Memorial Hermann Health Insurance Company ("MHHIC", "We", "Us", "Our") may change the Premiums of this Plan after sixty (60) days written notice to the Subscriber. However, We will not change the Premium schedule for this Plan on an individual basis, but only for all Subscribers in the same class and covered under the same Plan as You. Additionally, We may change the Premium rates no more frequently than annually.

[929 Gessner, Suite 1500]
Houston, TX 77024
[888-594-0671]

INDIVIDUAL TEXAS [PLAN NAME]
A PARTICIPATING PROVIDER ORGANIZATION

INDIVIDUAL POLICY

THIS IS NOT A POLICY OF WORKERS COMPENSATION INSURANCE. THE EMPLOYER DOES NOT BECOME A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM BY PURCHASING THIS PLAN, AND IF THE EMPLOYER IS A NON-SUBSCRIBER, THE EMPLOYER LOSES THOSE BENEFITS WHICH WOULD OTHERWISE ACCRUE UNDER THE WORKERS' COMPENSATION LAWS. THE EMPLOYER MUST COMPLY WITH THE WORKERS' COMPENSATION LAW AS IT PERTAINS TO NON-SUBSCRIBERS AND THE REQUIRED NOTIFICATIONS THAT MUST BE FILED AND POSTED.

Ten-Day Right to Examine

Within ten (10) days after receiving and examining this Plan, it may be cancelled for any reason by returning it to the MHHIC administrative office, agent, or the entity through whom it was purchased. Upon surrender, any Premiums paid will be promptly returned and the contract is considered void/never effective. Both parties are restored to the same position as if no contract had been issued. If claims were paid or services rendered by MHHIC on your or any dependents behalf during the ten day examination period, you are responsible for repaying MHHIC for such services or claims.

Guaranteed Renewable

This Plan is monthly medical coverage subject to continuous payment by the Subscriber. This Plan will renew except for the specific events stated in the Plan. Coverage under this Plan is effective at 12:01 a.m. Central time on the Effective Date shown on Page 2 of Your Policy. The Anniversary Date of this Plan is January 1 of each year, regardless of the Effective Date of coverage. This Plan will renew on January 1 of each year except as specifically stated.

This is not Medicare Supplement Insurance

This insurance provides limited benefits, if you meet the conditions listed in the Policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when it pays:

- the benefits stated in the Policy and coverage for the same event is provided by Medicare

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- other approved items and services

Before You Buy This Insurance

- Check the coverage in **all** health insurance policies you already have.
- For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare,* available from the insurance company.
- For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

<u>READ THIS ENTIRE DOCUMENT CAREFULLY.</u> It describes the rights and obligations of the You the contract holder, and Memorial Hermann Health Insurance Co. It is Your responsibility to understand all terms and conditions in this contract.

This Plan, including the endorsements and the attached papers, if any, constitutes the entire contract of insurance. A change in this Plan is not valid until the change is approved by an executive officer of the insurer and unless the approval is endorsed on or attached to the Plan. An agent does not have authority to change this Plan or to waive any of its provisions.

This Policy, including the endorsements, forms and attached papers, if any, constitute the entire Plan.

Effective Date & Anniversary Date

Contract Holder:	[JOHN DOE]
Contract Holder Number:	[000000]
Contract Holder Effective Date:	[00/00/00]

IMPORTANT NOTICE

To obtain information or make a complaint:

You may call Memorial Hermann Health Insurance Company's toll-free telephone number for information or to make a complaint at:

[1-888-594-0671]

You may also write to Memorial Hermann Health Insurance Company at:
Memorial Hermann Health
Insurance Company
[929 Gessner, Suite 1500
Houston, TX 77024]

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

1-800-252-3439

You may write the Texas Department of Insurance:
P.O. Box 149104
Austin, TX 78714-9104
Fax: (512) 490-1007
Web: www.tdi. texas.gov
Email: ConsumerProtection@tdi.texas.gov

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

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

AVISO IMPORTANTE

Para obtener información o para presentar una queja:

Usted puede llamar al número de teléfono gratuito de Memorial Hermann Health Insurance Company's para obtener información o para presentar una queja al:

[1-888-594-0671]

Usted también puede escribir a Memorial Hermann Health Insurance Company:
Memorial Hermann Health Insurance Company
[929 Gessner, Suite 1500
Houston, TX 77024]

Usted puede comunicarse con el Departamento de Seguros de Texas para obtener información sobre compañias, coberturas, derechos, o quejas al:

1-800-252-3439

Usted puede escribir al Departamento de Seguros de Texas a:
P.O. Box 149104
Austin, TX 78714-9104
Fax: (512) 490-1007
Sitio web: www.tdi. texas.gov
Email: ConsumerProtection@tdi.texas.gov

DISPUTAS POR PRIMAS DE SEGUROS O RECLAMACIONES:
Si tiene una disputa relacionada con su prima de seguro o con una reclamación, usted debe comunicarse con la compañia primero. Si la disputa no es resuelta, usted puede comunicarse con el Departamento de Seguros de Texas.

ADJUNTE ESTE AVISO A SU PÓLIZA:
Este aviso es solamente para propósitos informativos y no se convierte en parte o en condición del documento adjunto.

MEMORIAL HERMANN Health Insurance Co

Contact Information

Address:	[929 Gessner, Suite 1500 Houston, TX 77024]
Website:	[www.healthplan.memorialhermann.org]
Member Services:	[888-594-0671]

Provider Directory:
[http://healthplan.memorialhermann.org/members/]

Complaints & Grievances:	[888-594-0671]
Utilization Review for Medical Claims:	[888-252-7680 or 713-338-5594]
Compliance Hotline: (to report fraud, waste or abuse)	[877-448-4140 or 713-338-4140]
For Benefits, Claims Status or Authorization Requirements:	[713-338-4683] [or [888-594-0671]]
Or write to:	[Memorial Hermann Claims Department P.O. Box 660303 Dallas, TX 75266-0303]

[For Dental Benefits contact [FCL Dental]]

[Website:]	[www.fcldental.com]
[Customer Service, Verify Eligibility, Authorization Requirements,& Claims Status:]	[713- 338-5630] [or [(855) 571-5630]]
[For Claim Forms & Submissions, write to:]	[FCL Dental Claims Dept. 101 Parklane Blvd. Suite 301 Sugar Land, TX 77478]

For Prescription Drug Benefits contact [OptumRx]

Website:	[www.OptumRx.com]
Customer Service, Preferred Drug List & Utilization Review:	[877-633-4461]
Appeals of Utilization Review:	[800-626-0072]
For Non-Participating Pharmacy Claim Forms & Claim Submissions, write to:	[Optum RX P.O. Box 968022 Schaumburg, IL 60196-8022]
For Mail Orders, write to:	[OptumRX P.O. box 409014 Ft. Lauderdale, FL 33340-9014]

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I. INTRODUCTION

Understanding Your Coverage

Hello! Thank You for purchasing this health benefits Policy from Memorial Hermann Health Insurance Company ("MHHIC") regulated by the Texas Department of Insurance.

We take pride in providing You and Your Dependents with the benefits described in this Policy. Keep this document with Your other important papers so it is available for future reference.

This health benefit Policy replaces any others previously issued to You and/or Your Dependents, as of the stated or amended Effective Date. This Policy describes Your Benefits, rights and responsibilities covered under this Policy. We encourage You to read this entire Policy carefully.

Please call Us if You have questions about Your coverage, or any limits to the coverage available to You. Please be aware that Your Physician does not have a copy of Your Policy, and is not responsible for knowing or communicating Your Benefits to You.

Except for necessary technical terms, We use common words to describe the Benefits provided under this Policy. "MHHIC," "We," "Us", "Our" and "the Company" means Memorial Hermann Health Insurance Company "You", "Your", "Yourself ", "Contract Holder", "Policy Holder" or "Member" means You the Subscriber and/or Your enrolled Dependent.

This Policy contains many important terms that are defined in the "Definitions" section of the document. Please review the Definitions section first and be sure that You understand the meanings of these words as they pertain to this Policy. **C**apitalized words found throughout the document are defined in the "Definitions" section.

We are entering into this Policy with You based on the answers submitted by You and, if applicable, all other Members on Your signed Application. In consideration for the payment of the premiums stated in this Policy, MHHIC will provide the stated services and benefits listed for all Members that are eligible and accepted.

This Coverage and the Patient Protection and Affordable Care Act
The Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (the Affordable Care Act) were signed into law in March, 2010. Many of the provisions of the Affordable Care Act became effective in 2014. This coverage is compliant with and subject to the Affordable Care Act and covers all Essential Health Benefits required by law.

Covered Services

Under the terms and conditions of this Policy, You will receive covered services considered by Us to be:

- Medically Necessary
- Listed as a Covered Service
- Not in excess of any benefit limitations as described in the Service of Benefit section of this Policy
- Received while Your Policy is in force

[High Deductible Health Plan and Health Savings Accounts

This Policy is a High Deductible Health Plan (HDHP), as long as the Deductible meets the minimum required by federal law. This high Deductible coverage may be used in conjunction with a Health Savings Account (HSA), which a Member sets up through a financial institution. HSAs are portable, tax-advantaged savings accounts that act like a medical IRA. Unused money is rolled over from year to year, grows through interest and investments, and can be used to pay for a wide variety of health and wellness related products and services. The Internal Revenue Service, IRS, has established eligibility rules for HSAs.

Most adults who are covered by a high Deductible health plan, like this MHHIC product, and who have no other cost health coverage except for preventive care, may establish an HSA. We do not provide tax advice. Members that choose to take advantage of the Benefits of health savings accounts should learn about the laws affecting HSAs. They may wish to consult a qualified tax or financial advisor to ensure that they are eligible to establish an HSA, that they understand what other types of health coverage they may have without violating the HSA rules, what expenses may be paid from an HSA, and the many tax Benefits available to them if they properly comply with all IRS rules on health savings accounts.]

The Memorial Hermann Health Insurance Company's PPO Provider Network

MHHIC Members are able to choose which Providers will render their care. Nothing in this Policy restricts or interferes with Your right to select the Hospital or Physician of Your choice. Also, nothing in this Policy restricts Your right to receive, at Your expense, any treatment not covered. However, Your choice(s) will determine the amount MHHIC will pay for rendered Covered Services.

The MHHIC PPO Network consists of a broad number of physicians, hospitals and other allied health professionals. Those that have partnered with MHHIC are considered Participating or Preferred, In-network Providers. Those not contracted with MHHIC are considered Out of Network providers. Differences between the two are described below.

In-Network Providers
In-Network or Preferred Physicians, Hospitals and other Allied Health Professionals are those who have contracted with Us to participate in Our exclusive health care system to render covered services to our members. These Providers have agreed to accept the lesser of billed charges or a negotiated amount (an "Allowable Charge") as payment in full for Covered Services provided to Members. When a Member uses a Participating Provider, this Allowable Charge is used to determine the amount MHHIC pays for Medically Necessary Covered Services.

To obtain the highest level of Benefits available, Members should always verify if a chosen Hospital or health care professional is a current MHHIC Provider before service is rendered. Members can review their paper Provider directory check on-line at http://healthplan.memorialhermann.org/members/, or call Our Member's Service department for an up-to-date Provider listing.

Members should confirm a Provider's In-Network status each time before obtaining services. A Provider's status may change from time to time. It is also possible that a Provider may be contracted with MHHIC to perform services at one location, and be considered Out-of-Network when rendering services at another location. When a Provider performs services that are not

contracted with Us to perform (such as certain high-tech diagnostic or radiology procedures), claims for those services will be paid at the Out-of-Network level, which may result in significant additional costs.

Out –of-Network Providers
MHHIC provider network is extensive and should meet the needs of most Members. However, Members can still choose Providers who are not part of our network to render their care. Care obtained outside Our Network means the Member will have higher out-of-pocket costs and pay a higher Copayment, Deductible, and/or Coinsurance than if they had stayed In-Network. These additional costs may be significant.

MHHIC will pay a lower level of Benefits to Out-of- Network Providers based on a lower Allowable Charge. In addition, We only pay a portion of those charges and it is Your responsibility to pay the remainder. We recommend that You ask Out-of-Network providers to explain their billed charges to You, before You receive care.

It is the Member's responsibility to check and verify that the service(s) wanted are In-Network from the provider and location where they are seeking care.

Emergency Care

Emergency services performed in the Emergency department of a Hospital, will be paid, subject to Member Cost Sharing amounts, as applicable, regardless of location or provider. Members have access to Emergency care throughout Texas, nationally and globally as needed.

Service Area

MHHIC coverage is available only to individuals who legally live or work in Our Policy Service Area. To become a MHHIC Member, You must reside or work in one or more of the following Texas counties: Harris, Montgomery, Walker, Fort Bend, Brazoria, Wharton or Galveston.

Dependents do not have to reside in the Service Area to be covered.

II. DEFINITIONS

The following definitions contain the meanings of key terms used in this Policy.

Accidental Injury (or "Injury") - An accidental bodily injury sustained by a Member which is the direct cause of a loss independent of disease, bodily infirmity, or any other cause.

Acquired Brain Injury - 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. For purposes of the Acquired Brain Injury benefit, the following definitions apply:

- **Cognitive Communication Therapy** -therapy designed to address modalities of comprehension and expression, including understanding, reading, writing and verbal expression of information.

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

- **Community Reintegration Services** - services that facilitate the continuum of care as an affected individual transitions into the community.

- **Neurobehavioral Testing** - 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** -intervention that focuses on behavior and the variables that control behavior.

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

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

- **Neurophysiological Testing** - an evaluation of the functions of the nervous system.

- **Neurophysiological Treatment** - intervention that focuses on the functions of the nervous system.

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

- **Neuropsychological Treatment** - interventions designed to improve or minimize deficits in behavioral and cognitive processes.

- **Post-acute Care Treatment Services** - services provided after acute care confinement and/or treatment that are based on an assessment of the individual's physical, behavioral or cognitive functional deficits, which include a treatment goal of achieving functional changes by reinforcing, strengthening or re-establishing previously learned patterns of behavior and/or establishing new patterns of cognitive activity or compensatory mechanism.

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

- **Psychophysiological Testing** - an evaluation of the interrelationships between the nervous system and other bodily organs and behavior.

- **Psychophysiological Treatment** - interventions designed to alleviate or decrease abnormal physiological responses of the nervous system due to behavioral or emotional factors.

- **Remediation** - the process of restoring or improving a specific function.

- **Services for Acquired Brain Injury** - the work of testing, treatment and providing therapies to an individual with an acquired brain injury.

- **Therapy for Acquired Brain Injury** - the scheduled remedial treatment provided through direct interaction with the individual to improve a pathological condition resulting from an acquired brain injury.

Acute – The onset of disease or injury, or a change in condition that would require prompt medical attention.

Admission – The period from entry (Admission) into a Hospital or Skilled Nursing Facility or Unit for Inpatient care, until discharge. In counting days of care, the date of entry and the date of discharge are counted as one day.

Adverse Determination – a determination by a utilization review agent that health care services provided or proposed to be provided to a patient are not Medically Necessary or are experimental or investigational.

Allowed/Allowable Amount or Charge – The lesser of the billed charge or the amount established by MHHIC or negotiated as the maximum amount the plan will pay for all Provider services covered. For services rendered by Out of Network providers, plan must pay the claim, at a minimum at the Usual, Customary, and Reasonable charge (UCR) or based on claims data, and Member may be responsible for the remaining balance. Only the Allowed Amount will be applied to Member Cost Sharing accumulations.

Ambulance Service – Medically Necessary transportation by a specially designed Emergency vehicle for transporting the sick and injured. The vehicle must be equipped as an Emergency transport vehicle and staffed by trained ambulance personnel as required by appropriate state and local laws governing an Emergency transportation vehicle.

Ambulatory Surgical Center - A freestanding outpatient surgical facility that does not provide services or other accommodations for patients to stay overnight. It must be licensed as an outpatient clinic according to state and local laws, meet all requirements of an outpatient clinic providing surgical services and meet accreditation standards of the Joint Commission on Accreditation of Health Care Organizations or the Accreditation Association of Ambulatory Health Care.

Anniversary Date - The annual anniversary of the Policy Effective Date.

Annual Open Enrollment Period - A period of at least thirty-one (31) days consisting of an entire calendar month beginning on the first day of the month and ending on the last day of the

month. If the month is less than a thirty-one day month, the 31-day enrollment period shall continue into the next month.

Appeal – A request from You or Your authorized representative to change an Adverse Determination made by MHHIC.

Application – Any document(s) which must be completed by or on behalf of a person applying for coverage.

Authorization (Authorized) - A determination by MHHIC regarding an Admission, continued Hospital stay, or other health care service or supply which, based on the information provided, satisfies the clinical review criteria requirement for Medical Necessity, appropriateness of the health care setting, or level of care and effectiveness. An Authorization is not a guarantee of payment. Additionally, an Authorization is not a determination about the Member's choice of Provider.

Autism Spectrum Disorder (ASD) - Disorders characterized by severe and pervasive impairment in several areas of development: reciprocal social interaction skills, communication skills, or the presence of stereotyped behavior, interests, and activities. ASD includes conditions such as Autistic Disorder, Rhett's Disorder, Childhood Disintegrative Disorder, Asperger's Disorder, and Pervasive Development Disorder not otherwise specified.

Benefits – Coverage for health care services, treatment, procedures, equipment, drugs, devices, items or supplies provided under this Policy. A schedule of all health care services that are available to Members under the plan, including any copayments or Deductibles and a description of where and how to obtain services. Benefits provided by Us are based on the Allowable Charge for Covered Services.

Brand Name Prescription Drug (Brand Name) - A Prescription Drug that has been patented.

Chemical/Substance Dependency - The abuse of or psychological or physical dependence on or addiction to alcohol or a Controlled Substance.

Chemical/ Substance Dependency Treatment Center - A facility that provides a program for the treatment of Chemical Dependency pursuant to a written treatment plan approved by Us or our designated behavioral health administrator. The facility must be:

- affiliated with a Hospital under a contractual agreement with an established system for patient referral;
- accredited as such a facility by the Joint Commission on Accreditation of Healthcare Organizations;
- licensed, certified or approved as a Chemical Dependency treatment program or center by an agency of the state of Texas having legal authority to so license, certify or approve; or
- if outside Texas, licensed, certified or approved as a Chemical Dependency treatment program or center by the appropriate agency of the state in which it is located having the legal authority to so license, certify or approve.

Child/ren – persons including Newborns, under 26 years of age or persons who are disabled as described under the *Special Needs/Dependent Children over 26* provision. A child may be:

- born of the Subscriber; or

- legally placed for adoption with the Subscriber; or
- legally adopted by the Subscriber; or
- a child for whom the Subscriber or his or her legal spouse is a party to a suit to adopt; or
- a child for whom the Subscriber or his legal spouse has been granted legal custody or as a guardian ad litem; or
- a child supported by the Subscriber pursuant to a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN); or
- a stepchild of the Subscriber; or
- a grandchild who is under the age limit of the Policy and is a dependent of the Subscriber for federal income tax purposes at the time of application.

Claim – Written or electronic proof, in a form acceptable to MHHIC of charges for Covered Services that have been incurred by a Member during the time period when insured under this Policy. The provisions in effect at the time the service or treatment is received will govern the processing of any Claim expense actually incurred as a result of the service or treatment rendered.

Coinsurance – The sharing of eligible Allowable Charges for Covered Services between MHHIC and a Member. The sharing is expressed as a pair of percentages, a percentage that We pay, and a Member percentage that You pay. Once the Member has met any applicable Deductible Amount, Your percentage will be applied to the Allowable Charges for Covered Services to determine their financial responsibility. Our percentage will be applied to the Allowable Charges for Covered Services to determine the Benefits provided.

Community Reintegration Services - Services that facilitate the continuum of care as an affected individual transitions into the community.

Complaint – Any dissatisfaction expressed orally or in writing by a complainant to Us regarding any aspect of Our operation includes: dissatisfaction relating to plan administration, procedures related to review or appeal of an Adverse Determination, the denial, reduction, or termination of a service for reasons not related to medical necessity, the manner in which a service is provided, and a disenrollment decision.

Contract – This Policy, including the Application for Coverage, Schedule of Benefits and amendments/endorsements this agreement, if any, entitling a Member and any applicable Dependents to specified health and Accidental Injury coverage.

Copayment (Copay) – The specific dollar amount a Member must pay when specified Covered Services are rendered, as shown on the Schedule of Benefits. The Copayment may be collected directly from a Member by a Network Provider. Copayments do not count towards any Deductible.

Cost Sharing – Amounts You must pay for Covered Services, expressed as Coinsurance, Copayments and/or Deductibles when applicable.

Cosmetic Surgery – Performed to change the appearance of otherwise normal looking characteristics or features of the patient's body. A physical feature or characteristic is normal looking when the average person would consider that feature or characteristic to be within the range of usual variations of normal human appearance. Cosmetic surgery does not become Reconstructive Surgery because of psychological or psychiatric reasons.

Course of Treatment - A planned, structured, and organized sequence of treatment procedures based on an individualized evaluation to restore or improve health function, or to promote chemical free status. A Course of Treatment is complete when the patient has finished a series of treatments without a lapse in treatment or has been medically discharged.

Covered Service – A service or supply specified in this Policy for which Benefits are available when rendered by a Provider.

Covered Dependent - A member of a Subscriber's family who meets the eligibility provisions of this Policy, who the Subscriber has listed on the Application, and for whom required premium payments have been made.

Covered Expenses - Expenses incurred for Covered Services. Covered Expenses for Covered Services received from Participating Providers will not exceed the Negotiated Rate. Covered Expenses for Covered Services received from Non-Participating Providers will not exceed Usual, Customary, or Reasonable Charges. In addition, Covered Expenses may be limited by other specific maximums described in this Policy. Covered Expenses are subject to applicable Deductibles and other benefit limits. An expense is incurred on the date the Member receives the service or supply. In some cases, Covered Expenses may be less than the amount that You are actually billed.

Covered Services - Medically Necessary services or supplies that are listed in the benefit sections of this Policy, and for which You are entitled to receive benefits.

Crisis Stabilization Unit - A 24 hour residential program that is usually short term in nature and provides:

- intensive supervision; and
- highly structured activities to persons who are demonstrating an Acute demonstrable psychiatric crisis of moderate to severe proportions.

Custodial Care - Care provided primarily to meet Your personal needs. This includes help in walking, bathing, or dressing. It also includes preparing food or special diets, feeding, administration of medicine that is usually self-administered, or any other care that does not require continuing services of a medical professional.

Deductible - The amount of Covered Expenses You must pay for Covered Services before benefits are available to You under this Policy.

- Individual Benefit Period Deductible Amount – The dollar amount, as shown on the Schedule of Benefits, of charges for Covered Services that You must pay within a Benefit Period before this Policy starts paying Benefits.
- Family Benefit Period Deductible Amount – The dollar amount, as shown on the Schedule of Benefits, of charges for Covered Services that must be paid by a family within a Benefit Period before this Policy starts paying Benefits. When the Policy includes more than one Member, the Individual Benefit Period Deductible Amount is not applicable. Only the Family Benefit Period Deductible Amount is applicable. No Benefits are eligible for payment toward Covered Services on any Member until the Family Benefit Period Deductible Amount has been met. Once the Family Benefit Period Deductible Amount is met, this Policy starts paying Benefits for all Members of the family for the remainder of the Benefit Period.

Dental Care and Treatment – All procedures, treatment, and Surgery considered being within the scope of the practice of dentistry, which is defined as that practice which:

- represents themselves as being able to diagnose, treat, correct, operate, or prescribe for any disease, pain, injury, deficiency, deformity, or physical condition of the human teeth, alveolar process, gums, jaws or associated parts and offers or undertakes by certain means to diagnose, treat, correct, operate, or prescribe for any disease, pain, injury, deficiency, deformity, or physical condition of the same;
- takes impressions of the human teeth or jaws or performs any phase of any operation incident to the replacement of a tooth or part of a tooth or associated tissues by means of a filling, crown, denture, or other appliance; or
- furnishes, supplies, constructs, reproduces, repairs or offers to furnish, supply, construct, reproduce, or repair prosthetic dentures, bridges, or other substitute for natural teeth to the user or prospective user.

Dental Prostheses - Dentures, crowns, caps, bridges, clasps, habit appliances, and partials.

Dependent – A person, other than the Subscriber, who has been accepted for coverage as specified in and determined by the Schedule of Eligibility.

Diagnostic Service – Radiology, laboratory, and pathology services and other tests or procedures recognized by Us as accepted medical practice, rendered because of specific symptoms, and which are directed toward detection or monitoring of a definite condition, illness or injury. A Diagnostic Service must be ordered by a Provider prior to delivery of the service.

Domestic Partner - An individual who: may be the same or opposite gender of the Subscriber and has the same meaning and coverage as a “lawful spouse.” A Domestic Partner must meet the following criteria:

- at least 18 years of age or legally emancipated;
- mentally competent to consent to contract;
- has the competency to consent to a contract for a permanent residence and is not sharing a permanent residence with another person who has obtained the age of majority;
- has shared a common residence with the Subscriber for an extended period of time; and
- has shared financial assets and obligations with the Subscriber for an extended period of time.
- and has established a domestic partnership with the Policyholder by filing an affidavit of domestic partnership and obtaining a certificate of domestic partnership from their local registrar.

Drugs (Prescription Drugs) -Prescription Drugs approved by the State of Texas or the Food and Drug Administration for general use by the public. For purposes of this benefit, insulin is considered a Prescription Drug.

Durable Medical Equipment (DME) – Items and supplies which are used to serve a specific therapeutic purpose in the treatment of an illness or injury, can withstand repeated use, are generally not useful to a person in the absence of illness, injury, or disease, and are appropriate for use in the patient's home.

Effective Date - The date on which coverage under this Policy begins for the Member and/or their dependents. This Policy is effective at 12:01 am on the noted Effective Date.

Eligible Person or Member – A person entitled to apply to be a Subscriber or Dependent as specified in the Schedule of Eligibility.

Emergency Admission – An Inpatient Admission to a Hospital resulting from an Emergency Medical Condition.

Emergency Condition (or "Emergency") – A medical condition of recent onset and severity, including severe pain, that would lead a prudent layperson, acting reasonably and possessing an average knowledge of health and medicine, to believe that the absence of immediate medical attention could reasonably be expected to result in:

- Placing the health of the person, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy.
- Serious impairment to bodily function.
- Serious dysfunction of any bodily organ or part.
- Serious disfigurement of such person.

Emergency Medical Services – Any health care service provided to evaluate and/or treat an Emergency Medical Condition requiring immediate, unscheduled medical care.

Experimental/Investigational Procedures - Any medical, surgical, and/or other procedures, services, products, Drugs or devices, (including implants) is considered experimental or investigational if:

- Its use is mainly limited to laboratory and/or research.
- It has not been given approval for marketing by the United States Food & Drug.
- Administration at the time it is furnished and such approval is required by law.
- Reliable evidence shows it is the subject of ongoing phase I, II or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with the stated or means of treatment or diagnosis.
- Reliable evidence shows that the consensus of the opinion among experts is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with the stated means of treatment of diagnosis.
- Reliable evidence shows that it is not generally approved or used by Physicians in the medical community.
- It does not have final approval from the appropriate governmental regulatory body.

Exclusions – Health care services we do not pay for or Cover.

Expedited Appeal – A request for immediate review of an Adverse Determination involving an Admission, availability of care, continued Hospital stay, or health care service for which a Member has received Emergency services, but has not been discharged from a facility or for the denial of emergency care,
prescription drugs or intravenous infusions.

Expedited External Appeal – A request for immediate review, by an Independent Review Organization (IRO), of an initial Adverse Determination, which involves any of the following:

- A medical condition for which the time frame for completion of a standard External Appeal would seriously jeopardize the life or health of the Member or jeopardize the Member's

ability to regain maximum function, or a decision not to Authorize continued services for Members currently in the Emergency room, under observation, or receiving Inpatient care.

- A denial of coverage based on a determination the recommended or requested health care service or treatment is experimental or Investigational and the treating Physician certifies that any delay may pose an imminent threat to the Member's health, including severe pain, potential loss of life, limb or major bodily function.
- A denial of prescription drugs or intravenous infusions for which the Member is receiving benefits.

External Appeal – A request for review by an Independent Review Organization (IRO), to change an initial Adverse Determination made by the Company or to change a final Adverse Determination rendered on Appeal. External Appeal is available upon request by the Member or authorized representative for Adverse Determinations involving Medical Necessity, appropriateness of care, health care setting, level of care, effectiveness, experimental or Investigational treatment, or a Rescission.

Foreign Country Provider - Any institutional or professional provider of medical or psychiatric treatment or care who practices in a country outside the United States of America. A Foreign Country Provider may also be a supplier of medical equipment, Drugs, or medications.

Formulary - A listing, developed by the Pharmacy and Therapeutics Committee and reviewed quarterly, of Drugs which available medical literature indicates are clinically effective and safe while being reasonable in cost. **Non-Formulary** is a Drug which is not included on the Formulary listing. A change in the Formulary will not be effective until the next Policy annual renewal date, provided We provide 60 days prior notice of the change to the Subscriber.

Generic Drug – A Prescription Drug that is equivalent to a Brand-Name drug in dosage form, safety, strength, route of administration, quality, performance characteristics and intended use; or that MHHIC identifies as a Generic Drug based on a nationally recognized pricing source.

Grievance – A written expression of dissatisfaction with MHHIC or with Our Provider services that does not involve a Utilization Review determination.

Home Health Care – Health services rendered in the individual's place of residence by an organization licensed as a Home Health Care agency by the appropriate state agency and approved by Us. These organizations are primarily engaged in providing to individuals, at the written direction of a licensed Physician, in the individual's place of residence, skilled nursing services by or under the supervision of a Registered Nurse (R.N.) licensed to practice in the state.

