

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

LIMITATIONS AND EXCLUSIONS (continued)

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

H216100 07/07

- Services and supplies which are:

  - Rendered in connection with mental illnesses not classified in the International Classification of Diseases of the U.S. Department of Health and Human Services; or

  - Extended beyond the period necessary for evaluation and diagnosis of learning and behavioral disabilities or for mental retardation.

- Marriage counseling.

- Court-ordered *behavioral health* services.

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

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

H216500TX 07/07

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

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

- Any care, treatment, services, equipment or supplies received outside of the *service area*:

  - If *you* could have reasonably foreseen or anticipated their need prior to departure from the *service area*; and
  - Which are not authorized by *us* or to the extent they exceed the *maximum allowable fee*.

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

H216925TX 07/07

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

H216980TX

ELIGIBILITY AND EFFECTIVE DATES

Eligibility date

Employee eligibility date

The *employee* who lives or works in the *service area* is eligible for coverage on the date:

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

H217000

Dependent eligibility date

Each *dependent* is eligible for coverage on:

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

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

A *dependent* child who enrolls for other group coverage through any employment is no longer eligible for *group* coverage under the *master group contract*. If a *dependent* child becomes an *employee* of the *employer*, he or she is no longer eligible as a *dependent* and must make application as an eligible *employee*.

A covered *dependent* child who becomes an *employee* eligible for group coverage under the *master group contract* through employment is no longer eligible as a *dependent* for coverage under the *master group contract*.

H217100TX

ELIGIBILITY AND EFFECTIVE DATES (continued)

Enrollment

Open enrollment period

The *open enrollment period* is the annual period during which eligible *employees* may apply for coverage for themselves and for their eligible *dependents.*
H217200

How to enroll

To enroll, the *employee* must complete the enrollment/change form provided by *us*, carefully listing each person to be covered. The *employee* must submit the completed enrollment/change form to their *employer* within the time periods indicated below:

- To enroll during an *open enrollment period*, the *employee* must submit an enrollment/change form during the *open enrollment period*.

- To enroll outside of an *open enrollment period*, the *employee* must submit an enrollment/change form within thirty-one (31) days of their *eligibility date* or *special enrollment date*.

- To enroll a newly eligible *dependent* that becomes eligible to enroll outside of an *open enrollment period*, the *employee* must submit an enrollment/change form within thirty-one (31) days from the *dependent's* first date of eligibility or *special enrollment date.*

- If the *employee* or their eligible *dependents* do not enroll within 31 days of the *eligibility date* or *special enrollment date*, they are a *late applicant* and must wait until the *group's* next *open enrollment period* to enroll.

H217300 10/06

Employee enrollment

The *employee* must enroll as agreed by the *group plan sponsor* and *us*. Depending on the total number of *employees* covered by the *employer's master group contract*, *we* may require any *employee* to provide evidence of health status whenever enrolling as permitted by laws, rules, or regulations. *We* will not use evidence of health status to decline medical coverage to a dependent eligible under an accepted *master group contract.*

If the *employee* enrolls more than 31 days after the *employee's eligibility date* or more than 31 days after the *employee's special enrollment date*, or after the *employer's open enrollment period*, the *employee* is a *late applicant* and must wait until the *group's* next *open enrollment period* to enroll.
H217400TX

ELIGIBILITY AND EFFECTIVE DATES (continued)

Dependent enrollment

Check with the *employer* immediately on how to enroll for *dependent* coverage. The *employee* must enroll for *dependent* coverage and enroll additional *dependents* as agreed by the *group plan sponsor* and *us*.

Depending on the total number of *employees* covered by the *employer's master group contract*, *we* may require any *dependent* to provide evidence of health status whenever enrolling as permitted by laws, rules, or regulations. *We* will not use evidence of health status to decline medical coverage to a dependent eligible under an accepted *master group contract.*

A *dependent* enrolled more than 31 days after the *dependent's eligibility date, special enrollment date*, or after the *employer's open enrollment period* will be a *late applicant* and must wait until the *group's* next *open enrollment period* to enroll.
H217500TX

Newborn dependent enrollment

Coverage will be automatic for the first 31 days following the newborn child's date of birth. If you currently do not have *dependent* child coverage, additional premium will be incurred for the initial 31-day coverage period whether the newborn *dependent* is enrolled for coverage under the *master group contract* or not. *You* may notify *us* as soon as reasonably possible after the date of birth of your intention to decline coverage for the newborn *dependent* under the *master group contract* in order to avoid incurring a premium charge.

To continue coverage for the newborn *dependent* beyond the initial 31-day period, *you* must notify *us* within 31 days of the date of birth and pay the required premium to maintain the coverage in force. A newborn *dependent* enrolled more than 31 days after the date of birth will be a *late applicant* and must wait until the *group's* next *open enrollment period* to enroll.
H217600TX

Special enrollment

Loss of other coverage

If you are an *employee* or *dependent* who was previously eligible for coverage under the *master group contract* and had waived coverage, you may be eligible for the "Special Enrollment" provision.

You will <u>not</u> be considered a *late applicant* if the following applies:

- *You* declined enrollment under the *master group contract* at the time of initial enrollment because:
  - *You* were covered under a group health plan or other *health coverage* at the time of eligibility and *your* coverage terminated as a result of:

  - Termination of employment or eligibility;
  - Reduction in number of hours of employment;
  - Divorce, legal separation or death of a spouse; or
  - Termination of your employer's contribution for the coverage; or
- You had COBRA continuation coverage under another plan at the time of eligibility and such coverage has since been exhausted; and
- You stated, at the time of the initial enrollment, that coverage under another group health plan, other *health coverage* or COBRA continuation was your reason for declining enrollment; and
- You were covered under an alternate plan provided by the *employer* and you are replacing coverage with *the master group contract;*

- You apply for coverage within thirty-one (31) days after termination of coverage under another group health plan or other *health coverage* or COBRA.
- A court has ordered coverage to be provided for a spouse under the covered *employee's* plan and a request for enrollment is made within thirty-one (31) days after the issuance of the court order;
- A court has ordered coverage to be provided for a child under the covered *employee's* plan and a request for enrollment is made within thirty-one (31) days from the date the *employer* receives the court order or notification of the court order;
- A child of an *employee* who has lost coverage under Title XIX of the Social Security Act, or under Chapter 62, Health and Safety Code and a request for enrollment is made within thirty-one (31) days from the date the child loses coverage;
- A change in family status due to marriage, birth of a child, adoption of a child, or because *you* become a party in a suit for the adoption of a child and a request for enrollment is made within thirty-one (31) days of marriage, birth, adoption or within thirty-one (31) days of the date *you* become a party in a suit for the adoption of a child.

H217700TX

Dependent special enrollment period

The *dependent* Special Enrollment Period is a 31-day period from the *special enrollment date*.

If *dependent* coverage is available under the *employer's master group contract* or added to the *master group contract*, an *employee* who is a *covered person* can enroll eligible *dependents* during the Special Enrollment Period. An *employee*, who is otherwise eligible for coverage and had waived coverage under the *master group contract* when eligible, can enroll himself/herself and eligible *dependents* during the Special Enrollment Period. The *employee* or *dependent* enrolling within thirty-one (31) days from the *special enrollment date* will not be considered a *late applicant*. *Late applicants* must wait until the *group's* next *open enrollment* period to enroll.

H217800

Effective date

Employee effective date

The *employee's effective date* provision is the first of the month following, completion of the *waiting period* or the *special enrollment date*.

For *employees* who enroll during an *open enrollment period*, coverage will become effective on the date specified by the *employer*.

If the *employee* enrolls more than 31 days after his or her *eligibility date* or *special enrollment date*, or after the *employer's open enrollment period*, he or she is a *late applicant*.
H217900TX

Dependent effective date

The *dependent's effective date* will be determined as follows:

- If *we* receive enrollment on, prior to, or within 31 days of the *dependent's eligibility date* that *dependent* is covered on the first of the month following or coinciding with the date he or she is eligible.

- If we receive enrollment on, prior to, or within 31 days of the *employer's open enrollment period*, the *effective date* of the *dependent's* coverage is the date specified by the *employer*.

- If *we* receive enrollment on, prior to, or within 31 days of the *dependent's special enrollment date*, that *dependent's* coverage is effective on the first of the month following or coinciding with the *special enrollment date*.

- If *we* receive enrollment more than 31 days after the *dependent's eligibility date*, the *special enrollment date*, or after the *employer's open enrollment* period, that *dependent* is considered a *late applicant*.

However, no *dependent's effective date* will be prior to the *employee's effective date* of coverage.
H218000TX

Newborn dependent effective date

- If *we* are notified within 31 days of the newborn's date of birth, *dependent* coverage is effective on the newborn's date of birth.

- If *we* are notified more than 31 days after the newborn's date of birth, the newborn is considered a *late applicant*.

- If the *employee* already has *dependent* child coverage, *dependent* coverage is effective on the newborn's date of birth provided the *employee* notify *us* of the birth within 31 days.

Note: Premium is due for any period of newborn *dependent* coverage whether or not the newborn *dependent* is subsequently enrolled, unless specifically not allowed by applicable law.
H218100TX

Benefit changes

Benefit changes will become effective on the date specified by *us*.
H218200

Retired employee coverage

Retired employee eligibility date

Retired *employees* are eligible if the *group plan sponsor* requested such coverage on the Employer Group Application and the request is approved by *us*. An *employee* who retires while covered under the *master group contract* is considered eligible for retired *employee* medical coverage on the date of retirement if the eligibility requirements stated in the Employer Group Application are satisfied.
H218300TX

Retired employee enrollment

The *employer* must submit notification of the *employee's* retirement to us within 31 days of the date of retirement. If *we* receive the notification more than 31 days after the date of retirement, the retiree will be considered a *late applicant*.
H218400

Retired employee effective date

The *effective date* of coverage for an eligible retired *employee* is the date of retirement for an *employee* who retires after the date *we* approve the *employer's* request for a retiree classification, provided *we* receive notice of the retirement within 31 days.
H218500

Retired employee benefit changes

Additional or increased coverage or a decrease in coverage will become effective on the approved date of change.
H218600

REPLACEMENT OF COVERAGE

Applicability

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

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

Benefits available for *covered health services* under the *master group contract* will be reduced by any benefits payable by the Prior Plan during an extension period.
H221000TX

Deductible credit

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

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

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

This credit will not apply if the *master group contract* is replacing a health maintenance organization group plan.
H221100TX

Waiting period credit

If the *employee* had not completed the initial *waiting period* under the *group plan sponsor's* Prior Plan on the day that it ended, any period of time that the *employee* satisfied will be applied to the appropriate *waiting period* under the *master group contract*, if any. The *employee* will then be eligible for coverage under the *master group contract* when the balance of the *waiting period* has been satisfied.
H221200

Out-of-pocket limit

Any amount applied to the Prior Plan s *out-of-pocket limit* or stop-loss limit will not be credited toward the satisfaction of any *out-of-pocket limit*, if any, of the *master group contract*.
H221300

TERMINATION PROVISIONS

Termination of coverage

The date of termination, as described in this "Termination Provisions" section, is the end of the month, as specified on the Employer Group Application.

