Important

At Humana, it is important you are treated fairly.

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

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

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

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

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

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

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

Texas Regulatory Pre-enrollment Disclosure Guide for Group Health Products

PPO
Indemnity
HMO
POS

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TX14607HH 0123

INTRODUCTION

This document identifies certain plan provisions which may exclude, limit, reduce, modify, or terminate plan coverage. This information is provided to you prior to enrollment to help you make an informed health care coverage decision, and to help meet state pre-enrollment disclosure requirements.

The document is for informational purposes only. Information relating to employer-funded, customized or state-mandated plans may differ. While every effort has been made to provide the most accurate and up-to-date information, it is not intended to be a full description of coverage, does not constitute a contract, and will be updated periodically without notice. Benefit, coverage, and eligibility determinations will be based on the terms and conditions of the Contract.

The following terms have the meaning indicated below when used within this document:

"Covered Person" means an employee or dependent covered by the Contract.

"Contract" means the legal agreement between us and the Contractholder. The Contract may also be known as a policy or master group contract.

"Contractholder" means the legal entity identified as the policyholder or group plan sponsor on the face page of the Contract who establishes, sponsors and endorses an employee benefit plan for insurance or health care coverage.

The terms deductible and coinsurance within this Pre-Enrollment guide are applicable to HMO/NPOS Consumer Choice plans and PPO/Indemnity plans.

Please contact your Sales Agent if you need further assistance regarding the information presented here or are interested in specific plan information. Note information is also available regarding any standardized health plans which your state may require us to offer.

The agent does not have the authority to waive a complete answer to any question, determine coverage or insurability, alter any Contract, bind the insuring or offering entity by making any promise or representation, or waive any other rights or requirements of the insuring or offering entity.

ENROLLMENT

Each employee must complete the enrollment process to enroll for coverage under the Contract for themselves and their eligible dependents, if any.

We reserve the right to require an eligible employee and/or eligible dependent to submit evidence of health status. No eligible employee or eligible dependent will be refused enrollment or charged a different premium than other group members based on health status-related factors. Health status will not be used to determine the premium rates for products offered through a small employer group health plan. We will not use health status-related factors to decline medical coverage to an eligible employee or eligible dependent. We will administer this provision in a non-discriminatory manner.

Late applicant means an employee or dependent who requests enrollment for coverage under the Contract more than 31 days after his/her eligibility date, later than the time period specified in the "Special enrollment" provision, or after the open enrollment period.

Open enrollment period means no less than a 31-day period of time, occurring annually for the group, during which employees have an opportunity to enroll themselves and their eligible dependents for coverage under the Contract.

Special enrollment

Special enrollment is available if the following apply:

- You have a change in family status due to:
    - Marriage;
    - Divorce;
    - A Qualified Medical Child Support Order (QMCSO);
    - A National Medical Support Notice (NMSN);
    - The birth of a natural born child; or
    - The adoption of a child or placement of a child with the employee for the purpose of adoption or because you become a party in a suit for the adoption of a child; or
    - A child of an employee has lost coverage under Title XIX of the Social Security Act, or under Chapter 62, Health and Safety Code; and
    - You enroll within 31 days after the special enrollment date; or

- You are an employee or dependent eligible for coverage under the Contract, and:
    - You previously declined enrollment stating you were covered under another group health plan or other health insurance coverage; and
    - Loss of eligibility of such other coverage occurs, regardless of whether you are eligible for, or elect COBRA; and
    - You enroll within 31 days after the special enrollment date.

- Loss of eligibility of other coverage includes, but is not limited to:

- Termination of employment or eligibility;
- Reduction in number of hours of employment;
- Divorce, legal separation or death of a spouse;
- Loss of dependent eligibility, such as attainment of the limiting age;
- Termination of your employer's contribution for the coverage;
- Loss of individual HMO coverage because you no longer reside, live or work in the service area;
- Loss of group HMO coverage because you no longer reside, live or work in the service area, and no other benefit package is available;
- The plan no longer offers benefits to a class of similarly situated individuals; or

- You had COBRA continuation coverage under another plan at the time of eligibility, and:

  - Such coverage has since been exhausted; and
  - You stated at the time of the initial enrollment that coverage under COBRA was your reason for declining enrollment; and
  - You enroll within 31 days after the special enrollment date; or