Hospice(s) - Licensed providers according to state and local laws to provide skilled nursing and other services to support and care for persons experiencing the final phases of terminal Illness. They must be approved as Hospice providers under Medicare and the Joint Commission on Accreditation of Health Care Organizations.

Hospice Care Plan – Provision of an integrated set of services and supplies designed to provide palliative and supportive care to meet the special needs of Members during the final stages of terminal illness. Full scope health services are centrally coordinated through an interdisciplinary team directed by a Physician and provided by or through a Hospice Care agency approved by Us.

Hospital - a licensed public or private institution as defined by Chapter 241, Health and Safety Code, or Subtitle C, Title 7, Health and Safety Code. This definition excludes convalescent homes, convalescent facilities, rest facilities, nursing facilities, or homes or facilities primarily for the aged, and those primarily affording Custodial Care, educational care or those primarily affording care for mental and nervous disorders.

Hospitalization – Care in a Hospital that requires Admission as an impatient and usually requires an overnight stay.

Illness - A sickness, disease, or condition of a Member.

Immunization - The creation of immunity usually against a particular disease; treatment (as by vaccination) of an organism for the purpose of making it immune to a particular pathogen.

Independent Review Organization (IRO) – An Independent Review Organization, not affiliated with Us, which conducts external reviews of final Adverse Determinations. The decision of the IRO is binding on both the Member and Us.

Infertility – The inability of a couple to conceive after one (1) year of unprotected intercourse or maintain a pregnancy until fetal viability.

Infusion Therapy - The administration of Drugs (Prescription substances), by the intravenous (into a vein), intramuscular (into a muscle), subcutaneous (under the skin), and intrathecal (into the spinal canal) routes. For the purpose of this Policy, it will also include Drugs administered by aerosol (into the lungs) and by feeding tube.

Inpatient – A Member who is admitted to a Hospital as a registered bed patient for whom a Bed, Board and General Nursing Service charge is made. An Inpatient's medical symptoms or condition must require continuous twenty-four (24) hour a day Physician and nursing intervention. If the services can be safely provided to the Member as an Outpatient, the Member does not meet the criteria for an Inpatient.

Life-Threatening Illness – A severe, serious, or Acute condition for which death is probable.

Maintenance Prescription Drugs - Prescription Drugs taken for an extended period of time to treat a medical condition.

Medically Necessary (or "Medical Necessity") - Health care services, treatment, procedures, equipment, drugs, devices, items or supplies that a Provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

- in accordance with nationally accepted standards of medical practice;
- clinically appropriate, in terms of type, frequency, extent, level of care, site and duration, and considered effective for the patient's illness, injury or disease; and
- not primarily for the personal comfort or convenience of the patient or Provider, and not more costly than alternative services, treatment, procedures, equipment, drugs, devices, items or supplies or sequence thereof and that are as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

Member – The Subscriber, or a Covered Dependent, for whom required Premiums have been paid.

Mental, Emotional or Functional Nervous Disorders - Neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder of any kind as defined by generally recognized independent standards of current medical practice.
MHHIC, We, Our and Us – Memorial Hermann Health Insurance Company MHHIC is an insurance company regulated by the state of Texas.

Negotiated Rate – The rate of payment that We have contracted with a Participating Provider for Covered Services.

Network Provider - See Participating Provider.

Newborn/ Infant – An infant from the time of birth until age one (1) month or until such time as the infant is well enough to be discharged from a Hospital or neonatal Special Care Unit to his or her home, whichever period is longer.

Non-Participating Provider(Out of Network) – A provider that has not entered into a participating agreement with MHHIC at the time services are rendered.

Occupational Therapy (OT) – The evaluation and treatment of physical injury or disease, cognitive impairments, congenital or developmental disabilities, or the aging process by the use of specific goal directed activities, therapeutic exercises and/or other interventions that alleviate impairment and/or improve functional performance.

Office Visit - A visit by the Member, who is the patient, to the office of a Physician during which one or more of only the following three specific services are provided:
- History (gathering of information on an Illness or Injury)
- Examination
- Medical Decision Making (the Physician's diagnosis and plan of treatment)

This does not include other services (e.g. x-rays or lab services) even if performed on the same day.

Orthotic Device – A custom-fitted or custom-fabricated medical device that is applied to a part of the human body to correct a deformity, improve function or relieve symptoms of a disease.

Out-of-Pocket Amount or Maximum
- Individual Out-of-Pocket Amount – The maximum amount, as shown on the Schedule of Benefits, of un-reimbursable expenses (including any applicable Deductible Amount and Coinsurance), that must be paid by a Member for Covered Services in one (1) Benefit Period.

- Family Out-of-Pocket Amount - The maximum amount, as shown on the Schedule of Benefits, of un-reimbursable expenses (including any applicable Deductible Amount and Coinsurance), which must be paid by a family for Covered Services in one (1) Benefit Period. When the Policy includes more than one (1) Member, the Individual Out-of-Pocket Amount is not applicable, only the Family Out-of-Pocket Amount shall apply.

Outpatient – A Member who receives services or supplies while not in a hospital or Acute care setting.

Outpatient Day Treatment Services – Structured services provided to address deficits in physiological, behavioral and/or cognitive functions. Such services may be delivered in settings that include transitional residential, community integration, or non-residential treatment settings.

Participating Hospital (in network) - A Hospital that has a Participating Hospital agreement in effect with Us at the time services are rendered. Participating Hospitals agree to accept the Negotiated Rate as payment in full.

Participating Physician (in network) - A Physician who has a Participating Physician agreement in effect with Us at the time services are rendered. Participating Physicians agree to accept the Negotiated Rate as payment in full for Covered Services.

Participating Pharmacy - A licensed Pharmacy that has a Participating Pharmacy agreement in effect with Us at the time services are rendered.

Physical Therapy – The treatment of disease or injury by the use of therapeutic exercise and other interventions that focus on improving posture, locomotion, strength, endurance, balance, coordination, joint mobility, flexibility, and alleviating pain.

Physician - A Physician licensed to practice medicine or any other practitioner who is licensed and recognized as a provider of health care services in the state in which services are provided; and who provides services covered by the Policy that are within the scope of his or her licensure.

Physical and/or Occupational Therapy/Medicine -The therapeutic use of physical agents other than Drugs. It comprises the use of physical, chemical and other properties of heat, light, water, electricity, massage, exercise, spinal manipulation and radiation.

Plan - The set of benefits described in this Policy, forms and amendments (if any).

Policy – Includes an individual, blanket, or franchise insurance agreement or Contract, or Policy issued by an insurer.

Policy - any certificate, agreement, or contract, including a blended contract, that is issued to an enrollee and states the coverage to which the enrollee is entitled.

Post-Acute Care Treatment Services - Services provided after Acute care confinement and/or treatment that are based on an assessment of the individual's physical, behavioral or cognitive functional deficits, which include a treatment goal of achieving functional changes by reinforcing, strengthening or re-establishing previously learned patterns of behavior and/or establishing new patterns of cognitive activity or compensatory mechanism.

Post-Acute Transition Services - Services that facilitate the continuum of care beyond the initial insult through rehabilitation and community reintegration.

Pregnancy Care – Treatment or services related to all care prior to delivery, delivery, post-delivery care, and any complications arising from each pregnancy.

Preferred Drugs - Drugs listed in the Preferred Drug Program.

Preferred Drug Program – A list that identifies those Prescription Drugs preferred by Us for dispensing to Covered Persons when appropriate. Also known as the Preferred Drug List.
Premium – The amount that must be paid for Your health benefit coverage.

Prescription - A written order issued by a Physician.

Prescription Drugs – Medications, which includes Specialty Drugs, the sale or dispensing of which legally requires the order of a Physician or other health care professional and that carry the federally required product legend stipulating that such drugs may not be dispensed without a prescription, and which are currently approved by the FDA for safety and effectiveness, subject to the Limitations and Exclusions Article.

Prescription Drug Formulary – A list of specific Prescription Drugs that are covered under this benefits Policy.

Preventive or Wellness Care – Services designed to effectively prevent or screen for a disease for which there is an effective treatment when discovered in an early stage.

Private Duty Nursing Services – Services of an actively practicing Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.) who is unrelated to the patient by blood, marriage or adoption. These services must be ordered by the attending Physician and require the technical skills of an R.N. or L.P.N.

Primary Care Provider - A Physician or other health care provider who is a general caregiver and includes general and family practitioners, internists, pediatricians, or other provider who may be otherwise designated by MHHIC as a Primary Care Provider.

Professional Services – The specific services rendered by an occupational therapist, physical therapist, speech pathologist or audiologist, Physician, or chiropractor for Covered Services provided.

Prosthetic Appliance or Device – Appliances which replace all or part of a body organ, or replace all or part of the function of a permanently inoperative, absent, or malfunctioning body part. When referring to limb prostheses, it is an artificial limb designed to maximize function, stability, and safety of the patient, that is not surgically implanted and that is used to replace a missing limb. Limb Prosthetics do not include artificial eyes, ears, noses, dental appliances, ostomy products, or devices such as eyelashes or wigs.

Prosthetic Services – The science and practice of evaluating, measuring, designing, fabricating, assembling, fitting, aligning, adjusting, or servicing of prosthesis through the replacement of external parts of a human body lost due to amputation or congenital deformities to restore function, cosmesis, or both. Also includes Medically Necessary clinical care.

Provider – A Hospital, Allied Health Facility, Physician, or Allied Health Professional, licensed where required, performing within the scope of license, and approved by Us. If a Provider is not subject to state or federal licensure, We have the right to define all criteria under which a Provider's services may be offered to Our Members in order for Benefits to apply to a Provider's Claims. Claims submitted by Providers who fail to meet these criteria will be denied.

- Preferred Provider – A Provider who has entered into a contract with Us or another MHHIC plan to participate in a PPO Network. We call these Providers "PPO Providers," "Preferred Providers," or "Network Providers."
- Participating Provider – A Provider that has a signed contract with Us or another MHHIC.
- Non-Participating Provider – A Provider that does not have a signed contract with Us or another MHHIC plan.

Psychiatric Day Treatment Facility - An outpatient psychiatric facility which:
- Provides an organizational structure and individualized treatment plans separate from Hospital confinement programs.
- Provides no more than eight hours of treatment per patient in any 24-hour period.
- Is clinically supervised by a psychiatrist.
- Is accredited by the Joint Commission on Accreditation of Hospitals.

Reconstructive Surgery – Surgery to correct abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease. A feature or characteristic of the body is abnormal looking when an average person would consider it to be outside the range of general variations of normal human appearance.

Rehabilitative Care – Health care services and devices that help a person keep, resume or improve skills and functioning for daily living that have been lost or impaired because a patient was sick, hurt or disabled. These services may include Physical Therapy, Occupational Therapy, Speech/Language Pathology Therapy and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

Reliable evidence - The published reports and articles in authoritative medical and scientific literature; written protocol or protocols by the treating facility or other facilities studying substantially the same drug, device or medical treatment or procedure; or the medical informed consent used by the treating facility or other facilities studying substantially the same drug, device or medical treatment or procedure.

Remediation - The process of restoring or improving a specific function.

Rescission - Cancellation or discontinuance of coverage that has retroactive effect.

Research Institution – The institution or other person or entity conducting a phase I, phase II, phase III, or phase IV clinical trial.

Residential Treatment Center – A twenty-four (24) hour, non-Acute care treatment setting for the active treatment of specific impairments of Mental Health or substance abuse.

Retail Health (Walk-in) Clinic - A clinic that treats certain common, non-emergency conditions, such as sinus infections or upper respiratory infections, bladder infections, strep throat, pink eye or styes, minor injuries, such as burns and sprains, and skin conditions, such as eczema. A clinic may be staffed by a licensed nurse practitioner or physician's assistant, who can write a prescription, if necessary, with a doctor, employed by the clinic, available on call to the nurse practitioner or physician's assistant if a consultation is necessary or an emergency arises. The clinic may be located in stores or pharmacies and may have evening and weekend hours.

Self-Administered Injectable Drugs - Injectable Drugs, which are approved for self-administration by the Food and Drug Administration.
Service Area – The geographical area, designated by Us and approved by the State of Texas in which We provide Coverage. For this Policy, the Service area consists of: Harris, Montgomery, Walker, Fort Bend, Brazoria, Wharton and Galveston.

Skilled Nursing Facility or Unit – A facility licensed by the state in which it operates and is other than a nursing home, or in a unit within a Hospital (unless skilled nursing in the nursing home or unit within a Hospital was specifically approved by Us), that provides:

- Inpatient medical care, treatment and skilled nursing care as defined by Medicare and which meets the Medicare requirements for this type of facility;
- Full-time supervision by at least one Physician or Registered Nurse;
- Twenty-four (24) hour nursing service by Registered Nurses or Licensed Practical Nurses; and
- Utilization review plans for all patients.

Specialist – A physician who focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions.

Special Care Unit – A designated Hospital unit which is approved by Us and which has concentrated all facilities, equipment, and supportive services for the provision of an intensive level of care for critically ill patients, such as an intermediate care neonatal unit, telemetry unit for heart patients, or an isolation unit.

Specialty Drugs – Specialty Pharmaceuticals are typically high in cost and have one or more of the following characteristics:

- Specialized patient training on the administration of the drug (including supplies and devices needed for administration) is required.
- Coordination of care is required prior to drug therapy initiation and/or during therapy.
- Unique patient compliance and safety monitoring requirements.
- Unique requirements for handling, shipping and storage.
- Restricted access or limited distribution.

Speech/Language Pathology Therapy – The treatment used to manage speech/language, cognitive-communication and swallowing disorders. Goals are directed towards improving or restoring function.

Stabilize - With respect to an Emergency Medical Condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility. With respect to a pregnant woman who is having contractions, the term “stabilize” also means to deliver (including the placenta), if there is inadequate time to affect a safe transfer to another hospital before delivery or transfer may pose a threat to the health or safety of the woman or the unborn child.

Subscriber - The person to whom this Policy is issued (also known as a Policyholder).

Surgery -

- The performance of generally accepted operative and cutting procedures including specialized instrumentations, endoscopic exams, incisional and excisional biopsies and other invasive procedures.
- The correction of fractures and dislocations.
- Pregnancy Care to include vaginal deliveries and caesarean sections.
- Usual and related pre-operative and post-operative care.
- Other procedures as defined and approved by Us.

Telehealth Service - A health service, other than a Telemedicine Medical Service, delivered by a licensed or certified Physician acting within the scope of the Physician's license or certification 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 - A health care service initiated or provided by a Physician for purposes of patient assessment, diagnosis, consultation, treatment or the transfer of medical data, that requires the use of advanced telecommunications technology other than by telephone or facsimile, including:

- 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.

Temporomandibular Joint Disorder (TMJ) – Disorders resulting in pain and/or dysfunction of the temporomandibular/craniomandibular joint which arise out of rheumatic disease, dental occlusive disorders, internal or external joint stress, or other causes.

Usual, Customary and Reasonable Charge (UCR) - The fee based on generally accepted industry standards and practices for determining the customary billed charge for a service and that fairly and accurately reflects market rates, including geographic differences in costs.

Urgent Care – A sudden, Acute and unexpected medical condition that requires timely diagnosis and treatment but does not pose an immediate threat to life or limb. Examples of Urgent Care include, but are not limited to: colds and flu, sprains, stomachaches, and nausea.

Urgent Care Center – A clinic, with extended office hours, that provides Urgent Care and minor Emergency Care to patients on an unscheduled basis without need for appointment. The Urgent Care Center does not provide routine follow-up care or wellness examinations and refers patients back to their regular Physician for such routine follow-up and wellness care.

Us, We, Our, MHHIC – Memorial Hermann Health Insurance Company and anyone to whom we legally delegate performance on our behalf under this Policy.

Utilization Management – Evaluation of necessity, appropriateness and efficiency of the use of health care services, procedures and facilities

Utilization Review - A system for prospective, concurrent, or retrospective review of the Medical Necessity and appropriateness of health care services and a system for prospective, concurrent, or retrospective review to determine the experimental or investigational nature of health care services. The term does not include a review in response to an elective request for clarification of coverage.

Well Baby Care –Regularly scheduled, preventive care services, including immunizations, provided to children up to age twenty four (24) months or as otherwise mandated by law.

You, Your, **Yourself** – The Policyholder, Member or Subscriber who has applied and been accepted for coverage under this Policy as named.

Year – "Benefit Year", "Contract Year", "Policy Year" covered period lasting for 1 calendar year beginning January 1st at (Central Time) 12:01 AM and ending on December 31st at 11:59 PM (Central Time) unless otherwise noted. If Your coverage initially begins on a day other than January 1st, the first year will be shorter than 12 months and also end as of December 31st at 11:59 PM (Central Time).

III. SCHEDULE OF BENEFITS

Notes:

- Copayments are fixed dollar amounts (for example $15) that you pay when you receive service.
- If an Out-of-Network provider charges more than the Allowed Amount, You may have to pay the difference.
- This is not a complete list of covered benefits. Please read the entire document for other Covered Services, Benefits, Exclusions & Limitations.
- The Emergency Room Service copayment does not count toward satisfying the Deductible.
- In-Network benefits are paid based on the Negotiated Rate; Out-of-Network benefits are paid based on maximum Allowable Amounts.
- [Benefits are applied per Calendar Year.]
- This Policy does not cover – [Cosmetic surgery, Dental Care (Adult), Long Term Care, Non-Emergency care when traveling outside the U.S., Private duty nursing].

[Schedule of Benefits]

Annual	In-Network	Out-of-Network
Individual Deductible:	$[0-7,150]	[$[0-50,000]
Family Deductible:	$[0-14,300]	[$[0-50,000]
Individual Out-of-Pocket Maximum:	$[0-7,150]	[$[0-50,000]
Family Out-of-Pocket Maximum:	$[0-14,300]	[$[0-50,000]
[Individual Prescription Drug Out-of-Pocket Maximum:]	$[0-7,150]	[$[0-50,000]
[Family Prescription Drug Out-of-Pocket Maximum:]	$[0-14,300]	[$[0-50,000]
Coinsurance:	[0-50]%	[0-50]%
Payment Order:	Copayment applies first, then Deductible then Coinsurance (if applicable), Copay counts toward Maximum Out-of-Pocket.	

[Schedule of Benefits]				
Medical Event & Professional Services	**Services You May Need**	**Your Cost if You Use a Participating Provider (In-Network)**	**Your Cost if You Use a Non-Participating Provider (Out-of-Network)**	**Exclusions & Limitations**
Primary Care Office Visits *Also Applies to Walk-in Clinics	Primary Care (PCP) Visit to Treat an Illness or Injury	[[First] [1-99] Office Visits per Year][Deductible Waived][0%] [All other visits] *[$[0-100] Copay][,] [0-50%] [after Deductible][Deductible Waived]	[$[0-100] Copay][,] [0-50%] [after Deductible][Deductible Waived]	
	Specialist Visit	[[First] [1-99] Office Visits per Year][Deductible Waived][0%] [All other visits] [$[0-100] Copay][,] [0-50%] [after Deductible][Deductible Waived]	[$[0-100] Copay][,] [0-50%] [after Deductible][Deductible Waived]	
	Other Practitioner Office Visit	[[First] [1-99] Office Visits per Year][Deductible Waived][0%] [All other visits] [$[0-100] Copay][,] [0-50%] [after Deductible][Deductible Waived]	[$[0-100] Copay][,] [0-50%] [after Deductible][Deductible Waived]	
	Preventive Care/Screenings /Immunization	[$[0-100] Copay][,] [0-50%] [after Deductible][Deductible Waived]	[$[0-100] Copay][,] [0-50%] [after Deductible][Deductible Waived]	

[Schedule of Benefits]				
	Routine Care Services	[$[0-100] Copay][,] [0-50%] [after Deductible][Deductible Waived]	[$[0-100] Copay][,] [0-50%] [after Deductible][Deductible Waived]	
If you have a test	Diagnostic Test Lab	[$[0-100] Copay][,] [0-50%] [after Deductible][Deductible Waived]	[$[0-100] Copay][,] [0-50%] [after Deductible][Deductible Waived]	
	Diagnostic Test X-Ray	[$[0-100] Copay][,] [0-50%] [after Deductible][Deductible Waived]	[$[0-100] Copay][,] [0-50%] [after Deductible][Deductible Waived]	
	Imaging (CT/PET Scans, MRIs)	[$[0-100] Copay][,] [0-50%] [after Deductible][Deductible Waived]	[$[0-100] Copay][,] [0-50%] [after Deductible][Deductible Waived]	
If you need immediate medical attention	Ambulance Service (Ground or Air)	[$[0-100] Copay][,] [0-50%] [after Deductible][Deductible Waived]	[$[0-100] Copay][,] [0-50%] [after Deductible][Deductible Waived]	
	Ambulatory Surgical Center	[$[0-100] Copay][,] [0-50%] [after Deductible][Deductible Waived]	[$[0-100] Copay][,] [0-50%] [after Deductible][Deductible Waived]	
	Emergency Room Services	[$[0-100] Copay][,] [0-50%] [after Deductible][Deductible Waived]	[$[0-100] Copay][,] [0-50%] [after Deductible][Deductible Waived]	[Copay applies if the Emergency Room Visit does not result in an Inpatient Admission]
	Urgent Care Center	[$[0-100] Copay][,] [0-50%] [after Deductible][Deductible Waived]	[$[0-100] Copay][,] [0-50%] [after Deductible][Deductible Waived]	[For [first] [0-10] [Urgent Care] Visits, [Deductible] and [Copayment] [Waived]]

[Schedule of Benefits]				
	Inpatient Hospital Services	[$[0-100] Copay][,] [0-50%] [after Deductible][Deductible Waived]	[$[0-100] Copay][,] [0-50%] [after Deductible][Deductible Waived]	[Applies to [first] [0-10] [days][visits]]
	Surgery	[$[0-100] Copay][,] [0-50%] [after Deductible][Deductible Waived]	[$[0-100] Copay][,] [0-50%] [after Deductible][Deductible Waived]	
If you have outpatient surgery	Facility Fee (e.g. Ambulatory Surgery Center)	[$[0-100] Copay][,] [0-50%] [after Deductible][Deductible Waived]	[$[0-100] Copay][,] [0-50%] [after Deductible][Deductible Waived]	
	Physician/Surgeon Fees	[$[0-100] Copay][,] [0-50%] [after Deductible][Deductible Waived]	[$[0-100] Copay][,] [0-50%] [after Deductible][Deductible Waived]	
If you have mental health, behavioral health, or substance/chemical abuse needs	Mental/Behavioral Health & Substance Abuse Outpatient Services Professional Office Visits	[$[0-100] Copay][,] [0-50%] [after Deductible][Deductible Waived]	[$[0-100] Copay][,] [0-50%] [after Deductible][Deductible Waived]	
	Mental/Behavioral Health & Substance Abuse Outpatient Facility	[$[0-100] Copay][,] [0-50%] [after Deductible][Deductible Waived]	[$[0-100] Copay][,] [0-50%] [after Deductible][Deductible Waived]	
	Mental/Behavioral Health & Substance Abuse Inpatient Services	[$[0-100] Copay][,] [0-50%] [after Deductible][Deductible Waived]	[$[0-100] Copay][,] [0-50%] [after Deductible][Deductible Waived]	[Applies to first [0-10] [days][visits]]
If you are pregnant	Prenatal and Postnatal Care	[$[0-100] Copay][,] [0-50%] [after Deductible][Deductible Waived]	[$[0-100] Copay][,] [0-50%] [after Deductible][Deductible Waived]	
	Physician Delivery Services	[$[0-100] Copay][,] [0-50%] [after Deductible][Deductible Waived]	[$[0-100] Copay][,] [0-50%] [after Deductible][Deductible Waived]	

[Schedule of Benefits]

	Inpatient Facility Services	[$[0-100] Copay][,] [0-50%] [after Deductible][Deductible Waived]	[$[0-100] Copay][,] [0-50%] [after Deductible][Deductible Waived]	[Applies to [first] [0-10] [days][visits]] [of admission]
	Postpartum	[$[0-100] Copay][,] [0-50%] [after Deductible][Deductible Waived]	[$[0-100] Copay][,] [0-50%] [after Deductible][Deductible Waived]	
	Education Services	[$[0-100] Copay][,] [0-50%] [after Deductible][Deductible Waived]	[$[0-100] Copay][,] [0-50%] [after Deductible][Deductible Waived]	
Oral Contraceptives	All FDA Approved Prescriptions	100% of Negotiated Rate of the Drug per Prescription; not subject to Copayment for Generic or Brand Name Formulary Drugs, if Generic Drug not available	[$[0-100] Copay][,] [0-50%] [after Deductible][Deductible Waived]	
Contraceptive services and devices	All FDA approved devices	[$[0-100] Copay][,] [0-50%] [after Deductible][Deductible Waived]	[$[0-100] Copay][,] [0-50%] [after Deductible][Deductible Waived]	
If you need help recovering or have special health needs	Home Health Care	[$[0-100] Copay][,] [0-50%] [after Deductible][Deductible Waived]	[$[0-100] Copay][,] [0-50%] [after Deductible][Deductible Waived]	[Up to [60-100] visits per year][Limited to [0-10] visits per day]
	Rehabilitation & Habilitation Services	[$[0-100] Copay][,] [0-50%] [after Deductible][Deductible Waived]	[$[0-100] Copay][,] [0-50%] [after Deductible][Deductible Waived]	

[Schedule of Benefits]				
	Physical Therapy/ Occupational Therapy	[$[0-100] Copay][,] [0-50%] [after Deductible][Deductible Waived]	[$[0-100] Copay][,] [0-50%] [after Deductible][Deductible Waived]	[Up to [0-100] visits per year][Limited to [0-10] visits per day]
	[Acupuncture]	[$[0-100] Copay][,] [0-50%] [after Deductible][Deductible Waived]	[$[0-100] Copay][,] [0-50%] [after Deductible][Deductible Waived]	[Up to [0-100] visits per year][Limited to [0-10] visits per day]
	Acquired Brain Injury	[$[0-100] Copay][,] [0-50%] [after Deductible][Deductible Waived]	[$[0-100] Copay][,] [0-50%] [after Deductible][Deductible Waived]	
	Skilled Nursing Care	[$[0-100] Copay][,] [0-50%] [after Deductible][Deductible Waived]	[$[0-100] Copay][,] [0-50%] [after Deductible][Deductible Waived]	[Up to [0-100] Days per year]
	Durable Medical Equipment	[$[0-100] Copay][,] [0-50%] [after Deductible][Deductible Waived]	[$[0-100] Copay][,] [0-50%] [after Deductible][Deductible Waived]	
	Prosthetic & Orthotic Devices	[$[0-100] Copay][,] [0-50%] [after Deductible][Deductible Waived]	[$[0-100] Copay][,] [0-50%] [after Deductible][Deductible Waived]	
	Hospice Service	[$[0-100] Copay][,] [0-50%] [after Deductible][Deductible Waived]	[$[0-100] Copay][,] [0-50%] [after Deductible][Deductible Waived]	
If You and/or Your child has developmen	Autism Spectrum Disorder	[$[0-100] Copay][,] [0-50%] [after Deductible][Deductible Waived]	[$[0-100] Copay][,] [0-50%] [after Deductible][Deductible Waived]	

tal needs	Early Intervention Services	[$[0-100] Copay][,] [0-50%] [after Deductible][Deductible Waived]	[$[0-100] Copay][,] [0-50%] [after Deductible][Deductible Waived]	
[Pediatric Dental Services (Ages 0-19)]	[General, Minor, Major and Orthodontic]	[$[0-100] Copay][,] [0-50%] [after Deductible][Deductible Waived]	[$[0-100] Copay][,] [0-50%] [after Deductible][Deductible Waived][In-Network Deductible Applies]	
Vision Care	[Eye Exam with [PCP]]	[$[0-100] Copay][,] [0-50%] [after Deductible][Deductible Waived]	[$[0-100] Copay][,] [0-50%] [after Deductible][Deductible Waived]	[1 eye exam per year]
	[Eye Exam with Specialist]	[$[0-100] Copay][,] [0-50%] [after Deductible][Deductible Waived]	[$[0-100] Copay][,] [0-50%] [after Deductible][Deductible Waived]	
	[Glasses/Contacts]	[$[0-100] Copay][,] [0-50%] [after Deductible][Deductible Waived]	[$[0-100] Copay][,] [0-50%] [after Deductible][Deductible Waived]	[1 pair of eyeglasses OR 1 pair of contact lenses per year for ages 0-19 only]
	Pediatric Vision Needs	[$[0-100] Copay][,] [0-50%] [after Deductible][Deductible Waived]	[$[0-100] Copay][,] [0-50%] [after Deductible][Deductible Waived]	
Other Professional Services	Anesthesia	[$[0-100] Copay][,] [0-50%] [after Deductible][Deductible Waived]	[$[0-100] Copay][,] [0-50%] [after Deductible][Deductible Waived]	
	Speech & Hearing Exams	[$[0-100] Copay][,] [0-50%] [after Deductible][Deductible Waived]	[$[0-100] Copay][,] [0-50%] [after Deductible][Deductible Waived]	
	Speech & Hearing Therapy & Hearing Aids	[$[0-100] Copay][,] [0-50%] [after Deductible][Deductible Waived]	[$[0-100] Copay][,] [0-50%] [after Deductible][Deductible Waived]	[Hearing aids limited to [1 pair] every [1-36] months]

[Schedule of Benefits]

	Radiation Therapy	[$[0-100] Copay][,] [0-50%] [after Deductible][Deductible Waived]	[$[0-100] Copay][,] [0-50%] [after Deductible][Deductible Waived]	
	Infusion Therapy	[$[0-100] Copay][,] [0-50%] [after Deductible][Deductible Waived]	[$[0-100] Copay][,] [0-50%] [after Deductible][Deductible Waived]	
	Allergy Testing	[$[0-100] Copay][,] [0-50%] [after Deductible][Deductible Waived]	[$[0-100] Copay][,] [0-50%] [after Deductible][Deductible Waived]	
	Allergy Immunotherapy /Injections	[$[0-100] Copay][,] [0-50%] [after Deductible][Deductible Waived]	[$[0-100] Copay][,] [0-50%] [after Deductible][Deductible Waived]	
	Administration of covered injectable prescription drugs	[$[0-100] Copay][,] [0-50%] [after Deductible][Deductible Waived]	[$[0-100] Copay][,] [0-50%] [after Deductible][Deductible Waived]	
	Dialysis	[$[0-100] Copay][,] [0-50%] [after Deductible][Deductible Waived]	[$[0-100] Copay][,] [0-50%] [after Deductible][Deductible Waived]	
	Telehealth or Telemedicine Services	[No Charge][$[0-100] Copay][,] [0-50%] [after Deductible][Deductible Waived] [Copayment, Coinsurance, and Deductible amounts will not exceed amount for comparable medical services provided through a face-to-face consultation.]	[$[0-100] Copay][,] [0-50%] [after Deductible][Deductible Waived] [Copayment, Coinsurance, and Deductible amounts will not exceed amount for comparable medical services provided through a face-to-face consultation.]	