When *we* receive notification of a change in eligibility status in advance of the effective date of the change, coverage will terminate at the end of that month, as specified on the Employer Group Application. *H222000TX*

Otherwise, coverage terminates on the earliest of the following:

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

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

- 15 days following written notice of the date *we* determine that fraud or an intentional misrepresentation of a material fact has been committed by *you*;

H222100TX

You and the *employer* are responsible to notify *us* of any change in eligibility, including the lack of eligibility, of any *covered person*.
H222200TX

Termination for cause

We will terminate *your* coverage on the date we specify with at least 15 days prior written notice for cause under the following circumstances:

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

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

H222300TX

CONTINUATION

Continuation options in the event of termination

If coverage terminates:

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

A complete description of the "State Continuation of Coverage " and "Continuation of Coverage for Dependents" provisions follow.
H224000TX 10/04

State continuation of coverage

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

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

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

In order to be eligible for this option:

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

There is no right to continuation if:

- The termination of coverage occurred because the *employee* failed to pay the required premium contribution;
- The discontinued group coverage was replaced by similar group coverage within 31 days of the discontinuance;
- The *covered person* is covered by *Medicare*;
- The *covered person* has similar benefits under another group or individual plan whether insured or self-insured;

- The *covered person* is covered for similar benefits under another group plan whether insured or self-insured; or
- Similar benefits are provided for the *covered person* under any state or federal law.

Written application and payment of the first subscription for continuation must be made within 31 days after the date coverage terminates or within 31 days after the *covered person* has been given the required notice, whichever is later. No evidence of insurability is required to obtain continuation.

If this state continuation option is selected, continuation will be permitted for a maximum of six months. The premium rate will be 102% (one-hundred and two percent) of the *group* premium. The premium will be payable in advance to the *group plan sponsor* on a monthly basis. Continuation may not terminate until the earliest of:

- Six months after the date the election is made;
- The date timely premium payments are not made on *your* behalf;
- The date the *group* coverage terminates in its entirety;
- The date on which the *covered person* is covered under *Medicare*;
- The date on which the *covered person* is covered for similar benefits under another group or individual policy;
- The date on which the *covered person* is covered for similar benefits under another group plan; or
- The date on which similar benefits are provided for the *covered person* under any state or federal law.

The *group plan sponsor* is responsible for sending *us* the premium payments for those individuals who choose to continue their coverage. If the *group plan sponsor* fails to make proper payment of the premiums to *us*, *we* are relieved of all liability for any coverage that was continued and the liability will rest with the *group plan sponsor*.
H224100TX

Continuation of coverage for dependents

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

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

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

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

CONTINUATION (continued)

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

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

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

The *group plan sponsor* must notify *us* of the choice to continue coverage upon receipt of it.

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

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

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

Continued coverage terminates on the earliest of the following dates:

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

The *group plan sponsor* is responsible for sending *us* the premium payments for those individuals who choose to continue their coverage. If the *group plan sponsor* fails to make proper payment of the premiums to *us*, *we* are relieved of all liability for any coverage that was continued and the liability will rest with the *group plan sponsor*.
H224200TX

Texas Health Insurance Risk Pool

You and/or *your dependents* may be eligible for coverage under the Texas Health Insurance Risk Pool. Information regarding this coverage may be obtained by calling 1-888-398-3927/TDD 1-800-313-4750 or writing to the following address:

Texas Health Insurance Risk Pool
Post Office Box 6089
Abilene, Texas 79608-6089

H224300TX

COORDINATION OF BENEFITS

This coordination of benefits (COB) provision applies when a person has health care coverage under more than one *plan*. The order of benefit determination rules below determine which *plan* will pay as the *primary plan*. The *primary plan* pays first without regard to the possibility another *plan* may cover some expenses. A *secondary plan* pays after the *primary plan* and may reduce the benefits it pays so that payments from all *plans* do not exceed 100% of the total *allowable expense.*
H226000

Definitions

The following definitions are used exclusively in this provision.

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

Plan includes:

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

Plan does not include:

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

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

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

COORDINATION OF BENEFITS (continued)

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

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

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

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

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

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

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

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

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

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

Custodial parent means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.
H226100 06/06

Order of determination rules

General

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

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

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

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

H226200

Rules

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

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

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

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

    - The parents are married;

- The parents are not separated (whether or not they have been married); or
- A court decree awards joint custody without specifying that one part has the responsibility to provide health care coverage.

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

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

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

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

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

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

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

If the preceding rules do not determine the *primary plan*, the *allowable expenses* shall be shared equally between the *plans* meeting the definition of *plan* under this provision. In addition, this *plan* will not pay more that it would have had it been *primary*.
H226300

COORDINATION OF BENEFITS (continued)

Effects on the benefits of this plan

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

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

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

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

If a *covered person* is enrolled in two or more *closed panel plans* and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one *closed panel plan*, COB shall not apply between that *plan* and the other *closed panel plan*.
H226400 10/06

Right to receive and release needed information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this *plan* and other *plans*. *We* may get the facts *we* need from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under this *plan* and other *plans* covering the person claiming benefits. *We* need not tell, or get the consent of, any person to do this. Each person claiming benefits under this *plan* must give *us* any facts *we* need to apply those rules and determine benefits payable.
H226500

Facility of payment

A payment made under another *plan* may include an amount that should have been paid under this *plan*. If it does, *we* may pay that amount to the organization that made the payment. That amount will then be treated as though it were a benefit paid under this *plan*. *We* will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means a reasonable cash value of the benefits provided in the form of services.
H226600

COORDINATION OF BENEFITS (continued)

Right of recovery

If the amount of the payments made by *us* is more than *we* should have paid under this COB provision, *we* may recover the excess from one or more of the persons *we* have paid or for whom *we* have paid; or any other person or organization that may be responsible for the benefits or services provided for the *covered person*. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.
H226700

COORDINATION OF BENEFITS FOR MEDICARE ELIGIBLES

Definitions

Medicare Part B means the Medicare program that provides medical insurance benefits.
H227000 06/06

General coordination of benefits with Medicare

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

You are considered to be eligible for *Medicare* on the earliest date coverage under *Medicare* could have become effective for *you*.
H227100 06/06

Coordination of benefits with Medicare Part B

If *you* are eligible for *Medicare Part B*, but are not enrolled, *your* benefits under the *master group contract* may be coordinated as if *you* were enrolled in *Medicare Part B*. *We* may not pay benefits to the extent that benefits would have been payable under *Medicare Part B*, if *you* had enrolled. Therefore, it is important that *you* enroll in *Medicare Part B* if *you* are eligible to do so.
H227200 06/06

CLAIMS

Notice of claim

Network providers will submit claims to *us* on *your* behalf. If *you* utilize a *non-network provider* for *covered health services*, *you* must submit a notice of claim to *us*. Notice of claim must be given to *us* in writing or by electronic mail as required by *your* plan, or as soon as is reasonably possible thereafter. Notice must be sent to *us* at *our* mailing address shown on *your* identification documentation or at *our* Website at www.humana.com.
H228000TX 05/05

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

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

The forms necessary for filing proof of loss are available via the internet at *our* Website. *When* requested by *you*, *we* will send *you* the forms for filing proof of loss. If the requested forms are not sent to *you* within 15 days, *you* will have met the proof of loss requirements by sending *us* a written or *electronic* statement of the nature and extent of the loss containing the above elements within the time limit stated in the "Proof of Loss" provision.
H228100TX

Proof of loss

You must give written or electronic proof of loss within 90 days after the date of loss. *Your* claims will not be reduced or denied if it was not reasonably possible to give such proof. In any event, written or electronic notice must be given within one year after the date proof of loss is otherwise required, except if *you* were legally incapacitated.
H228200

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

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

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

If a *covered person* receives written notice that a claim will be paid in whole or in part, payment will be made not later than the 5th business day after the date of such written notice.
H228250TX

Right to require medical examinations

We have the right to require a medical examination on any *covered person* as often as *we* may reasonably require. If *we* require a medical examination, it will be performed at *our* expense. *We* also have a right to request an autopsy in the case of death, if state law so allows.
H228300

To whom benefits are payable

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

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

If any *covered person* to whom benefits are payable is a minor or, in *our* opinion, not able to give a valid receipt for any payment due him or her, such payment will be made to his or her parent or legal guardian. However, if no request for payment has been made by the parent or legal guardian, *we* may, at *our* option, make payment to the person or institution appearing to have assumed his or her custody and support.
H228400TX

Time of payment of claims

Payments due under the *master group contract* will be paid no more than 30 days after receipt of written or electronic proof of loss.
H228500

Right to request overpayments

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

- Made in error; or
- Made to *you* and/or any party on *your* behalf, where *we* determine such payment made is greater than the amount payable under the *master group contract*; or
- Made to *you* and/or any party on *your* behalf, based on fraudulent or misrepresented information; or

- Made to *you* and/or any party on *your* behalf for charges that were discounted, waived or rebated.

We reserve the right to adjust any amount applied in error to the deductible or *out-of-pocket limit*, if any.
H228700TX 05/05

Right to collect needed information

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

- Authorizing the release of medical information including the names of all providers from whom *you* received medical attention;
- Obtaining medical information and/or records from any provider as requested by *us*;
- Providing information regarding the circumstances of *your illness*, *bodily injury* or *accident*;
- Providing information about other insurance coverage and benefits, including information related to any *bodily injury* or *illness* for which another party may be liable to pay compensation or benefits; and
- Providing information *we* request to administer the *master group contract*.

If *you* fail to cooperate or provide the necessary information, *we* may recover payments made by *us* and deny any pending or subsequent claims for which the information is requested.
H228800

Recovery rights

You as well as *your dependents* agree to the following, as a condition of receiving benefits under the *master group contract*.
H229000

Duty to cooperate in good faith

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

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

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

In the event that *you* fail to cooperate with *us*, *we* shall be entitled to recover from *you* any payments made by *us*.
H229100

Duplication of benefits/other insurance

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

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

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

When applicable, *you* are required to provide *us* with authorization to obtain information about the other coverage available, and to cooperate in the recovery of overpayments from the other coverage, including executing any assignment of rights necessary to obtain payment directly from the other coverage available.
H229200

Workers' Compensation

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

The recovery rights will be applied even though:

- The Workers' Compensation benefits are in dispute or are made by means of settlement or compromise;

- No final determination is made that *bodily injury* or *illness* was sustained in the course of or resulted from *your* employment;

- The amount of Workers' Compensation due to medical or health care is not agreed upon or defined by *you* or the Workers' Compensation carrier, or

- Medical or health care benefits are specifically excluded from the Workers' Compensation settlement or compromise.

You hereby agree, in consideration for the coverage provided by the *master group contract*, *you* will notify *us* of any Workers' Compensation claim *you* make, and *you* agree to reimburse *us* as described above.
H229300

Right of subrogation

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

- Any legally liable person or their carrier;
- Any uninsured motorist or underinsured motorist coverage;
- Medical payments/expense coverage under any automobile, homeowners, premises or similar coverages; or
- No-fault or other similar coverage.