- You were covered under an alternate plan provided by the employer that terminates, and:

  - You are replacing coverage with the Contract; and
  - You enroll within 31 days after the special enrollment date; or

- You are an employee or dependent eligible for coverage under the Contract, and:

  - Your Medicaid coverage or your Children's Health Insurance Program (CHIP) coverage terminated as a result of loss of eligibility; and
  - You enroll within 60 days after the special enrollment date; or

- You are an employee or dependent eligible for coverage under the Contract, and

  - You become eligible for a premium assistance subsidy under Medicaid or CHIP; and
  - You enroll within 60 days after the special enrollment date.

Dependent special enrollment

The dependent special enrollment is the time period specified in the "Special enrollment" provision.

If dependent coverage is available under the employer's Contract or added to the Contract, an employee who is a Covered Person can enroll eligible dependents during the applicable special enrollment. An employee, who is otherwise eligible for coverage and had waived coverage under the Contract when eligible, can enroll himself/herself and eligible dependents during the special enrollment. The employee and/or dependent enrolling within the time period specified in the "Special enrollment" provision after the special enrollment date will not be considered a late applicant.

The employee and/or dependent are a late applicant if enrolled later than the time period specified in the "Special enrollment" provision after the special enrollment date. A late applicant must wait to enroll for coverage during the open enrollment period.

MEDICAL LIMITATIONS AND EXCLUSIONS

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

- Treatments, services, supplies, or surgeries that are not medically necessary, except for the preventive services required by the U.S. Department of Health and Human Services (HHS). For a list of these recommended services refer to the HHS website at www.healthcare.gov.

- A sickness or bodily injury which is covered under any Workers' Compensation or similar law. This limitation also applies to a Covered Person who is not covered by Workers' Compensation and lawfully chose not to be.

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

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

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

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

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

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

- Any service not ordered by a health care practitioner.

- Services provided to you, if you do not comply with the HMO/POS Contract's requirements. These include services:

    - Not provided by a network provider, unless the services provided by a non-network provider are for any of the limited circumstances specified in the evidence of coverage;
    - Received in an emergency room, unless required because of emergency care; and
    - Which require a primary care physician referral if a referral was not obtained {this applies only to some HMO plans}.

- Private duty nursing, unless medically necessary while you are hospital confined (exception applies only to HMO and POS plans).

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

- Any service not rendered by the billing provider.

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

- For PPO, Indemnity and POS plans, any amount billed for a professional component of an automated:

  - Laboratory service; or
  - Pathology service.

- For PPO, Indemnity and POS plans, any expenses for services, prescriptions, equipment, or supplies received outside the United States or from a foreign provider unless:

  - For emergency care;
  - The employee is traveling outside the United States due to employment with the employer sponsoring the Contract and the services are not covered under any Workers' Compensation or similar law; or
  - The employee and dependent live outside the United States and the employee is in active status with the employer sponsoring the Contract.

- Education or training, except for diabetes self-management training and habilitative services specified in the "Covered Expenses" section of the certificate.

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

- Services provided by a Covered Person's family member except as allowed by state law for covered expenses provided by a dentist.

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

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

- Vitamins, except for preventive services with a prescription from a health care practitioner, dietary supplements, and dietary formulas, except enteral formulas, nutritional supplements or low protein modified food products for the treatment of an inherited metabolic disease, e.g., phenylketonuria (PKU) and amino-acid based elemental formulas as stated in the certificate.

- Over-the-counter, non-prescription medications, unless for drugs, medicines or medications or supplies on the Preventive Medication Coverage Drug List with a prescription from a health care practitioner (non-grandfathered religious employers and eligible organizations may elect to not provide contraceptive coverage).

- Over-the-counter medical items or supplies that can be provided or prescribed by a health care practitioner but are also available without a written order or prescription, except for preventive services (non-grandfathered religious employers and eligible organizations may elect to not provide contraceptive coverage).

- Growth hormones (medications, drugs or hormones to stimulate growth) unless specified in the pharmacy services section of the certificate.