Pharmacy Services [Schedule of Benefits]	
Payment Order:	• Deductible applies first then Copayment/Coinsurance (if applicable); • Copayment and Coinsurance counts toward Maximum Out-of-Pocket unless otherwise noted.

Pharmacy Services				
		In-Network	Out-of-Network	
[30 Day Retail Pharmacy Service]	[Generic Drugs]	[$[0-300] Copay][,] [0-50]% [after Deductible][Deductible Waived]	[$[0-100] Copay][,] [0-50]% [after Deductible][Deductible Waived]	[Specialty Drugs are subject to Utilization Review]
	[Brand Name Formulary Drugs]	[$[0-300] Copay][,] [0-50]% [after Deductible][Deductible Waived]	[$[0-100] Copay][,] [0-50]% [after Deductible][Deductible Waived]	
	[Brand Name Non-Formulary Drugs]	[$[0-300] Copay][,] [0-50]% [after Deductible][Deductible Waived]	[$[0-100] Copay][,] [0-50]% [after Deductible][Deductible Waived]	
	[Specialty Drugs]	[$[0-300] Copay][,] [0-50]% [after Deductible][Deductible Waived]	[$[0-100] Copay][,] [0-50]% [after Deductible][Deductible Waived]	
[90 Day Retail [and Mail] Service Supply]	[Generic Drugs]	[$[0-300] Copay][,] [0-50]% [after Deductible][Deductible Waived]	[$[0-100] Copay][,] [0-50]% [after Deductible][Deductible Waived]	[Some prescription drugs and/or medications are not available through the Mail Order Service.]
	[Brand Name Formulary Drugs]	[$[0-300] Copay][,] [0-50]% [after Deductible][Deductible Waived]	[$[0-100] Copay][,] [0-50]% [after Deductible][Deductible Waived]	
	[Brand Name Non-Formulary Drugs]	[$[0-300] Copay][,] [0-50]% [after Deductible][Deductible Waived]	[$[0-100] Copay][,] [0-50]% [after Deductible][Deductible Waived]	
	[Specialty Drugs]	[Not Covered]	[Not Covered]	

[Pediatric Dental Schedule of Benefits]	
ANNUAL DEDUCTIBLE:	$[0-1,500]
ANNUAL MAXIMUM:	$[0-5,000]
MAXIMUM OUT-OF-POCKET BENEFIT:	[Out of pocket maximum for a Certificate of Coverage with one covered child is $350. The out of pocket maximum for a Certificate of Coverage with two or more covered children is $350 per individual child or $700 combined for all children.]

[Pediatric Dental Schedule of Benefits]			
CATEGORY	**SERVICES YOU MAY NEED**	**IN-NETWORK**	**OUT-OF-NETWORK**
Class A Pediatric Dental Services (Basic Services)	Diagnostic and Treatment Services Preventive Services Minor procedures related to Emergency Services	[$0-100 Copay][After Deductible] [[0-50%] Coinsurance] [Deductible Waived]	[$0-100 Copay][After Deductible] [[0-50%] Coinsurance] [Deductible Waived]
Class B Pediatric Dental Services (Intermediate Services)	Minor Restorative Services Endodontic Services* Periodontal Services* Prosthodontic Services* Oral Surgery	[$0-100 Copay][After Deductible] [[0-50%] Coinsurance] [Deductible Applies]	[$0-100 Copay][After Deductible] [[0-50%] Coinsurance] [Deductible Applies]
Class C Pediatric Dental Services (Major Services)	Major Restorative Services Endodontic Services** Periodontal Services** Prosthodontic Services** Implants**	[$0-100 Copay][After Deductible] [[0-50%] Coinsurance] [Deductible Applies]	[$0-100 Copay][After Deductible] [[0-50%] Coinsurance] [Deductible Applies]
Class D Pediatric Dental Services (Orthodontic)	Orthodontic treatment as a result of congenital or developmental malformation which are related to or developed as a result of cleft palette with or without cleft lip	[$0-100 Copay][After Deductible] [[0-50%] Coinsurance] [Deductible Applies]	[$0-100 Copay][After Deductible] [[0-50%] Coinsurance] [Deductible Applies]
General Pediatric Dental Services	Anesthesia Services Intravenous Sedation Consultations Medications	[$0-100 Copay][After Deductible] [[0-50%] Coinsurance] [Deductible Applies]	[$0-100 Copay][After Deductible] [[0-50%] Coinsurance] [Deductible Waived]

[Pediatric Dental Schedule of Benefits]

Additional pediatric dental benefits are available under this Plan for an Insured who is under the age of 19.

1. CLASS A PEDIATRIC DENTAL SERVICES - BASIC SERVICES

Diagnostic and Treatment Services

- D0120 Periodic oral evaluation, established patient -Limited to 1 every 6 months
- D0140 Limited oral evaluation - problem focused - Limited to 1 every 6 months
- D0150 Comprehensive oral evaluation, new or established patient - Limited to 1 every 6 months
- D0180 Comprehensive periodontal evaluation, new or established patient - Limited to 1 every 6 months
- D0210 Intraoral – complete series of radiographic images - 1 every 60 (sixty) months
- D0220 Intraoral - periapical first radiographic image
- D0230 Intraoral - periapical each additional radiographic image
- D0240 Intraoral - occlusal radiographic image
- D0270 Bitewing – single radiographic image - 1 set every 6 months
- D0272 Bitewings – two radiographic images -1 set every 6 months
- D0274 Bitewings – four radiographic images - 1 set every 6 months
- D0277 Vertical bitewings – 7 to 8 radiographic images - 1 set every 6 months
- D0330 Panoramic radiographic image – 1 film every 60 (sixty) months
- D0340 Cephalometric radiographic image
- D0350 Oral/ Facial photographic image obtained intraorally or extraorally
- D0391 Interpretation of Diagnostic Image
- D0470 Diagnostic casts

Preventive Services

- D1120 Prophylaxis – Child - Limited to 1 every 6 months
- D1206 Topical fluoride varnish - 2 in 12 months
- D1208 Topical application of fluoride (excluding prophylaxis) – child - Limited to 2 every 12 months
- D1351 Sealant - per tooth - unrestored permanent molars - 1 sealant per tooth every 36 months
- D1352 Preventive resin restoration in a moderate to high caries risk patient - permanent tooth - 1 sealant per tooth every 36 months.
- D1510 Space maintainer – fixed – unilateral
- D1515 Space maintainer – fixed – bilateral
- D1520 Space maintainer - removable – unilateral

- D1525 Space maintainer - removable – bilateral
- D1550 Re-cement or re-bond space maintainer

Additional Procedures Covered as Basic Services

- D9110 Palliative (emergency) treatment of dental pain – minor procedure

2. CLASS B PEDIATRIC DENTAL SERVICES - INTERMEDIATE SERVICES

Minor Restorative Services

- D2140 Amalgam - one surface, primary or permanent
- D2150 Amalgam - two surfaces, primary or permanent
- D2160 Amalgam - three surfaces, primary or permanent
- D2161 Amalgam - four or more surfaces, primary or permanent
- D2330 Resin–based composite - one surface, anterior
- D2331 Resin-based composite - two surfaces, anterior
- D2332 Resin-based composite - three surfaces, anterior
- D2335 Resin-based composite - four or more surfaces or involving incisal angle (anterior)
- D2910 Re-cement ore re-bond inlay, onlay, veneer or partial coverage restoration
- D2920 Re-cement or re-bond crown

- D2929 Prefabricated porcelain crown – primary – Limited to 1 every 60 months
- D2930 Prefabricated stainless steel crown - primary tooth – Under age 15 - Limited to 1 per tooth in 60 months
- D2931 Prefabricated stainless steel crown - permanent tooth - Under age 15 - Limited to 1 per tooth in 60 months
- D2940 Protective Restoration
- D2951 Pin retention - per tooth, in addition to restoration

Endodontic Services*

- D3220 Therapeutic pulpotomy (excluding final restoration) removal of pulp coronal to the dentinocemental junction and application of medicament - If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service since it is considered a part of the root canal procedure and benefits are not payable separately.
- D3222 Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development - If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service since it is considered a part of the root canal procedure and benefits are not payable separately.

- D3230 Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration) - Limited to primary incisor teeth for Insureds up to age 6 and for primary molars and cuspids up to age 11 and is limited to once per tooth per lifetime.
- D3240 Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration). Incomplete endodontic treatment when You discontinue treatment. - Limited to primary incisor teeth for Insureds up to age 6 and for primary molars and cuspids up to age 11 and is limited to once per tooth per lifetime.

- D3354 Pulpal regeneration (completion of regenerative treatment in an immature permanent tooth with a necrotic pulp); does not include final restoration.

Periodontal Services*

- D4271 Free soft tissue graft procedure (including donor site surgery)

- D4341 Periodontal scaling and root planing - four or more teeth per quadrant – Limited to 1 every 24 months

- D4342 Periodontal scaling and root planing - one to three teeth, per quadrant – Limited to 1 every 24 months

- D4910 Periodontal maintenance – 4 in 12 months combined with prophylaxis after the completion of active periodontal therapy
- D7921 Collect – Apply Autologous Product – Limited to 1 in 36 months

Prosthodontic Services*

- D5410 Adjust complete denture – maxillary
- D5411 Adjust complete denture – mandibular
- D5421 Adjust partial denture – maxillary
- D5422 Adjust partial denture - mandibular
- D5510 Repair broken complete denture base
- D5520 Replace missing or broken teeth - complete denture (each tooth)
- D5610 Repair resin denture base
- D5620 Repair cast framework
- D5630 Repair or replace broken clasp
- D5640 Replace broken teeth - per tooth
- D5650 Add tooth to existing partial denture
- D5660 Add clasp to existing partial denture

- D5710 Rebase complete maxillary denture - Limited to 1 in a 36-month period 6 months after the initial installation

- D5720 Rebase maxillary partial denture - Limited to 1 in a 36-month period 6 months after the initial installation

- D5721 Rebase mandibular partial denture - Limited to 1 in a 36-month period 6 months after the initial installation

- D5730 Reline complete maxillary denture - Limited to 1 in a 36-month period 6 months after the initial installation
- D5731 Reline complete mandibular denture - Limited to 1 in a 36-month period 6 months after the initial installation
- D5740 Reline maxillary partial denture - Limited to 1in a 36-month period 6 months after the initial installation
- D5741 Reline mandibular partial denture - Limited to 1 in a 36-month period 6 months after the initial installation
- D5750 Reline complete maxillary denture (laboratory) - Limited to 1 in a 36-month period 6 months after the initial installation
- D5751 Reline complete mandibular denture (laboratory) - Limited to 1 in a 36-month period 6 months after the initial installation
- D5760 Reline maxillary partial denture (laboratory) - Limited to 1 in a 36-month period 6 months after the initial installation
- D5761 Reline mandibular partial denture (laboratory) Rebase/Reline - Limited to 1 in a 36-month period 6 months after the initial installation.
- D5850 Tissue conditioning (maxillary)
- D5851 Tissue conditioning (mandibular)
- D6519 Inlay/onlay – porcelain/ceramic – Limited to 1 every 60 months
- D6520 Inlay – metallic – two surfaces – Limited to 1 every 60 months
- D6530 Inlay – metallic – three or more surfaces - Limited to 1 every 60 months
- D6543 Onlay – metallic – three surfaces - 1 every 60 months
- D6544 Onlay – metallic – four or more surfaces -1 every 60 months
- D6930 Recement fixed partial denture
- D6973 Core buildup for retainer, including any pins - 1 every 60 months
- D6980 Fixed partial denture repair necessitated by restorative material failure

Oral Surgery

- D7140 Extraction, erupted tooth or exposed root (elevation and/or forceps removal)
- D7210 Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated.
- D7220 Removal of impacted tooth - soft tissue
- D7230 Removal of impacted tooth – partially bony
- D7240 Removal of impacted tooth - completely bony
- D7241 Removal of impacted tooth - completely bony, with unusual surgical complications
- D7250 Surgical removal of residual tooth roots (cutting procedure)

- D7251 Coronectomy - intentional partial tooth removal
- D7270 Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth
- D7280 Surgical access of an unerupted tooth
- D7310 Alveoloplasty in conjunction with extractions – four or more teeth or tooth spaces, per quadrant
- D7311 Alveoloplasty in conjunction with extractions-one to three teeth or tooth spaces, per quadrant
- D7320 Alveoloplasty not in conjunction with extractions – four or more teeth or tooth spaces, per quadrant
- D7321 Alveoloplasty not in conjunction with extractions-one to three teeth or tooth spaces, per quadrant
- D7471 Removal of lateral exostosis (maxilla or mandible)
- D7510 Incision and drainage of abscess - intraoral soft tissue
- D7910 Suture of recent small wounds up to 5 cm
- D7953 Bone replacement graft for ridge preservation-per site
- D7971 Excision of pericoronal gingiva

3. CLASS C PEDIATRIC DENTAL SERVICES - MAJOR SERVICES

Major Restorative Services

- D0160 Detailed and extensive oral evaluation - problem focused, by report
- D2510 Inlay - metallic – one surface – An alternate benefit will be provided
- D2520 Inlay - metallic – two surfaces – An alternate benefit will be provided
- D2530 Inlay - metallic – three surfaces – An alternate benefit will be provided
- D2542 Onlay - metallic - two surfaces – Limited to 1 per tooth every 60 months
- D2543 Onlay - metallic - three surfaces – Limited to 1 per tooth every 60 months
- D2544 Onlay - metallic - four or more surfaces – Limited to 1 per tooth every 60 months
- D2740 Crown - porcelain/ceramic substrate - Limited to 1 per tooth every 60 months
- D2750 Crown - porcelain fused to high noble metal - Limited to 1 per tooth every 60 months
- D2751 Crown - porcelain fused to predominately base metal – Limited to 1 per tooth every 60 months
- D2752 Crown - porcelain fused to noble metal – Limited to 1 per tooth every 60 months
- D2780 Crown - 3/4 cast high noble metal – Limited to 1 per tooth every 60 months
- D2781 Crown - 3/4 cast predominately base metal – Limited to 1 per tooth every 60 months
- D2783 Crown - 3/4 porcelain/ceramic – Limited to 1 per tooth every 60 months
- D2790 Crown - full cast high noble metal– Limited to 1 per tooth every 60 months
- D2791 Crown - full cast predominately base metal – Limited to 1 per tooth every 60 months
- D2792 Crown - full cast noble metal– Limited to 1 per tooth every 60 months
- D2794 Crown – titanium– Limited to 1 per tooth every 60 months
- D2950 Core buildup, including any pins when required – Limited to 1 per tooth every 60 months
- D2954 Prefabricated post and core, in addition to crown– Limited to 1 per tooth every 60 months

- D2980 Crown repair necessitated by restorative material failure
- D2981 Inlay Repair
- D2982 Onlay Repair
- D2983 Veneer Repair
- D2990 Resin infiltration/smooth surface-Limited to 1 in 36 months

Endodontic Services**

- D3310 Endodontic therapy, anterior tooth (excluding final restoration)
- D3320 Endodontic therapy, bicuspid tooth (excluding final restoration)
- D3330 Endodontic therapy, molar (excluding final restoration)
- D3346 Retreatment of previous root canal therapy-anterior
- D3347 Retreatment of previous root canal therapy-bicuspid
- D3348 Retreatment of previous root canal therapy-molar
- D3351 Apexification/recalcification – initial visit (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.)
- D3352 Apexification/recalcification – interim medication replacement
- D3353 Apexification/recalcification - final visit (includes completed root canal therapy, apical closure/calcific repair of perforations, root resorption, etc.)
- D3410 Apicoectomy – anterior
- D3421 Apicoectomy - bicuspid (first root)
- D3425 Apicoectomy - molar (first root)
- D3426 Apicoectomy (each additional root)
- D3450 Root amputation - per root
- D3920 Hemisection (including any root removal) - not including root canal therapy

Periodontal Services**

- D4210 Gingivectomy or gingivoplasty – four or more contiguous teeth or tooth bounded spaces per quadrant - Limited to 1 every 36 months
- D4211 Gingivectomy or gingivoplasty – one to three contiguous teeth or tooth bounded spaces per quadrant.
- D4212 Gingivectomy or gingivoplasty – with restorative procedures, per tooth – Limited to 1 every 36 months
- D4240 Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant – Limited to 1 every 36 months
- D4249 Clinical crown lengthening-hard tissue

- D4260 Osseous surgery (including elevation of a full thickness flap entry and closure), four or more contiguous teeth or tooth bounded spaces per quadrant – Limited to 1 every 36 months

- D4261 Osseous surgery (including flap entry and closure), one to three contiguous teeth or bounded teeth spaces per quadrant – Limited to 1 every 36 months
- D4263 Bone replacement graft – first site in quadrant – Limited to 1 every 36 months
- D4270 Pedicle soft tissue graft procedure
- D4273 Subepithelial connective tissue graft procedures, per tooth

- D4275 Soft tissue allograft – Limited to 1 every 36 months

- D4277 Free soft tissue graft 1st tooth

- D4278 Free soft tissue graft-additional teeth

- D4355 Full mouth debridement to enable comprehensive evaluation and diagnosis – Limited to 1 per lifetime

Prosthodontic Services**

- D5110 Complete denture - maxillary – Limited to 1 every 60 months
- D5120 Complete denture - mandibular – Limited to 1 every 60 months
- D5130 Immediate denture - maxillary – Limited to 1 every 60 months
- D5140 Immediate denture - mandibular – Limited to 1 every 60 months

- D5211 Maxillary partial denture - resin base (including any conventional clasps, rests and teeth) – Limited to 1 every 60 months

- D5212 Mandibular partial denture - resin base (including any conventional clasps, rests and teeth) – Limited to 1 every 60 months

- D5213 Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)– Limited to 1 every 60 months

- D5214 Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) – Limited to 1 every 60 months
- D5281 Removable unilateral partial denture-one piece cast metal (including clasps and teeth) – Limited to 1 every 60 months

NOTE: An implant is a covered procedure of the Plan only if determined to be a **dental necessity.** Claim review is conducted by a panel of licensed dentists who review the clinical documentation submitted by the treating dentist. If the dental consultants determine an arch can be restored with a standard prosthesis or restoration, no benefits will be allowed for the individual implant or implant procedures. Only the second phase of treatment (the prosthodontic phase-placing of the implant crown, bridge denture or partial denture) may be subject to the alternate benefit provision of the plan.

- D6010 Surgical placement of implant body: endosteal implant - 1 every 60 months
- D6012 Surgical placement of interim implant body for transitional prosthesis: endosteal implant - 1 every 60 months
- D6040 Surgical placement: eposteal implant – 1 every 60 months
- D6050 Surgical placement: transosteal implant– 1 every 60 months
- D6053 Implant/abutment supported removable denture for completely edentulous arch.
- D6054 Implant/abutment supported removable denture for partially edentulous arch
- D6055 Connecting Bar – implant or abutment supported - 1 every 60 months
- D6056 Prefabricated Abutment – includes modification and placement – 1 every 60 months
- D6058 Abutment supported porcelain/ceramic crown -1 every 60 months
- D6059 Abutment supported porcelain fused to metal crown (high noble metal) - 1 every 60 months
- D6060 Abutment supported porcelain fused to metal crown (predominately base metal) - 1 every 60 months
- D6061 Abutment supported porcelain fused to metal crown (noble metal) - 1 every 60 months
- D6062 Abutment supported cast metal crown (high noble metal) - 1 every 60 months
- D6063 Abutment supported cast metal crown (predominately base metal) - 1 every 60 months
- D6064 Abutment supported cast metal crown (noble metal) - 1 every 60 months
- D6065 Implant supported porcelain/ceramic crown - 1 every 60 months
- D6066 Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal) - 1 every 60 months
- D6067 Implant supported metal crown (titanium, titanium alloy, high noble metal) - 1 every 60 months
- D6068 Abutment supported retainer for porcelain/ceramic fixed partial denture - 1 every 60 months
- D6069 Abutment supported retainer for porcelain fused to metal fixed partial denture (high noble metal) - 1 every 60 months
- D6070 Abutment supported retainer for porcelain fused to metal fixed partial denture (predominately base metal)- 1 every 60 months
- D6071 Abutment supported retainer for porcelain fused to metal fixed partial denture (noble metal) - 1 every 60 months
- D6072 Abutment supported retainer for cast high noble metal fixed partial denture - 1 every 60 months

- D6073 Abutment supported retainer for predominately base metal fixed partial denture - 1 every 60 months
- D6074 Abutment supported retainer for cast noble metal fixed partial denture - 1 every 60 months
- D6075 Implant supported retainer for ceramic fixed partial denture - 1 every 60 months
- D6076 Implant supported retainer for porcelain fused to metal fixed partial denture (titanium, titanium alloy, or high noble metal) - 1 every 60 months
- D6077 Implant supported retainer for cast metal fixed partial denture (titanium, titanium alloy, or high noble metal) - 1 every 60 months
- D6078 Implant/abutment supported fixed partial denture for completely edentulous arch - 1 every 60 months
- D6079 Implant/abutment supported fixed denture for partially edentulous arch - 1 every 60 months
- D6080 Implant Maintenance Procedures -1 every 60 months
- D6090 Repair implant supported prosthesis, by report -1 every 60 months
- D6091 Replacement of Semi-Precision or Precision Attachment (male or female component) of implant/abutment supported prosthesis, per attachment -1 every 60 months
- D6095 Repair Implant Abutment , by report -1 every 60 months
- D6100 Implant Removal, by report -1 every 60 months
- D6101 Debridement per implant defect, covered if implants are covered – Limited to 1 every 60 months
- D6102 Debridement and osseous per implant defect, covered if implants are covered – Limited to 1 every 60 months
- D6103 Bone graft per implant defect, covered if implants are covered
- D6104 Bone graft implant replacement, covered if implants are covered
- D6190 Implant IndexD6190 Radiographic/surgical implant index, by report -1 every 60 months
- D6210 Pontic - cast high noble metal – Limited to 1 every 60 months
- D6211 Pontic - cast predominately base metal – Limited to 1 every 60 months
- D6212 Pontic - cast noble metal– Limited to 1 every 60 months
- D6214 Pontic – titanium – Limited to 1 every 60 months
- D6240 Pontic - porcelain fused to high noble metal – Limited to 1 every 60 months
- D6241 Pontic - porcelain fused to predominately base metal – Limited to 1 every 60 months
- D6242 Pontic - porcelain fused to noble metal – Limited to 1 every 60 months
- D6245 Pontic - porcelain/ceramic – Limited to 1 every 60 months
- D6545 Retainer - cast metal for resin bonded fixed prosthesis -1 every 60 months
- D6548 Retainer - porcelain/ceramic for resin bonded fixed prosthesis -1 every 60 months
- D6740 Crown - porcelain/ceramic -1 every 60 months
- D6750 Crown - porcelain fused to high noble metal - 1 every 60 months
- D6751 Crown - porcelain fused to predominately base metal - 1 every 60 months
- D6752 Crown - porcelain fused to noble metal - 1 every 60 months

- D6780 Crown - 3/4 cast high noble metal - 1 every 60 months
- D6781 Crown - 3/4 cast predominately base metal - 1 every 60 months
- D6782 Crown - 3/4 cast noble metal - 1 every 60 months
- D6783 Crown - 3/4 porcelain/ceramic - 1 every 60 months
- D6790 Crown - full cast high noble metal - 1 every 60 months
- D6791 Crown - full cast predominately base metal - 1 every 60 months
- D6792 Crown - full cast noble metal - 1 every 60 months
- D9940 Occlusal guard, by report - 1 in 12 months for patients 13 and older

4. CLASS D PEDIATRIC DENTAL SERVICES - ORTHODONTIC

Orthodontic Services

- D8010 Limited orthodontic treatment of the primary dentition
- D8020 Limited orthodontic treatment of the transitional dentition
- D8030 Limited orthodontic treatment of the adolescent dentition
- D8050 Interceptive orthodontic treatment of the primary dentition
- D8060 Interceptive orthodontic treatment of the transitional dentition
- D8070 Comprehensive orthodontic treatment of the transitional dentition
- D8080 Comprehensive orthodontic treatment of the adolescent dentition
- D8210 Removable appliance therapy
- D8220 Fixed appliance therapy
- D8660 Pre-orthodontic treatment visit
- D8670 Periodic orthodontic treatment visit (as part of contract)
- D8680 Orthodontic retention (removal of appliances, construction and placement of retainer(s))

5. GENERAL PEDIATRIC DENTAL SERVICES

Anesthesia Services

- D9220 Deep sedation/general anesthesia - first 30 minutes
- D9221 Deep sedation/general anesthesia - each additional 15 minutes

Intravenous Sedation

- D9241 Intravenous conscious sedation/analgesia - first 30 minutes
- D9242 Intravenous conscious sedation/analgesia - each additional 15 minutes

Consultations

- D9310 Consultation (diagnostic service provided by dentist or physician other than practitioner providing treatment)

Medications

- D9610 Therapeutic parenteral drug, single administration

Post Surgical Services

- D9930 Treatment of complications (post-surgical) unusual circumstances, by report

5. PEDIATRIC DENTAL EXCLUSIONS & LIMITATIONS:

The following are not covered under this Plan:

- D0310 Sialography
- D0320 Temporomandibular joint arthrogram, including injection
- D0321 Other temporomandibular joint radiographic images, by report.
- D0322 Tomographic survey
- D0416 Viral culture
- D0418 Analysis of saliva sample
- D0425 Caries susceptibility tests
- D0431 Adjunctive pre-diagnostic test
- D0472 Accession of tissue, gross examination, preparation and transmission of written report
- D0473 Accession of tissue, gross and microscopic examination, preparation and transmission of written report
- D0474 Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation, and transmission of report
- D0475 Decalcification procedure
- D0476 Special stains for microorganisms
- D0477 Special stains not for microorganisms
- D0478 Immunohistochemical stains
- D0479 Tissue in-situhybridization, including interpretation
- D0481 Electron microscopy - diagnostic
- D0482 Direct immunofluorescence
- D0483 Indirect immunofluorescence
- D0484 Consultation on slides prepared elsewhere
- D0485 Consultation including preparation of slides from biopsy material supplied by referring source
- D0486 Laboratory accession of transepithelial cytologic sample, microscopic examination, preparation and transmission of written report

- D0502 Other oral pathology procedures, by report
- D1310 Nutritional counseling for control of dental disease
- D1320 Tobacco counseling for the control and prevention of oral disease
- D1330 Oral Hygiene Instructions
- D1555 Removal of fixed space maintainer
- D2410 Gold Foil 1 surface
- D2420 Gold Foil 2 surfaces
- D2430 Gold Foil 3 surfaces
- D2799 Provisional Crown
- D2955 Post Removal
- D2970 Temporary Crown (fractured tooth)
- D2975 Coping
- D3460 Endodontic endosseous implant
- D3470 Intentional reimplantation (including necessary splinting)
- D3910 Surgical procedure for isolation of tooth with rubber dam
- D3950 Canal preparation and fitting of preformed dowel or post
- D4230 Anatomical crown exposure 4 or more contiguous teeth per quadrant
- D4231 Anatomical crown exposure 1-3 teeth per quadrant
- D4320 Provisional splinting - intracoronal
- D4321 Provisional splinting - extracoronal
- D5810 Interim complete denture (maxillary)
- D5811 Interim complete denture (mandibular)
- D5820 Interim partial denture (maxillary)
- D5821 interim partial denture (mandibular)
- D5862 Precision Attachment, by report
- D5867 Replacement of replaceable part of semi-precision or precision attachment (male or female component).
- D5911 Facial Moulage (sectional)
- D5912 Facial Moulage (complete)
- D5913 Nasal Prosthesis
- D5914 Auricular Prosthesis
- D5915 Orbital Prosthesis
- D5916 Ocular Prosthesis
- D5919 Facial Prosthesis
- D5922 Nasal Septal Prosthesis
- D5923 Ocular Prosthesis (interim)
- D5924 Cranial Prosthesis
- D5925 Facial Augmentation implant prosthesis
- D5926 Nasal Prosthesis (replacement)
- D5927 Auricular Prosthesis (replacement)
- D5928 Orbital Prosthesis (replacement)
- D5929 Facial Prosthesis (replacement)