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

If *we* are precluded from exercising *our* rights of subrogation, *we* may exercise *our* right of reimbursement.
H229400

Right of reimbursement

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

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

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

The obligation to reimburse *us* in full exists, regardless of whether the settlement, compromise, or judgment designates the recovery as including or excluding medical expenses.
H229500

Assignment of recovery rights

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

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

If benefits are paid under the *master group contract* and *you* recover under any automobile, homeowner's, premises or similar coverage, *we* have the right to recover from *you* an amount equal to the amount *we* paid.
H229600

Cost of legal representation

The costs of *our* legal representation in matters related to *our* recovery rights shall be borne solely by *us*. The costs of legal representation incurred by *you* shall be borne solely by *you*, unless *we* were given timely notice of the claim and an opportunity to protect *our* own interests and *we* failed or declined to do so.
H229700

COMPLAINT AND APPEAL PROCEDURES

Definitions

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

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

Complaint Process

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

After receipt of the written *complaint* or one-page *complaint* form from the *covered person*, *we* will investigate and send a letter with o*ur* resolution to the *covered person*. The total time for acknowledging, investigating and resolving the *covered person's complaint* will not exceed 30 calendar days after the date *we* receive the *complaint*.

Appeals to the Plan

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

- *We* shall send an acknowledgment letter to the *covered person* not later than the fifth business day after the date of receipt of the request for appeal.
- *We* shall appoint members to the complaint appeal panel, which shall advise *us* on the resolution of the dispute. The complaint appeal panel shall be composed of an equal number of o*ur* staff, health care practitioners, and other persons covered under a health plan provided by *us*. A member of the complaint appeal panel may not have been previously involved in the disputed decision.

- Not later than the fifth business day before the scheduled meeting of the panel, unless the *covered person* agrees otherwise, *we* shall provide to the *covered person* or *covered person's* designated representative:
  - Any documentation to be presented to the panel by *our* staff;
  - The specialization of any *health care practitioner* consulted during the investigation; and
  - The name and affiliation of each of *our* representatives on the panel.
- The *covered person* or the *covered person's* designated representative if the *covered person* is a minor or disabled, are entitled to:
  - Appear in person before the complaint appeal panel;
  - Present alternative expert testimony; and
  - Request the presence of and question any person responsible for making the prior determination that resulted in the appeal.

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

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

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

Notification of Adverse Determinations

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

Appeals of Adverse Determinations

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

COMPLAINT AND APPEAL PROCEDURES

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

After review of the appeal of an *adverse determination*, *we* will issue a response letter to the *covered person*, or a person acting on behalf of the *covered person* and the *covered person's health care practitioner* explaining the resolution of the appeal as soon as practical, but in no case later than the 30th calendar day after the date *we* receive the appeal. If the appeal is for *emergency care*, or denial of a continued stay for hospitalized patients, the time frame for resolution will be based on the medical or dental immediacy of the condition, procedure or treatment, but may not exceed one working day from the date the request is received. The resolution letter will contain the clinical basis for the appeal's denial, the specialty of the *health care practitioner* making the denial, and notice of the appealing party's right to seek review of the denial by an independent review organization (IRO).

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

Filing Complaints with the Texas Department of Insurance

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

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

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

COMPLAINT AND APPEAL PROCEDURES

Appeals Process to Internal Review Organization (IRO)

In a circumstance involving a *life threatening* condition, the *covered person* is entitled to an immediate appeal to an independent review organization (IRO) and is not required to comply with procedures for an internal review of *our adverse determination*. The procedure for filing an immediate appeal to an IRO is included in *our* initial denial notice.

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

The appeal process does not prohibit the *covered person* from pursuing other appropriate remedies, including injunctive relief, a declaratory judgment, or relief available under law, if the requirement of exhausting the process for appeal and review places the *covered person's* health in serious jeopardy.
H230000TX

Exhaustion of remedies

You must complete all levels of the appeal process available to *you* under state or federal law, including external review, before filing a lawsuit. This assures that both *you* and *we* have a full and fair opportunity to complete the record and resolve the dispute. Contact *us* if *you* believe *your* condition requires the use of the shorter time lines applicable to emergency health conditions.

The appeal process, however, does not preclude *you* from pursuing other appropriate remedies, including seeking injunctive relief or equitable relief, if the requirement of exhausting the process for appeals, including the emergency appeal process, would place *your* health in serious jeopardy.

A coverage denial does not mean that *your* provider cannot provide the service or supply. *Our* denial only means *we* will not pay for the service or supply, unless *our* decision is reversed on appeal or in a subsequent lawsuit.
H230100 05/05

Legal actions and limitations

No lawsuit with respect to plan benefits may be brought after the expiration of three years after the latter of:

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

H230200TX 06/06

MISCELLANEOUS PROVISIONS

Entire contract

The entire contract is made up of the *master group contract*, the Employer Group Application of the *group plan sponsor*, incorporated by reference herein, and the applications of the *employees*, if any. All statements made by the *group plan sponsor* or by an *employee* are considered to be representations, not warranties. This means that the statements are made in good faith. No statement will void the *master group 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 or her beneficiary.
H232000

Additional group plan sponsor responsibilities

In addition to responsibilities outlined in the *master group contract*, the *group plan sponsor* is responsible for:

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

No *group plan sponsor* has the power to change or waive any provision of the *master group contract*.
H232100 06/06

Certificates

A *certificate* setting forth a statement of benefits the *employee* and the *employee's* covered *dependents* are entitled will be available via the Internet or in writing when requested. The *employer* is responsible for providing *employees* access to the *certificate*.
H232200

This *certificate* is part of the *master group contract* that controls our obligations regarding coverage. No document that is viewed as being not consistent with the *master group contract* shall take precedence over it. This is true, also, when the *certificate* is incorporated by reference into a summary description of plan benefits prepared and distributed by the administrator of a group plan subject to ERISA. This *certificate* is not subject to the ERISA style and content conventions that apply to summary plan descriptions. So if the terms of a summary plan description appear to differ with the terms of this *certificate* respecting coverage, the terms of this *certificate* will control.
H232300

MISCELLANEOUS PROVISIONS (continued)

Incontestability

All statements made by the *group plan sponsor* or by an *employee* are considered to be representations, not warranties. This means that the statements are considered to be truthful and are made to the best of the *group plan sponsor* or *employee's* knowledge and belief. No statement will be used to void, cancel or non-renew the *master group contract*, or reduce the benefits it provides unless it is contained in a written application and a copy is furnished to the person making such statement or his or her representative.

After two years from the effective date of the *master group contract*, no misstatement made by the *group plan sponsor*, except a fraudulent misstatement made in the group application may be used to void the *master group contract*.

After *you* are covered without interruption for two years, *we* cannot contest the validity of *your* coverage except for fraud or an intentional misrepresentation of material fact on the enrollment application.

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

An independent incontestability period begins for each type of change in coverage when a new Employee Enrollment Application is completed.

We reserve the right to increase the premium in accordance with applicable law upon a 60 day written notice to the *group plan sponsor*.
H232400TX

Fraud

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

If *you* commit fraud against *us* or *your employer* commits fraud pertaining to *you* against *us*, as determined by *us*, *your* coverage ends automatically, without notice, as of the date fraud is committed or as of the date otherwise determined by *us*.
H232500

Clerical error, misstatement of age or gender

If it is determined that information about the age or gender of *you* or *your dependents* was omitted or misstated in error, the amount of coverage for which *you* are properly eligible will be in effect. An equitable premium adjustment will be made. This provision applies equally to *you* and to *us*.
H232600

MISCELLANEOUS PROVISIONS (continued)

Modification of master group contract

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

The *master group contract* may be modified by *us* at anytime without prior consent of, or notice to, the *group plan sponsor* when the changes are:

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

Modifications due to reasons other than those listed above, may be made by *us*, upon renewal of the *master group contract*, in accordance with state and federal law. The *group plan sponsor* will be notified in writing or *electronically* at least 60 days prior to the effective date of such changes. The *group plan sponsor* may terminate this *master group contract* by giving written notice to *us* no later than 31 days prior to the desired termination date.
H232700TX 11/07

Premium contributions

Your employer must pay the required premium to *us* as they become due. *Your employer* may require *you* to contribute toward the cost of *your* coverage. Failure of *your employer* to pay any required premium to *us* when due may result in the termination of *your* coverage.
H232800

Premium rate change

We reserve the right to change any premium rates in accordance with applicable law upon notice to the *employer*. *We* will provide notice to the *employer* of any such premium changes. Questions regarding changes to premium rates should be addressed to the *employer*.
H232900

MISCELLANEOUS PROVISIONS (continued)

Electronic transactions

Coverage information will be available at *our* internet web site. *You* may access this information by logging into the web site, using a User ID and PIN number provided to *you*. At initial log in, *we* will ask *you* to provide *your* individual password. *We* will send to *your* attention a security access code to provide for confidentiality. Each individual adult *covered person* shall have his or her own PIN number.

We will send *you* an *electronic mail* notification, directing *you* to *our* web site anytime that information and/or notices required by federal or state laws, rules or regulations are available for viewing in *your* individual message box. *You* need to check *your* personal message box anytime *you* receive *electronic mail* notification from *us*, as important information regarding *your* benefits may be located within *your* individual folder.

We will send *you* and *your* adult *dependents electronic mail* notification to the *electronic mail* address that *you* provided to *us* on *your* application. Each individual adult covered may provide a different *electronic mail* address. It is important that *you* contact *us* with a new *electronic mail* address when *you* change *your* address or would like *us* to direct *your electronic mail* notifications to a different *electronic mail* address.

All transactions between *you* and *us* may be transacted *electronically* or in writing. Forms *you* will need for *electronic* transactions can be found on *our* web site at www.humana.com.
H233000

Assignment

The *master group contract* and its benefits may not be assigned by the *group plan sponsor*.
H233100

Conformity with statutes

Any provision of the *master group contract* which is not in conformity with applicable state law(s) or other applicable law(s) shall not be rendered invalid, but shall be construed and applied as if it were in full compliance with the applicable state law(s) and other applicable law(s).
H233200

GLOSSARY

Terms printed in italic type in this *certificate* have the meaning indicated below. Defined terms are printed in italic type wherever found in this *certificate*.
H234000

A

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

Acquired brain injury means a neurological insult to the brain, which is not hereditary, congenital, or degenerative. The injury to the brain has occurred after birth and results in a change in neuronal activity, which results in an impairment of physical functioning, sensory processing, cognition, or psychosocial behavior.

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

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

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

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

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

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

Alternative medicine provider means a practitioner licensed and/or certified to practice within their state and who performs tasks defined within their scope of practice as defined by the licensing or certifying agency. Specifically, for the purposes of this definition, *alternative medicine provider* means a licensed and/or certified:

- Acupuncturist;
- Doctor of Medicine (M.D.);
- Doctor of Osteopathy (D.O.);
- Nurse practitioner (N.P.);
- Doctor of Naturopathy (N.D.);
- Massage therapist;
- Social worker with graduate degree;
- Psychologist;
- Nutritionist; and
- Doctor of Chiropractic (D.C.).