- Prescription drugs and self-administered injectable drugs, except as specified in the "Covered Expenses – Pharmacy Services" section of the certificate or unless administered to you:

- While an inpatient in a hospital, skilled nursing facility, health care treatment facility, or residential treatment facility for adults, chemical dependency treatment center, or crisis stabilization unit, psychiatric day treatment facility, or residential treatment center for children and adolescents;

- By the following, when deemed appropriate by us:

  - A health care practitioner:

    - During an office visit; or
    - While an outpatient; or

  - A home health care agency as part of a covered home health care plan.

- Certain specialty drugs administered by a qualified provider in a hospital's outpatient department, except as specified in the "Covered Expenses – Pharmacy Services" section of the certificate.

- (For some Consumer Choice Large Employer HMO and POS plans) For a Covered Person 19 years of age or older, hearing aids, the fitting of hearing aids or advice on their care; implantable hearing devices, except for cochlear implants as otherwise stated in the certificate.

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

- Hospital inpatient services when you are in observation status.

- Infertility services; or reversal of elective sterilization.

- In vitro fertilization regardless of the reason for treatment, except as provided by Rider. (Rider offered on Non-Consumer Choice plans only)

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

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

- Not approved by us, based on our established criteria.

- Expenses are eligible to be paid under any private or public research fund, government program except Medicaid, or another funding program, whether or not such funding was applied for or received.

- The expense relates to the transplantation of any non-human organ or tissue, unless otherwise stated in the Contract.

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

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

- No benefits will be provided for:

  - Immunotherapy for recurrent abortion;

- Chemonucleolysis;
- Sleep therapy;
- Light treatments for Seasonal Affective Disorder (S.A.D.);
- Immunotherapy for food allergy;
- Prolotherapy; or
- Sensory integration therapy.

- Cosmetic surgery and cosmetic services or devices, unless for reconstructive surgery resulting from craniofacial abnormalities to improve the function of or attempt to create a normal appearance.

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

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

  For a large employer, the following types of care of the feet:

- The following types of care of the feet:

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

  For a small employer, the following types of care of the feet:

- The following types of care of the feet:

  - Shock wave therapy of the feet;
  - The treatment of weak, strained, flat, unstable, or unbalanced feet;
  - Arch supports (foot orthotics) or orthopedic shoes, except as covered by Medicare; and
  - Shoe inserts, except as covered by Medicare.

- The following types of care of the feet, unless you have diabetes:

  - Hygienic care, and the treatment of superficial lesions of the feet, such as corns, calluses or hyperkeratosis;
  - Non-surgical treatment of tarsalgia, metatarsalgia or bunion;
  - The cutting of toenails, except the removal of the nail matrix;
  - Heel wedges or lifts.

- Custodial care and maintenance care.

- Any loss contributed to, or caused by:

  - War or any act of war, whether declared or not;

- Insurrection; or
- Any conflict involving armed forces of any authority.

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

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

  This exclusion does not apply to any sickness or bodily injury resulting from an act of domestic violence or a medical condition (including both physical and mental health conditions).

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

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

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

  - Common household items including air conditioners, air purifiers, water purifiers, vacuum cleaners, waterbeds, hypoallergenic mattresses or pillows, or exercise equipment;
  - Motorized transportation equipment (e.g. scooters), escalators, elevators, ramps, or modifications or additions to living/working quarters or transportation vehicles;
  - Personal hygiene equipment including bath/shower chairs, transfer equipment or supplies or bed side commodes;
  - Personal comfort items including cervical pillows, gravity lumbar reduction chairs, swimming pools, whirlpools, spas, or saunas;
  - Medical equipment including:

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

    - PUVA lights; and

    - Stethoscopes;

  - Communication system, telephone, television, or computer systems and related equipment or similar items or equipment;
  - Communication devices, except after surgical removal of the larynx or a diagnosis of permanent lack of function of the larynx.

- Duplicate or similar rentals or purchases of durable medical equipment or diabetes equipment.

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

  - The American Academy of Allergy and Immunology; or

- The Department of Health and Human Services or any of its offices or agencies.

- Lodging accommodations or transportation.

- Communications or travel time.

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

- Sickness or bodily injury for which no fault medical payment or expense coverage benefits are paid or payable under any homeowners, premises or any other similar coverage.

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

- Alternative medicine.

- Acupuncture, unless:

  - The treatment is medically necessary, appropriate and is provided within the scope of the acupuncturist's license; and
  - You are directed to the acupuncturist for treatment by a licensed physician.