- D5931 Obturator Prosthesis (surgical)
- D5932 Obturator Prosthesis (definitive)
- D5933 Obturator Prosthesis (modification)
- D5934 Mandibular resection Prosthesis with guide flange
- D5935 Mandibular resection Prosthesis without guide flange
- D5936 Obturator Prosthesis (interim)
- D5937 Trismus Appliance (not for TMD treatment)
- D5951 Feeding Aid
- D5952 Speech Aid prosthesis (pediatric)
- D5954 Palatal Augmentation Prosthesis
- D5955 Palatal Lift Prosthesis (definitive)
- D5958 Palatal Lift Prosthesis (interim)
- D5959 Palatal Lift Prosthesis (modification)
- D5960 Speech Aid Prosthesis (modification)
- D5982 Surgical Stent
- D5983 Radiation Carrier
- D5984 Radiation Shield
- D5985 Radiation Cone locator
- D5986 Fluoride Gel Carrier
- D5987 Commissure Splint
- D5988 Surgical Splint
- D5992 Adjust maxillofacial prosthetic appliance, by report
- D5993 Maintenance and cleaning of a maxillofacial prosthesis (extra or intraoral) other than required adjustments, by report
- D6057 Custom fabricated abutment – includes placement
- D6253 Provisional Pontic – further treatment or completion of diagnosis necessary prior to final impression.
- D6920 Connector bar
- D6940 Stress breaker
- D6950 Precision Attachment
- D6975 Coping
- D7285 Biopsy of oral tissue – hard (bone, tooth)
- D7286 Biopsy of oral tissue (soft)
- D7292 Surgical placement: temporary anchorage device (screw retained plate) requiring surgical flap
- D7293 Surgical placement: temporary anchorage device requiring surgical flap
- D7294 Surgical placement: temporary anchorage device without surgical flap
- D7295 Harvest of bone for use in autogenous grafting procedure
- D7410 Excision of benign lesion up to 1.25 cm
- D7411 Excision of benign lesion greater than 1.25 cm
- D7412 Excision of benign lesion, complicated
- D7413 Excision of malignant lesion up to 1.25 cm

- D7414 Excision of malignant lesion greater than 1.25 cm
- D7415 Excision of malignant lesion, complicated
- D7440 Excision of malignant tumor – lesion diameter up to 1.25 cm
- D7441 Excision of malignant tumor – lesion diameter greater than 1.25 cm
- D7460 Removal of Benign nonodontogenic cyst or tumor – lesion diameter up to 1.25 cm
- D7461 Removal of Benign nonodontogenic cyst or tumor – lesion diameter greater than 1.25 cm
- D7465 Destruction of lesion(s) by physical or chemical method, by report
- D7490 Radical resection of maxilla or mandible
- D7530 Removal of foreign body
- D7540 Removal of reaction producing foreign bodies, musculoskeletal system
- D7550 Partial Ostectomy/sequestrectomy for removal of non-vital bone
- D7560 Maxillary Sinusotomy for removal of tooth fragment or foreign body
- D7610 Maxilla – open reduction
- D7620 Maxilla – closed reduction
- D7630 Mandible – open reduction
- D7640 Mandible – closed reduction
- D7650 Malar and/or zygomatic arch – open reduction
- D7660 Malar and/or zygomatic arch – closed reduction
- D7670 Alveolus, closed reduction
- D7671 Alveolus, open reduction
- D7680 Facial bones (simple)
- D7710 Maxilla – open reduction
- D7720 Maxilla – closed reduction
- D7730 Mandible - open reduction
- D7740 Mandible – closed reduction
- D7750 Malar and/or zygomatic arch open red.(compound)
- D7760 Malar and/or zygomatic arch closed red.(compound)
- D7770 Alveolus open red.(compound - stabilization of teeth)
- D7771 Alveolus closed red. (compound – stabilization of teeth)
- D7780 Facial bones - complicated
- D7810 Open reduction of dislocation
- D7820 Closed reduction of dislocation
- D7830 Manipulation under anesthesia
- D7840 Condylectomy
- D7850 Surgical discectomy, with/without implant
- D7852 Disc repair
- D7854 Synovectomy
- D7856 Myotomy
- D7858 Joint reconstruction
- D7860 Arthrotomy
- D7865 Arthroplasty
- D7870 Arthrocentesis

- D7871 Non-Arthroscopic lysis and lavage
- D7872 Arthroscopy – diagnosis, with or without a biopsy
- D7873 Arthoscopy - surgical
- D7874 Arthoscopy surgical disc
- D7875 Arthoscopy surgical: synovectomy
- D7876 Arthoscopy surgical: discectomy
- D7877 Arthoscopy surgical: debridement
- D7880 Occlusal orthotic device, by report
- D7899 Unspecified TMD therapy, by report
- D7911 Complicated suture - up to 5 cm.
- D7912 Complicated suture - greater than 5 cm.
- D7920 Skin graft
- D7940 Osteoplasty deformities
- D7941 Osteotomy mandibular rami
- D7943 Osteotomy mandibular rami with bone graft
- D7944 Osteotomy segmented or subapical
- D7945 Osteotomy body of mandible
- D7946 Lefort I (maxilla – total)
- D7947 Lefort I (maxilla – segmented)
- D7948 Lefort II or Lefort III without bone graft
- D7949 Lefort II or Lefort III with bone graft

- D7950 Osseous, osteoperiosteal, or cartilage graft of the mandible or maxilla, autogenous or nonautogenous by report
- D7951 Sinus Augmentation with bone or bone substitutes
- D7955 Repair of Maxillofacial soft and/or hard tissue defect
- D7980 Sialolithotomy
- D7981 Excision of salivary gland, by report
- D7982 Sialodochoplasty
- D7983 Closure of salivary fistula
- D7990 Emergency tracheotomy
- D7991 Coronoidectomy
- D7995 Synthetic graft – mandible or facial bones, by report
- D7996 Implant-mandible for augmentation purposes (excluding alveolar ridge), by report
- D7997 Appliance Removal (not by dentist who placed appliance), includes removal of archbar
- D7998 Intraoral placement of a fixation device not in conjunction with a fracture
- D9210 Local Anesthesia not in conjunction with operative or surgical procedures
- D9211 Regional Block Anesthesia
- D9212 Trigeminal Division Block Anesthesia
- D9215 Local Anesthesia in conjunction with operative or surgical procedures
- D9230 Inhalation of nitrous oxide/analgesia, anxiolysis
- D9248 Non-intravenous conscious sedation
- D9410 House / extended care facility call

- D9420 Hospital or ambulatory surgical center call
- D9450 Case presentation, detailed and extensive treatment planning
- D9630 Other drugs and/or medicaments, by report
- D9920 Behavior Management, by report
- D9941 Fabrication of athletic mouthguard
- D9950 Occlusion analysis - mounted case
- D9951 Occlusal adjustment - limited
- D9952 Occlusal adjustment - complete
- D9970 Enamel microabrasion
- D9971 Odontoplasty 1-2 teeth; includes removal of enamel projections
- D9972 External bleaching - per arch – performed in office
- D9973 External bleaching - per tooth
- D9974 Internal bleaching - per tooth
- Repair of damaged orthodontic appliances
- Replacement of lost or missing appliance
- Services to alter vertical dimension and/or restore or maintain the occlusion. Such procedures include, but are not limited to, equilibration, periodontal splinting, full mouth rehabilitation, and restoration for misalignment of teeth
- Services and treatment which are not dentally necessary or which do not meet generally accepted standards of dental practice
- Any services that are considered strictly cosmetic in nature including, but not limited to, charges for personalization or characterization of prosthetic appliances
- Services related to the diagnosis and treatment of Temporomandibular Joint Dysfunction (TMJ)
- Services and treatment received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, VA hospital or similar person or group
- Services and treatment resulting from Your failure to comply with professionally prescribed treatment
- Any charges for failure to keep a scheduled appointment
- Office infection control charges
- State or territorial taxes on dental services performed
- Those submitted by a dentist, which is for the same services performed on the same date for the same Insured Person by another dentist;
- Those provided free of charge by any governmental unit, except where this exclusion is prohibited by law;
- Those performed by a dentist who is compensated by a facility for similar covered services performed for Insureds;
- Duplicate, provisional and temporary devices, appliances, and services;
- Plaque control programs, oral hygiene instruction, and dietary instructions;
- Gold foil restorations

- Treatment or services for injuries resulting from the maintenance or use of a motor vehicle if such treatment or service is paid or payable under a plan or policy of motor vehicle insurance, including a certified self-insurance plan
- Charges by the provider for completing dental forms
- Adjustment of a denture or bridgework which is made within 6 months after installation by the same Dentist who installed it
- Use of material or home health aids to prevent decay, such as toothpaste, fluoride gels, dental floss and teeth whiteners
- Sealants for teeth other than permanent molars
- Precision attachments, personalization, precious metal bases and other specialized techniques
- Replacement of dentures that have been lost, stolen or misplaced
- Any other services excluded under the "Exclusions and Limitations: What the Plan Does Not Pay For" section of this Plan
- Repair of damaged orthodontic appliances
- Replacement of lost or missing appliances
- Fabrication of athletic mouth guard
- Internal bleaching
- Nitrous oxide
- Oral sedation
- Topical medicament center
- Bone grafts when done in connection with extractions, apicoetomies or non-covered/non eligible implants.
- When two or more services are submitted and the services are considered part of the same service to one another the Plan will pay the most comprehensive service (the service that includes the other non benefited service) as determined by Us.
- When two or more services are submitted on the same day and the services are considered mutually exclusive (when one service contradicts the need for the other service), the Plan will pay for the service that represents the final treatment as determined by Us.

IV. ELIGIBILITY & ENROLLMENT

Eligible enrolled Members who live or reside in the MHHIC Service Area are covered under this Policy and their dependents. If You are enrolled in Medicare, You are not eligible to purchase or be enrolled in this Policy.

Types of Coverage

The Policyholder may elect coverage just for him/herself or may add one or more eligible Dependents for coverage. The possible types of coverage are listed below.

- Single Coverage - for only one person, the Policyholder.
- Family Coverage - for You, Your Spouse and/or Your Dependent Child or coverage for multiple children that share a common legal guardian, or for when there exists a valid

medical support order requiring health benefit coverage whether or not there is an adult who will be provided coverage.
- Child Only – Coverage for a child or children. This Policy covers only individuals under the age of 21.

Who is Eligible

- The Subscriber or Member (You) - who resides, lives or works in the noted Service Area.

Eligible Dependents:
A Dependent means a Subscriber's:
- Lawful spouse
- Child(ren)
- Domestic Partner who may be the same or opposite gender of the Subscriber.

Special Needs/Dependent Children Over 26
You may have a child(ren) with a mental or physical handicap, or developmental disability, who is incapable of earning a living. Subject to all of the terms of this section and the Policy, such a child(ren) may stay eligible for Dependent health benefits past this Policy's age limitation of 26 for eligible Dependents. The child will stay eligible as long as the child is incapable of earning a living, and if:

- The child's condition started before he or she reached this Policy's age limit;
- The child became covered under this Policy or any other Policy or Contract before the child reached the age limit and stayed continuously covered or covered after reaching such limit; and
- The child depends on You for most of his or her support and maintenance.

For the child to stay eligible, You must send Us written proof that the child is incapacitated or developmentally disabled and depends on You for most of his or her support and maintenance. You have 31 calendar days from the date the child reaches the age limit to do this. We can ask for periodic proof that the child's condition continues. Otherwise, the child(ren)'s coverage ends when Your coverage ends.

In order to obtain and continue health care coverage with Us, the Covered Person, who is not covered as either a Dependent Spouse or as a Dependent Child, must reside or work in Our Service Area. We reserve the right to require proof that such Covered Person resides or works in Our Service Area.
You must notify MHHIC of all changes that may affect any Member's eligibility.

Enrollment and Coverage Start

A potential member and their eligible dependents may apply for coverage under this Policy through MHHIC directly, our associated Private Exchange(s) and/or a licensed insurance agent.

When an Application has been approved and all premiums for coverage have been paid, the Member(s) will be deemed "Enrolled". Member coverage will begin on the MHHIC assigned Effective Date. No Claims will be paid for dates of service prior to the assigned Effective Date. Coverage is for a calendar year beginning January 1st at 12:01 AM (Central Time) ending on December 31st at 11:59 PM (Central Time), unless otherwise noted. If Your coverage initially

begins on a day other than January1st, the first year will be shorter than 12 months and also end as of December 31st at 11:59 PM (Central Time).

Adding Dependents to Your Policy

Benefit coverage for new Members becomes effective in accordance with the following provisions:

- *Spouse/Significant Other*
  You may apply to add Your Dependent by notifying MHHIC in writing. If Your Application is submitted to Us within 60 days of Your marriage, documented Domestic Partnership or civil union, the Dependent will be covered as of the first of the month following the date We receive the Application. In case of a court order, coverage will be effective as of the date specified in the court order.

  If You do not submit an Application within 60 days of Your Significant Other becoming eligible, You may apply to add coverage for Your Spouse/Significant Other during Our Annual Open Enrollment or during an applicable Special Enrollment Period.

- *Newborn Children*
  A Member or a dependent's Newborn child(ren) is eligible for coverage., MHHIC must be notified within 31 calendar days of birth to add the Newborn as a Covered Dependent and continue coverage beyond the first 31 days after the Newborn's birth. Coverage continues for the first 31 days after birth. An additional premium will apply.

- *Adopted Children*
  A Member's adopted child is eligible for coverage, including a child placed for adoption or a child for whom the Member or his or her legal spouse is a party to a suit to adopt. MHHIC must be notified within 31 calendar days of adoption, placement for adoption, or the date the Member or Member's legal spouse becomes a party to a suit to adopt the child to add the adopted child as a Covered Dependent. An additional premium will apply.

- *Court Ordered Dependent*
  If a court has ordered a Subscriber to provide coverage for an Eligible Dependent (including spouse),Eligible Dependent(s) will be eligible for coverage. MHHIC must be notified within 31 calendar days of court order to add the Eligible Dependent(s) as a Covered Dependent. An additional premium or premiums will apply.

- *Grandchildren and Other Dependents*
  A written Application must be received within 31 days of the date that a person first qualifies as an eligible family member or dependent. Coverage will become effective on the first day of the month following the date the Application for coverage is received, approved and any required premium is paid.

As noted, You will need to make all Policy changes through Your agent or MHHIC's Member Service department. It is extremely important that You follow the enrollment timing rules. <u>If You do not complete and send written change of status information to us within the timeframes noted, Your benefit coverage will not be expanded to include the additional family member(s).</u>

Annual Open Enrollment

A Member and their Dependents may apply for enrollment during the Annual Open Enrollment Period. No enrollment changes will be allowed after the Open Enrollment Period closes unless there is a Special Enrollment event as explained below or the Member dis-enrolls from coverage.

Special Enrollment

An individual who was eligible, but did not enroll in coverage during the Annual Open Enrollment Period, may apply for enrollment within the 60 days following the date of the noted events:

- Acquires an eligible dependent, whether by marriage, birth, adoption/placement for adoption or court order.
- Loss of coverage during the year as a consequence of:
  - Loss of eligibility for coverage under another plan the individual was enrolled in as a result of termination of employment (except for gross misconduct), reduction of work hours, death, divorce, or loss of dependent status under that health plan;
  - Changing residence to an area not served by the health plan under which the individual was enrolled;
  - Their health plan stops offering benefits to a certain class of similarly situated individuals of which the individual was a Member;
  - Termination of employer contributions towards a person's coverage under another health plan in which the individual was enrolled; and
  - Exhaustion of COBRA continuation coverage.
  - An individual demonstrates that the health plan in which he or she is enrolled substantially violated a material provision of its Contract in relation to the individual.

Termination of Coverage

A Member will become ineligible for MHHIC coverage:

- When premiums are not paid according to the due dates and grace periods. No Benefits are available for Covered Services rendered after the date of termination of coverage. However, if a Member or dependent is an Inpatient in a Hospital on the date of termination, medical Benefits in connection with the Admission for that patient will terminate at the end of that Admission.
- When the Subscriber is no longer covered, spousal coverage is terminated. However, in the event of the Subscriber's death the spouse of the Subscriber, if covered under the Policy, shall become the Subscriber.
- When a Member no longer meets the eligible dependent requirements coverage terminates automatically, without notice, unless it is specifically otherwise stated in this Policy or as provided by law. Premiums are required to be paid until the Dependent ceases to be eligible.
- In the event of fraud or intentional misrepresentation of a material fact by a Member. After the second anniversary of the date this Policy is issued, a misstatement, other than a fraudulent misstatement, made by the applicant in the application for the Policy may not be used to void the policy or to deny a claim for loss incurred or disability beginning after that anniversary.

The issuance of this Policy is conditioned on the material representations and statements contained on the Application. MHHIC upholds the right to rescind this Policy and all coverage if:

- A Member performs an act or practice that constitutes fraud, or makes an intentional misrepresentation of material fact under the terms of this Policy.
- Any information intentionally omitted from the application, as to any proposed Subscriber or Member constitutes an intentional misrepresentation of material fact.
- A Member's intentional enrollment of someone who is not eligible for coverage constitutes an act of fraud or intentional misrepresentation of material fact.

In such an event, MHHIC will give the Subscriber written notice by certified mail and will include the reason for rescission. Rescission could be retroactive to the Effective Date of coverage.

Extension of Benefits

When Your coverage under this Policy ends, benefits stop. But, if You are totally disabled on the date the Policy terminates, continued benefits may be available for the treatment of the injury or sickness that is the cause of the total disability. Total disability means You are prevented because of injury or disease from engaging in any work or other gainful activity. Total disability for a minor means that the minor is prevented because of injury or disease from engaging in substantially all normal activities of a person of like age and sex who is in good health. In the event of the Subscriber's death Your Spouse, if covered under the Policy, will become the Subscriber.

If We accept a premium for coverage extending beyond the date, age or event specified for termination of You or Your dependent, then coverage will continue during the period for which an identifiable premium was accepted, unless due to a misstatement of age the amounts payable under this Policy are the amounts the premium paid would have purchased at the correct age. In the event of cancellation or refusal to renew Your Policy by Us, We will extend coverage for pregnancy commencing while the Policy is in force and for which benefits would have been payable had the Policy continued in force.

Termination of the Policy by Us shall be without prejudice to any continuous loss which commenced while the Policy was in force, but the extension of benefits beyond the period the Policy was in force may be predicated upon the continuous Total Disability of You and limited to the following:

- The duration of the Policy benefit period;
- Payment of the maximum benefits; or
- To a time period of three months.

Continuing Benefits

If You are totally disabled on the date Your coverage under this Policy ends, we will continue to pay for Your care under this Policy during an uninterrupted period of total disability until the first of the following:

- The date You are no longer totally disabled.
- 12 months from the date this Policy terminated.

Continuance of Coverage Due to Change in Marital Status

If a Member loses coverage due to a change in marital status, that person may be offered an Policy that nearly approximates the Policy which was in effect prior to the change in marital status. The new Policy will have the same effective date as the Policy under which coverage was afforded prior to the change in marital status. The inception date of the Policy issued to provide continuity of coverage, will not precede the earliest date required to maintain such continuity, and

will have the same expiration date as the Policy under which coverage was issued prior to the change in marital status unless stated otherwise by the insurer.

Limitations
We will not pay extended benefits for any Member who is not totally disabled on the date coverage under this Policy ends. We also do not cover Members beyond the extent in which We would have paid benefits under this Policy if the coverage had not ended.

V. HOW YOUR POLICY WORKS

Medical Necessity

MHHIC covers the benefits described in this Policy as long as the health care service, procedure, treatment, test, device, Prescription Drug or supply (collectively, “service”) is Medically Necessary. The fact that a Provider has furnished, prescribed, ordered, recommended or approved the service does not make it Medically Necessary or mean that MHHIC will cover it.

We may base our decision on a review of: Your medical records; our medical policies and clinical guidelines; medical opinions of a professional society, peer review committee or other groups of physicians; reports in peer-reviewed medical literature; reports and guidelines published by nationally recognized health care organizations that include supporting scientific data; professional standards of safety and effectiveness, which are generally-recognized in the United States for diagnosis, care, or treatment; the opinion of Health Care Professionals in the generally-recognized health specialty involved; and the opinion of the attending Providers, which have credence but do not overrule contrary opinions.

Services will be deemed Medically Necessary only if:

- They are clinically appropriate in terms of type, frequency, extent, site, and duration and considered effective for Your illness, injury or disease;
- They are required for the direct care and treatment or management of that condition;
- Your condition would be adversely affected if the services were not provided;
- They are provided in accordance with generally-accepted standards of medical practice;
- They are not primarily for the convenience of You, Your family, or You Provider;
- They are not more costly than an alternative service or sequence of services, that is they are at least as likely to produce equivalent therapeutic or diagnostic results;
- When services that can be safely provided to You in a lower cost setting will not be Medically Necessary if they are performed in a higher cost setting. For example We will not provide coverage for an inpatient Admission for surgery if the surgery could have been performed on an outpatient basis.

See the Utilization review & External Appeals section of this Policy for Your right to an internal appeal and external appeal of our determination that service is not Medically Necessary.

Service Providers

Notice of Physician or Provider Termination /Continuity of Care/Special Circumstances
If You or Your Covered Dependent has a "special circumstance", We will continue to provide coverage at Our usual contract rate for that terminated physician or provider, unless the termination was for reason of medical competence or professional behavior. The treating physician or provider must identify the special circumstance, request that the Member be allowed

to continue treatment, and agree not to seek payment from the Member for any amount for which the Member would not be responsible if the physician or provider remained in Our network.

In the event of a Special Circumstance, We will continue to provide coverage for services of the physician or provider until the earlier of: the date You or Your Covered Dependent ceases to receive treatment from that physician or provider; or, if You or Your Covered Dependent has been diagnosed with a terminal illness at the time of the physician's or provider's termination, the expiration of the nine-month period after the effective date of termination; or, if You or Your Covered Dependent is past the 24th week of pregnancy at the time of the physician's or provider's termination, the delivery of the child, immediate postpartum care and a follow-up checkup within the six week period following delivery; or, for all other conditions, the 90th day after the effective date of the physician's or provider's termination.

A "special circumstance," for purposes of this provision, is a condition regarding which the treating physician or provider reasonably believes that discontinuing care by that physician or provider could cause harm to You or Your Covered Dependent who is a patient. Special circumstance may include a disability, Acute condition, life-threatening illness or pregnancy past the 24th week. The treating physician or provider must identify the special circumstance and request the continuation of coverage.

Non-Participating Providers Special Circumstances Access

Covered Expenses for the services of a Non-Participating Provider will be paid at the Network benefit Coinsurance or Copayment level (subject to the in-network cost share):

- When the services are not available through Participating Providers; or
- When the services are for a Medical Emergency.

If a service is not available through a Participating Provider, We may authorize care from a Non-Participating Provider. Contact Us to obtain the prior Authorization. We will make a determination within the time appropriate to the circumstances relating to the delivery of the services and Your condition, no more than five (5) business days after receipt of reasonably requested documentation.

No Authorization is needed to obtain care from Non-Participating Providers for emergency services. Please notify Us as soon as possible after obtaining emergency services. In most situations, out-of-network services must receive prior Authorization in order to be covered at the "In-Network" level. Your provider may obtain prior Authorization when it is required for continued services by calling Us. For more information on what services may require prior Authorization, please refer to the Schedule of Benefits. Benefits will be paid, at minimum, at the Usual, Customary, and Reasonable charge.

When a service is not available through a Participating Provider or when emergency care or services are medically necessary, any difference between the Allowable Amount and the Non-Participating Provider's actual charge, over any applicable deductible, copayment, or coinsurance, will be credited to the Member's PPO annual deductible and annual Out-Of-Pocket Maximum.

Specialists and Other Providers

A specialist is a doctor who provides health care services for a specific disease or part of the body. There are many kinds of specialists. Here are a few examples:

- Oncologists care for patients with cancer.
- Cardiologists care for patients with heart conditions.
- Orthopedists care for patients with certain bone, joint, or muscle conditions.

The Participating Providers listed in the Provider Directory have agreed to provide You with Your health care coverage. You may go to our Participating Specialist Providers listed in the directory without a referral; however, some services may require prior Authorization.
If You have been going to one Participating Provider, You are not required to continue going to that same provider.

Treatment Received from Foreign Country Providers

Benefits for services and supplies received from Foreign Country Providers are covered for Medical Emergencies where treatment could not have been reasonably delayed until the Member was able to return to the United States. We do not accept assignment of benefits from Foreign Country Providers. You can file a claim with Us for services and supplies from a Foreign Country Provider, but any payment will be sent to You. You are responsible for paying the Foreign Country Provider. You are also responsible at Your expense for obtaining an English language translation of Foreign Country Provider claims and any medical records that may be required. Benefits are subject to all terms, conditions, limitations, and exclusions of this Policy and will not be more than would be paid if the service or supply had been received in the MHHIC Service Area.

Participating Hospitals, Physicians, and Other Participating Providers

Covered Expenses for Participating Providers are based on Our Negotiated Rate. Participating Providers have agreed NOT to charge You and MHHIC more than the MHHIC Negotiated Rates. In addition, Participating Providers will file claims with Us for You. A directory of local MHHIC Participating Providers is available through Our website, shown in the Contact Information section in the Introduction to this Policy, or by calling Our member service department at the toll free number shown in the Contact Information section in the Introduction to this Policy. We will make an updated list of local Participating Providers available annually. You will always be responsible for any expense incurred which is not covered under this Policy.
We will provide written notice to You within a reasonable period of time of any Participating Provider's termination or breach of, or inability to perform under, any provider contract, if We determine that an Member may be materially and adversely effected, and provide You with a current list of Participating Providers.

Texas Department of Insurance Notice

You have the right to an adequate network of preferred providers (also known as “network providers”):

- If You believe that the network is inadequate, You may file a complaint with the Texas Department of Insurance.
- If You relied on materially inaccurate directory information, You may be entitled to have an out-of-network claim paid at the in-network percentage level of

reimbursement and Your out-of-pocket expenses counted toward Your in-network deductible and out-of-pocket maximum.

You have the right, in most cases, to obtain estimates in advance:
- from out-of-network providers of what they will charge for their services; and
- from Us of what We will pay for the services.

You may obtain a current directory of preferred providers at the following website: www.healthplan.memorialhermann.org or by calling Us at the toll free number shown on the Schedule of Benefits for assistance in finding available preferred providers. If the directory is materially inaccurate, You may be entitled to have an out-of-network claim paid at the in-network level of benefits.

If You are treated by a provider or hospital that is not a preferred provider, You may be billed for anything not paid by the insurer.

If the amount You owe to an out-of-network hospital-based radiologist, anesthesiologist, pathologist, emergency department physician, neonatologist, or assistant surgeon is greater than $500 (not including Your copayment, coinsurance, and deductible responsibilities) for services received in a network hospital, You may be entitled to have the parties participate in a teleconference, and, if the result is not to Your satisfaction, in a mandatory mediation at no cost to you. You can learn more about mediation at the Texas Department of Insurance website: www.tdi.texas.gov/consumer/cpmmediation.html.

For an estimate of the amount of reimbursement that will be paid to a Non-Participating Provider for a particular service, contact Us at the Customer Service telephone number shown under the Contact Information.

Emergency Care

Coverage for Emergency Care includes coverage of trauma services at any designated level I or II trauma center (freestanding emergency medical care facility, or comparable emergency facility) as Medically Necessary and Appropriate, to be continued at least until, in the judgment of the attending physician, the Covered Person is medically stable, no longer requires critical care, and can be safely transferred to another Facility. We also provide coverage for a medical screening examination provided upon a Covered Person's arrival in a Hospital, as required to be performed by the Hospital in accordance with Federal law, but only as necessary to determine whether an Emergency medical condition exists.

Covered Expenses will be paid for initial care for a Medical Emergency. However, You will have to pay any charges that exceed the Allowable Charge as well as any applied Deductibles and Coinsurance.

If You have a medical emergency:
- **Get help as quickly as possible.** Call 911 for help or go to the nearest emergency room or hospital. Call for an ambulance if You need it. You do not need to get approval or authorization first from Us.

- As soon as possible, make sure that We have been told about Your emergency. We need to follow up on Your Emergency Care. You or your authorized designee or healthcare provider should call to tell Us about Your Emergency Care, usually within 48 hours. Please notify Us when You have a medical emergency by calling Our Customer Service Department at the telephone number listed on the back of Your Member ID card. Your healthcare provider may notify MHHIC medical management at 888-252-7680 or 713-338-5594.

Medical Emergencies and Ambulance Services (in which getting to the emergency room in any other way could endanger Your health) are covered at all times, anywhere in the United States or its territories. MHHIC also covers any medical screening examination or other evaluation in a hospital emergency facility or comparable facility required by state or federal law which is necessary to determine whether an emergency medical condition exists. For more information, see the Schedule of Benefits and Comprehensive Benefits and Services sections of this Policy.

If You have an emergency, We will talk with the doctors who are giving You Emergency Care to help manage and follow up on Your care. The doctors who are giving You Emergency Care will decide when Your condition is stable and the Medical Emergency is over.

After the Emergency is over, You are entitled to follow-up care to ensure Your condition continues to be stable. Your follow-up care will be covered by Us. If Emergency Care is provided by Non-Participating Providers, We will try to arrange for Participating Providers to take over Your care as soon as Your medical condition and the circumstances allow. Post-stabilization and follow-up care outside the network area may be covered upon prior Authorization from Us. Approval or denial of coverage of post-stabilization care as requested by a treating physician or provider will be within the time appropriate to the circumstances relating to the delivery of the services and Your condition, but not to exceed one from the time of the request. Continued care without prior Authorization from Us will not be covered, even if the initial onset of Your condition was of an emergency basis.