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

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

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

Autism spectrum disorder means a neurobiological disorder that includes autism, Asperger's syndrome, or Pervasive Developmental Disorder not otherwise specified.
H234800TX 07/07

B

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

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

Bone marrow means the transplant of human blood precursor cells which are administered to a patient following high-dose, ablative or myelosuppressive chemotherapy. Such cells may be derived from bone marrow, circulating blood, or a combination of bone marrow and circulating blood obtained from the patient in an autologous transplant or from a matched related or unrelated donor or cord blood. If chemotherapy is an integral part of the treatment involving an *organ transplant* of *bone marrow*, the term *bone marrow* includes the harvesting, the transplantation and the chemotherapy components.
H235100 07/07

C

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

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

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

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

Cognitive communication therapy means *services* designed to address modalities of comprehension and expression, including understanding, reading, writing, and verbal expression of information.

Cognitive rehabilitation therapy means *services* designed to address therapeutic cognitive activities, based on an assessment and understanding of the individual's brain-behavioral deficits.

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

Community reintegration services means *services* that facilitate the continuum of care as an affected individual transitions into the community.

Complications of pregnancy means:

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

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

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

Complication of pregnancy does not mean:

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

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

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

Copayment means the specified dollar amount that *you* must pay to a provider for certain *covered health services* regardless of any amounts that may be paid by *us*.

GLOSSARY (continued)

Copayment limit means the amount of *copayment* that must be paid by a *covered person*, either individually or combined as a covered family, per *year* before *copayments* are no longer required for the remainder of that *year*.

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

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

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

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

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

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

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

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

Creditable coverage does not include any of the following:

- Accident only coverage, disability income insurance, or any combination thereof;
- Supplemental coverage to liability insurance;

- Liability insurance, including general liability insurance and automobile liability insurance;
- Workers' compensation or similar insurance;
- Automobile medical payment insurance;
- Credit-only insurance;
- Coverage for on site medical clinics;

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

- Benefits if offered as independent, non-coordinated benefits:
  - Specified disease or illness coverage; and
  - Hospital indemnity or other fixed indemnity insurance;

- Benefits offered as a separate policy:
  - *Medicare* supplement insurance;
  - Supplemental coverage to the health plan for active military personnel, including TRICARE; and
  - Similar supplemental coverage provided to group health plan coverage.

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

Custodial care means services given to *you* if:

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

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

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

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

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

H236100TX 07/07

GLOSSARY (continued)

D

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

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

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

Dependent means a covered *employee's*:

- Legally recognized spouse;

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

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

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

    - Such QMCSO or NMSN is no longer in effect; or

    - The child is enrolled for comparable health coverage, which is effective no later than the termination of the child's coverage under the *master group contract*.

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

The coverage for each *dependent* child is subject to the END OF THE MONTH that he or she attains the age of 25; or

You must furnish satisfactory proof to *us*, upon *our* request, that the above conditions continuously exist. If satisfactory proof is not submitted to *us*, the child's coverage will not continue beyond the last date of eligibility.

A covered *dependent* child who becomes an *employee* eligible for group coverage under the *master group contract* through employment is no longer eligible as a *dependent* for coverage under the *master group contract*.

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

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

In order for the covered *dependent* child to remain eligible as specified above, *we* must receive notification within 31 days of the covered *dependent* child attaining the limiting age.
A handicapped *dependent* child, as defined in the bulleted items above, who attained the limiting age while covered under the *employer's* previous group medical plan (Prior Plan) is eligible for coverage under this plan.

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

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

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

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

Durable medical equipment means equipment, defined by *Medicare* Part B, that meets all of the following criteria:

- It can stand repeated use;
- It is primarily and customarily used to serve a medical purpose rather than being primarily for comfort or convenience;
- It is usually not useful to *you* in the absence of *illness* or *bodily injury*;

- It is appropriate for home use;
- It is related to *your* physical disorder;
- It is not typically furnished by a *hospital* or s*killed nursing facility*; and
- It is *medically necessary* and necessitated by *your bodily injury* or *sickness*; and
- It is provided in the most cost effective manner required by *your* condition, including, at *our* discretion, rental or purchase.

H236800TX 07/07

E

Effective date means the date *your* coverage begins under the *master group contract*.

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

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

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

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

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

- An employee who is covered under:
- Another health plan;
- A self-funded ERISA plan;
- Medicaid if the employee elects not to be covered;
- Another federal program, including Tricare or Medicare, if the employee elects not to be covered; or
- A plan established in another country if the employee elects not to be covered.

GLOSSARY (continued)

Emergency care means services provided in a *hospital* emergency facility or a comparable facility to evaluate and stabilize medical conditions of a recent onset and severity for a *bodily injury* or *illness* manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect 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; or
- Serious dysfunction of any bodily organ or part; or
- Serious disfigurement; or
- In the case of a pregnant woman, serious jeopardy to the health of the fetus.

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

Employee means any individual employed by the *employer*.

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

Enrollment date means:

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

The term *enrollment date* in this *certificate* is used for the determination and application of *creditable coverage*.

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

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

- Is a device required to receive Premarket Approval (PMA) or 510K approval by the FDA but has not received a PMA or 510K approval;
- Is not identified as safe, widely used and generally accepted as effective for the proposed use as reported in nationally recognized peer reviewed medical literature published in the English language as of the date of service;
- Is the subject of a National Cancer Institute (NCI) Phase I, II or III trial or a treatment protocol comparable to a NCI Phase I, II or III trial, or any trial not recognized by NCI regardless of phase; or
- Is identified as not covered by the Centers for Medicare and Medicaid Services (CMS) Medicare Coverage Issues Manual, a CMS Operational Policy Letter or a CMS National Coverage Decision, except as required by state or federal law.

H238000TX 07/07

F

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

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

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

H238300TX 07/07

G

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

Group plan sponsor means the legal entity identified as the *group plan sponsor* on the face page of the *master group contract* who establishes, sponsors and endorses an employee benefit plan for health care coverage.

H238450 07/07

H

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

GLOSSARY (continued)

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

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

Health status-related factor means any of the following:

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

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

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

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

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

- It must provide, for a fee, medical care and treatment of sick or injured patients on an *inpatient* basis;

- It must provide or operate, either on its premises or in facilities available to the *hospital* on a pre-arranged basis, medical, diagnostic and surgical facilities;

- Care and treatment must be given by and supervised by physicians. Nursing services must be provided on a 24-hour basis and must be given by or supervised by registered nurses;

- It must be licensed by the laws of the jurisdiction where it is located. It must be operated as a hospital as defined by those laws;

- It must not be primarily a:

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

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

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

H239200TX 07/07

I

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

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

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

- Artificial insemination;
- In vitro fertilization;
- Gamete Intrafallopian Transfer (GIFT);
- Zygote Intrafallopian Transfer (ZIFT);
- Tubal ovum transfer;
- Embryo freezing or transfer;
- Sperm storage or banking;
- Ovum storage or banking;

- Embryo or zygote banking;
- Diagnostic and/or therapeutic laparoscopy;
- Hysterosalpingography;
- Ultrasonography;
- Endometrial biopsy; and
- Any other assisted reproductive techniques or cloning methods.

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

Intensive outpatient program means *outpatient* services providing:

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

Intensive outpatient program does not include services that are for:

- *Custodial care*; or
- Day care.

H239600TX 07/07

J

K

L

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

Late applicant means an *employee* or *dependent* who applies for coverage more than 31 days after his/her *eligibility date*, more than 31 days after the *special enrollment date*, or after the *open enrollment period* ends.

Life Threatening means a disease or condition for which the likelihood of death is probable unless the course of the disease or condition is interrupted.

H239750TX 07/07

M

Maintenance care means services and supplies furnished mainly to:

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

Master group contract means the document describing the benefits *we* provide as agreed to by *us* and the *group plan sponsor*.

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

Medically necessary means the required extent of health care service, treatment or product that a *health care practitioner* would provide to his or her patient for the purpose of diagnosing, palliating or treating an *illness* or *bodily injury*, or its symptoms. Such health care service, treatment or product must be:

- In accordance with nationally recognized standards of medical practice and identified as safe, widely used and generally accepted as effective for the proposed use;
- Clinically appropriate in terms of type, frequency, intensity, toxicity, extent, setting, and duration;
- Not primarily for the convenience of the patient, physician or other health care provider;
- Clearly substantiated and supported by the medical records and documentation concerning the patient's condition;
- Performed in the most cost effective setting required by the patient's condition; and
- Supported by the preponderance of nationally recognized peer review medical literature, if any, published in the English language as of the date of service.

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

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

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

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

H240300 07/07

N

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

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

Neurobehavioral testing means an evaluation of the history of neurological and psychiatric difficulty, current symptoms, current mental status, and premorbid history, including the identification of problematic behavior and the relationship between behavior and the variables that control behavior. This may include interviews of the individual, family, or others.

Neurobehavioral treatment means interventions that focus on behavior and the variables that control behavior.

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

Neurocognitive rehabilitation means *services* designed to assist cognitively impaired individuals to compensate for deficits in cognitive functioning by rebuilding cognitive skills and/or developing compensatory strategies and techniques.

Neurocognitive therapy means *services* designed to address neurological deficits in informational processing and to facilitate the development of higher level cognitive abilities.

Neurofeedback therapy means *services* that utilize operant conditioning learning procedure based on electroencephalography (EEG) parameters, and which are designed to result in improved mental performance and behavior, and stabilized mood.

Neurophysiological testing means an evaluation of the functions of the nervous system.

Neurophysiological treatment means interventions that focus on the functions of the nervous system.

Neuropsychological testing means the administering of a comprehensive battery of tests to evaluate neurocognitive, behavioral, and emotional strengths and weaknesses and their relationship to normal and abnormal central nervous system functioning.

Neuropsychological treatment means interventions designed to improve or minimize deficits in behavioral and cognitive processes.

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

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

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

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.).
H241000TX 07/07

O

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

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

Open enrollment period means an annual thirty-one (31) day period of time determined by the *employer* and *us* during which eligible *employees* may enroll themselves and their eligible *dependents* under the *policy*.

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

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

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

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

Out-of-pocket limit means the amount of *covered health services*, excluding expenses used to satisfy *deductibles* and *copayments*, that must be paid by a *covered person*, either individually or combined as a covered family, per *year* before a benefit percentage will be increased.

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

Outpatient surgery means *surgery* performed in a *health care practitioner's* office, *ambulatory surgical center*, or the *outpatient* department of a *hospital*.
H241600TX 07/07

P

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

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

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

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

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

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

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

Partial hospitalization does not include services that are for:

- *Custodial care*; or
- Day care.

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

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

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

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

Pre-surgical/procedural testing means:

- Laboratory tests or radiological examinations done on an *outpatient* basis in a *hospital* or other facility accepted by the *hospital* before *hospital confinement* or *outpatient surgery* or procedure;

- The tests must be accepted by the *hospital* or *health care practitioner* in place of like tests made during *confinement*; and

- The tests must be for the same *bodily injury* or *illness* causing *you* to be *hospital confined* or to have the *outpatient surgery* or procedure.

Preauthorization means approval by *us*, or *our* designee, of a service prior to it being provided. Certain services, except *primary care physician* services, gynecological and obstetrical services and *emergency care* require medical review by *us* in order to determine eligibility for coverage.