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

- Services of a midwife, unless the midwife is licensed.

- Vision examinations or testing for the purposes of prescribing corrective lenses, except comprehensive eye exams for small employer plans.

- Orthoptic/vision training (eye exercises).

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

- For a plan that does not include benefits for pediatric vision care, the purchase or fitting of eyeglasses or contact lenses, except as the result of an accident or following cataract surgery as stated in the certificate.

- For a plan that includes benefits for pediatric vision care, the purchase or fitting of eyeglasses or contact lenses, except as:

  - The result of an accident or following cataract surgery as stated in the certificate.
  - Otherwise specified in the "Covered Expenses – Pediatric Vision Care" section in the certificate.

- Services and supplies which are:

  - Rendered in connection with mental illnesses not classified in the International Classification of Diseases of the U.S. Department of Health and Human Services; or
  - Extended beyond the period necessary for evaluation and diagnosis of learning and behavioral disabilities or for mental retardation.

- Marriage counseling.

- Expenses for:

  - Employment;
  - School;
  - Sport;
  - Camp;
  - Travel; or
  - The purposes of obtaining insurance.

- Expenses for care and treatment of non-covered procedures or services.

- Expenses for treatment of complications of non-covered procedures or services.

- Expenses incurred for services prior to the effective date or after the termination date of your coverage under the Contract. Coverage will be extended as described in the "Understanding Your Coverage" and "Extension of Benefits" sections of the certificate, if such coverage is required by state law.

- For HMO plans, 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 usual and customary fee.

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

- Home health care for:

  - Charges for mileage or travel time to and from the Covered Person's home;
  - Wage or shift differentials for any representative of a home health care agency;
  - Charges for supervision of home health care agencies;
  - Custodial care; or
  - The provision or administration of self-administered injectable drugs, unless otherwise determined by us.

- Hospice care for:

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

- Orthotics if:

  - Repair or replacement orthotics when due to misuse or loss;
  - Dental braces; or
  - Oral or dental splints and appliances, unless custom made for the treatment of documented obstructive sleep apnea.

- Repair or replacement of a prosthetic device when covered by the manufacturer.

- Repair or maintenance of durable medical equipment or diabetes equipment except insulin pumps, unless the:

  - Manufacturer's warranty is expired;
  - Repair or maintenance is not a result of misuse or abuse; and
  - Repair cost is less than replacement cost.

- Replacement of purchased durable medical equipment and diabetes equipment, unless the:

  - Manufacturer's warranty is expired;
  - Replacement cost is less than repair cost; and
  - Replacement is not due to lost or stolen equipment, or misuse or abuse of the equipment; or
  - Replacement is required due to a change in your condition that makes the current equipment non-functional.

- Reconstructive surgery due to a psychological condition.

- Routine costs for an approved clinical trial do not include services or items that are:

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

- For a plan that includes benefits for pediatric dental:

  - Any expense arising from the completion of forms.

  - Any expense due to your failure to keep an appointment.

  - Any expense for a service we consider cosmetic, unless it is due to an accidental dental injury.

  - Expenses incurred for:

    - Precision or semi-precision attachments;
    - Overdentures and any endodontic treatment associated with overdentures;
    - Other customized attachments;
    - Any services for 3D imaging (cone beam images);
    - Temporary and interim dental services; or
    - Additional charges related to materials or equipment used in the delivery of dental care.

  - Charges for services rendered:

    - In a dental facility or health care treatment facility sponsored or maintained by the employer under this plan or an employer of any Covered Person covered by the Contract.
    - By an employee of any Covered Person covered by the Contract.

    For the purposes of this exclusion, Covered Person means the employee and the employee's dependents enrolled for benefits under the Contract and as defined in the "Glossary" section.

  - Any service related to:

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

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

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

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

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

- Any service that:

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

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

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

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

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

  - Partial pulpotomy for apexogenesis;
  - Vital pulpotomy; or
  - Pulp debridment or pulpal therapy.