Paying for Services

Deductibles
If applicable, Deductibles are annually set amounts of covered expenses. Members must pay the entire deductible amount before We will pay any benefits for such charges. The Deductible cannot be met with Non-Covered Charges. Only Covered Charges incurred by the Covered Person can be used to meet the Deductible. The Deductible amount is shown in the Schedule of Benefits.

Once the Deductible is met, MHHIC will pay benefits for other Covered Charges above the Member's reached Deductible amount. The Deductible does not include any Coinsurance or Copayments applicable for the rest of the Policy Year. All charges must be incurred while the Member(s) are insured under this Policy. Expenses applied to the In Network Deductible will not be applied to the Out-of-Network Deductible.

Family Deductibles
If applicable, The Family Deductible is a cumulative amount all family members enrolled in the same Policy meet annually . Although family members incur covered charges independently based on the individual Deductible amount, each paid expense contributes to the cumulative family Deductible limit.

The Family Deductible Limit can be met by a combination of family members with no single individual within the family contributing more than the Individual Deductible limit amount in a Policy Year. Once this Family Deductible Limit is satisfied for that Year, We provide coverage for all Covered Charges for all Members who are part of the covered family, less any applicable Coinsurance or Copayment, for the rest of the Calendar Year.

Prescription Drug Deductibles
If applicable, the Prescription Drug Deductible is the amount of Covered Expenses for Prescription Drugs You must pay for each Member before any Prescription Drug benefits are available. Only Covered Expenses are applied to a Deductible. Any expenses You incur in addition to Covered Expenses are never applied to a Deductible. Deductibles will be credited on Our files in the order in which Your claims are processed, not necessarily in the order in which You receive the service or supply. If You submit a claim for services which have a maximum payment limit, We will only apply the allowed per visit, per day, or per event amount (whichever applies) toward the applicable Deductible.]

Copayments
A Copayment is a specified dollar amount a Member must pay for specified Covered Charges which are usually collected at the time of service (e.g. at Your physician visit). Your Policy may be subject to a Deductible and Copayment per inpatient Admission to any Participating or Non-Participating Hospital. If indicated on the Schedule of Benefits, this admission Deductible is separate from any other Policy Deductible, and does not count toward satisfying the applicable Deductible. For any Covered Services for which both a Copayment and Deductible apply, the Copayment will apply before the Deductible.

Coinsurance
Coinsurance is the percentage of a Covered Charge that must be paid by a Covered Person. Once any applicable Deductible, Copayment or the Prescription Drug Deductible, are satisfied, Participating Providers will be paid at the Coinsurance percentage as shown on the Schedule of Benefits. We will waive the Coinsurance requirement once the Maximum Out of Pocket has been reached. This Policy's Coinsurance, as shown below, does not include Deductibles, Copayments, penalties incurred under this Policy's Utilization Review provisions, or any other Non-Covered Charge.

Out-of-Pocket Maximums
The Out-of-Pocket Maximum is the amount of Copayment each Member, if Dependents are covered by the Subscriber, and a Family, will incur for Covered Expenses in a Year. The Out-of-Pocket Maximum includes any applicable Deductibles, Copayments and the Prescription Drug Deductible, if any, but it does not include any amounts in excess of Covered Expenses, or amounts in excess of other benefit limits of this Policy. The Out-of-Pocket Maximum also does not include any utilization review penalties or non-covered charges.

When You have met Your Out-of-Pocket Limit in payment of Deductibles(if applicable), Copayments and Coinsurance for an Policy Year as noted in the Schedule of Benefits section, We will provide coverage for 100% of the Allowed Amount for Covered Services for the remainder of the Policy Year. If other than Individual coverage applies, when members of the same family covered under this Policy have collectively met the family Out-of-Pocket Limit of Deductibles, Copayments, and Coinsurance for an Policy year as noted in the Schedule of Benefits section, We will provide coverage for 100% of the Allowed Amount for the rest of the

Policy Year. No family member may contribute more than the Per Member within a Family Out-of-Pocket Amount, as shown on the Schedule of Benefits, for Covered Services received In-Network.

Please note that Deductible, Copayment and Coinsurance charges accrue to meet Your Out-of-Pocket Amount. However, the following do not accrue to the Out-of-Pocket Amount:

- any charges in excess of the Allowable Charge;
- any penalties the Member or Provider must pay; and
- charges for non-Covered Services.

Emergency Room Visits

If shown on the Schedule of Benefits, an Emergency Room visit, which does not result in an inpatient Admission immediately following the Emergency Room visit, is subject to the Emergency Room Visit Copayment, if any, in addition to any other applicable Copayment or Deductible and does not count toward satisfying the applicable Deductible.

Penalties

There are penalties for failure to comply with the Utilization Review Program and Procedures. A penalty is an amount of Covered Expenses that is:

- Not counted towards any Deductible, Copayment or the Prescription Drug Deductible, if any;
- Not counted towards Your Out-of-Pocket maximum; and
- Not eligible for benefit payment.

MHHIC has the right to change the rate charged in accordance with applicable regulation.

VI. COMPREHENSIVE BENEFITS & SERVICES

This section lists the types of benefits and services We will consider as Covered Charges.

Before this Policy pays for any benefits, a Member must satisfy any applicable Deductible or Copayment. After the applicable Deductible or Copayment has been satisfied, We will begin paying for Covered Services as described. What We will pay is subject to all the terms of this Policy.

The benefits described in this section will be paid for Covered Expenses incurred on the date a Member received the service or supply for which the charge is made. These benefits are subject to all terms, conditions, exclusions, and limitations of this Policy. All services are paid at the percentages indicated and subject to limits outlined in the Section titled "How Your Policy Works."

Ambulance and Pre-Hospital Emergency Benefits

Pre-Hospital Emergency Medical Services means the prompt evaluation and treatment of an Emergency Condition and/or transportation to a Hospital. We cover pre-hospital emergency medical services for the treatment of an Emergency condition, when such services are provided by an Ambulance Service licensed under the state of Texas Department of State Health Services.

The following Ambulance Services are eligible for this benefit:

- Base charge, mileage and non-reusable supplies of a licensed ambulance company for ground or air service for transportation to and from a Hospital or Skilled Nursing Facility.
- Monitoring, electrocardiograms (EKGs or ECGs), cardiac defibrillation, cardiopulmonary resuscitation (CPR) and administration of oxygen and intravenous (IV) solutions in connection with Ambulance Service. An appropriate licensed person must render the services.

We do not cover travel or transportation expenses unless connected to an Emergency Condition or due to a facility transfer approved by Us, even though prescribed by a Physician. We also do not cover non-ambulance transportation such as ambulance, van or taxi cab.

Hospital/Inpatient Benefits

All Admissions (including, but not limited to, elective or non-Emergency, Emergency, and Pregnancy Care Admissions) must be Authorized as outlined in Care Management. In addition, at regular intervals during the Inpatient stay, We will perform a Concurrent Review to determine the appropriateness of continued hospitalization as well as the level of care.
Please refer to the Schedule of Benefits for Cost Sharing Requirements, day or visit limits, and any Preauthorization requirements that may apply to these benefits. Pre-Hospital Emergency Medical Services and Ambulance Services for the treatment of an Emergency condition do not require preauthorization. The following services furnished to You by a Hospital are eligible for coverage: Inpatient hospital services, including room and board, general nursing care, meals and special diets when Medically Necessary, use of operating room and related facilities, use of intensive care unit and services, X-ray services, laboratory and other diagnostic tests, drugs, medications, biologicals, anesthesia and oxygen services, special duty nursing when Medically Necessary, radiation therapy, inhalation therapy, administration of whole blood and blood plasma, and short-term rehabilitation therapy services in the Acute hospital setting.

Payments of Inpatient Covered Expenses are subject to the following conditions:

- Inpatient services and supplies provided by the Hospital except private room charges above the prevailing semi-private room rate of the facility.
- Services must be those which are regularly provided and billed by the Hospital.
- Services are provided only for the number of days required to treat the Member's Illness or Injury.
- Concurrent care.

No benefits will be provided for personal items such as TV, radio, guest trays, etc.

Payment of outpatient Hospital Covered Expenses is subject to these conditions:

- Outpatient services and supplies including those in connection with emergency room services, outpatient surgery and surgery performed at an Ambulatory Surgical Center.
- If shown on the Schedule of Benefits, an Emergency Room visit, which does not result in an inpatient Admission immediately following the Emergency Room visit, is subject to the Emergency Room Visit Copayment, if any, in addition to any other applicable Copayment or Deductible.
- Care received when outpatient surgery is performed. Covered Services are operating room use, supplies, ancillary services, Drugs and medicines. These services are also payable when an outpatient surgery is performed at an Ambulatory Surgical Center.
- Radiation therapy.

- Hemodialysis treatment.

Medically Necessary extraction of impacted wisdom teeth performed in an inpatient or a surgical day care unit or ambulatory surgical facility are covered necessary to that setting because of the Member's medical condition. Services must be provided by an Oral Surgeon who is a Participating Provider.

Medical and Surgical Benefits

Benefits for the following surgical and medical services are available and may require Authorization. See the Schedule of Benefits to determine which services require Authorization. You must pay any applicable Deductible Amounts, and Coinsurance percentages shown on the Schedule of Benefits.

Surgery
The Allowable Charge for Inpatient and Outpatient Surgery includes all pre-operative and post-operative medical visits. The pre-operative and post-operative period is defined and determined by Us and is that period of time which is appropriate as routine care for the particular surgical procedure. When performed in the Physician's office, the Allowable Charge for the Surgery includes the office visit. No additional Benefits are allowed toward charges for office visits on the same day as the Surgery.

Reconstructive Surgery will be the same as for treatment of any other sickness such as:
- Treatment provided for the correction of defects incurred in an Accidental Injury sustained by the Member.
- Treatment provided for Reconstructive Surgery following cancer surgery.
- Surgery performed on a member for the treatment or correction of a congenital defect other than conditions of the breast.
- Reconstruction of the breast on which mastectomy has been performed; surgery and reconstruction of the other breast to achieve a symmetrical appearance; and prostheses and treatment of physical complications, including lymphedemas, at all stages of the mastectomy.
- Reconstructive Surgery for craniofacial abnormalities to improve the function of, or to attempt to create a normal appearance of, an abnormal structure caused by congenital defects, developmental deformities, trauma, tumors, infections, or disease.

Incidental Procedure
An incidental procedure is one carried out at the same time as a more complex primary procedure and which requires little additional Physician resources and/or is clinically integral to the performance of the primary procedure. The Allowable Charge for the primary procedure includes coverage for the incidental procedure(s). If the primary procedure is not covered, any incidental procedure(s) will not be covered.

Unbundled Procedure
Unbundled procedures occurs when two (2) or more procedure codes are used to describe Surgery performed when a single, more comprehensive procedure code exists that accurately describes the entire Surgery performed. The unbundled procedures will be re-bundled for assignment of the proper comprehensive procedure code as determined by Us. The Allowable

Charge includes the re-bundled procedure. We will provide Benefits according to the proper comprehensive procedure code for the re-bundled procedure, as determined by Us.

Mutually Exclusive Procedure(s)
Mutually exclusive procedures are two (2) or more procedures that are usually not performed at the same operative session on the same patient on the same date of service. Mutually exclusive rules may also include different procedure code descriptions for the same type of procedures in which the Physician should be submitting only one (1) of the codes. Mutually exclusive procedures are two (2) or more procedures that by medical practice standards should not be performed on the same patient, on the same day of service, for which separate billings are made. The Allowable Charge includes all procedures performed at the same surgical setting. Procedure(s), which are not considered Medically Necessary, will not be covered.

Organ & Tissue Transplants
Benefits are payable for Hospital and professional services as described on the previous pages for an:

- Member who receives the organ or tissue
- Member who donates the organ or tissue
- Organ or tissue donor who is not a Member, if the organ or tissue recipient is a Member.

Services are payable only after benefits have been paid for the Member's expenses, and then only to the extent benefits are available under the recipient's Policy.
Exceptions:

- Charges incurred prior to pre-transplant evaluation.
- Charges incurred for testing administered to people other than the Member or living donor.
- Charges for any treatment, supply, or device which is found by Us to be Experimental, Investigative or not a generally accepted medical practice.
- Charges for transplant of animal organs to a human recipient.
- Charges for mechanical devices designed to replace human organs. Use of a mechanical heart to keep a patient alive until a human donor heart becomes available, or a kidney dialysis machine are Covered Expenses.
- Charges incurred for keeping a donor alive for a transplant operation.
- Charges for personal comfort or convenience items.
- Alcohol, drugs or tobacco

Assistant Surgeon
An assistant surgeon is a Physician licensed physician assistant, certified registered nurse first assistant (CRNFA), registered nurse first assistant (RNFA) or certified nurse practitioner. Coverage for an assistant surgeon is provided only if the use of an assistant surgeon is required with reference to nationally established guidelines. The Allowable Charge for the assistant surgeon is based on a percentage of the fee paid to the primary surgeon.

Anesthesia
General anesthesia services are covered when requested by the operating Physician and performed by a certified registered nurse anesthetist (CRNA) or Physician, other than the operating Physician or the assistant surgeon, for covered surgical services. Coverage is also provided for other forms of anesthesia services as defined and approved by Us. Medical direction

or supervision of anesthesia administration includes pre-operative, operative and post-operative anesthesia administration care.

Anesthetic or sedation procedures performed by the operating Physician, his assistant surgeon, or an advanced practice registered nurse will be covered as a part of the surgical or diagnostic procedure unless We determine otherwise.

Benefits for anesthesia will be determined by applying the Coinsurance to the Allowable Charge based on the primary surgical procedure performed. Benefits are available for the anesthesiologist or CRNA who performs the service. When an anesthesiologist medically directs or supervises the CRNA, payment may be divided between the medical direction or supervision and administration of anesthesia, when billed separately.

Second Surgical Opinion

Second surgical opinions are covered subject to any applicable Copayments, Coinsurance and Deductible amounts, but are not mandatory in order to receive Benefits.

Oral Surgery Benefits

Coverage is provided for Dental Care and Treatment including Surgery and dental appliances required to correct Accidental Injuries of the jaws, cheeks, lips, tongue, roof or floor of mouth, and of sound natural teeth. For the purposes of this section, sound natural teeth include those which are capped, crowned or attached by way of a crown or cap to a bridge. Sound natural teeth may have fillings or a root canal.

Coverage includes:

- Excision of exostoses or tori of the jaws and hard palate.
- Incision and drainage of abscess and treatment of cellulitis.
- Incision of accessory sinuses, salivary glands, and salivary ducts.
- Anesthesia for the above services or procedures when rendered by an oral surgeon.
- Anesthesia for the above services or procedures when rendered by a dentist who holds all required permits or training to administer such anesthesia.
- Excision of tumors or cysts (excluding odontogenic cysts) of the jaws, gums, cheeks, lips, tongue, roof and floor of mouth.
- Extraction of impacted teeth.

Anesthesia when rendered in a Hospital setting and for associated Hospital charges when Your mental or physical condition requires dental treatment to be rendered in a Hospital setting. Anesthesia Benefits for Temporomandibular Joint (TMJ) are provided for a condition that is the result of an accident, a trauma, a congenital defect, a developmental defect, or a pathology.

Pregnancy, Pediatrics and Reproductive Benefits

Pregnancy

Pregnancy Care and Newborn Benefits are available to a Member whose coverage is in effect at the time such services are furnished in connection with her pregnancy. This Policy pays for pregnancies the same way We would cover an Illness. The charges We cover for delivery and newborn child are explained below.

Surgical and Medical Services

MHHIC covers the following surgical and medical services for expecting Members:

- Initial office visit and visits during the term of the pregnancy.
- Diagnostic Services.

- Delivery, including necessary pre-natal and post-natal care.
- Abortion.

Elective deliveries prior to the thirty-ninth (39th) week of gestation are not covered unless shown to be Medically Necessary. Facility and other charges associated with an elective early delivery that is not Medically Necessary are also considered to be non-covered.

Facility Services

Pregnancy Care Benefits for Hospital services required in connection with pregnancy and abortions (as described above) are subject to the Benefit Period Deductible Amount and applicable Coinsurance percentage shown on the Schedule of Benefits. The Hospital (nursery) charge for well-baby care is included in the mother's Benefits for the covered portion of her Admission for Pregnancy Care.

An Authorization is required for a Hospital stay in connection with childbirth for the covered mother or covered well newborn child only if the mother's length of stay exceeds forty-eight (48) hours following a vaginal delivery or ninety-six (96) hours following a caesarean section. An Authorization is required if a newborn's stay exceeds that of the mother. An Authorization is also required for a newborn that is admitted separately because of neonatal complications.

Complications of Pregnancy

Complications of Pregnancy are covered under this Policy as any other medical condition. Such complications include conditions, requiring Hospital, whose diagnoses are distinct from the pregnancy, but are adversely affected by the pregnancy. Diagnosis include are not limited to:

- Acute nephritis
- Nephrosis
- Cardiac decompression
- Missed abortion and similar medical and surgical conditions of comparable severity

Complications of Pregnancy also include non-elective cesarean section, termination of ectopic pregnancy, and spontaneous termination of pregnancy, occurring during a period of gestation in which a viable birth is not possible. They do not include, elective cesarean section, non-elective cesarean section, false labor, occasional spotting, morning sickness, Physician prescribed rest during the period of pregnancy, hyperemesis gravidarium, preeclampsia, and similar conditions associated with the management of a difficult pregnancy not constituting a distinct complication of pregnancy.

Newborn Care

If a newborn is covered at birth as a dependent, Surgical and medical services rendered by a Physician; for treatment of illness; pre-maturity; post-maturity; or congenital condition of a newborn and circumcision is included. Services of a Physician for Inpatient Well Baby Care immediately following delivery until discharge are covered.

Hospital Services, including services related to circumcision during the newborn's post-delivery stay and treatment of illness, pre-maturity, post-maturity, or congenital condition of a newborn are covered. Charges for a well newborn, which are billed separately from the mother's Hospital bill, are not covered. The Hospital (nursery) charge for a well newborn is included in the mother's Hospital bill for the covered portion of her Admission for Pregnancy Care.

When a child is born to a Member with Subscriber only coverage, the child is granted 30 days of automatic coverage on the Policy from the date of birth and the Deductible will increase from an Individual Deductible to a Family Deductible. The Claim for the delivery charges may be applied to the new Family Deductible. The Family Deductible Amount, as shown on the Schedule of Benefits, applies to all charges when a newborn is added to a Policy of a Subscriber with a Family Policy.

Newborns are covered for screening test for hearing loss from birth through the date the child is 30 days of age as well as necessary diagnostic follow-up care related to the screening test from birth through the date the child is 24 months of age.

Post Delivery Programs
We have several maternity programs available to help pregnant Members deliver healthy babies. Please call Our Member Service Department at the number on the back of Your ID card when You learn You are having a baby. When You call, we'll let You know what programs are available to You.

Our Post-Delivery Care consists of postpartum health care services provided in accordance with accepted maternal and neonatal physical assessments. This includes parent education, assistance and training in breast-feeding and bottle-feeding, and the performance of any necessary and appropriate clinical tests. The timeliness of the care will be determined in accordance with recognized medical standards for that care.

Diagnosis of Infertility
The diagnosis of infertility is covered under this Policy as any other medical condition. However, services or supplies related to the treatment of Infertility are not covered including, but not limited to:

- In vitrogamete intrafallopian tube transfer (GIFT) or zygote intrafallopian tube transfer (ZIFT) procedures uterine embryo lavage
- Embryo transfer
- Artificial insemination
- Cost for ovum donor, donor sperm, or sperm storage
- Cryopreservation and storage of embryos
- Ovulatory predictor kits
- All cost related to surrogate motherhood
- Low tubal ovum transfer
- Drug, infusion or hormonal therapy

[In Vitro Fertilization
Benefits for In vitro fertilization procedures are provided to the same extent as benefits provided for other pregnancy-related procedures under this Policy.]

Sterilization
Benefits are available for surgical procedures that result in permanent sterilization, including vasectomy and hysteroscopic placement of micro-inserts into the fallopian tubes. Tubal ligation and hysteroscopic placement of micro-inserts into the fallopian tubes are available as a Preventive or Wellness Care Benefit.
The reversal of tubal ligation or reversals of vasectomies are not covered.

Reproductive Benefits/Family Planning
All Prescription contraceptives or contraceptive devices approved by the FDA are covered.

Pediatric Benefits

Pediatric Dental Benefits
Additional pediatric dental benefits are covered for a Member who is under the age of 19. The covered Dental Services and applicable Copayments are shown on the Schedule of Benefits. The following dental benefits are NOT covered or offered under the pediatric dental benefit:

- Oral surgery requiring the setting of fractures or dislocations;
- treatment of congenital malformations;
- treatment of malignancies, neoplasms, or cysts including biopsies; dispensing of drugs;
- any hospitalization costs.

[Please review the Dental section of this Policy for additional information.]

Pediatric Vision
We cover the vision benefits described in this provision for Covered Persons through the end of the month in which the Covered Person turns age 19. We cover:

- One pair of eye glasses, (including single, bifocal, trifocal, lenticular lens powers, fashion and gradient tinting, oversized glass-grey #3 prescription sunglass lenses, polycarbonate prescription lenses with scratch resistance coating and low vision items and standard frames, low vision items, ultraviolet protective coating, blended segment lenses, intermediate vision lenses, standard progressives, premium progressives, photochromic glass lenses, plastic photosensitive lenses, polarized lenses, standard anti-reflective (AR) coating, premium AR coating, ultra AR coating, or hi-index lenses) per Year;
  - Standard frames, refers to frames that are not designer frames such as Coach, Burberry, Prada and other designers.
- One comprehensive eye examination by a Network ophthalmologist or optometrist in a 12 month period.
- Screenings as allowed under the Child and Adult Preventive Care Services benefit; and
- Low vision services: After pre-authorization by MHHIC, covered low vision services will include one comprehensive low vision evaluation every 5 years, and follow-up care with four visits in any five-year period.

The following coverage is provided for a child under the age of 19:

Benefits	Allowable Amount (subject to Copayments set forth in the Schedule of Benefits)
Single Vision Lenses	Up to [$50 -$500]
Bifocal Lenses	Up to [$50 -$500]
Trifocal Lenses	Up to [$50 -$500]
Lenticular Lenses	Up to [$50 -$500]
Frames	Up to [$50 -$500]
Necessary Contact Lenses	Up to [$50 -$500]
Elective Contact Lenses	Up to [$50 -$500]

Dental

Dental care for an Accidental Injury to natural teeth that occurs while the Member(s) is covered under this Policy is subject to the following:

- Services must be received during the six months following the date of Injury;
- No benefits are available to replace or repair existing Dental Prostheses even if damaged in an eligible Accidental Injury; and
- Damage to natural teeth due to chewing or biting is not considered an Accidental Injury.

In addition, this Policy provides benefits for up to three (3) days of Inpatient Hospital services when a Hospital stay is ordered by a Physician and a Dentist for dental treatment required due to an unrelated medical condition. We determine whether the dental treatment could have been safely provided in another setting. Hospital stays for the purpose of administering general anesthesia are not considered Medically Necessary, unless the Member is unable to undergo dental treatment in an office setting or under local anesthesia due to a documented physical, mental or medical reason as determined by the Member's Physician or by the Dentist providing the dental care.

General Provisions

- Any medical treatment which is necessary in conjunction with dental care because of the general health and physical limits of the Member as indicated by said Member's personal physician or the MHHIC dentist.
- Any treatment requested or appliance made which in the opinion of the treating dentist is not necessary for maintaining or improving the Member's health.
- Any treatment covered or provided for by Workers Compensation or employer's liability laws by a federal or state government agency or provided without cost by any municipality, county or other governmental subdivision.
- Any procedure considered to be experimental or investigational is eligible for independent review.
- Any dental care provided by a Non-Participating Provider General Dentist or Specialist except when authorized by MHHIC.
- Dental treatment and expenses incurred for such treatment started prior to the Member's eligibility to receive benefits under this Policy, or started after a Member's termination.

Specific Provisions

- General anesthesia and intravenous sedation are excluded.
- Replacement of lost or stolen prosthetic devices. Dentures or appliances will be replaced only after 5 years have elapsed since such dentures or appliances were provided under any MHHIC program unless the denture becomes unsatisfactory due to Illness or other causes not controlled by ordinary circumstances. Replacement under this Policy will be made only if the existing denture is unsatisfactory and cannot be made satisfactory.
- Prophylaxis, adult/child: once every six months unless required more often due to dental necessity as determined by Member's primary dental provider.
- Full mouth x-rays: Once every 36 months unless required more often due to dental necessity as determined by Member's primary dental provider.
- Panoramic x-rays: Once every 36 months unless required more often due to dental necessity as determined by Member's primary dental provider.
- Special requests by patients for titanium partial dentures, personalized and cosmetic full dentures or partial dentures (including gold for all removable appliances) differing from

standard full or partial dentures will be provided at additional fees determined by the dentist.

Orthodontic Exclusions and Limitations

- Replacement of appliances due to theft, loss or breakage.
- Re-treatment by an MHHIC dentist when the original treatment was done by a different MHHIC dentist or treatment in progress at inception of eligibility unless treatment is continued by an MHHIC dentist.
- Failure to follow prescribed treatment or accidents occurring during the treatment.
- If Your coverage terminates, You will be responsible for payment of the balance due for treatment at the dentist's normal fee.
- Special requests by patients for braces differing from standard braces for cosmetic purposes will be provided at additional fees determined by the dentist.

Mental Health & Substance Abuse

Mental Health

We Cover inpatient mental health care services relating to the diagnosis and treatment of mental (including Serious Mental Illness), nervous and emotional disorders comparable to other similar Hospital, medical and surgical cover provided under this Policy. Serious Mental Illness as defined by the American Psychiatric Association in the Diagnostic and Statistical Manual (DSM) includes the following psychiatric Illnesses:

- Schizophrenia;
- Paranoid and other psychotic disorders;
- Bipolar disorders (mixed, manic, hypomanic and depressive);
- Major depressive disorders (single episode or recurrent);
- Schizo-affective disorders (bipolar or depressive);
- Obsessive-compulsive disorders;
- Depression in childhood and adolescence; and
- Clinical diagnosis of Alzheimer's disease by a physician licensed in Texas pursuant to the Insurance Code Chapter 1354 as proof of an organic disease.

In order to qualify for inpatient benefits, services for Mental, Emotional or Functional Nervous Disorders must meet the following conditions of service:

- Services must be for the treatment of a Mental, Emotional or Functional Nervous Disorder that can be improved by standard medical practice.
- The Member must be under the direct care and treatment of a Physician for the condition being treated.
- Services must be those which are regularly provided and billed by a Hospital.
- Services are provided only for the number of days required to treat the Member's condition.
- Services must be received in a Hospital, Psychiatric Day Care Facility, Crisis Stabilization Unit or Residential Treatment Center.

We also provide inpatient mental health care services relating to the diagnosis and treatment of mental, nervous and emotional disorders at Facilities that provide residential treatment including room and board charges. Coverage for inpatient services for mental health care is limited to facilities such as:

- A psychiatric center or impatient facility under the jurisdiction of the Texas Department of state health services.
- A state or local government-run psychiatric inpatient facility.
- A part of a Hospital providing inpatient mental health care services under an operating certificate issued by the Texas State of health services.
- A comprehensive Psychiatric emergency program or other facility providing inpatient mental health care that has been issued an operating certificate by the Texas State of Health Services.

Each two days of treatment in a Psychiatric Day Care Facility, Crisis Stabilization Unit or Residential Treatment Center will be considered equal to one day of treatment in a Hospital or inpatient program.

Chemical Dependency (Substance Use Disorder)
Chemical Dependency is the abuse of or psychological or physical dependence on or addiction to alcohol, a toxic inhalant or substance designated as a controlled substance in the Texas Health and Safety Code.

Benefits for treatment of substance abuse are available. Covered Services will be only those which are for treatment for abuse of alcohol, drugs or other chemicals and the resultant physiological and/or psychological dependency which develops with continued use.

Covered Services shown below for the treatment of Chemical Dependency:

- Inpatient Hospital services as stated in the Hospital provision of this section for detoxification or rehabilitation.
- Hospital services for partial hospitalization.
- Inpatient and outpatient services in a Chemical Dependency Treatment Center.
- Physician's visits during a covered inpatient stay or for intensive outpatient treatment.

Inpatient substance use services are limited to Facilities in Texas which are certified by the Texas Department of State Health Services and those facilities that are licensed or certified by a similar state agency or which are credited by the Joint Commission as alcoholism, substance abuse, or chemical dependence treatment programs. We do not pay for Custodial Care, education or training.

Rehabilitative & Habilitative Therapy

Rehabilitative/Habilitative Care Benefits will be available for services and devices provided on an Inpatient or Outpatient basis, including services for Occupational Therapy, Physical Therapy, Speech/Language Pathology Therapy, and/or Chiropractic Services. Benefits are available when these services are rendered by a Provider licensed and practicing within the scope of his license. Rehabilitation and services that, in the opinion of the Participating Physician are Medically Necessary, will not be denied, limited or terminated as long as they meet or exceed Treatment goals for You or Your Covered Dependent in accordance with an Individual Treatment Plan. For a physical disability, treatment goals may include maintenance of functioning, prevention of deterioration, or slowing of further deterioration.

Occupational Therapy
Occupational Therapy services are covered when performed by a Provider licensed and practicing within the scope of his license, including, but not limited to, a licensed occupational

therapist, a licensed and certified Occupational Therapy assistant supervised by a licensed occupational therapist, or a licensed advanced practice registered nurse.