Preauthorization is granted when such a review determines that a given service is a *covered health service* according to the terms and provisions of the *master group contract*.

Preventive services means services determined to be effective and accepted for the detection and prevention of disease in persons with no symptoms as recommended by the U.S. Preventive Services Task Force.

Primary care physician means a *network health care practitioner* with a specialty of internal medicine, pediatrics or family medicine/general practice who provides initial and primary care services to *covered persons*, maintains the continuity of *covered persons* medical care and helps direct *covered persons* to *specialty care physicians* and other providers.

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

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

- Is clinically supervised by a certified psychiatrist.

Psychophysiological testing means an evaluation of the interrelationships between the nervous system and other bodily organs and behavior.

Psychophysiological treatment means interventions designed to alleviate or decrease abnormal physiological responses of the nervous system due to behavioral or emotional factors.
H242585TX 07/07

Q

Qualified individual means:

- A postmenopausal woman who is not receiving estrogen replacement therapy; or
- An individual with:
  - Vertebral abnormalities;
  - Primary hyperparathyroidism; or
  - A history of bone fractures; or
- An individual who is:
  - Receiving long-term glucocorticoid therapy; or
  - Being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy.

H242590TX

R

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

Residential treatment center for children and adolescents means a child-care institution which:

- Provides residential care and treatment for emotionally disturbed children and adolescents; and
- Is accredited as a residential treatment center by the Council on Accreditation, the Joint Commission on Accreditation of Hospitals, or the American Association of Psychiatric Services for Children.

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

Routine nursery care means the charges made by a *hospital* or licensed birthing center for the use of the nursery. It includes normal services and supplies given to well newborn children following birth. *Health care practitioner* visits are not considered *routine nursery care*. Treatment of a *bodily injury, illness*, birth abnormality, congenital defect following birth and care resulting from prematurity is not considered *routine nursery care*.
H242900TX 07/07

S

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

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

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

Service area means the geographic area designated by *us*, or as otherwise agreed upon between the *group plan sponsor* and *us* and approved by the Department of Insurance of the state in which the *master group contract* is issued, if such approval is required. The *service area* is the geographic area where the *network provider* services are available to *you*. A description of the *service area* is provided in the provider directories.

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

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

GLOSSARY (continued)

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

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

Sound natural tooth means a tooth that:

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

Special enrollment date means:

- The date of change in family status after the initial *eligibility date* as follows:
    - Date of marriage;
    - Date of divorce;
    - Date specified in a Qualified Medical Child Support Order (QMCSO);
    - Date specified in a National Medical Support Notice (NMSN);
    - Date of birth of a natural born child; or
    - Date of adoption of a child or date of placement of a child with the *employee* for the purpose of adoption; or

- The date of termination of coverage under a group health plan or other *health coverage*, as specified under the "Special Enrollment" provision.

Specialty care physician means a *health care practitioner* who has received training in a specific medical field other than the specialties listed as primary care.

Surgery means services categorized as Surgery in the Current Procedural Terminology (CPT) Manuals published by the American Medical Association. The term *surgery* includes, but is not limited to: excision or incision of the skin or mucosal tissues or insertion for exploratory purposes into a natural body opening; insertion of instruments into any body opening, natural or otherwise, done for diagnostic or other therapeutic purposes; and treatment of fractures.
H243800TX 07/07

T

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

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

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

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

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

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

Toxic inhalant means a volatile chemical under Chapter 484, Health and Safety Code, or abusable glue or aerosol paint under Section 485.001, Health and Safety Code.
H243950TX 07/07

U

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

Urgent care center means any licensed public or private non-hospital *free-standing facility* which has permanent facilities equipped to provide *urgent care services* on an *outpatient* basis.
H244200 07/07

Usual and customary means:

- The fee established by *us* by comparing rates from one or more regional or national databases or schedules for the same or similar services from a geographical area determined by *us*; or
- The standard fee based upon rates negotiated by *us* or other payors with one or more *network providers* in a geographic area determined by *us* for the same or similar services.

H244210TX

V

W

Waiting period means the period of time, elected by the *group plan sponsor*, which must pass before an *employee* is eligible for coverage under the *master group contract*. The *waiting period* for a *small employer* may not exceed 90 days from the first day of employment.

We, us or ***our*** means the offering company as shown on the cover page of this *master group contract* and *certificate*.
H244400TX 07/07

X

Y

Year means the period of time which begins on any January 1st and ends on the following December 31st. When *you* first become covered by the *master group contract*, the first *year* begins for *you* on the effective date of *your* coverage and ends on the following December 31st.

You or ***your*** means any *covered person*.
H244600 07/07

Z

PRESCRIPTION DRUG BENEFIT RIDER

This rider is made part of the *master group contract* to which it is attached. The effective date of this change is the latter of the effective date of the *certificate* or the date this benefit is added to the *master group contract*.

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

Any expenses incurred by *you* under provisions of this rider do not apply toward *your out-of-pocket limit*, if any.

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

All terms used in this benefit rider have the same meaning given to them in the *certificate* unless otherwise specifically defined in this benefit rider.
H1800000 10/04

Prescription drug cost sharing

You are responsible for any and all payments of the following, when applicable, according to the "Schedule of Benefits-Prescription Drugs" section of this benefit rider:

- The *drug deductible*, if any; and
- The *copayment**.

* If the dispensing *pharmacy's* charge is less than the *copayment*, *you* will be responsible for the lesser amount. The amount paid by *us* to the dispensing *pharmacy* may not reflect the ultimate cost to *us* for the drug. *Your copayments* are made on a per *prescription* or refill basis and will not be adjusted if Humana receives any retrospective volume discounts or *prescription* drug rebates.
H1800100

Definitions

The following terms are used in this benefit rider:
H1800200

Brand-name medication means a drug, medicine or medication that is manufactured and distributed by only one pharmaceutical manufacturer, or any drug product that has been designated as brand-name by an industry-recognized source used by *us*.
H1800400 06/06

PRESCRIPTION DRUG BENEFIT RIDER (continued)

Copayment means the amount to be paid by *you* toward the cost of each separate *prescription* or refill of a covered *prescription* drug when dispensed by a *pharmacy*.
H1800600

Dispensing limit means the monthly drug dosage limit and/or the number of months the drug usage is usually needed to treat a particular condition, as determined by *us*. Diabetic supplies are not subject to dispensing limits.
H1800800TX 06/06

Drug deductible means a specified amount of *prescription* drug expenses *you* must incur per *year* before benefits will be paid under this benefit rider. These expenses do not apply toward any other *deductible*, if any, stated in the *master group contract*.
H1800850

Drug list means a list of *prescription* drugs, medicines, medications and supplies specified by *us*. This list identifies drugs as *level 1*, *level 2*, *level 3*, or *level 4* and indicates applicable *dispensing limits* and/or any *prior authorization* requirements. This list is subject to change without notice.
H1800900 06/06

Generic medication means a drug, medicine or medication that is manufactured, distributed, and available from a pharmaceutical manufacturer and identified by the chemical name, or any drug product that has been designated as generic by an industry-recognized source used by *us*.
H1801000 06/06

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."
H1801100

Level 1 drugs means a category of *prescription* drugs, medicines or medications within the *drug list* that are designated by *us* as *level 1 drugs*.
H1801200

Level 2 drugs means a category of *prescription* drugs, medicines or medications within the *drug list* that are designated by *us* as *level 2 drugs*.
H1801300

Level 3 drugs means a category of *prescription* drugs, medicines or medications within the *drug list* that are designated by *us* as *level 3 drugs*.
H1801400

Level 4 drugs means a category of *prescription* drugs, medicines or medications within the *drug list* that are designated by *us* as *level 4 drugs*.
H1801500

Mail order pharmacy means a *pharmacy* that provides covered *mail order pharmacy* services, as defined by *us*, and delivers covered *prescriptions* or refills through the mail to *covered persons*.
H1801700 06/06

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 *prescriptions* or refills delivered through the mail.
H1801800 06/06

Non-network pharmacy means a *pharmacy* that has not signed a direct agreement with *us* or has not been designated by *us* to provide:

- Covered *pharmacy* services
- Covered *specialty pharmacy* services; or
- Covered *mail order pharmacy* services,

as defined by *us*, to *covered persons*, including covered *prescriptions* or refills delivered through the mail.
H1801900 06/06

Orphan drug means a drug or biological used for the diagnosis, treatment, or prevention of rare diseases or conditions, which:

- Affects less than 200,000 persons in the United States; or

- Affects more than 200,000 persons in the United States, however, there is no reasonable expectation that the cost of developing the drug and making it available in the United States will be recovered from the sales of that drug in the United States.

H1802000

Pharmacist means a person who is licensed to prepare, compound and dispense medication and who is practicing within the scope of his or her license.
H1802200

Pharmacy means a licensed establishment where *prescription* medications are dispensed by a *pharmacist*.
H1802300

Prescription means a direct order for the preparation and use of a drug, medicine or medication. The *prescription* must be given by a *health care practitioner* to a *pharmacist* for *your* benefit and use for the treatment of an *illness* or *bodily injury* which is covered under this plan. The drug, medicine or medication must be obtainable only by *prescription*. The *prescription* may be given to the *pharmacist* verbally, *electronically* or in writing by the *health care practitioner*. The *prescription* must include at least:

- *Your* name;
- The type and quantity of the drug, medicine or medication prescribed, and the directions for its use;
- The date the *prescription* was prescribed; and
- The name and address of the prescribing *health care practitioner*.

H1802400TX 06/06

Prior authorization means the required prior approval from *us* for the coverage of *prescription* drugs, medicines and medications, including the dosage, quantity and duration, as appropriate for *your* diagnosis, age and sex. Certain *prescription* drugs, medicines or medications may require *prior authorization*.
H1802500

Self-administered injectable drugs means an FDA-approved medication which a person may administer to himself/herself by means of intramuscular, intravenous, or subcutaneous injection, excluding insulin, and is intended for use by *you*.
H1802600

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

- Require nursing services or special programs to support patient compliance;
- Require disease-specific treatment programs;
- Have limited distribution requirements; or
- Have special handling, storage or shipping requirements.

H1802625TX

Specialty pharmacy means a *pharmacy* that provides covered *specialty pharmacy* services, as defined by *us*, to *covered persons*.
H1802650

Year means the period of time which begins on any January 1st and ends on the following December 31st. When *you* first become covered by the *master group contract*, the first *year* begins for *you* on the effective date of *your* coverage and ends on the following December 31st.
H1802690

Coverage description

We will cover *prescription* drugs that are received by *you* from a *network pharmacy* while *you* are covered under this Prescription Drug Benefit Rider. Benefits may be subject to *dispensing limits* and *prior authorization* requirements, if any.