- For a plan that includes benefits for pediatric vision care, benefits are limited as follows:

- In no event will benefits exceed the lesser of the limits of the Contract, shown in the "Schedule of Benefits – Pediatric Vision Care" or in the "Schedule of Benefits" of the certificate.
- Materials covered by the Contract that are lost, stolen, broken, or damaged will only be replaced at normal intervals as specified in the "Schedule of Benefits – Pediatric Vision Care."

- For a plan that includes benefits for pediatric vision care, unless specifically stated otherwise, no benefits will be provided for, or on account of, the following items:

- Orthoptic or vision training and any associated supplemental testing.
- Two or more pair of glasses, in lieu of bifocals or trifocals.
- Medical or surgical treatment of the eye, eyes or supporting structures.

- Any services and materials required by an employer as a condition of employment.
- Safety lenses and frames.
- Contact lenses, when benefits for frames and lenses are received.
- Cosmetic items.
- Any services or materials not listed in this benefit section as a covered benefit or in the "Schedule of Benefits – Pediatric Vision Care."
- Expenses for missed appointments.
- Any charge from a providers' office to complete and submit claim forms.
- Treatment relating to or caused by disease.
- Non-prescription materials or vision devices.
- Costs associated with securing materials.
- Pre- and post-operative services.
- Orthokeratology.
- Maintenance of materials.
- Refitting or change in lens design after initial fitting.
- Artistically painted lenses.

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

PRESCRIPTION DRUG LIMITATIONS AND EXCLUSIONS

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

- Legend drugs which are not deemed medically necessary by us.
- Prescription drugs not included on the drug list.
- Any amount exceeding the default rate.
- Specialty drugs for which coverage is not approved by us.
- Drugs not approved by the FDA.
- Any drug prescribed for intended use other than for:
  - Indications approved by the FDA; or
  - Off-label indications recognized through peer-reviewed medical literature.
- Any drug prescribed for a sickness or bodily injury not covered under the Contract.
- Any drug, medicine or medication that is either:
  - Labeled "Caution - limited by federal law to investigational use;" or
  - Experimental, investigational or for research purposes,

  even though a charge is made to you.
- Allergen extracts.
- Therapeutic devices or appliances, including, but not limited to:
  - Hypodermic needles and syringes (except when prescribed by a health care practitioner for use with insulin and self-administered injectable drugs, whose coverage is approved by us);
  - Support garments;
  - Test reagents;
  - Mechanical pumps for delivery of medications; and
  - Other non-medical substances.
- Dietary supplements and nutritional products, except enteral formulas and nutritional supplements for the treatment of phenylketonuria (PKU) or other inherited metabolic disease. Refer to the “Covered Expenses” section of the certificate for coverage of low protein modified foods.
- For PPO, HMO and POS plans, non-prescription, over-the-counter minerals, except as specified on the Preventive Medication Coverage drug list when obtained from a network pharmacy with a prescription from a health care practitioner.
- For Indemnity plans, non-prescription, over-the-counter minerals, except as specified on the Preventive Medication Coverage drug list when obtained from a pharmacy with a prescription from a health care practitioner.

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

- For PPO, HMO and POS plans herbs and vitamins, except prenatal (including greater than one milligram of folic acid), pediatric multi-vitamins with fluoride and vitamins on the Preventive Medication Coverage drug list when obtained from a network pharmacy with a prescription from a health care practitioner.

- For Indemnity plan, herbs and vitamins, except prenatal (including greater than one milligram of folic acid), pediatric multi-vitamins with fluoride and vitamins on the Preventive Medication Coverage drug list when obtained from a pharmacy with a prescription from a health care practitioner.

- Anabolic steroids {this does not apply to small employer plans}.

- Any drug used for the purpose of weight loss.

- Any drug used for cosmetic purposes, including but not limited to:

  - Dermatologicals or hair growth stimulants; or
  - Pigmenting or de-pigmenting agents.

- Any drug or medicine that is lawfully obtainable without a prescription (over-the-counter drugs), except:

  - Insulin; and

  - For PPO, HMO and POS plan, drugs, medicines or medications and supplies on the Preventive Medication Coverage drug list when obtained from a network pharmacy with a prescription from a health care practitioner.

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

- Compounded drugs that:

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

- Abortifacients (drugs used to induce abortions).

- Infertility services including medications.

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

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

- The administration of covered medication(s).