Occupational Therapy must be referred or ordered by a Physician, advanced practice registered nurse, dentist, podiatrist, or optometrist prior to the receipt of services. Benefits for eligible treatment by an Occupational Therapist are limited to one (1) visit per day and are payable subject to the maximum benefit limits shown on the Schedule of Benefits, per Member per Year.

Physical Therapy
Members are also covered for eligible services by a Physician for any combination of Physical Therapy or Medicine as noted on the Schedule of Benefits. Physical Therapy must be prescribed or referred by a Physician, dentist, podiatrist, or chiropractor prior to the receipt of service unless performed under the following circumstances:

- To children with a diagnosed developmental disability pursuant to the Member's plan of care.
- As part of a Home Health Care agency pursuant to the Member's plan of care.
- To a patient in a nursing home pursuant to the Member's plan of care.
- Related to conditioning or to providing education or activities in a wellness setting for the purpose of injury prevention, reduction of stress, or promotion of fitness.

Benefits for the therapeutic use of heat, cold, exercise, electricity, ultraviolet, manipulation of the spine, manual or electrical muscle stimulation, spinal or other manipulative or ultrasound therapy for vertebrae, disc, spine, back and neck, or massage to improve circulation, strengthen muscles, encourage return of motion, or for treatment of Illness or Injury are payable up to the combined maximum payment and number of visits as stated above. The term "visit" includes any outpatient visit to a Physician during which one or more Covered Services are provided and subject to limitation per benefit year as shown on the Schedule of Benefits.

Additional visits for Physical and/or Occupational Therapy/Medicine may be covered if:

- This follows an inpatient hospitalization following severe trauma such as spinal Injury or stroke;
- We determine that additional treatment is likely to result in significant improvement by measurably reducing the Member's impairment; and
- We Authorize this in advance.

Speech/Language Pathology Therapy
Benefits for Covered Expenses will be provided for speech and hearing therapy and the necessary care and treatment of loss or impairment of speech or hearing. This includes services of a Physician for speech and hearing therapy, hearing examinations and hearing aids. Hearing aids are limited to one pair every 36 months.

Speech/Language Pathology Therapy services are covered when performed by a Provider licensed to practice in the state in which the services are rendered and included, but not limited to, a speech pathologist or by an audiologist. The therapy must be used to improve or restore speech language deficits or swallowing function.

Chiropractic Services
A licensed chiropractor may make recommendations to personal hygiene and proper nutritional practices for the rehabilitation of a patient and may order such diagnostic tests as are necessary for determining conditions associated with the functional integrity of the spine.

Early Intervention Services for Treatment of Developmental Delays for Children
Early intervention services means Medically Necessary speech and language therapy, occupational therapy, physical therapy and assistive technology services and devices for dependents from birth to age three (3). Early intervention services for treatment of developmental delays for children under three years of age will be not be subject to plan limits for Physical and/or Occupational Therapy.

Payment for Medically Necessary early intervention services for treatment of diagnosed developmental delays will be provided to a child under three years of age, who is certified by the Department of Mental Health, Mental Retardation and Substance Abuse Services as eligible for services under Part H of the Individual with Disabilities Education Act, for rehabilitative and habilitative therapies prescribed by a Physician including:

- Occupational Therapy evaluations and services;
- Physical Therapy evaluations and services;
- Speech therapy evaluations and services;
- Dietary or nutritional evaluations;
- Services designed to help the child attain or retain the capability to function age-appropriately within his/her environment, including services that enhance functional ability without affecting a cure.

Skilled Nursing Facility
For any eligible condition, We will pay Covered Expenses for Inpatient services and supplies provided by the Skilled Nursing Facility except private room charges above the prevailing two-bed room rate of the facility. Payment of benefits for Skilled Nursing Facility services are subject to all of the following conditions:

- The Member must be referred to the Skilled Nursing Facility by a Physician.
- Services must be those which are regularly provided and billed by a Skilled Nursing Facility.
- The services must be consistent with the Member's Illness, Injury, degree of disability and medical needs. Benefits are provided only for the number of days required to treat the Illness or Injury.
- The Member must remain under the active medical supervision of a Physician treating the Illness or Injury for which the Member is confined in the Skilled Nursing Facility.

No benefits will be provided for Personal items, such as TV, radio, guest trays, etc.

Home Health Care
When home health care can take the place of Inpatient care, We cover such care furnished to a Covered Person under a written home health care plan. Benefits are provided when You or Covered Dependents are confined at home under the active supervision of a Physician, subject to the maximum benefit limits shown on the Schedule of Benefits. The Physician must be treating the Illness or Injury that necessitates home health care and he or she must renew any order for these services at least once every two months. We cover all Medically Necessary and Appropriate services or supplies, such as:

- Routine Nursing Care furnished by or under the supervision of a registered Nurse;
- Physical therapy;
- Occupational therapy;
- Medical social work;
- Nutrition services;

- Speech therapy;
- Home health aide services;
- Medical appliances and equipment, drugs and medications, laboratory services and special meals to the extent such items and services would have been covered under this Policy if the Covered Person had been in a Hospital; and
- Any Diagnostic or therapeutic service, including surgical services performed in a Hospital Outpatient department, a Practitioner's office or any other licensed health care Facility, provided such service would have been covered under the Policy if performed as Inpatient Hospital services.
- Home Health services and supplies directly related to Infusion Therapy are included in the Infusion Therapy Benefit and are not payable under this health home care benefit.

Payment is subject to all of the terms of this Policy and to the following conditions:

- The Covered Person's Practitioner must certify that home health care is needed in place of Inpatient care in a recognized Facility. Home health care is covered **only** in situations where continuing hospitalization or confinement in a Skilled Nursing Facility or Rehabilitation Center would otherwise have been required if Home Health Care were not provided.
- The services and supplies must be:
  - Ordered by the Covered Person's Practitioner;
  - Included in the home health care plan; and
  - Furnished by, or coordinated by, a Home Health Agency according to the written home health care plan.

Services must be provided by a Health Home Agency or a Visiting Nurse Association. The services and supplies must be furnished by recognized health care professionals on a part-time or intermittent basis, except when full-time or 24 hour service is needed on a short-term (no more than three-day) basis. The home health care plan must be set up in writing by the Covered Person's Practitioner within 14 days after home health care starts and it must be reviewed by the Covered Person's Practitioner at least once every 60 days.

We do not pay for:

- Services furnished to family members, other than the patient; or
- Services and supplies not included in the home health care plan.

Hospice Services

Hospices are providers that are licensed according to state and local laws to provide skilled nursing and other services to support and care for persons experiencing the final phases of terminal Illness. They must be approved as Hospice providers under Medicare and the Joint Commission on Accreditation of Health Care Organizations.

The Member must be suffering from a terminal illness as certified by the attending Physician and submitted to Us in writing. The Physician must consent to the Member’s care by the Hospice and must be consulted in the development of the Member’s treatment plan. The Hospice must submit a written treatment plan to Us every 30 days.

To be eligible for this benefit, the provider must be appropriately licensed according to state and local laws to provide skilled nursing and other services to support and care for persons experiencing the final phases of terminal Illness. The provider must also be approved as a

Hospice provider under Medicare and the Joint Commission on Accreditation of Hospitals or by the appropriate agency in the state of Texas.

We do not Cover Expenses for the noted:

- Services and supplies provided by volunteers or others who do not regularly charge for their services;
- Funeral services and arrangements;
- Legal or financial counseling or services;
- Treatment not included in the Hospice Care Plan; or
- Services supplied to family persons who are not Covered Persons

Centers of Excellence Features

A "Center of Excellence" is a Provider that has entered into an agreement with MHHIC to provide health benefit services for specific procedures. A Member must undergo a pre-treatment screening evaluation to review past and present medical records and current x-ray and laboratory results by the Center of Excellence to determine whether the Member is an appropriate candidate for the surgical procedure (or medical therapy performed at the Center of Excellence. In order for charges to be Covered Charges, the Center of Excellence must:

- Perform a Pre-Treatment Screening Evaluation; and
- Determine that the Procedure is Medically Necessary and Appropriate for the treatment of the Covered Person.

Benefits for services and supplies at a Center of Excellence will be subject to the terms and conditions of this Policy. However, the Utilization Review Features will not apply.

Other Benefits & Services

Treatment for Diabetes - Equipment and Supplies

<u>We cover</u>: blood glucose monitors, including noninvasive glucose monitors and glucose monitors designed to be used by or adapted for the legally blind persons; test strips specified for use with a corresponding glucose monitor; lancets and lancet devices; visual reading strips and urine testing strips and tablets which test for glucose, ketones and protein; insulin and insulin analog preparations; injection aids, including devices used to assist with insulin injection and needleless systems; insulin syringes; biohazard disposal containers; insulin pumps, both external and implantable, and associated appurtenances, which include: insulin infusion devices; batteries; skin preparation items; adhesive supplies; infusion sets; insulin cartridges; durable and disposable devices to assist in the injection of insulin; other required disposable supplies; podiatric appliances, including therapeutic footwear, for the prevention of complications associated with diabetes; glucagon emergency kits; prescription medications that bear the legend “Caution: Federal Law prohibits dispensing without a prescription” and medications available without a prescription for controlling blood sugar levels; and repairs and necessary maintenance of insulin pumps not otherwise provided for under a manufacturer’s warranty or purchase agreement, and rental fees for pumps during the repair and necessary maintenance of insulin pumps, neither of which will exceed the purchase price of a similar replacement pump.

As new or improved treatment and monitoring equipment or supplies become available and are approved by the United States Food and Drug Administration, such equipment or supplies will be covered if determined to be Medically Necessary and appropriate by a treating Physician or other health care practitioner through a written order. All supplies, including medications and equipment for the control of diabetes, will be dispensed as written, including brand name

products, unless substitution is approved by the Physician or other health care practitioner who issues the written order for the supplies or equipment.

Diabetes Education and Training for Self-Management
Members that have insulin-dependent diabetes, insulin-using diabetes, gestational diabetes or non-insulin diabetes may need to be educated on their condition and trained to manage their condition.
Coverage is available for self-management training and education, dietitian visits and for the equipment and necessary supplies for the training, if prescribed by the Member's Physician.

Evaluations and training program for diabetes self-management are covered subject to: The program must be determined to be Medically Necessary by a Physician and provided by a licensed health care professional who certifies that You have successfully completed the training program.

The program will comply with the National Standard for Diabetes Self-Management Education Program as developed by the American Diabetes Association.

Mastectomy and Related Procedures

Benefits are payable for Hospital and professional services under this Policy for mastectomy and lymph node dissection for the treatment of breast cancer and for the treatment of physical complications of all stages of mastectomy including lymphedemas, whether or not the mastectomy occurred while the Member was covered under this Policy.

Benefits will be provided for Covered Expenses for inpatient Hospital care for a minimum of 48 hours following a mastectomy, a minimum of 24 hours following a lymph node dissection for the treatment of breast cancer. If You elect breast reconstruction in connection with any mastectomy, benefits will also be provided for Covered Expenses for the following:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and services and other supplies necessary for any physical complication, including lymphedemas, at all stages of the mastectomy.

These Covered Services will be delivered in a manner determined in consultation with You and the attending Physician and, if applicable, will be subject to any Deductible, and Coinsurance.

Acquired Brain Injury

Medical services for Acquired Brain Injury are paid on the same basis as any other medical condition, except that services and supplies provided by a Skilled Nursing Facility or services or supplies for any kind of covered outpatient therapy for Acquired Brain Injury are covered only under this benefit and are subject to the benefit maximums shown on the Schedule of Benefits.

Benefits will be provided for Covered Services as a result of and related to an Acquired Brain Injury, which include: Cognitive Rehabilitation Therapy, Cognitive Communication Therapy, Neurocognitive Therapy and Rehabilitation, Neurobehavioral, Neurophysiological, Neuropsychological, and Psychophysiological Testing or Treatment, Neurofeedback Therapy, Remediation, Post-Acute Transition Services, or Community Reintegration Services, including outpatient day treatment services or other post-acute care treatment services.

Post-Acute care treatment includes coverage for the reasonable expenses related to periodic reevaluation of the care of a Member covered under the Policy who has incurred an Acquired Brain Injury and:

- Has been unresponsive to treatment;
- Becomes responsive to treatment at a later date.

Determination of whether the above expenses are reasonable will include consideration of factors including:

- Cost and the time elapsed since the previous evaluation;
- Any differences in the expertise of the physician or practitioner performing the evaluation;
- Changes in technology; and
- Advances in medicine.

Covered services include testing, treatment and therapies provided to treat an Acquired Brain Injury. Therapy includes scheduled remedial treatment provided through direct interaction with the Member to improve a pathological condition resulting from an Acquired Brain Injury.

Telehealth & Telemedicine Services

Telehealth Service means a health service, other than a Telemedicine Medical Service, delivered by a licensed or certified Physician acting within the scope of the Physician's license or certification 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;
- Other technology that facilitates access to health care services or medical specialty expertise.

Telemedicine Medical Service means a health care service initiated or provided by a Physician for purposes of patient assessment, diagnosis, consultation, treatment or the transfer of medical data, that requires the use of advanced telecommunications technology other than by telephone or facsimile, including:

- 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.

Urgent Care

An Urgent Care Clinic is a facility dedicated to the delivery of medical care outside of a hospital emergency department, usually on an unscheduled, walk-in basis. Urgent Care Clinics are primarily used to treat patients who have non-life threatening, Acute injuries or illnesses, that require immediate care, but are not serious enough to warrant a visit to an emergency room. A clinic may be staffed by doctors trained in primary or emergency medicine. We will pay Covered Expenses for:

- Services of a Physician
- Services at a Retail Health (Walk-in) Clinic or Urgent Care Clinic

- Services of an anesthesiologist or an anesthetist
- Outpatient diagnostic radiology and laboratory services
- Radiation therapy and hemodialysis treatment
- Surgical implants
- Artificial eyes
- The first pair of contact lenses or the first pair of eyeglasses when required as a result of eye surgery
- Blood transfusions, including blood processing and the cost of unreplaced blood and blood products
- Contraceptive services and devices provided by a Physician, including but not limited to: injectable Drugs and implants, intra-uterine devices, diaphragms, and the professional services associated with them
- Telehealth Service or Telemedicine Medical Service by Physicians who are licensed to practice medicine and/or osteopathic medicine, including diagnosis of ailments or recommendations of therapy through either a telephone or video consultation
- Rental or purchase at Our option, of Durable Medical Equipment, corrective appliances, Orthotic and Prosthetic Devices required for therapeutic use, including repairs and necessary maintenance of such purchased devices, not otherwise provided for under a manufacturer's warranty or purchase agreement and not as the result of misuse or loss by You. If the equipment is purchased, We may require the return of the equipment to Us when it is no longer in use or if the Member's coverage with Us is terminated within six (6) months of the date of such purchase. Equipment and/or supplies must meet all of the following requirements:
    - Ordered by a Physician
    - Of no further use when medical need ends
    - Usable only by the patient
    - Not primarily for Your comfort or hygiene
    - Not for environmental control
    - Not for exercise, and
    - Manufactured specifically for medical use

Equipment and supplies must meet **all** of the above guidelines in order to be eligible for benefits under this Policy. The fact that a Physician prescribes or orders equipment or supplies does not necessarily qualify the equipment or supply for payment.) Rental charges that exceed the reasonable purchase price of the equipment are not covered. All Durable Medical Equipment used in Infusion Therapy will be excluded under this Policy except where specifically stated under the benefit for Infusion Therapy.

Attention Deficit/Hyperactivity Disorder

The diagnosis of and treatment for Attention Deficit/Hyperactivity Disorder is covered when rendered or prescribed by a Physician or Allied Health Professional.

Autism Spectrum Disorders (ASD)

Coverage is provided for expenses relating to the treatment of Autism Spectrum Disorders. Treatment may include generally recognized services contained in a treatment plan recommended by the Member's primary Physician. Services may include, but are not limited to: evaluation and assessment services; applied behavior analysis; behavior training and

management; speech, physical and occupational therapy; medications or nutritional supplements used to address symptoms of the ASD.

An individual providing treatment for Autism Spectrum Disorder must be a health care practitioner or an individual acting under the supervision of a health care practitioner:

- Who is licensed, certified or registered by an appropriate agency in the state of Texas;
- Whose professional credential is recognized and accepted by an appropriate agency of the United States; or
- Who is certified as a provider under the TRICARE military health system.

Medical services for ASD are paid on the same basis as any other medical condition. ASD Benefits are subject to the Deductible and Coinsurance amounts that are applicable to the Benefits obtained. (Example: A Member obtains speech therapy for treatment of ASD. Member will pay the applicable Deductible or Coinsurance amount shown on the Schedule of Benefits for speech therapy.)

Cleft Lip and Cleft Palate Services

The following services for the treatment and correction of Cleft Lip and Cleft Palate are covered:

- Oral and facial Surgery, surgical management, and follow-up care.
- Prosthetic treatment, such as obturators, speech appliances, and feeding appliances.
- Orthodontic treatment and management.
- Preventive and restorative dentistry to ensure good health and adequate dental structures for orthodontic treatment or prosthetic management or therapy.
- Speech-language evaluation and therapy.
- Audiological assessments and amplification devices.
- Otolaryngology treatment and management.
- Psychological assessment and counseling.
- Genetic assessment and counseling for patient and parents.

Coverage is also provided for secondary conditions and treatment attributable to the primary medical condition.

Dietitian Visits

Benefits are available for visits to registered dietitians Diabetics that need the services of a Dietitian should receive those services as part of their Benefits for Diabetes Education and Training for Self-Management.

Disposable Medical Equipment or Supplies

Disposable medical equipment or supplies which have a primary medical purpose are covered and are subject to reasonable quantity limits as determined by Us. The equipment and supplies are subject to the Member’s medical Deductible and Coinsurance.

Durable Medical Equipment, Orthotic Devices, Prosthetic Appliances, Devices and Services

Durable Medical Equipment

Durable Medical Equipment is covered when the equipment is prescribed by a Physician prior to obtaining the equipment. The equipment must not be provided mainly for the comfort or convenience of the Member or others. In addition, the equipment must meet all of the following criteria:

- It must withstand repeated use;
- It is primarily and customarily used to serve a medical purpose;
- It is generally not useful to a person in the absence of illness or injury; and
- It is appropriate for use in the patient's home.

Benefits for rental or purchase of Durable Medical Equipment include:

- Benefits for the rental of Durable Medical Equipment will be based on the rental Allowable Charge (but not to exceed the purchase Allowable Charge).
- At the Company's option, Benefits will be provided for the purchase of Durable Medical Equipment, appropriate supplies, and oxygen required for therapeutic use. The purchase of Durable Medical Equipment will be based on the purchase Allowable Charge.
- Benefits based on the Allowable Charge for standard equipment will be provided toward any deluxe equipment when a Member selects deluxe equipment solely for his comfort or convenience.
- Benefits for deluxe equipment based on the Allowable Charge for deluxe equipment will only be provided when documented to be Medically Necessary.
- Accessories and medical supplies necessary for the effective functioning of covered Durable Medical Equipment are considered an integral part of the rental or purchase allowance and will not be covered separately.
- Repair or adjustment of purchased Durable Medical Equipment or for replacement of components is covered. Replacement of equipment lost or damaged due to neglect or misuse or for replacement of equipment within five (5) years of purchase or rental will not be covered.

Limitations in connection with Durable Medical Equipment:

- There is no coverage during rental of Durable Medical Equipment for repair, adjustment, or replacement of components and accessories necessary for the effective functioning and maintenance of covered equipment as this is the responsibility of the Durable Medical Equipment supplier.
- There is no coverage for equipment where a commonly available supply or appliance can substitute to effectively serve the same purpose.
- There is no coverage for repair or replacement of equipment lost or damaged due to neglect or misuse.
- Reasonable quantity limits on Durable Medical Equipment items and supplies will be determined by Us.

Orthotic Devices, Prosthetic Appliances & Devices (Non-Limb)

Coverage is provided for prosthetic devices, orthotic devices, and professional services related to the fitting and use of those devices that equals the coverage provided under federal laws for health insurance for the aged and disabled under Sections 1832, 1833, and 1834, Social Security Act (42 U.S.C. Sections 1395k, 1395l, and 1395m), and 42 C.F.R. Sections 410.100, 414.202, 414.210, and 414.228, as applicable. Benefits as specified in this section will be available for the

purchase of Orthotic Devices that are the most appropriate model of Orthotic Device that adequately meets the medical needs of the Member as determined by the Member's treating physician or podiatrist or orthotist, as applicable. These Benefits will be subject to the following:

- Repair or replacement of the Orthotic Device is covered unless the repair or replacement is necessitated by misuse or loss by the Member.
- Benefits based on the Allowable Charge for standard devices will be provided toward any deluxe device when a Member selects a deluxe device solely for his comfort or convenience.
- Benefits for deluxe devices based on the Allowable Charge for deluxe devices will only be provided when documented to be Medically Necessary.

Benefits for Prosthetic Appliances and Devices and Prosthetic Services of the Limbs are the same as for non-limb with the addition of:

- A Member may choose a Prosthetic Appliance or Device that is priced higher than the Benefit payable under this Policy and may pay the difference between the price of the device and the Benefit payable, without financial or contractual penalty to the provider of the device.
- Prosthetic Appliances and Devices of the limb must be prescribed by a licensed Physician and provided by a facility accredited by the American Board for Certification in Orthotics Prosthetics and Pedorthics (ABC) or by the Board for Orthotics/Prosthetics Certification (BOC).

You are also covered for any services or supplies in connection with routine foot care, including the removal of warts, corns, or calluses, or the cutting and trimming of toenails, in connection with diabetes circulatory disorders of the lower extremities, peripheral vascular disease, peripheral neuropathy, or chronic arterial or venous insufficiency.

Private Duty Nursing Services

Coverage is available to You for Private Duty Nursing Services when performed on an Outpatient basis and when the nurse is not related to You by blood, marriage or adoption. Private Duty Nursing Services are covered at the Coinsurance level. Inpatient Private Duty Nursing Services are not covered.

Sleep Studies

Medically Necessary home or laboratory sleep studies and associated professional Claims are eligible for coverage. Only sleep studies performed in the home or in a network-accredited sleep laboratory are eligible for coverage. Members should check their provider directory or contact a customer service representative at the number listed on his ID card to verify that a sleep laboratory is accredited.

Clinical Trials

Benefits are provided to a Member for Routine Patient Care Costs in connection with a phase I, phase II, phase III, or phase IV clinical trial if the clinical trial is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is described in any of the following subparagraphs:

- The study or investigation is approved or funded by one or more of the following:
    - The Centers for Disease Control and Prevention of the United States Department of Health and Human Services;
    - The National Institutes of Health;

- The Agency for Health Care Research and Quality;
  - The Centers for Medicare & Medicaid Services;
  - Cooperative group or center of any of the entities, the Department of Defense or the Department of Veteran Affairs;
  - The United States Department of Defense;
  - The United States Department of Veterans Affairs;
  - The United States Food and Drug Administration;
  - A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants;
  - An institutional review board of an institution in this state that has an agreement with the Office for Human Research Protections of the United States Department of Health and Human Services.
  - The United States Department of Energy, if the study or investigation conducted by such Department has been reviewed and approved through a system of peer review that the Secretary determines to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review:
- The study or investigation is a drug trial that is exempt from having such an investigational new drug Application.

Clinical Trial Limitations
We are not required to reimburse the Research Institution conducting the clinical trial for the cost of routine patient care provided through the Research Institution unless the Research Institution, and each health care professional providing routine patient care through the Research Institution, agrees to accept reimbursement under this Policy, at the rates that are established under the Policy, as payment in full for the routine patient care provided in connection with the clinical trial, and the treatment is pre-approved by MHHIC. We are also not required to provide benefits for services that are a part of the subject matter of the clinical trial and that are customarily paid for by the Research Institution conducting the clinical trial.

VII. PRESCRIPTION DRUG BENEFITS

Coverage is available for Prescription Drugs if shown as covered on the Schedule of Benefits. The Prescription Drugs must be dispensed on or after the Member's Effective Date by a licensed pharmacist or a pharmacy technician under the direction of a licensed pharmacist, upon the prescription of a Physician or an Allied Health Professional who is licensed to prescribe drugs. Benefits are based on the Allowable Charge that We determine and only those Prescription Drugs that We determine are Medically Necessary will be covered. Certain Prescription Drugs may be subject to Step Therapy or require prior Authorization as shown on the Schedule of Benefits.

What Is Covered

- Outpatient drugs and medications that federal and/or State of Texas law restrict to sale by Prescription only.
- Pharmaceuticals to aid smoking cessation.
- Insulin.
- Insulin syringes prescribed and dispensed for use with insulin.

- Amino acid-based elemental formulas when prescribed by a Physician and medically necessary for the treatment of:
  - Immunoglobulin E and non-immunoglobulin E mediated allergies to multiple food proteins;
  - Severe food protein-induced enterocolitis syndrome;
  - Eosinophilic disorders, as evidenced by the results of a biopsy; and
  - Impaired absorption of nutrients caused by disorders affecting the absorptive surface, functional length, and motility of the gastrointestinal tract.
- Prescription contraceptives or contraceptive devices approved by the FDA.
- Formulas for the treatment of Phenylketonuria (PKU) or other heritable diseases.
- Self-administered injectable Drugs and syringes for the self-administration of those drugs.
- Any Prescription Drug prescribed to treat a Member for a chronic, disabling, or life threatening illness if the Drug:
  - Has been approved by the Food and Drug Administration for at least one indication; and
  - Is recognized for the treatment of the indication for which the Drug is prescribed in:
    - Prescription Drug reference compendium approved by the Commissioner of Insurance; or
    - Substantially accepted peer-reviewed medical literature.
- Orally administered anticancer medication that is used to kill or show the growth of cancerous cells. Benefits for such medications are subject to the same Deductible or Copayment requirement as would apply to chemotherapy provided as Infusion Therapy.

Conditions of Service

The Drug or medicine must be:

- Prescribed in writing by a Physician and dispensed within 1 year of being prescribed, subject to federal or state laws.
- Approved for use by the Food and Drug Administration.
- For the direct care and treatment of the Member's Illness, Injury or condition Dietary supplements, health aids or Drugs for cosmetic purposes are not included.
- Purchased from a licensed retail Pharmacy or ordered through the mail service program.

The Drug or medicine must not be used while the Member is an inpatient in any facility. The Prescription must not exceed a 30-day supply (unless ordered through the mail service program, in which case the supply limit is shown on the Schedule of Benefits.)

Preferred Drug Program

In order to continue providing an affordable Pharmacy benefit, MHHIC has developed a Preferred Drug Program. The program is designed to help manage rapidly escalating Prescription Drug costs while remaining flexible and sensitive to Members’ medical needs. Preferred Drugs that have equivalent medical results will be substituted for non-preferred medications upon approval from the prescribing Physician.

Prescription Drug Formulary

This Policy covers Prescription Drugs. A Prescription Drug Formulary is a list of Prescription Drugs covered under this Policy. As noted on the Schedule of Benefits, placement of Prescription

Drugs on a drug tier may be based on a drug's quality, safety, clinical efficacy, available alternatives, and cost. Company reviews the Prescription Drug Formulary at least once per year.

Information about Your formulary is available to You in several ways. Most Members receive information in the mail about their Prescription Drug coverage, including information about specific drugs, cost, and drug lists. We also have information available for You to print and discuss with Your doctor. You can review and print formulary information immediately from Our website at:
http://healthplan.memorialhermann.org/members/resource-center/pharmacy-benefit-information/

You may also contact Us at the telephone number on Your ID card to ask whether a specific drug is included in Your formulary.

Medications in a four-tier benefit structure are divided into four groups;

1. Generic Drugs are in the first tier copayment;
2. Certain Brand Name Drugs, including Preferred Brand Name Drugs, are in the second tier copayment; and
3. Non-Preferred Brand Name Drugs are in the third tier copayment.
4. Specialty Drugs are in the fourth tier subject to a copayment or coinsurance.

In most cases, there are Generic and/or Preferred Brand Name alternatives for Non-Preferred Brand Name Drugs. Discuss the possibility of being prescribed a Preferred Brand Name or Generic Drug with the Physician, if appropriate. The Member's Physician always has the final decision on drug selection. If the Member's Physician prescribes a Non-Preferred Brand Name Drug even after the Member has explained his/her preference for a Preferred Brand or Generic Drug, the Non-Preferred Brand Name Drug will still be covered, but at the higher copayment.

If a Prescription Drug is on Your Prescription Drug Formulary, this does not guarantee that Your Physician or other authorized prescriber will prescribe the drug for a particular medical condition or mental illness. You may file a written Appeal to Us if a Prescription Drug is not included in the formulary and Your Physician or authorized prescriber has determined that the drug is Medically Necessary for You. Instructions for filing an Appeal are included in this Policy. We will cover any approved
Prescription Drug at the benefit level until Your Renewal Date regardless of whether the drug has been removed from Your Prescription Drug Formulary before the Renewal Date.

Under urgent circumstances, when a Member has a disease that may seriously jeopardize their life, health, or ability to regain maximum function or if the Member is already prescribed a certain Non-Formulary Drug, We must provide a written notice of favorable determination (mailed or otherwise transmitted) not later than 24 hours after the date of the request for Utilization Review and all medical information necessary to substantiate the need for the treatment or service recommended is received by Medical Management. Adverse determinations must be communicated within 24 hours in writing to the provider of record if the Member is not hospitalized at the time of the adverse determination. The nurses make outbound calls to the provider informing them of the denial.