Covered *prescription* drugs are:

- Drugs, medicines or medications that under federal or state law, may be dispensed only by *prescription* from a *health care practitioner;*
- Drugs, medicines or medications that are included on the *drug list*;
- Insulin and *diabetes supplies*;
- Contraceptive drugs and contraceptive drug delivery implants approved by the FDA;

- Hypodermic needles or syringes when prescribed by a *health care practitioner* for use with insulin or *self-administered injectable drugs*; (Hypodermic needles and syringes used in conjunction with covered drugs may be available at no cost to *you*);

- *Specialty Drugs* and *self-administered injectable drugs* approved by *us*;

- Formulas necessary for the treatment of phenylketonuria or other inherited diseases;

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

Notwithstanding any other provisions of the *master group contract*, *we* may decline coverage or, if applicable, exclude from the *drug list* any and all *prescriptions* until the conclusion of a review period not to exceed six months following FDA approval for the use and release of the *prescriptions* into the market.
H1802700TX 06/06

Schedule of benefits - prescription drugs

You are responsible for the following:

RETAIL *PHARMACY* / *SPECIALTY PHARMACY*

Level 1 drugs	$5 *copayment* per *prescription* or refill per 30-day supply
Level 2 drugs	$35 *copayment* per *prescription* or refill per 30-day supply
Level 3 drugs	$55 *copayment* per *prescription* or refill per 30-day supply
*Level 4 drugs***	25% up to a maximum *copayment* of $100 per *prescription* or refill per 30-day supply

Some retail *pharmacies* participate in *our* program which allows *you* to receive a 90-day supply of a *prescription* or refill. *Your* cost is 2 times the applicable *copayment* as outlined above. *Self-administered injectable drugs* and *specialty drugs* are limited to a 30-day supply from a retail *pharmacy* or *specialty pharmacy*, unless otherwise determined by *us*.

MAIL ORDER PHARMACY

For up to a 90-day supply of a *prescription* or refill	2 times the applicable *copayment*, as outlined above under Retail *Pharmacy* / *Specialty Pharmacy*

H1802800TX 07/06

** After *copayments* for *level 4 drugs* equal $2500 in a *year* for a *covered person*, no further *copayments* must be made for that *covered person* for *level 4 drugs* for the remainder of that *year*.
H1803000

When *you* do not present *your* I.D. card at the time of purchase to the *network pharmacy*, *you* will also be responsible for 30% of the actual charge made by the dispensing *pharmacy*, after the applicable *copayment*.
H1803400

When *you* request a *brand-name medication* when a *generic medication* is available, *you* are responsible for the applicable *generic medication copayment* and 100% of the difference between the amount *we* would have paid the dispensing *pharmacy* for the *brand-name medication* and the amount *we* would have paid the dispensing *pharmacy* for the *generic medication*; unless the prescribing *health care practitioner* determines that the *brand name medication* is *medically necessary*, then *you* will only be responsible for the applicable *copayment* for a *brand-name medication on the drug list*.
H1803100

Limitations and exclusions

No benefit is provided for:
H1803600

- *Legend drugs* which are not deemed *medically necessary* by *us*;

H1803700 06/06

- Any drug prescribed for intended use other than for:
  - Indications approved by the FDA; or
  - Off-label indications recognized through peer-reviewed medical literature;

H1804000

- Any drug prescribed for an *illness* or *bodily injury* not covered under the *master group contract*;

H1804100TX

- Any drug, medicine or medication labeled "Caution-limited by federal law to investigational use" or any *experimental or investigational* drug, medicine or medication, even though a charge is made to *you*;

H1804200 06/06

PRESCRIPTION DRUG BENEFIT RIDER (continued)

- Allergen extracts;

H1804300

- Therapeutic devices or appliances including, but not limited to

  - Hypodermic needles and syringes (except needles and syringes for use with insulin, and *self-administered injectable drugs* whose coverage is approved by *us*);
  - Support garments;
  - Test reagents;
  - Mechanical pumps for delivery of medications; and
  - Other non-medical substances;

H1804400 06/06

- Dietary supplements; (except for formulas or low protein modified foods necessary for the treatment of phenylketonuria or certain other heritable diseases of amino and organic acids);

H1804500

- Nutritional products;

H1804600

- Fluoride supplements;

H1804700

- Minerals;

H1804800

- Growth hormones (medications, drugs or hormones to stimulate growth), unless there is a laboratory confirmed diagnosis of growth hormone deficiency;

H1804900

- Herbs and vitamins, except prenatal (including greater than one milligram of folic acid) and pediatric multi-vitamins with fluoride;

H1805000

- Anabolic steroids;

H1805100

- Anorectic or any drug used for the purpose of weight control;

H1805200

PRESCRIPTION DRUG BENEFIT RIDER (continued)

- Any drug used for cosmetic purposes, including but not limited to:
  - Tretinoin, e.g. Retin A, except if *you* are under the age of 45 or are diagnosed as having adult acne;
  - Dermatologicals or hair growth stimulants; or
  - Pigmenting or de-pigmenting agents, e.g. Solaquin;

H1805300

- Any drug or medicine that is:
  - Lawfully obtainable without a *prescription* (over the counter drugs), except insulin; or
  - Available in prescription strength without a *prescription*;

H1805400

- Compounded drugs in any dosage form; except when prescribed for pediatric use for children up to 19 years of age;

H1805500

- Progesterone crystals or powder in any compounded dosage form;

H1805600

- Abortifacients (drugs used to induce abortions);

H1805800

- *Infertility services* including medications;

H1805900

- Any drug prescribed for impotence and/or sexual dysfunction, e.g. Viagra;

H1806000

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

H1806100

- The administration of covered medication(s);

H1806200

- *Prescriptions* that are to be taken by or administered to *you*, in whole or in part, while *you* are a patient in a facility where drugs are ordinarily provided by the facility on an inpatient basis. *Inpatient* facilities include, but are not limited to:
  - *Hospital*;
  - *Skilled nursing facility*; or
  - *Hospice facility*;

H1806300

- Injectable drugs, including but not limited to:
  - Immunizing agent;
  - Biological sera;
  - Blood plasma;
  - Self administered injectable drugs or speciality drugs for which coverage is not approved by us,

H1806400 06/06

- *Prescription* refills:
  - In excess of the number specified by the *health care practitioner*; or
  - Dispensed more than one year from the date of the original order;

H1806500

- Any portion of a *prescription* or refill that exceeds a 90-day supply, received from a *mail order pharmacy* or a retail *pharmacy* that participates in *our* program which allows *you* to receive a 90-day supply of a *prescription* or refill;

H1806600 06/06

- Any portion of a *prescription* or refill that exceeds a 30-day supply, received from a retail *pharmacy* that does not participate in *our* program which allows *you* to receive a 90-day supply of a *prescription* or refill;

H1806640

- Any portion of a *specialty drug* or *self-administered injectable drug* received from a retail *pharmacy* or a *specialty pharmacy* that exceeds a 30-day supply, unless otherwise determined by *us*;

H1806650

- Any portion of a *prescription* or refill that:
  - Exceeds *our* drug specific *dispensing limit*, e.g. IMITREX; or
  - Is dispensed to a *covered person* whose age is outside the drug specific age limits defined by *us*;
  - Exceeds the duration-specific *dispensing limit*;

H1806700

- Any drug for which *prior authorization* is required, as determined by *us*, and not obtained;

H1806800

- Any drug for which a charge is customarily not made;

H1806900

- Any drug, medicine or medication received by *you*:
  - Before becoming covered under this rider; or
  - After the date *your* coverage under this rider has ended;

H1807000 07/06

PRESCRIPTION DRUG BENEFIT RIDER (continued)

- Any costs related to the mailing, sending or delivery of *prescription* drugs;

H1807100

- Any intentional misuse of this benefit, including *prescriptions* purchased for consumption by someone other than *you*;

H1807200

- Any *prescription* or refill for drugs, medicines or medications that are lost, stolen, spilled, spoiled or damaged;

H1807300

- Any service, supply or therapy to eliminate or reduce a dependency on, or addiction to tobacco and tobacco products, including but not limited to nicotine withdrawal therapies, programs, services or medications;

H1807400

- Drug delivery implants; except contraceptive drug delivery implants approved by the FDA;

H1807500TX

- Treatment for onychomycosis (nail fungus);

H1807600

- More than one *prescription* or refill for the same drug or therapeutic equivalent medication prescribed by one or more *health care practitioners* and dispensed by one or more *pharmacies* until *you* have used, or should have used, at least 75% of the previous *prescription* or refill, unless the drug or therapeutic equivalent medication is purchased through a *mail order pharmacy*, or a r*etail pharmacy* that participates in *our* program which allows *you* to receive a 90-day supply of a *prescription* or refill, in which case *you* have used, or should have used 66% of the previous *prescription*. (Based on the dosage schedule prescribed by the *health care practitioner*);

H1807700 06/06

- Any drug or biological that has received designation as an *orphan drug*, unless approved by *us*;

H1807800

- Any *copayment you* paid for a *prescription* that has been filled, regardless of whether the *prescription* is revoked or changed due to adverse reaction or change in dosage or *prescription*;

H1807900 07/06

- *Prescriptions* filled at a *non-network pharmacy* except for *prescriptions* required during an emergency; or

H1807950

These limitations and exclusions apply even if a *health care practitioner* has performed or prescribed a medically appropriate procedure, service, treatment, supply, or *prescription*. This does not prevent *your health care practitioner* or *pharmacist* from providing or performing the procedure, service, treatment, supply, or *prescription*; however, the procedure, service, treatment, supply or *prescription* will not be a *covered expense.*
H1807955

Humana Health Plan of Texas, Inc.

Michael B. McCallister
President

H1808000

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.

Coverage of Tests for Detection of Human Papillomavirus and Cervical Cancer

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

If any person covered by this plan has questions concerning the above, please call Humana Health Plan of Texas, Inc. at 1-666-4ASSIST, or write us 14614 Lexington, KY, 40512-4614.

NOTICES

The following pages contain important information about Humana's claims procedures and certain federal laws. There may be differences between the Certificate of Insurance and this Notice packet. There may also be differences between this notice packet and state law. The Plan participant is eligible for the rights more beneficial to the participant.

This section includes notices about:

Claims and Appeal Procedures

Federal Legislation

- **Women's Health and Cancer Rights Act**
- **Statement of Rights Under the Newborns' and Mothers' Health Protection Act**
- **Medical Child Support Orders**
- **General Notice of COBRA Continuation of Coverage Rights**
- **Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA)**
- **Family And Medical Leave Act (FMLA)**
- **Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)**
- **Your Rights Under ERISA**

Privacy and Confidentiality Statement

Claims and appeals procedures

Federal standards

The Employee Retirement Income Security Act of 1974 (ERISA) established minimum requirements for claims procedures, Humana complies with these standards. Covered persons in insured plans subject to ERISA should also consult their insurance benefit plan documents (e.g., the Certificate of Insurance or Evidence of Coverage). Humana complies with the requirements set forth in any such benefit plan document issued by it with respect to the plan unless doing so would prevent compliance with the requirements of the federal ERISA statute and the regulations issued thereunder. The following claims procedures are intended to comply with the ERISA claims regulation, and should be interpreted consistent with the minimum requirements of that regulation. Covered persons in plans not subject to ERISA, should consult their benefit plan documents for the applicable claims and appeals procedures.