- Prescriptions that are to be taken by or administered to you, in whole or in part, while you are a patient in a facility where drugs are ordinarily provided by the facility on an inpatient basis. Inpatient facilities include, but are not limited to:

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

- Injectable drugs, including, but not limited to:

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

- Prescription fills or refills:

  - In excess of the number specified by the health care practitioner; or
  - Dispensed more than one year from the date of the original order.

- Any portion of a prescription fill or refill that exceeds a 90-day supply when received from a mail order pharmacy or a retail pharmacy that participates in our program, which allows you to receive a 90-day supply of a prescription fill or refill.

- Any portion of a prescription fill or refill that exceeds a 30-day supply when received from a retail pharmacy that does not participate in our program, which allows you to receive a 90-day supply of a prescription fill or refill.

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

- Any portion of a prescription fill or refill that:

  - Exceeds our drug-specific dispensing limit;
  - Exceeds the duration specific dispensing limit;
  - Is dispensed to a Covered Person, whose age is outside the drug-specific age limits defined by us;
  - Is refilled early, as defined by us, except for refills of prescription eye drops when:

    - The product is written for additional fills;
    - The refill does not exceed the total quantity of dosage units authorized by the prescribing provider on the original prescription; and
    - The eye drop refill is dispensed on or before the last day of the prescribed dosage period and not earlier than the:

- 21st day after the date a 30-day supply is dispensed;
- 42nd day after the date a 60-day supply is dispensed; or
- 63rd day after the date a 90-day supply is dispensed.

- Any drug for which we require prior authorization or step therapy and it is not obtained.

- Any drug for which a charge is customarily not made.

- Any drug, medicine or medication received by you:

  - Before becoming covered; or
  - After the date your coverage has ended.

- Any costs related to the mailing, sending or delivery of prescription drugs.

- Any intentional misuse of the prescription drug benefit, including prescriptions purchased for consumption by someone other than you.

- Any prescription fill or refill for drugs, medicines or medications that are lost, stolen, spilled, spoiled, or damaged.

- Drug delivery implants and other implant systems or devices.

- Treatment for onychomycosis (nail fungus) {this does not apply to small employer plans}.

- Any amount you paid for a prescription that has been filled, regardless of whether the prescription is revoked or changed due to adverse reaction or change in dosage or prescription.

- For HMO plans and some POS plans, prescriptions filled at a non-network pharmacy, except for prescriptions required during an emergency.

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.

HIGH DEDUCTIBLE HEALTH PLAN REQUIREMENT

The IRS has certain requirements that a High Deductible Health Plan (HDHP) must meet in order for members to be eligible for a Health Savings Account (HSA). One requirement is that the deductible amount must not be lower than the "minimum annual deductible" as defined by the IRS. Each year, the IRS reviews the deductible amounts to determine if the minimum annual deductible should be increased.

If you have an HDHP or a Savings HSA plan and the deductible amount of your HDHP does not satisfy the IRS minimum annual deductible requirement, you will be required to move to a valid deductible amount. For most groups, this deductible change will happen on your next renewal date. However, the deductible adjustment may be applied on your initial effective date, if that is required in order to comply with IRS regulations.

PREAUTHORIZATION REQUIREMENTS FOR COVERAGE

Humana requires preauthorization for some services and procedures your physician or other provider may recommend for you. Humana does this solely to determine whether the service or procedure qualifies for payment under your benefit plan. You and your health care provider decide whether you should have such services or procedures. Some providers may qualify for an exemption from the preauthorization requirements as required by state law. Humana's preauthorization determination relates solely to payment by Humana. To find a list of these services and supplies, please visit our website at Humana.com or call Customer Service.

- For PPO and POS plans, failure to obtain necessary preauthorization for non-network services when required may result in a reduction of otherwise payable benefits.

- For indemnity plans, failure to obtain necessary preauthorization for services when required may result in a reduction of otherwise payable benefits.

MAXIMUM ALLOWABLE FEE/USUAL AND CUSTOMARY FEE

We use fee schedules to pay providers for your coverage based on the criteria set forth in the following definition. For PPO plans the term used is maximum allowable fee. For HMO plans, the term usual and customary fee is used.