A request for such an expedited review must include:

- Information related to the existence of the exigency and a description of the harm that could reasonably occur to the Member if the requested Non-Formulary Drug is not provided in the timeframe; and
- Justification supporting the need for the Non-Formulary Drug to treat the Member's condition, including a statement that all covered Formulary Drugs, on any tier, will be or have been ineffective, are less effective, or would result in adverse effects.

If We deny a request for Utilization Review of a Drug that is not part of Our Preferred Drug list, the Member or the Member's prescribing Physician may appeal Our decision by calling Us at the toll free number for complaints, shown in the Contact Information section in the Introduction to this Policy. If You are not satisfied with the resolution based on Your inquiry, You may file an appeal with Us by following the procedures described under "Appeal of Adverse Determination" in the "Utilization Review Program and Procedures" section of Your Policy titled "Complaints, Grievances & Appeals."

Utilization Review Program

Prescription Drug benefits may be subject to Utilization Review of Prescription Drug usage for Your health and safety. If there are patterns of over-utilization or misuse of Drugs, We will notify Your Physician or pharmacist. We reserve the right to limit benefits to prevent over-utilization of Drugs.
Certain Drugs may require Utilization Review. For information on which specific Drugs require Utilization Review, call the toll free number shown in the Contact Information section in the Introduction to this Policy. If a Member fills a Prescription for a Drug that requires Utilization Review, the Member will receive a letter informing him/her of the requirement, and of how to obtain approval for any refills.

Benefits may be reduced if Utilization Review is required and a Member fails to obtain it. Benefits will not be reduced more than 50% or a maximum of $500.

Generics

Many Prescription Drugs are available in Generic form, which is more cost effective for Members. It may be to the Member's advantage to ask the Physician to prescribe, and the pharmacist to dispense, Generic Drugs whenever possible.

Retail Pharmacies

Participating Retail Pharmacies

When a Member has a Prescription filled, they must present their ID Card. The Pharmacy will calculate the Copayment and Deductible responsibilities, if any. Members will not need to submit claim forms but are responsible for paying applicable Deductible and Copayment amounts to the Pharmacy. Any applicable Deductible and/or Copayment are shown on the Schedule of Benefits.

For self-administered injectable Drugs and syringes Members pay the Copayment rate shown on the Schedule of Benefits per 30-day supply per Prescription for self-administered injectable Drugs, syringes and any combination kit or package containing both oral and self-administered injectable Drugs, except insulin.

No coverage is provided for a Prescription Drug from a Non-Participating Pharmacy.

Mail Service Program

Prescription Drugs may be purchased through the OptumRx Home Delivery mail service program, as indicated on the Schedule of Benefits. A maximum number of days' supply per Prescription and/or refill will be dispensed per order, shown on the Schedule of Benefits, will apply. Maintenance Drugs (an ongoing Prescription) can be purchased through the mail, subject to the Deductible, Copayment and the Prescription Drug Deductible, if any, shown on the Schedule of Benefits.

Please note that some Prescription Drugs and/or medications may not be available through the mail service program. Check with the mail service Pharmacy customer service department for availability of the Drug or medication.

The Prescription must state the Drug name, dosage, directions for use, quantity, number of refills (if permitted), the Physician's name and phone number, the patient's name and address, and be signed by a Physician. Submit it with the appropriate payment for the amount of the purchase, and a properly completed order form. Members need only pay any applicable Deductible amount and the Copayment or Prescription Drug Deductible, if any. The first mail service pharmacy Prescription must include a completed Patient Profile form. This form may be obtained by calling the toll free number listed in the "Contact Information" section of this Policy.

Prescription Drug Exclusions and Limitations

Prescription Drug reimbursement is subject to and treated as part of any benefit maximums, or any other exclusions or limitations contained in this Policy. In addition, reimbursement will not be provided for:

- Drugs and medications not requiring a Prescription, except insulin.
- Non-medical substances or items, with the exception that pharmaceuticals to aid smoking cessation are covered.
- Dietary supplements, cosmetics, health or beauty aids.
- Any vitamin, mineral, herb or botanical product which is thought to have health benefits, but does not have a Food and Drug Administration (FDA) approved indication to treat, diagnose or cure a medical condition, even if it is thought to have health benefits.
- Drugs taken while the Member is in a Hospital, Skilled Nursing Facility, rest home, sanitarium, convalescent Hospital or similar facility.
- Any Drug labeled "Caution, limited by federal law to investigational use" or Non-FDA approved Investigational Drugs. Any drug or medication prescribed for experimental indications (such as progesterone suppositories).
- Syringes and/or needles, except those dispensed for use with insulin or self-administered injectable drugs.
- Durable Medical Equipment, devices, appliances and supplies except as specifically stated under the Professional and Other Services section of this Policy.
- Immunizing agents, biological sera, blood, blood products or blood plasma.
- Oxygen.
- Professional charges in connection with administering, injecting or dispensing of Drugs.

- Drugs and medications dispensed or administered in an outpatient setting, including but not limited to outpatient Hospital facilities and doctor's offices. Such drugs and medications are covered under the Professional and Other Services benefit.
- Drugs used for cosmetic purposes.
- Drugs used for the primary purpose of treating Infertility or promoting fertility, except in association with an approved Course of Treatment for In vitro Fertilization.
- Anorexiants or drugs associated with weight loss, except as provided under Child and Adult Preventive Care Services.
- Allergy desensitization products, allergy serum.
- All Infusion Therapy is excluded under this Policy except as specifically stated in the Covered Services section.
- Drugs for treatment of a condition, Illness, or Injury for which benefits are excluded or limited by a Policy limitation.
- Select classes of Drugs where non-preferred medications, which have therapeutic, alternatives, have shown no benefit regarding efficacy or side effects over Preferred Drugs. However, this will not apply if the Prescriber denotes, “dispense as written” or “do not substitute” for prescriptions reviewed as clinically appropriate by the health plan.
- Prescription Drugs with a non-prescription (over the counter) chemical and dose equivalent, except insulin.
- Replacement of lost or stolen Prescription Drugs.

VIII. PREVENTIVE AND WELLNESS CARE

The following Wellness Care and Preventive services are available to a Member upon the effective date required for the coverage. These services are provided for the purpose of promoting good health and early detection of disease.

If a Member receives Preventive or Wellness Covered Services from an In Network Provider, Benefits will be paid at one hundred percent (100%) of the Allowable Charge with no Deductible or Copayment. When Preventive or Wellness Care Covered Services are rendered by a Non-Network Provider, Benefits will be subject to Copayment amounts (if applicable) and Coinsurance percentages shown on the Schedule of Benefits. Also, if a preventive service is provided during an office visit in which the preventive service is not the primary purpose of the visit, a copay or coinsurance will still apply. The Deductible Amount will not apply to Covered Services received for Preventive or Wellness Care.

Well Woman Examinations

- One (1) routine annual visit per Benefit Period to an obstetrician/gynecologist. Additional visits recommended by the Member’s obstetrician/gynecologist may be subject to the Deductible Amount, Copayment or Coinsurance percentage shown on the Schedule of Benefits, if not a preventive service.
- One (1) routine Pap smear, cervical and ovarian cancer screening per Benefit Period for early detection including:
    - Blood, laboratory and Diagnostic Services in connection with evaluating the Pap Smear.
    - the provider’s charge for administration of the test, for any covered female age 18 or older, not to exceed one per calendar year for:

    - (1) a CA 125 blood test; and
    - (2) a conventional Pap smear screening or a screening using liquid-based cytology methods, as approved by the United States Food and Drug Administration (FDA), alone or in combination with a test approved by the FDA for the detection of the human papillomavirus.
- Mammograms. We cover mammograms for the screening of breast cancer as follows:
  - One (1) baseline screening by low-dose mammography annually for women age 35 and over.

All preventive mammograms are covered at no cost to You when obtained from a Network Provider. Film Mammograms obtained from a Non-Network Provider will be subject to Coinsurance as shown on the Schedule of Benefits.

Annual well-woman preventive care visits are another opportunity for women to obtain the recommended adult preventive care services that are age and developmentally appropriate including:

- Preconception and prenatal care.
- Screening for gestational diabetes for pregnant women between 24 and 28 weeks of gestation and at the first prenatal visit for pregnant women identified to be at high risk for diabetes.
- High-risk human papillomavirus DNA testing in women with normal cytology results, beginning at 30 years of age and occurring no more frequently than once every three years.
- Annual counseling on sexually transmitted infections for all sexually active women.
- Annual screening and counseling for human immune-deficiency virus infection for all sexually active women.
- Prescription FDA-approved contraceptive methods, sterilization procedures and patient education and counseling for all women with reproductive capacity, including Injectable Drugs and implants, intra-uterine devices, diaphragms, and the professional services associated with them.
- Comprehensive lactation support and counseling by a trained provider during pregnancy and/or in the postpartum period and rental of breastfeeding equipment.
- Annual screening and counseling for women for interpersonal and domestic violence.

Preventive care and screening for women provided are supported by the U.S. Health Resources and Services Administration and performed in accordance with the guidelines adopted by the American College of Obstetricians and Gynecologists or another similar national organization of medical professionals recognized by the Insurance Commissioner.

Physical Examinations and Testing

Routine Wellness Physical Exam

You are eligible for a physical examination once every Policy year, after 365 days have passed since the previous physical examination visit. Eye and ear examinations for children are covered through age 17, to determine the need for vision and hearing correction complying with established medical guidelines. Vision screens do not include refractions.

Certain routine wellness diagnostic tests ordered by Your Physician are covered. Examples of routine wellness diagnostic tests that would pay under this Preventive or Wellness Care Benefit

include, but are not limited to tests such as a urinalysis, complete blood count (CBC), serum chemistries, calcium, potassium, cholesterol and blood sugar levels.

High Tech services such as an MRI, MRA, CT scan, PET scan, nuclear cardiology and endoscopy are not covered under this Preventive or Wellness Care Benefit. These higher tech services may be covered under standard Policy Benefits when the tests are Medically Necessary.

Adult Immunizations
MHHIC will cover adult immunizations as rated as “A” or “B” by the United States Preventive Services Task Force (USPSTF) and recommended by the Advisory Committee on Immunization Practices (ACIP) and supported by the Health Resources, Services Administration (HRSA) and the Centers for Disease Control and Prevention.

Child Immunizations
MHHIC covers immunizations for children and adolescents recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. Coverage for child members from birth through the date of the child's sixth birthday Coverage includes immunization against: diphtheria, haemophilus influenzae type b, hepatitis, measles, mumps, pertussis, polio, rubella, tetanus, varicella, rotovirus, and any other immunization that is required for the child by law.

This benefit is not subject to Copayments, Deductibles or Coinsurances when provided by Participating or Non-Participating Providers in accordance with the recommendations of ACIP.

Well Baby & Well Child Care
Well Baby Care routine examinations will be covered for infants under the age of 24 months for whom no diagnosis is made. Routine examinations ordered after the infant reaches 24 months will be subject to the Routine Wellness Physical Exam Benefit.

Prostate Cancer Screening
One (1) physical rectal exam and one (1) prostate-specific antigen (PSA) test per Benefit Period, is covered for Members fifty (50) years of age or older and asymptomatic or if the Member is over forty (40) years of age with a family history of prostate cancer or another prostate cancer risk factor . A second visit will be permitted if recommended by the Member’s Physician for follow-up treatment within sixty (60) days after either visit if related to a condition diagnosed or treated during the visits.

Cardiovascular Screening
Screening for cardiovascular disease every 5 years for a male older than 45 years of age or a female older than 55 years of age, who is diabetic or has an intermediate or higher risk for developing coronary heart disease (based on a score derived using the Framingham Heart Study coronary prediction algorithm).

Colorectal Cancer Screening
A FIT (Fecal Immunochemical test for blood), flexible sigmoidoscopy, or routine colonoscopy can be provided in accordance with the most recently published recommendations established by the American College of Gastroenterology, in Consultation with the American Cancer Society, for the ages, family histories and frequencies referenced in such recommendations.

Selected generic Physician prescribed colonoscopy preparation and supplies for colonoscopies covered under the Preventive and Wellness benefit will be covered at first dollar when obtained from a Network Pharmacy. Routine colorectal cancer screening will not mean services otherwise excluded from Benefits because the services are deemed by Us to be Investigational. Brand-name colonoscopy preparation and supplies will be covered at no cost to the Member only under the following circumstances: Physician prescribes brand-name colonoscopy preparation and supplies because of Member's inability to tolerate selected generic colonoscopy preparation and supplies.

Nicotine Dependence Treatment
Prescription Drugs which have been approved by the U.S. Food and Drug Administration for the management of nicotine dependence. MHHIC's various nicotine treatment options are noted on our 2017 formulary.

Bone Mass Measurement
Scientifically proven tests for the diagnosis and treatment of osteoporosis if a Member is:

- a postmenopausal woman who is not receiving estrogen replacement therapy;
- an individual with: vertebral abnormalities; primary hyperparathyroidism; or has 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.

Services recommended by the U.S. Preventive Services Task Force (receiving grades of A or B), the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, and the Health Resources and Services Administration.

The list of covered preventive/wellness services changes from time to time. To check the current list of recommended Preventive or Wellness Care services for adults, children and women required by PPACA, visit the U.S. Department of Health and Human Services' website at https://healthcare.gov/preventive-care-benefits/

IX. CLAIMS PROVISIONS

The Claims Process

Within 20 days after You receive Covered Services, or as soon as reasonably possible, You or someone on Your behalf must notify Us in writing of Your claim.

Within 15 days after We receive Your written notice of claim, We must:

- Acknowledge receipt of the claim;
- Begin any investigation of the claim;
- Specify the information You must provide to file proof of loss. (We can request additional information during the investigation if necessary); and
- Send You any forms We require for filing proof of loss. If We do not send You the forms within this time period, You can file proof of loss by giving Us a letter describing the occurrence, the nature and the extent of Your claim. You must give Us this letter within the time period for filing proof of loss.

Within 90 calendar days after You receive Covered Services, You must send Us written proof of loss.

Within 15 business days after We receive all the information required to secure final proof of loss, We must:

- Give You written notice that Your claim or part of Your claim has been accepted and pay benefits within five business days after We notify You of Our acceptance; or
- Give You written notice that Your claim has been rejected and tell You the reason(s) for the rejection; or
- Give You written notice if We need more time to make Our decision and the reasons We need additional time.

If You have any questions about any of the information in this section, You may call Your insurance agent or Our Member Services Department at the telephone number shown on Your ID card.

How To File a Claim For Benefits

MHHIC and our Providers have entered into agreements that eliminate the need for a Member to personally file a Claim for Benefits. Preferred and Participating Providers will file Claims for Members either by mail or electronically.

Prescription Drug Claims
Most Members will not be required to file Claims to obtain Prescription Drug Benefits as this is done automatically when You present Your ID card to a Participating Pharmacist. However, if You must file a claim to access Your Prescription Drug Benefit, You must use the Prescription Drug Claim Form.

The Prescription Drug Claim Form, or an attachment acceptable to Us, may require the signature of the dispensing pharmacist. The claim form should then be sent to Our Pharmacy Benefit Manager, whose telephone number should be found on Your ID card. Benefits will be paid to the Member based on the Allowable Charge for the Prescription Drug.

Other Medical Claims
When You receive other medical services (clinics, provider offices, etc.) You should ask if the Provider is a Preferred or Participating Provider. If yes, this Provider will file Your claim with Us. In some situations, the Providers may request payment and ask You to file. If this occurs, be sure the claim form is complete before forwarding to MHHIC. If You are filing the claim, the claim must contain the itemized charges for each procedure or service. Statements, canceled checks, payment receipts and balance forward bills may not be used in place of itemized bills.

Itemized bills submitted with claim forms must include the following:

- Full name of patient
- Date(s) of service
- Description of and procedure code for service
- Diagnosis code
- Charge for service
- Name and address of provider of service

Claims for Durable Medical Equipment (DME)
DME claims are processed like other Medical claims, may be subject to review for Medical Necessity and will be processed at the Allowable Rate. For processing charges on the rental,

purchase and necessary repairs/maintenance of wheelchairs, braces, crutches, etc. the invoice must include:

- On the bill of the supplying firm
- Provided with a description of the item rented, purchased or serviced
- Noted with the date, charge, and patient's name

A statement from the attending Physician or Allied Health Provider that services were Medically Necessary may also need to be filed with these bills.

Rental charges that exceed the reasonable purchase price of the equipment are not covered. All Durable Medical Equipment used in Infusion Therapy will be excluded under this Policy except where specifically stated under the benefit for Infusion Therapy.

Claims Questions
Your claim(s) will be processed according to the terms of this Policy, in the time frames required by law. Members may write Us at the claims address noted on the Contact Page or call Our Member Service Department at the telephone number shown on their ID card.

Payment of Claims

Payment to You, Your Beneficiary or Your Estate: Benefits will be paid to You, unless assigned as outlined below. Any unassigned benefits that are unpaid at Your death will be paid either to the Beneficiary or to Your estate if no Beneficiary is named. If benefits are payable to Your estate or to You or to a Beneficiary who cannot execute a valid release, We may pay benefits up to $1,000 to someone related to You or a Beneficiary by blood or marriage whom We deem to be equitably entitled to such benefits. We will be discharged to the extent of any such payments made by Us in good faith.

Assignment of Claim Payments: We will recognize any assignment made under the Policy, if:

- It is duly executed on a form acceptable to Us; and
- A copy is on file with Us; and
- It is made by a provider licensed and practicing within the United States.

We assume no responsibility for the validity or effect of an assignment. Payment for services provided by a Participating Provider is automatically assigned to the provider. The Participating Provider is responsible for filing the claim and We will make prompt payments to the provider for any benefits payable under this Policy. Payment for services provided by a Non-Participating Provider are payable to You unless assignment is made as above.

Payment to a Possessory or Managing Conservator
Benefits paid on behalf of a covered dependent child may be paid to a person who is not the Subscriber. The Subscriber can also be paid benefits if an order is issued by a court of competent jurisdiction in this or any other state names such person the possessory or managing conservator of the child.

To be entitled to receive benefits, a possessory or managing conservator of a child must submit to Us with the claim form, written notice that such person is the possessory or managing conservator of the child on whose behalf the claim is made and submit a certified copy of a court order establishing the person as possessory or managing conservator. This will not apply in the case of any unpaid medical bill for which a valid assignment of benefits has been exercised or to

claims submitted by the Subscriber where the Subscriber has paid any portion of a medical bill that would be covered under the terms of the Policy.

Claims Provisions

A claimant's right to make a claim for any benefits provided by this Policy is governed as follows:

- *Notice Of Loss*
  A claimant should send a written notice of claim to Us within 20 days of a loss. No special form is required to do this. The notice need only identify the claimant and the Policyholder. When We receive the notice, We will send a proof of claim form to the claimant. The claimant should receive the proof of claim form within 15 days of the date We received the notice of claim. If the form is received within such time, it should be completed, as instructed, by all persons required to do so.

- *Proof Of Loss*
- In the case of a Claim for a loss other than a Claim for a loss of time for disability, written proof of loss must be provided to Us at Our designated office before the 91st day after the termination of the period for which We are liable. For a claim for any other loss, a written proof of loss must be provided to Us at Our designated office before the 91st day after the date of the loss. Subsequent written proofs of the continuance of the disability must be provided to Us at intervals as reasonably required by Us. Failure to provide the proof within the required time does not invalidate or reduce any claim if it was not reasonably possible to give proof within the required time. In that case, the proof must be provided as soon as reasonably possible but not later than one year after the time proof is otherwise required, except in the event of a legal incapacity.

  When You file proof of loss, You may direct Us, in writing, to pay health care benefits to the recognized Provider of health care who provided the covered service for which benefits became payable. For covered services, We will Determine to pay either the Covered Person or the Facility or the Practitioner.

- *TimelyPayment Of Claims*
  Indemnities payable under this Policy for any loss, other than a loss for which this Policy provides any periodic payment, will be paid immediately on receipt of due written proof of the loss.

- *Physical Exams*
  We, at our expense, have the right to examine the Member. This may be done as often as reasonably needed to process a claim. We also have the right to have an autopsy performed, at Our expense.

Legal Actions

You cannot sue on any claim before 60 days after written proof of loss has been given as required. You cannot sue on any claim after 3 years from the time written proof of loss is required to be given.

* If You call for information about a Claim, We can better help You if You have the Policy number, patient's name and date of service readily available.

X. COMPLAINT, GRIEVANCE & APPEALS

Complaints and Grievances

MHHIC wants to know when a Member is unhappy about the care or services received from one of our Providers. If a Member wants to register a Complaint or file a formal written Grievance about Us or a Provider, please refer to the procedures below.

A Complaint is an expression of dissatisfaction with Us or with Provider services. Members may call Member Services to register a Complaint. A Grievance is a written expression of dissatisfaction with Us or with Provider services. Grievances apply to any issue not relating to a Medical Necessity, experimental or investigational determination by Us. Grievances only apply to contractual benefit, or issues or concerns You have regarding our administrative policies or access to providers. To file a Complaint or Grievance, please contact us at:

Memorial Hermann Health Plan
[929 Gessner Road, Suite 1500
Houston, TX 77024]
Attn: Appeals and Grievances
Phone: [(713) 338-6535] or [1-888-594-0671]
Fax: [(713) 338-6550]

A letter will be sent within five (5) days acknowledging the date of receipt of the complaint or grievance. A response will be mailed to the Member within thirty (30) business days. MHHIC will investigate and resolve a complaint concerning an emergency or a denial of continued hospitalization:

- In accordance with the medical or dental immediacy of the case; and
- Not later than one business day after We receive the complaint.

Member does not feel their Complaint was adequately resolved or they wish to file a formal Grievance, the Member must submit this in writing within 180 days of the event that led to the dissatisfaction. Our Member Service Department will assist the Member if necessary.

Informal Reconsideration
An Informal Reconsideration is a request by telephone, made by an authorized Provider on the Member's behalf, to speak to Our medical director or a peer reviewer about a Utilization Management decision that We have made. An Informal Reconsideration is typically based on submission of additional information or a peer-to-peer discussion.

An Informal Reconsideration is available only for initial determinations that are requested within ten (10) days of the denial or Concurrent Review determination. We will conduct an Informal Reconsideration within one (1) working day of Our receipt of the request.

Appeals

Appeal Procedures

- A Member may be unhappy about decisions We make regarding Covered Services, after the Complaint and Grievance procedures. We consider the Member's request to change Our coverage decision an Appeal. We define an Appeal as a request from a Member or

authorized representative to change a previous decision made by Us about covered services. Examples of issues that qualify as Appeals include denied Authorizations, Claims based on Adverse Determinations of Medical Necessity, or Benefit determinations. Note: Multiple requests to Appeal the same Claim, service, issue or date of service will not be considered at any level of review.

- If a Member is not satisfied with Our denial of services, a written request to Appeal must be submitted within 180 days following receipt of the initial adverse Benefit determination.
- If the Member has questions or needs assistance putting the Appeal in writing, the Member may call Our Member Service Department at [1-888-594-0671].
- The Member has the right to appoint an authorized representative to speak on their behalf in their Appeals. An authorized representative is a person to whom the Member has given written consent to represent the Member in an internal or external review of a denial. The authorized representative may be the Member's treating Provider, if the Member appoints the Provider in writing.

In addition to the Appeals rights, the Member's Provider is given an opportunity to speak with a Medical Director for a peer-to-peer discussion about a Member's plan of treatment and Our coverage decision when they concern Medical Necessity determinations. MHHIC will distinguish a Member's Appeal as an Administrative Appeal or a Medical Necessity Appeal. The Member is encouraged to provide Us with all available information to help Us completely evaluate the Member's Appeal.

You or Your health care provider, with Your consent, may Appeal an adverse benefit determination, within 180 days of receipt of the adverse benefit determination. There are several methods for initiating an internal Appeal:

- Verbally: Member Services at [1-888-594-0671]
- In Writing: Any pertinent clinical information to substantiate the case should be forwarded with the Appeal letter to:

Memorial Hermann Health Plan
[929 Gessner Road, Suite 1500
Houston, TX 77024]
Attn: Appeals and Grievances

All written Appeals should include the following elements, when applicable;

- Covered Person's name and Identification number.
- The date of service, health care Provider, claim amount (if applicable).
- The reasons for the Appeal, including an explanation why You think the denial was incorrect.
- Any supporting documentation to support Your written request i.e. medical records.

Please review Your "Complaint Rights" and "Appeals Rights" as presented with Your Policy documents. Upon request by the Member and free of charge, we will provide reasonable access to and copies of all documents, records, and other information relevant to the Member's Claim for Benefits.

The Appeals process has only one level of internal review.

Administrative Appeals
Administrative Appeals involve contractual issues other than Medical Necessity or Investigational denials. Examples include Rescission of coverage and adverse Benefit determinations based on Contract limitations or exclusions. Administrative Appeals should be submitted in writing to:
Memorial Hermann Health Solutions, Inc.
[929 Gessner Road
Suite 1500
Houston, TX 77024]
Attn: Administrative Appeals

MHHIC will promptly investigate the Member's concerns. If We change Our original decision at the first level, We will process the Member's Claim and notify the Member and all appropriate Providers. If the original determination on the Member's Claim is upheld, We will notify the Member and all appropriate Providers of the decision. Notice of the administrative Appeal decision will be sent in writing within thirty (30) calendar days of Our receipt of the Member's request; unless it is mutually agreed that an extension of the time is warranted.

Medical Appeals
For Medical Appeals a second level of review will be handled by an external Independent Review Organization (IRO) that is not affiliated with Us and randomly assigned by the Texas Department of Insurance. Any decision by an IRO is binding on both the Member and Us. Administrative Appeals are not eligible for the External Appeal process. The External Appeal process is discussed in further detail below.

Persons not involved in previous decisions regarding the Member's claim will decide all Appeals. A Physician or other health care professional; in the same or an appropriate specialty that typically manages the medical condition, procedure, or treatment under review and who is not subordinate to any previous decision-maker on the Member's Claim, will review Medical Necessity Appeals. A Member must exhaust all internal Appeal opportunities prior to requesting an External Appeal conducted by an Independent Review Organization. Administrative Appeals are not eligible for External Appeal.

After a binding decision in favor of an enrollee relating to a health care service already provided, MHHIC pay the cost of the service, if not already paid, no later than 45 days after the date We receive notice of the binding decision.

External Appeals

If, You (or Your health care Provider, with Your consent) are dissatisfied with the results of the internal Appeal process, You (or Your health care Provider, with Your consent) have the right to pursue Your Appeal through an Independent Health Care Appeals Program to an Independent Review Organization (IRO) after final internal adverse benefit Determinations, except where the final internal adverse benefit Determination was based on eligibility, including rescission, or the Application of a Contract exclusion or limitation not related to medical necessity.

To initiate an external Appeal, You (or Your health care Provider, with Your consent) will within 60 days from receipt of the final internal adverse benefit determination, file a written request with the Texas Department of Insurance.

XI. UTILIZATION REVIEW PROGRAM AND PROCEDURES

This Policy includes a program to evaluate inpatient and outpatient Hospital and Ambulatory Surgical Center Admissions, and specified non-Emergency outpatient surgeries and diagnostic procedures and other services, if indicated on the Schedule of Benefits. This program ensures that Hospital and Ambulatory Surgical Facility care is received in the most appropriate setting, and that any other specified surgery or Service are Medically Necessary. This program is known as Utilization Review.

Utilization Review does not guarantee that You have coverage, that benefits will be paid, or the amount of benefits. Payment of benefits will be determined by the terms, conditions, exclusions, and limitations of Your Policy including Medical Necessity and Experimental/Investigational Procedures. Preauthorized services based on Medical Necessity and Experimental/Investigational Procedures will only be denied or reduced if the physician or provider has materially misrepresented the proposed services or has substantially failed to perform the preauthorized services. No benefits are payable unless the Member's coverage is in force at the time services are rendered.

Approval will be provided only when:

- The services are Medically Necessary as determined by Us;
- The services are not Experimental and Investigational; and
- The services are determined by Us to be eligible under this Policy.

Utilization Review may be undertaken:

- At least three calendar days before a non-Emergency Hospital or Ambulatory Surgical Center Admission or any of the specified services, if specified on the Schedule of Benefits. This is known as preauthorization (see below).
- Before a Hospital or Ambulatory Surgical Center admission or any of the specified services, if specified on the Schedule of Benefits. This is known as admission review (see below).
- During a Hospital stay. This is known as continued stay review (see below).
- Following discharge from a Hospital or an Ambulatory Surgical Center or after any of the specified services are performed, if specified on the Schedule of Benefits, or when a claim for benefits is made. This is known as a retrospective review (see below).

If We determine that a Hospital stay or any surgery or any other service is not Medically Necessary, You are responsible for payment of the charges for those services.

Preauthorization

You are always responsible for initiating preauthorization. There are penalties for some services if preauthorization is not performed as outlined on the Schedule of Benefits. Note: These penalties are not counted toward the Deductible, Prescription Drug Deductible, if any, or Your Out-of-Pocket maximum.

To initiate preauthorization, instruct Your Physician to call the MHHIC Review Center at the telephone number shown in the Contact Information section in the Introduction to this Policy at least 3 calendar days prior to any admission or scheduled date of a proposed service requiring preauthorization. Remember, You are responsible for making sure Your Physician calls. If the MHHIC Review Center determines that the admission or surgery is not Medically Necessary or

Experimental or Investigational, You and Your Physician will be notified by telephone within one calendar day after You file Your request for preauthorization.