Discretionary authority

With respect to paying claims for benefits or determining eligibility for coverage under a policy issued by Humana, Humana as administrator for claims determinations and as ERISA claims review fiduciary, shall have full and exclusive discretionary authority to:

- Interpret plan provisions;
- Make decisions regarding eligibility for coverage and benefits; and
- Resolve factual questions relating to coverage and benefits.

Definitions

Adverse determination means a decision to deny benefits for a *pre-service claim* or a *post-service claim* under a *group health plan*.

Claimant means a covered person (or authorized representative) who files a claim.

Concurrent-care decision means a decision by the plan to reduce or terminate benefits otherwise payable for a course of treatment that has been approved by the plan (other than by plan amendment or termination) or a decision with respect to a request by a *claimant* to extend a course of treatment beyond the period of time or number of treatments that has been approved by the plan.

Group health plan means an employee welfare benefit plan to the extent the plan provides medical care to employees or their dependents directly (self insured) or through insurance (including HMO plans), reimbursement or otherwise.

Health insurance issuer means the offering company listed on the face page of your Certificate of Insurance and referred to in this document as "Humana".

Post-service claim means any claim for a benefit under a *group health plan* that is not a *pre-service claim*.

Pre-service claim means a request for authorization of a benefit for which the plan conditions receipt of the benefit, in whole or in part, on advance approval.

Urgent-care claim (expedited review) means a claim for covered services to which the application of the time periods for making non-urgent care determinations:

- Could seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function; or

- In the opinion of a physician with knowledge of the covered person's medical condition, would subject the covered person to severe pain that cannot be adequately managed without the service that is the subject of the claim.

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

Submitting a claim

This section describes how a *claimant* files a claim for plan benefits. A claim must be filed in writing and delivered by mail, postage prepaid, by FAX or e-mail. A request for pre-authorization may be filed by telephone. The claim or request for pre-authorization must be submitted to Humana or to Humana's designee at the address indicated in the covered person's benefit plan document or identification card. This is particularly important with respect to mental health coordinators and other providers to whom Humana has delegated responsibility for claims administration. Claims will be not be deemed submitted for purposes of these procedures unless and until received at the correct address.

Claims submissions must be in a format acceptable to Humana and compliant with any legal requirements. Claims not submitted in accordance with the requirements of applicable federal law respecting privacy of protected health information and/or electronic claims standards will not be accepted by Humana.

Claims submissions must be timely. Claims must be filed as soon as reasonably possible after they are incurred, and in no event later than the period of time described in the benefit plan document.

Claims submissions must be complete and delivered to the designated address. At a minimum they must include:

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

Presentation of a prescription to a pharmacy does not constitute a claim for benefits under the plan. If a covered person is required to pay the cost of a covered prescription drug, he or she may submit a written claim for plan benefits to Humana.

A general request for an interpretation of plan provisions will not be considered a claim. Requests of this type, such as a request for an interpretation of the eligibility provisions of the plan, should be directed to the plan administrator.

Failure to provide necessary information

If a *pre-service claim* submission is not made in accordance with the plan's requirements, Humana will notify the *claimant* of the problem and how it may be remedied within five (5) days (or within 24 hours, in the case of an *urgent-care claim*). If a *post-service claim* is not made in accordance with the plan's requirement, it will be returned to the submitter.

Authorized representatives

A covered person may designate an authorized representative to act on his or her behalf in pursuing a benefit claim or appeal. The authorization must be in writing and authorize disclosure of health information. If a document is not sufficient to constitute designation of an authorized representative, as determined by Humana, the plan will not consider a designation to have been made. An assignment of benefits does not constitute designation of an authorized representative.

Any document designating an authorized representative must be submitted to Humana in advance or at the time an authorized representative commences a course of action on behalf of the covered person. Humana may verify the designation with the covered person prior to recognizing authorized representative status.

In any event, a health care provider with knowledge of a covered person's medical condition acting in connection with an *urgent-care claim* will be recognized by the plan as the covered person's authorized representative.

Covered persons should carefully consider whether to designate an authorized representative. Circumstances may arise under which an authorized representative may make decisions independent of the covered person, such as whether and how to appeal a claim denial.

Claims decisions

After a determination on a claim is made, Humana will notify the *claimant* within a reasonable time, as follows:

- ***Pre-service claims*** - Humana will provide notice of a favorable or *adverse determination* within a reasonable time appropriate to the medical circumstances but no later than 15 days after the plan receives the claim.

This period may be extended by an additional 15 days, if Humana determines the extension is necessary due to matters beyond the control of the plan. Before the end of the initial 15-day period, Humana will notify the *claimant* of the circumstances requiring the extension and the date by which Humana expects to make a decision.

If the reason for the extension is because Humana does not have enough information to decide the claim, the notice of extension will describe the required information, and the *claimant* will have at least 45 days from the date the notice is received to provide the necessary information.

- ***Urgent-care claims (expedited review)*** - Humana will determine whether a particular claim is an *urgent-care claim*. This determination will be based on information furnished by or on behalf of a covered person. Humana will exercise its judgment when making the determination with deference to the judgment of a physician with knowledge of the covered person's condition. Humana may require a *claimant* to clarify the medical urgency and circumstances supporting the *urgent-care claim* for expedited decision-making.

  Notice of a favorable or *adverse determination* will be made by Humana as soon as possible, taking into account the medical urgency particular to the covered person's situation, but not later than 72 hours after receiving the *urgent-care claim*.

  If a claim does not provide sufficient information to determine whether, or to what extent, services are covered under the plan, Humana will notify the *claimant* as soon as possible, but not more than 24 hours after receiving the *urgent-care claim*. The notice will describe the specific information necessary to complete the claim. The *claimant* will have a reasonable amount of time, taking into account the covered person's circumstances, to provide the necessary information but not less than 48 hours.

  Humana will provide notice of the plan's *urgent-care claim* determination as soon as possible but no more than 48 hours after the earlier of:

  - The plan receives the specified information; or
  - The end of the period afforded the *claimant* to provide the specified additional information.

- ***Concurrent-care decisions*** - Humana will notify a *claimant* of a *concurrent-care decision* involving a reduction or termination of pre-authorized benefits sufficiently in advance of the reduction or termination to allow the *claimant* to appeal and obtain a determination.

  Humana will decide *urgent-care claim*s involving an extension of a course of treatment as soon as possible taking into account medical circumstances. Humana will notify a *claimant* of the benefit determination, whether adverse or not, within 24 hours after the plan receives the claim, provided the claim is submitted to the plan 24 hours prior to the expiration of the prescribed period of time or number of treatments.

- ***Post-service claims*** - Humana will provide notice of a favorable or *adverse determination* within a reasonable time appropriate to the medical circumstances but no later than 30 days after the plan receives the claim.

  This period may be extended an additional 15 days, if Humana determines the extension is necessary due to matters beyond the plan's control. Before the end of the initial 30-day period, Humana will notify the affected *claimant* of the extension, the circumstances requiring the extension and the date by which the plan expects to make a decision.

  If the reason for the extension is because Humana does not have enough information to decide the claim, the notice of extension will describe the required information, and the *claimant* will have at least 45 days from the date the notice is received to provide the specified information. Humana will make a decision on the earlier of the date on which the *claimant* responds or the expiration of the time allowed for submission of the requested information.

Initial denial notices

Notice of a claim denial (including a partial denial) will be provided to *claimants* by mail, postage prepaid, by FAX or by e-mail, as appropriate, within the time frames noted above. With respect to adverse decisions involving *urgent-care claim*s, notice may be provided to *claimants* orally within the time frames noted above. If oral notice is given, written notification must be provided no later than 3 days after oral notification.

A claims denial notice will convey the specific reason for the *adverse determination* and the specific plan provisions upon which the determination is based. The notice will also include a description of any additional information necessary to perfect the claim and an explanation of why such information is necessary. The notice will disclose if any internal plan rule, protocol or similar criterion was relied upon to deny the claim. A copy of the rule, protocol or similar criterion will be provided to *claimants*, free of charge, upon request.

The notice will describe the plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review.

If an *adverse determination* is based on medical necessity, experimental treatment or similar exclusion or limitation, the notice will state that an explanation of the scientific or clinical basis for the determination will be provided, free of charge, upon request. The explanation will apply the terms of the plan to the covered person's medical circumstances.

In the case of an adverse decision of an *urgent-care claim*, the notice will provide a description of the plan's expedited review procedures.

Appeals of adverse determinations

A claimant must appeal an *adverse determination* within 180 days after receiving written notice of the denial (or partial denial). An appeal may be made by a claimant by means of written application to Humana, in person, or by mail, postage prepaid.

A claimant, on appeal, may request an expedited appeal of an adverse *urgent-care claim* decision orally or in writing. In such case, all necessary information, including the plan's benefit determination on review, will be transmitted between the plan and the claimant by telephone, FAX, or other available similarly expeditious method, to the extent permitted by applicable law.

Determination of appeals of denied claims will be conducted promptly, will not defer to the initial determination and will not be made by the person who made the initial adverse claim determination or a subordinate of that person. The determination will take into account all comments, documents, records, and other information submitted by the claimant relating to the claim.

On appeal, a claimant may review relevant documents and may submit issues and comments in writing. A claimant on appeal may, upon request, discover the identity of medical or vocational experts whose advice was obtained on behalf of the plan in connection with the *adverse determination* being appealed, as permitted under applicable law.

If the claims denial is based in whole, or in part, upon a medical judgment, including determinations as to whether a particular treatment, drug, or other service is experimental, investigational, or not medically necessary or appropriate, the person deciding the appeal will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The consulting health care professional will not be the same person who decided the initial appeal or a subordinate of that person.

Time periods for decisions on appeal

Appeals of claims denials will be decided and notice of the decision provided as follows:

- ***Urgent-care claims*** - As soon as possible but not later than 72 hours after Humana receives the appeal request;
- ***Pre-service claims*** - Within a reasonable period but not later than 30 days after Humana received the appeal request;
- ***Post-service claims*** - Within a reasonable period but not later than 60 days after Humana receives the appeal request;
- ***Concurrent-care decisions*** - Within the time periods specified above depending on the type of claim involved.

Appeals denial notices

Notice of a claim denial (including a partial denial) will be provided to *claimants* by mail, postage prepaid, by FAX or by e-mail, as appropriate, within the time periods noted above.

A notice that a claim appeal has been denied will include:

- The specific reason or reasons for the *adverse determination*;
- Reference to the specific plan provision upon which the determination is based;
- If any internal plan rule, protocol or similar criterion was relied upon to deny the claim. A copy of the rule, protocol or similar criterion will be provided to the claimant, free of charge, upon request;
- A statement describing any voluntary appeal procedures offered by the plan and the claimant's right to obtain the information about such procedures, and a statement about the claimant's right to bring an action under §502(a) of ERISA;
- If an *adverse determination* is based on medical necessity, experimental treatment or similar exclusion or limitation, the notice will state that an explanation of the scientific or clinical basis for the determination will be provided, free of charge, upon request. The explanation will apply the terms of the plan to the covered person's medical circumstances.