For PPO and Indemnity plans, maximum allowable fee for a covered expense is the lesser of:

- The fee charged by the provider for the services;

- The fee that has been negotiated with the provider whether directly or through one or more intermediaries or shared savings contracts for the services;

- The fee established by us by comparing rates from one or more regional or national databases or schedules for the same or similar services from a geographical area determined by us;

- For PPO and POS plans, the fee based upon rates negotiated as payment in full by us or other payors with one or more network providers in a geographic area determined by us for the same or similar services;

- For Indemnity plans, the fee based upon rates negotiated as payment in full by us or other payors with one or more contracted providers in a geographic area determined by us for the same or similar services;

- The fee based on the provider's costs for providing the same or similar services as reported by such provider in its most recent publicly available Medicare cost report submitted to the Centers for Medicare & Medicaid Services (CMS) annually; or

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

For Indemnity plans, you may be responsible to pay the provider any amount over the maximum allowable fee for covered expenses, in addition to any copayment, deductible and/or coinsurance.

For PPO and POS plans, if services are received from a non-network provider, you may be responsible to pay the non-network provider any amount over the maximum allowable fee for covered expenses, in addition to any copayment, deductible and/or coinsurance. However, if certain services are received from a non-network provider, as specified in the definition of qualified payment amount, you will only be responsible to pay the network provider

copayment, deductible and/or coinsurance, based on the qualified payment amount, for such covered expenses. If the following services are received from a non-network provider in the state of Texas, you will only be responsible to pay the network provider copayment, deductible and coinsurance based on the maximum allowable fee:

- Emergency care;
- Services preauthorized by us when a network provider is not available; or
- Services from a diagnostic imaging provider or laboratory service provider if the services are associated with a covered expense performed by a network provider.

Qualified payment amount means the lesser of:

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

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

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

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

For HMO/NPOS plans, usual and customary fee for a covered health service is the lesser of:

- The fee charged by the provider for the services;

- The fee that has been negotiated with the provider whether directly or through one or more intermediaries or shared savings contracts for the services;

- The fee established by us by comparing rates from one or more regional or national databases or schedules for the same or similar services from a geographical area determined by us;

- The fee based upon rates negotiated by us or other payors with one or more network providers in a geographic area determined by us for the same or similar services;

- The fee based upon the provider's cost for providing the same or similar services as reported by such provider in its most recent publicly available Medicare cost report submitted to the Centers for Medicare & Medicaid Services (CMS) annually; or

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

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

For HMO/NPOS plans, if certain services are received from a non-network provider, as specified in the definition of qualified payment amount, you will only be responsible to pay the network provider copayment, deductible and/or coinsurance, based on the qualified payment amount, for such covered expenses. If the following services are received from a non-network provider in the state of Texas, you will only be responsible to pay the network provider copayment, deductible and coinsurance based on the usual and customary fee:

- Emergency care;
- Services other than emergency care, that are not available to you through a network provider; or
- Services from a diagnostic imaging provider or laboratory service provider if the services are associated with a covered health service performed by a network provider.

Qualified payment amount means the lesser of:

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

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

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

- Air ambulance services;
- Emergency care outside the state of Texas;
- Ancillary services when you are at a network facility outside the state of Texas;
- Ancillary services, other than those provided by a facility based physician, when you are at a network facility in the state of Texas;
- Services that are not considered ancillary services when you are at a network facility, and you did not consent to the non-network provider to obtain such services; or
- Post-stabilization services provided outside the state of Texas when:

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

MODIFICATION OF COVERAGE

The Contract may be modified by us, upon renewal of the Contract, as permitted by state and federal law. The Contractholder will be notified in writing or electronically at least 60 days prior to the effective date of the change.

The Contract may be modified by agreement between us and the Contractholder 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 Contract. No agent has authority to modify the Contract, waive any of the Contract provisions, extend the time of premium payment, or bind us by making any promise or representation.

Corrections due to clerical errors or clarifications that do not change benefits are not modifications of the Contract and may be made by us at any time without prior consent of, or notice to, the Contractholder.

CONTRACTHOLDER RESPONSIBILITIES

In addition to responsibilities outlined in the Contract, the Contractholder is responsible for:

- Collection of premium; and
- Distributing and providing Covered Persons access to:

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

No Contractholder has the power to change or waive any provision of the Contract.