In the event an appealed claim is denied, the claimant will be entitled to receive without charge reasonable access to, and copies of, any documents, records or other information that:

- Was relied upon in making the determination;
- Was submitted, considered or generated in the course of making the benefit determination, without regard to whether such document, record or other information was relied upon in making the benefit determination;
- Demonstrates compliance with the administrative processes and safeguards required in making the determination;
- Constitutes a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit for the claimant's diagnosis, without regard to whether the statement was relied on in making the benefit determination.

Exhaustion of remedies

Upon completion of the appeals process under this section, a claimant will have exhausted his or her administrative remedies under the plan. If Humana fails to complete a claim determination or appeal within the time limits set forth above, the claim shall be deemed to have been denied and the claimant may proceed to the next level in the review process.

After exhaustion of remedies, a claimant may pursue any other legal remedies available, which may include bringing civil action under ERISA section 502(a) for judicial review of the plan's determination. Additional information may be available from the local U.S. Department of Labor Office.

Legal actions and limitations

No lawsuit may be brought with respect to plan benefits until all remedies under the plan have been exhausted.

No lawsuit with respect to plan benefits may be brought after the expiration of the applicable limitations period stated in the benefit plan document. If no limitation is stated in the benefit plan document, then no such suit may be brought after the expiration of the applicable limitations under applicable law.

Federal legislation

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

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

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

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

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

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

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

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

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

Medical child support orders

An individual who is a child of a covered employee shall be enrolled for coverage under the group health plan in accordance with the direction of a Qualified Medical Child Support Order (QMCSO) or a National Medical Support Notice (NMSO).

A QMCSO is a state-court order or judgment, including approval of a settlement agreement that:

- Provides for support of a covered employee's child;
- Provides for health care coverage for that child;
- Is made under state domestic relations law (including a community property law);
- Relates to benefits under the group health plan; and
- Is "qualified," i.e., it meets the technical requirements of ERISA or applicable state law.

QMCSO also means a state court order or judgment enforcing state Medicaid law regarding medical child support required by the Social Security Act §1908 (as added by Omnibus Budget Reconciliation Act of 1993).

An NMSO is a notice issued by an appropriate agency of a state or local government that is similar to a QMCSO requiring coverage under the group health plan for a dependent child of a non-custodial parent who is (or will become) a covered person by a domestic relations order providing for health care coverage.

Procedures for determining the qualified status of medical child support orders are available at no cost upon request from the plan administrator.

General notice of COBRA continuation coverage rights

Introduction

You are receiving this notice because you have recently become covered under a group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

NOTICES (continued)

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event". Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary". You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, the qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced; or
- Your employment ends for any reason other than gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a "dependent child".

When is COBRA coverage available?

The plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or commencement of a proceeding in bankruptcy with respect to the employer, the employer must notify the Plan Administrator of the qualifying event.

You must give notice of some qualifying events

For the other qualifying events (<u>divorce</u> or <u>legal separation</u> of the employee and spouse or a <u>dependent child's losing eligibility for coverage</u> as a dependent child) you must notify the Plan Administrator within 60 days after the qualifying event occurs.

How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children. Once the Plan Administrator offers COBRA continuation coverage, the qualified beneficiaries must elect such coverage within 60 days.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction in the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee last until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which the employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to at total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended:

- ***Disability extension of 18-month period of continuation coverage*** - If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator within 60 days of such determination, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage;

- ***Second qualifying event extension of 18-month period of continuation coverage*** - If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is given to the Plan within 60 days of the event. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting your group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gob/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep your plan informed of address changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information:

Humana
Billing/Enrollment Department
101 E Main Street
Louisville, KY 40201
1-800-872-7207

Important notice for individuals entitled to Medicare tax equity and fiscal responsibility act of 1982 (TEFRA) options

Where an employer employs more than 20 people, the Tax Equity And Fiscal Responsibility Act of 1982 (TEFRA) allows covered employees in active service who are age 65 or older and their covered spouses who are eligible for Medicare to choose one of the following options:

- ***Option 1*** - The benefits of their group health plan will be payable first and the benefits of Medicare will be payable second.
- ***Option 2*** - Medicare benefits only. The employee and his or her dependents, if any, will not be insured by the group health plan.

The employer must provide each covered employee and each covered spouse with the choice to elect one of these options at least one month before the covered employee or the insured spouse becomes age 65. All new covered employees and newly covered spouses age 65 or older must be offered these options. If Option 1 is chosen, its issue is subject to the same requirements as for an employee or dependent that is under age 65.

Under TEFRA regulations, there are two categories of persons eligible for Medicare. The calculation and payment of benefits by the group health plan differs for each category.

- ***Category 1*** Medicare eligibles are:

  - Covered employees in active service who are age 65 or older who choose Option 1;
  - Age 65 or older covered spouses; and
  - Age 65 or older covered spouses of employees in active service who are either under age 65 or age 70 or older;

- ***Category 2*** Medicare eligibles are any other covered persons entitled to Medicare, whether or not they enrolled. This category includes, but is not limited to:

  - Retired employees and their spouses; or
  - Covered dependents of a covered employee, other than his or her spouse.

Calculation and payment of benefits

For covered persons in Category 1, benefits are payable by the policy without regard to any benefits payable by Medicare. Medicare will then determine its benefits.

For covered persons in Category 2, Medicare benefits are payable before any benefits are payable by the policy. The benefits of the policy will then be reduced by the full amount of all Medicare benefits the covered person is entitled to receive, whether or not the eligible individual is actually enrolled for Medicare Benefits.

Family and Medical Leave Act (FMLA)

If an employee is granted a leave of absence (Leave) by the employer as required by the Federal Family and Medical Leave Act, s/he may continue to be covered under the plan for the duration of the Leave under the same conditions as other employees who are currently employed and covered by the plan. If the employee chooses to terminate coverage during the Leave, or if coverage terminates as a result of nonpayment of any required contribution, coverage may be reinstated on the date the employee returns to work immediately following the end of the Leave. Charges incurred after the date of reinstatement will be paid as if the employee had been continuously covered.

Uniformed services employment and reemployment rights act of 1994 (USERRA)

Continuation of benefits

Effective October 13, 1994, federal law requires health plans offer to continue coverage for employees that are absent due to service in the uniformed services and/or dependents.

Eligibility

An employee is eligible for continuation under USERRA if he or she is absent from employment because of voluntary or involuntary performance of duty in the Armed Forces, Army National Guard, Air National Guard, or commissioned corps of the Public Health Service. Duty includes absence for active duty, active duty for training, initial active duty for training, inactive duty training and for the purpose of an examination to determine fitness for duty.

An employee's dependents that have coverage under the plan immediately prior to the date of the employee's covered absence are eligible to elect continuation under USERRA.

If continuation of Plan coverage is elected under USERRA, the employee or dependent is responsible for payment of the applicable cost of coverage. If the employee is absent for not longer than 31 days, the cost will be the amount the employee would otherwise pay for coverage. For absences exceeding 30 days, the cost may be up to 102% of the cost of coverage under the plan. This includes the employee's share and any portion previously paid by the employer.

Duration of coverage

If elected, continuation coverage under USERRA will continue until the earlier of:

- 24 months beginning the first day of absence from employment due to service in the uniformed services; or
- The day after the employee fails to apply for a return to employment as required by USERRA, after the completion of a period of service.

Under federal law, the period coverage available under USERRA shall run concurrently with the COBRA period available to an employee and/or eligible dependent.

Other information

Employees should contact their employer with any questions regarding coverage normally available during a military leave of absence or continuation coverage and notify the employer of any changes in marital status, or change of address.

NOTICES (continued)

Your rights under the Employee Retirement Income Security Act of 1974 (ERISA)

Under ERISA, all plan participants covered by ERISA are entitled to certain rights and protections, as described below. Notwithstanding anything in the group health plan or group insurance policy, following are a covered person's minimum rights under ERISA. ERISA requirements do not apply to plans maintained by governmental agencies or churches.

Information about the plan and benefits

Plan participants may:

- Examine, free of charge, all documents governing the plan. These documents are available in the plan administrator's office;

- Obtain, at a reasonable charge, copies of documents governing the plan, including a copy of any updated summary plan description and a copy of the latest annual report for the plan (Form 5500), if any, by writing to the plan administrator;

- Obtain, at a reasonable charge, a copy of the latest annual report (Form 5500) for the plan, if any, by writing to the plan administrator.

As a plan participant, you will receive a summary of any material changes made in the plan within 210 days after the end of the plan year in which the changes are made unless the change is a material reduction in covered services or benefits, in which case you will receive a summary of the material reduction within 60 days after the date of its adoption.

If the plan is required to file a summary annual financial report, you will receive a copy from the plan administrator.

Responsibilities of plan fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the plan. These people, called "fiduciaries" of the plan, have a duty to act prudently and in the interest of plan participants and beneficiaries.

No one, including an employer, may discharge or otherwise discriminate against a plan participant in any way to prevent the participant from obtaining a benefit to which the participant is otherwise entitled under the plan or from exercising ERISA rights.

Continue group health plan coverage

Participants may be eligible to continue health care coverage for themselves, their spouse or dependents if there is a loss of coverage under the group health plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review the COBRA notice in this document regarding the rules governing COBRA continuation coverage rights.

Participants should review their group health plan document regarding reduction or elimination of exclusionary periods for preexisting conditions due to creditable coverage from another plan. The group health plan or health insurance issuer should provide a certificate of creditable coverage when coverage ends under the plan, the participant becomes entitled to elect COBRA continuation coverage, COBRA continuation coverage ceases (if COBRA is requested before losing coverage) or, if requested, up to 24 months after losing coverage. Without evidence of creditable coverage, a participant may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after the coverage enrollment date.

Claims determinations

If a claim for a plan benefit is denied or disregarded, in whole or in part, participants have the right to know why this was done, to obtain copies of documents relating to the decision without charge and to appeal any denial within certain time schedules.

Enforce your rights

Under ERISA, there are steps participants may take to enforce the above rights. For instance:

- If a participant requests a copy of plan documents and does not receive them within 30 days, the participant may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until the participant receives the materials, unless the materials were not sent because of reasons beyond the control of the plan administrator;

- If a claim for benefits is denied or disregarded, in whole or in part, the participant may file suit in a state or Federal court;

- If the participant disagrees with the plan's decision, or lack thereof, concerning the qualified status of a domestic relations order or a medical child support order, the participant may file suit in Federal court;

- If plan fiduciaries misuse the plan's money, or if participants are discriminated against for asserting their rights, they may seek assistance from the U.S. Department of Labor, or may file suit in a Federal court.

The court will decide who should pay court costs and legal fees. If the participant is successful, the court may order the person sued to pay costs and fees. If the participant loses, the court may order the participant to pay the costs and fees.

Assistance with questions

- Contact the group health plan human resources department or the plan administrator with questions about the plan;

- For questions about ERISA rights, contact the nearest area office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or:

  The Division of Technical Assistance and Inquiries
  Employee Benefits Security Administration
  U.S. Department of Labor
  200 Constitution Avenue N.W.
  Washington, D.C. 20210;

- Call the publications hotline of the Employee Benefits Security Administration to obtain publications about ERISA rights.

Privacy and confidentiality statement

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

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

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

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

NOTICES (continued)

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

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

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

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

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