RENEWAL OR TERMINATION OF COVERAGE

The Contractholder may terminate the Contract by giving written notice to us no later than 31 days prior to the desired termination date.

The Contractholder may terminate the coverage provided under any provision of the Contract, with our consent, by giving written notice to us as of a date mutually agreeable to the Contractholder and us.

The large employer may terminate the coverage for Covered Persons who no longer meet the participation criteria of the large employer.

We may terminate the Contract, as allowed by applicable law, by giving written notice to the Contractholder. Written notice will be mailed no later than 31 days prior to the termination date, except as otherwise outlined below.

We may refuse to renew or we may terminate the Contract if:

- The Contractholder fails to pay us any premium due, except coverage will continue during the grace period.

- The Contractholder has failed to comply with our minimum contribution requirements, as specified in the Employer Group Application.

- The Contractholder has failed to comply with our minimum participation, as specified in the Employer Group Application. We may refuse to renew the policy at the first renewal date following the end of the six month period the minimum participation requirement was not met.

- The Contractholder is not an employer.

- For HMO and POS plans, the end of the month, following a 30 day written notice, in which no Covered Person resides, lives, or works in the service area.

- The Contractholder has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact. We may terminate the Contract after giving 30 day advanced written notice to the Contractholder for instances of fraud or intentional misrepresentation of a material fact.

- We decide to discontinue offering a particular group health Contract:

    - Notice of such discontinuation will be provided at least 90 days prior to the date of discontinuation. The Contractholder is responsible for distributing and providing Covered Persons access to the notice; and
    - The Contractholder will be given the option to purchase all (or in the case of a large employer, any) other group Contract providing medical benefits that is being offered by us at such time.

The Contractholder will again be notified by us in writing of such discontinuation 30 days prior to the discontinuance date.

- We cease to do business in either the small employer or the large employer group medical market, as applicable and as allowed by the state requirements. If we cease doing business in the small employer or the large employer group market, notice for the Contractholders, Covered Persons and the Commissioner of Insurance will be provided at least 180 days prior to the date of discontinuation of such coverage. The Contractholder is responsible for distributing and providing Covered Persons access to the notice.

The Contractholder will again be notified by us in writing of such termination 30 days prior to the termination date.

Termination of a Covered Person's coverage under a group Contract will occur for the following reasons:

- The group Contract terminates;

- Premium was due to us and not received by us.

  For HMO/NPOS, if a Covered Person receives services during the grace period granted to the Contractholder for the late payment of required premium, the Covered Person will be held liable for the services received. The Contractholder is allowed a grace period of 31 days following the premium due date for the payment of required premium;

- The Covered Person no longer meets the eligibility requirements of the plan. You and the Contractholder are responsible to notify us of any change in eligibility, including the lack of eligibility of any Covered Person;

- The employee requests termination of coverage for himself/herself or covered dependents; or

- The Covered Person commits fraud or an intentional misrepresentation of a material fact, as determined by us.

We will also terminate your coverage for cause under the following circumstances:

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

- If you or the Contractholder 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.

FRAUD

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

If you commit fraud against us or your employer commits fraud pertaining to you against us, as determined by us, we reserve the right to rescind your coverage after we provide you a 30 calendar day advance written notice that coverage will be rescinded. You have the right to appeal the rescission.

SMALL EMPLOYER CONTRACT RATING FACTORS

The following rating information applies only to small employer groups as defined by state and federal regulation.

Rate guarantee

Each small employer group's initial medical rates are guaranteed, as permitted by applicable law, for 12 months from the effective date of coverage. Thereafter, a minimum of 60 days notice of any premium rate change will be given.

If the group health plan benefits or an individual's coverage are modified other than on a premium due date, any applicable change in premium resulting from the modification will become effective on the date the change in coverage becomes effective.

Rate disclosure

Each Contractholder's group rate will be based on benefit plan, age, geographic location, and family composition.

No Contractholder's group coverage will be terminated based on the Contractholder's group claims experience or a particular medical condition. The Company reserves the right to modify its renewal rating procedures and otherwise adjust rates consistent with applicable law.

Insured by Humana Insurance Company or
Offered by Humana Health Plan of Texas, Inc.

Please refer to your Benefit Plan Document (Certificate of Insurance/Evidence of Coverage) for more information on the company providing your benefits.

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