Pre-Authorization is required for charges incurred in connection with:

- Inpatient Services (except if admitted due to an Emergency)
  Mental Health & Substance Abuse Outpatient Services
- Non-Emergency Outpatient Surgeries & Diagnostic Procedures
- ABA in Cognitive Therapy
- Skilled Nursing Facility Admission
- Durable Medical Equipment
- Rehabilitation & Habilitation Services
- Prenatal & Postnatal Care
- Genetic Testing
- Home Health Care
- Hospice Care
- Certain Prescription Drugs including Specialty Pharmaceuticals and certain injectable drugs
- Services and/or Prescription Drugs to enhance fertility
- Complex Imaging Services

Non-compliance may result in a penalty. For services and supplies which are not Pre-Authorized by Us may be subject to reduced benefits. For more information regarding the services for which We require Pre-Authorization, consult Our website at www.healthplan.memorialhermann.org or contact member services.

Subject to the notice requirements and prior to the issuance of an Adverse Determination, if We question the Medical Necessity or appropriateness or the Experimental or Investigational nature of a service, We will give the Physician who ordered it a reasonable opportunity to discuss with Our physician Your treatment plan and the clinical basis for Our determination. You and Your Physician will be sent a written notice within three calendar days of the telephone notice. The written notice will include: the principal reasons for the adverse determination; the clinical basis for the Adverse Determination; a description of the source of the screening criteria used as guidelines in making the Adverse Determination; the professional specialty of the physician, doctor, or other health care provider that made the Adverse Determination; a description of the complaint and Appeal process; a copy of the request for a review by an independent review organization form; and notice of the independent review process with instructions. If You have a life-threatening condition or if We are denying the provision of prescription drugs or intravenous infusions for which You are receiving benefits under this Policy, the notice will include a description of Your right to an immediate review by an independent review organization and the procedures to obtain that review.

For an Emergency Admission or procedure, We must be notified within 48 hours of the Admission or procedure or as soon as reasonably possible. We may take into account whether or not Your condition was severe enough to prevent You from notifying Us, or whether or not a member of Your family was available to notify Us for You.

Admission Review

If preauthorization is not performed, We will determine at the time of Admission if the Hospital or Ambulatory Surgical Center Admission or specified non-Emergency outpatient surgery or diagnostic procedure is Medically Necessary.

Concurrent Care Review

Request for Approval of Additional Benefits
If, while a Member is undergoing a Course of Treatment for an Illness or Injury for which MHHIC has approved benefits, the Member would like to request an approval of benefits for additional treatments (extension of benefits):

- Request the additional benefits at least 24 hours prior to the end of the initially prescribed and approved Course of Treatment.
- If the Member requests an extension of benefits less than 24 hours prior to the end of the initially prescribed and previously approved Course of Treatment, the request will be handled as if it were a new request for benefits, rather than an extension of benefits, and depending on the benefits.
- If MHHIC receives a request for additional benefits at least 24 hours prior to the end of the initially prescribed and previously approved Course of Treatment, We must notify the Member of Our decision regarding the request within 24 hours of receipt of the request, if the request is for urgent care benefits.
- If MHHIC denies a request for additional benefits, in whole or in part, We must explain the reason for the adverse benefit decision and the Policy provisions upon which the decision was based.
- Members may appeal the adverse benefit decision according to the rules for an appeal of an urgent, pre-service, or post-service benefit decision, depending on the circumstances.

Reduction or End of Benefits
If after approving a request for benefits in connection with a Member's Illness, Injury, disease or other condition, MHHIC decides to reduce or end these benefits, in whole or in part:

- MHHIC must notify You sufficiently in advance of the reduction in, or end of benefits to allow a Member the opportunity to appeal that decision before the reduction in, or end of, benefits occurs. The notice will explain the reason for reducing or ending benefits and the Policy provisions upon which the decision was made.
- To keep the benefits MHHIC has already approved, a Member must successfully appeal MHHIC's decision to reduce or end those benefits. A Member must appeal to MHHIC at least 24 hours prior to the reduction in, or end of, benefits.
- If a Member appeals the decision to reduce or end benefits less than 24 hours prior to the reduction in, or end of, benefits, the appeal will be treated as if the Member was appealing an urgent care adverse benefit decision.
- If MHHIC receives an appeal for benefits at least 24 hours prior to the reduction in, or end of, benefits, We must notify the Member of Our decision regarding the appeal within 24 hours of receipt of the appeal. If MHHIC denies an appeal of the decision to reduce or end the Member's benefits, in whole or in part, We must explain the reason for the adverse benefit decision and the Policy provisions upon which the decision was based.
- Members may further appeal the adverse benefit decision according to the rules for appeal of an urgent care adverse benefit decision.

- MHHIC may not deny or reduce previously preauthorized benefits based on medical necessity, appropriateness, experimental, or investigational nature, unless the physician or provider has materially misrepresented the proposed services or failed to perform the proposed services.

Continued Stay Review

We also will determine if a continued Hospital or Skilled Nursing Facility stay is Medically Necessary. We will provide notice of Our determination within 24 hours by either telephone or electronic transmission to the provider of record, followed by written notice within three working days to the Member and the provider of record. If We are approving or denying post-stabilization care subsequent to Emergency treatment, or care related to a life-threatening condition, We will notify the treating Physician or other 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 to exceed one hour after the request for approval is made. If MHHIC issues an Adverse Determination in response to a request for post-stabilization treatment or a request for treatment involving a life-threatening condition, MHHIC will provide the Member, and the Member's provider of record, notification relating to Independent Review of Adverse Determinations.

Retrospective Review

If neither Preauthorization, nor Admission review, nor Continued Stay review was performed, We will use Retrospective Review to determine if a scheduled or an Emergency Admission to a Hospital or any surgery at a Hospital or an Ambulatory Surgical Center or an outpatient surgery or a diagnostic procedure was Medically Necessary. In the event services are determined to be Medically Necessary, benefits will be provided as described in the Policy. If it is determined that a Hospital stay or any other service was not Medically Necessary, The Member is responsible for payment of the charges for those services. We will provide notice of Our Adverse Determination in writing to the Member and the provider of record within a reasonable period, but not later than 30 days after the date on which the claim is received, provided We may extend the 30-day period for up to 15 more days if: We determine that an extension is necessary due to matters beyond Our control; and We notify the Member and the provider of record, within the initial 30-day period, of the circumstances requiring the extension and the date by which We expect to make a determination. If the period is extended because of the Member's failure or the failure of the provider of record to submit the information necessary to make the determination, the period for making the determination is tolled from the date We send Our notice of the extension to the Member or the provider until the earlier of: the date the Member or the provider responds to Our request; or the date by which the specified information was to have been submitted.

Appeal of Adverse Determination

Our determination that treatment or services the Member requested or received are not Medically Necessary or appropriate or are Experimental or Investigational, based on Our Utilization Review standards is an "Adverse Determination," which means that the Member's request for coverage of the treatment or services is denied. A Member, person acting on the Member's behalf, or the Member's physician or other health care provider, has the right to Appeal the Adverse Determination to Us orally or in writing in accordance with Our internal Appeal procedures. If a Member, person acting on the Member's behalf; or the Member's physician or other health care provider, notifies Us orally, We will send a one-page form to the individual to use for making a written Appeal.

Within five (5) working days of receipt of a written request, We will acknowledge a request and advise if We need additional documents to consider the Appeal. We will provide Our decision no later than thirty (30) days after the later of the date We receive the Appeal or the date the Member provides any additional information We request in order to consider the Appeal. If Your Appeal is denied, Our notice will include a clean and concise statement of the clinical basis for the denial and Your right to seek review of the denial from an independent review organization (IRO) and the procedures for obtaining that review.

If not later than the 10th working day after the date an Appeal is denied the Member's health care provider states in writing good cause for having a particular type of specialty provider review the case, a health care provider who is of the same or a similar specialty as the health care provider who would typically manage the medical or dental condition, procedure, or treatment under consideration for review will review the decision denying the Appeal. The specialty review must be completed within 15 working days of the date the health care provider's request for specialty review is received. Notification of the Appeal under this paragraph must be in writing.

For expedited Appeals for emergency care denials, denials of care for life-threatening conditions, and denials of continued stays for hospitalized Members:

- The Appeal will include a review by a health care provider who has not previously reviewed the case and who is of the same or a similar specialty as the health care provider that typically manages the medical condition, procedure, or treatment under review;
- An expedited Appeal will be completed based on the immediacy of the medical or dental condition, procedure, or treatment, but may in no event exceed one working day from the date all information necessary to complete the Appeal is received; and
- An expedited Appeal determination may be provided by telephone or electronic transmission, but must be followed with a letter within three working days of the initial telephonic or electronic notification.

If You have a life-threatening condition, You have the right to an immediate review by an independent review organization (IRO) and You are not required to first request an internal review by Us.

Review by Independent Review Organization (IRO)

Any party who's Appeal of an Adverse Determination is denied by Us may seek review of that determination by an independent review organization assigned to the Appeal. We will pay for the IRO review and We will comply with the IRO's determination regarding the Medical Necessity or appropriateness of the treatment or services or the Experimental or Investigational nature of such treatment or services.

XII. EXCLUSIONS AND LIMITATIONS

The following Services, supplies and treatment for services that are not covered under this Policy and complications from services, supplies and treatment for services that are not covered under this Policy. MHHIC will not pay for any charges incurred for or in connection with:

- Care or treatment by means of acupuncture except when used as a substitute for other forms of anesthesia.
- The amount of any charge which is greater than the Allowed Charge.

- Services for Ambulance for transportation from a Hospital or other health care Facility, unless the Covered Person is being transferred to another Inpatient health care Facility.
- Blood or blood plasma which is replaced by or for a Covered Person.
- Services or supplies for which the Provider has not obtained a certificate of need or such other approvals as required by law.
- Care and or treatment by a Christian Science Practitioner.
- Completion of claim forms.
- Services or supplies related to Cosmetic Surgery except as otherwise stated in this Policy; complications of Cosmetic Surgery; drugs prescribed for cosmetic purposes.
- Services related to custodial or domiciliary care.
- Dental care or treatment, including appliances and dental implants, except as otherwise stated in this Policy.
- Care or treatment by means of dose intensive chemotherapy, except as otherwise stated in this Policy.
- Services or supplies, the primary purpose of which is educational providing the Covered Person with any of the following: training in the activities of daily living; instruction in scholastic skills such as reading and writing; preparation for an occupation; or treatment for behavior problems or learning disabilities except as otherwise stated in this Policy.
- Experimental or Investigational treatments, procedures, hospitalizations, drugs, biological products or medical devices, except as otherwise stated in this Policy.
- Extraction of teeth, except as otherwise stated in this Policy.
- Services or supplies for or in connection with:
    - Except as otherwise stated in this Policy for Covered Persons through the end of the month in which he or she turns age 19, exams to determine the need for (or changes of) eyeglasses or lenses of any type;
    - Except as otherwise stated in this Policy for Covered Persons through the end of the month in which he or she turns age 19 eyeglasses or lenses of any type; this exclusion does not apply to initial replacements for loss of the natural lens; or
    - Eye Surgery such as radial keratotomy or Lasik Surgery, when the primary purpose is to correct myopia (nearsightedness), hyperopia (farsightedness) or astigmatism (blurring).
- Services or supplies provided by one of the following members of Your family: Spouse, child, parent, in- law, brother, sister or grandparent (this exclusion does not apply to the provision of dental benefits under this Policy).
- All services related to the evaluation or treatment of fertility and/or Infertility, including, but not limited to, all tests, consultations, examinations, medications, invasive, medical, laboratory or surgical procedures including sterilization reversals and In vitro fertilization, except as specifically stated under Comprehensive Benefits.
- Services or supplies furnished in connection with any procedures to enhance fertility which involve harvesting, storage and/or manipulation of eggs and sperm. This includes, but is not limited to the following: a) procedures: embryo transfer; embryo freezing; and Gamete Intra-fallopian Transfer (GIFT) and Zygote Intra-fallopian Transfer (ZIFT); donor sperm, surrogate motherhood; b) Prescription Drugs not eligible under the Prescription Drugs section of the Policy; and c) ovulation predictor kits. See also the separate Exclusion addressing sterilization reversal.
- Except as stated in the Newborn Hearing Screening and Hearing Aids provisions, Services or supplies related to hearing aids and hearing exams to determine the need for hearing aids or the need to adjust them.
- Services or supplies related to herbal medicine.

- Services or supplies related to hypnotism.
- Services or supplies necessary because the Covered Person engaged, or tried to engage, in an illegal occupation or committed or tried to commit an indictable offense in the jurisdiction in which it is committed, or a felony.
- Except as stated below, Illness or Injury, including a condition which is the result of disease or bodily infirmity, which occurred on the job and which is covered or could have been covered for benefits provided under workers' compensation, employer's liability, occupational disease or similar law.

  Exception: This exclusion does not apply to the following persons for whom coverage under workers' compensation is optional unless such persons are actually covered for workers' compensation: a self-employed person or a partner of a limited liability partnership, members of a limited liability company or partners of a partnership who actively perform services on behalf of the self-employed business, the limited liability partnership, limited liability company or the partnership.
- Local anesthesia charges billed separately if such charges are included in the fee for the Surgery.
- Membership costs for health clubs, weight loss clinics and similar programs.
- Services and supplies related to marriage, career or financial counseling, sex therapy or family therapy, nutritional counseling and related services, except as otherwise stated in this Policy.
- Charges for missed appointments.
- Charges for nicotine dependence treatments and management drugs, unless otherwise stated in the Preventive Care section of this Policy.
- Any charge identified as a Non-Covered Charge or which are specifically limited or excluded elsewhere in this Policy, or which are not Medically Necessary and Appropriate, except as otherwise stated in this Policy.
- Non-Prescription Drugs or supplies, except
  - Insulin needles and syringes and glucose test strips and lancets;
  - Colostomy bags, belts and irrigators; and
  - As stated in this Policy for food and food products for Inherited Metabolic Diseases.
- Services provided by a pastoral counselor in the course of his or her normal duties as a religious person.
- Personal convenience or comfort items including, but not limited to, such items as TV's, telephones, first aid kits, exercise equipment, air conditioners, humidifiers, saunas, hot tubs.
- The following exclusions apply specifically to Outpatient coverage of Prescription Drugs
  - Charges to administer a Prescription Drug.
  - Charges for:
    - Immunization agents,
    - Allergens and allergy serums
    - Biological sera, blood or blood plasma, unless they can be self-administered.
  - Charges for a Prescription Drug which is: labeled "Caution — limited by Federal Law to Investigational use"; or Experimental.
  - Charges for refills in excess of that specified by the prescribing Practitioner, or refilled too soon, or in excess of therapeutic limits.
  - Charges for refills dispensed after one year from the original date of the prescription.
  - Charges for Prescription Drugs as a replacement for a previously dispensed Prescription Drug that was lost, misused, stolen, broken or destroyed.

- Charges for drugs, except insulin, which can be obtained legally without a Practitioner's prescription.
- Charges for a Prescription Drug which is to be taken by or given to the Covered Person, in whole or in part, while confined in:
  - A Hospital
  - A rest home
  - A sanitarium
  - An Extended Care Facility
  - A Hospice
  - A Substance Abuse Center
  - An alcohol abuse or Mental Health Center
  - A convalescent home
  - A nursing home or similar institution
  - A Provider's office
- Charges for:
  - Therapeutic devices or appliances.
  - Hypodermic needles or syringes, except insulin syringes.
  - Support garments.
  - Other non-medical substances, regardless of their intended use.
- Charges for vitamins, except Legend Drug vitamins.
- Charges for topical dental fluorides.
- Charges for any drug used in connection with baldness.
- Charges for drugs needed due to conditions caused, directly or indirectly, by a Covered Person taking part in a riot or other civil disorder.
- Covered Person taking part in the commission of a felony.
- Charges for drugs needed due to conditions caused, directly or indirectly, by declared or undeclared war or an act of war.
- Charges for drugs dispensed to a Covered Person while on active duty in any armed force.
- Charges for drugs for which there is no charge. This usually means drugs furnished by the Covered Person's employer, labor union, or similar group in its medical department or clinic; a Hospital or clinic owned or run by any government body; or any public program, except Medicaid, paid for or sponsored by any government body. But, if a charge is made, and We are legally required to pay it, We will.
- Charges for drugs covered under Home Health Care; or Hospice Care section of the Policy.
- Except as stated below, charges for drugs needed due to an on-the-job or job-related Injury or Illness; or conditions for which benefits are payable by Workers' Compensation, or similar laws. Exception: This exclusion does not apply to the following persons for whom coverage under workers' compensation is optional unless such persons are actually covered for workers' compensation: a self-employed person or a partner of a limited liability partnership, members of a limited liability company or partners of a partnership who actively perform services on behalf of the self-employed business, the limited liability partnership, limited liability company or the partnership.
- Compounded drugs that do not contain at least one ingredient that requires a Prescription Order.
- Drugs used solely for the purpose for weight loss.
- Life Enhancement Drugs for the treatment of sexual dysfunction, (e.g. Viagra).

- Services or supplies that are not furnished by an eligible Provider.

- Services related to Private Duty Nursing care, except as provided under the Home Health Care section of this Policy.
- Services or supplies related to rest or convalescent cures.
- Room and board charges for a Covered Person in any Facility for any period of time during which he or she was not physically present overnight in the Facility.
- Except as stated in the Preventive Care section, Routine examinations or Preventive Care, including related x-rays and laboratory tests, except where a specific Illness or Injury is revealed or where definite symptomatic condition is present; premarital or similar examinations or tests not required to diagnose or treat Illness or Injury.
- Self-administered services such as: biofeedback, patient-controlled analgesia on an Outpatient basis, related diagnostic testing, self-care and self-help training.
- Services provided by a social worker, except as otherwise stated in this Policy.
- Services or supplies:
    - Eligible for payment under either federal or state programs (except Medicaid and Medicare). This provision applies whether or not the Covered Person asserts his or her rights to obtain this coverage or payment for these services;
    - For which a charge is not usually made, such as a Practitioner treating a professional or business associate, or services at a public health fair;
    - For which a Covered Person would not have been charged if he or she did not have health care coverage;
    - For which the Covered Person has no legal obligation to reimburse the Provider;
    - Provided by or in a Government Hospital except as stated below, or unless the services are for treatment:
        - Of a non-service Emergency; or
        - By a Veterans' Administration Hospital of a non-service related Illness or Injury;

Exception: This exclusion does not apply to military retirees, their Dependents and the Dependents of active duty military personnel who are covered under both this Policy and under military health coverage and who receive care in facilities of the Uniformed Services.

Subject to Our Pre-Approval, eligibility for full-time student status, provided the Covered Person is either enrolled and attending an Accredited School in a foreign country; or is participating in an academic program in a foreign country, for which the institution of higher learning at which the student matriculates in the United States, grants academic credit. Charges in connection with full-time students in a foreign country for which eligibility as a full-time student has not been Pre-Approved by Us are Non-Covered Charges.

Travel to obtain medical treatment, drugs or supplies is not covered. In addition, We will not cover treatment, drugs or supplies that are unavailable or illegal in the United States.

- Stand-by services required by a Provider.
- Sterilization reversal - services and supplies rendered for reversal of sterilization.
- Charges for third party requests for physical examinations, Diagnostic Services and immunizations in connection with: obtaining or continuing employment; obtaining or maintaining a license issued by a municipality, state or federal government; obtaining insurance coverage; foreign travel; school admissions; or attendance including examinations required for participation in athletic activities.
- Transplants, except as otherwise listed in this Policy.
- Transportation, travel.
- Vision therapy.

- For pediatrics vision: any vision service, treatment or materials not specifically listed as a covered service; Services and materials that are Experimental or Investigational; Services and materials not meeting accepted standards of optometric practice; Special lens designs or coatings other than those described in this Policy; Replacement of lost/stolen eyewear; Non-prescription lenses; Insurance of contact lenses; Laser vision correction.
- Vitamins and dietary supplements.
- Services or supplies received as a result of a war, or an act of war, if the Illness or Injury occurs while the Covered Person is serving in the military, naval or air forces of any country, combination of countries or international organization and Illness or Injury suffered as a result of special hazards incident to such service if the Illness or Injury occurs while the Covered Person is serving in such forces and is outside the home area.
- Weight reduction or control including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, food or food supplements, appetite suppressants or other medications; exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including morbid obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions, except as otherwise provided in the Surgical Treatment of Morbid Obesity section of this Policy.

- Wigs, toupees, hair transplants, hair weaving or any drug if such drug is used in connection with baldness with the exception of hair loss following chemotherapy/radiotherapy or for Syphilitic alopecia up to 1 per lifetime or maximum dollar amount of $350.

XIII. GENERAL PROVISIONS

Consumer Rights and Responsibility

You have rights and responsibilities as Member of MHHIC. As a parent, caretaker, or legal guardian of a juvenile consumer or Member, You have rights and responsibilities, as well as liability.
You have the right to:

- Receive coverage for covered medical benefits and treatment that are available when You need them and are handled in a way that is fair, and respects Your privacy and dignity.
- Receive information You need about Your health benefit Policy, including information about services that are covered and not covered and any costs that You will be responsible for paying, in a language You understand, including that language in written form when requested.
- Receive covered services. Your race, ethnic group, original country, language, religion, gender and age do not matter. Your mental or physical disabilities, sexual orientation and family medical history do not matter.
- Obtain information about the qualifications of clinical staff that support MHHIC programs and services.
- Have access to a current list of in-network doctors, hospitals and places You can receive care and information about a particular doctor's education, training and practice.
- Select a Primary Care Provider for Yourself and each Member of Your family per Your benefit Policy, and change Your Primary Care Provider for any reason.
- Have Your medical information kept confidential by MHHIC and Your doctor. MHHIC complies with the confidentiality of all consumers' information and adheres to all federal

and state regulations regarding confidentiality and the release of personal health information.

- Participate with Your healthcare professional in treatment decisions and have Your healthcare professional give You information about Your medical condition and Your treatment options/risk, regardless of coverage or cost. Members who are unable to fully participate in treatment decisions have the right to be represented by parents, guardians, family members or other conservators. You have the right to receive this information in terms and language You understand.
- Be asked for Your consent for all care, unless there is an emergency and Your life and health are in serious danger, and learn about any care You receive.
- Be advised of who is available to assist You with any special MHHIC programs or services You receive and who can assist You with any requests to change programs or services.
- Access emergency healthcare services when and where the need arises.
- Refuse medical care. If You refuse medical care, ask what happens if You refuse treatment. We urge You to discuss Your concerns about care with Your Primary Care Provider or other participating healthcare professional. Your doctor or healthcare professional will give You advice, but You will have the final decision.
- A fair, efficient and reasonable process for resolving differences of Your complaint(s) or concern about MHHIC and/or the quality of care You receive from healthcare professionals and the various places You receive care in our network; provide a courteous, prompt response; including guidance through our process for Appeal of an Adverse Determination if You do not agree with our decision.
- Make recommendations regarding MHHIC policies that affect Your rights and responsibilities.

<u>You have the responsibility to:</u>

- Review and understand the information You receive about Your health benefit Policy and any rules for getting care. Please call Customer Service when You have questions or concerns.
- Understand how to obtain services and supplies that are covered under Your Policy.
- Show Your ID card before You receive care and not allow anyone else to use Your ID card with the purpose of fraud and abuse.
- Respect the healthcare professionals who are giving You care and follow their advice.
- Schedule an appointment with any Participating Provider for care needed, build a comfortable relationship with Your doctor, ask questions about things You don't understand and follow Your doctor's advice. Know that Your condition may not improve and may even get worse if You don't follow Your healthcare professional's advice.
- Understand Your health condition and work with Your doctor to develop a treatment plan with goals that You both agree upon. Ask for more information if You do not understand Your health condition or treatment.
- Provide honest, complete information to the healthcare professionals caring for You. Know that dishonesty compromises Your healthcare.
- Know what medicine You take, and why and how to take it.
- Pay all Copayments, Deductibles, the Prescription Drug Deductible, if any, for which You are responsible at the time service is rendered or when they are due.
- Keep scheduled appointments and notify the healthcare professional's office ahead of time if You are going to be late or miss an appointment.

- Pay all charges for missed appointments and for services that are not covered by Your Policy.
- Voice Your opinions, concerns or complaints to MHHIC Consumer Service and/or Your healthcare professional.
- Notify MHHIC and Your treating healthcare professional as soon as possible about any changes in family status, address, phone number or status with other health benefit coverage.

Access to Information

To get information from us in a way that works for You, please call Customer Service.
Our Policy has people and free language interpreter services available to answer questions from non-English speaking Members. We can also give You information in Braille, in large print, or other alternate formats if You need it. If You are eligible for Medicare because of a disability, We are required to give You information about the Policy's benefits that is accessible and appropriate for You.

If You have any trouble getting information from our Policy because of problems related to language or a disability, please call Customer Service at the telephone number shown in the Contact Information section in the Introduction to this Policy, and tell them that You want to file a complaint.

Alternate Cost Containment Provision

If it will result in less expensive treatment, We may approve services under an alternate treatment plan. An alternate treatment plan may include services or supplies otherwise limited or excluded by the Policy. It must be mutually agreed to by Us, You, and Your Physician, Provider, or other health care practitioner. Our offering an alternate treatment plan in a particular case in no way commits Us to do so in another case, nor does it prevent MHHIC from strictly applying the express benefits, limitations, and exclusions of the Policy at any other time or for any other Member.

Assignment

No assignment or transfer by the Policyholder of any of the Policyholder's interest under this Policy or by a Covered Person of any of his or her interest under this Policy is valid unless We consent.

Clerical Error – Misstatements

No clerical error or programming or systems error by the Policyholder or by Us in keeping any records pertaining to coverage under this Policy will reduce a Covered Person's Coverage. Neither will delays in making entries on those records reduce it. However, if We discover such an error or delay, a fair adjustment of premiums will be made.

Premium adjustments involving return of unearned premium to the Policyholder will be limited to the period of 12 months preceding the date of Our receipt of satisfactory evidence that such adjustments should be made.

If any relevant facts are found to have been misstated, and the premiums are thereby affected, an equitable adjustment of premiums will be made. If such misstatement involves whether or not the person's coverage would have been accepted by Us, subject to this Policy's **Incontestability** section, the true facts will be used in determining whether coverage is in force under the terms of this Policy.

Complaints

If You have a complaint about anything related to Our coverage, You may contact Us at the telephone number or address shown on the "Important Notice" page at the beginning of this Policy. You may also contact the Texas Department of Insurance; contact information for the Department is also shown on the Important Notice page.

If Your complaint concerns an Adverse Determination (denial of coverage) on proposed or received services or treatment, please see the subsection entitled "Appeal of Adverse Determination" under "Utilization Review Program and Procedures" in the section of Your Policy entitled "How the Policy Works."

Please be advised that We may not engage in any retaliatory action, including refusing to renew or cancelling of Your coverage, against You because You or a person acting on Your behalf has filed a complaint against Us or appealed Our Adverse Determination. Further, We may not engage in any retaliatory action, including refusing to renew or terminating a Contract, against a Physician or other health care provider because the Physician or provider, on Your behalf, reasonably filed a complaint against Us or appealed Our Adverse Determination.

Conformity with Law

Any provision of this Policy which, is in conflict with the laws of the State of Texas, or with Federal law, will be construed and applied as if it were in full compliance with the minimum requirements of such State law or Federal law.

Continuing Rights

Our failure to apply terms or conditions does not mean that We waive or give up any future rights under this Policy.

Coordination Of This Policy's Benefits With Other Benefits

The Coordination of Benefits (COB) provision applies when a person has health care coverage under more than one plan. The order of benefit determination rules govern the order in which each plan will pay a claim for benefits. The plan that pays first is called the primary plan. The primary plan must pay
benefits in accord with its Policy terms without regard to the possibility that another plan may cover some expenses. The plan that pays after the primary plan is the secondary plan. The secondary plan may reduce the benefits it pays so that payments from all plans equal 100% of the total allowable expense.

For clarification:

a) A “plan” is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

(1) Plan includes: group, blanket, or franchise accident and health insurance policies, excluding disability income protection coverage; individual and group health maintenance organization evidences of coverage; individual accident and health insurance policies; individual and group preferred provider benefit plans and exclusive provider benefit plans; group insurance contracts, individual insurance contracts and subscriber contracts that pay or reimburse for the cost of dental care; medical care components of individual and group long-term care contracts; limited benefit coverage that is not issued to supplement individual or group in force policies; uninsured arrangements of group or group-type coverage; the medical benefits coverage in automobile insurance contracts; and Medicare or other governmental benefits, as permitted by law.

(2) Plan does not include: disability income protection coverage; the Texas Health Insurance Pool; workers’ compensation insurance coverage; hospital confinement indemnity coverage or other fixed indemnity coverage; specified disease coverage; supplemental benefit coverage; accident only coverage; specified accident coverage; school accident-type coverages that cover students for accidents only, including athletic injuries, either on a “24-hour” or a “to and from school” basis; benefits provided in long-term care insurance contracts for non-medical services, for example, personal care, adult day care, homemaker services, assistance with activities of daily living, respite care, and Custodial Care or for contracts that pay a fixed daily benefit without regard to expenses incurred or the receipt of services; Medicare supplement policies; a state plan under Medicaid; a governmental plan that, by law, provides benefits that are in excess of those of any private insurance plan; or other nongovernmental plan; or an individual accident and health insurance Policy that is designed to fully integrate with other policies through a variable Deductible.

Each contract for coverage under (a)(1) or (a)(2) 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.

(b) “This Policy” means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from this Policy. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with like benefits, and may apply other separate COB provisions to coordinate other benefits.

The order of benefit determination rules determine whether this Policy is a primary plan or secondary plan when the person has health care coverage under more than one plan. When this Policy is primary, it determines payment for its benefits first before those of any other plan without considering any other plan’s benefits. When this Policy is secondary, it determines its benefits after those of another plan and may reduce the benefits it pays so that all plan benefits equal 100 percent of the total allowable expense.

(c) "Allowable expense" is a health care expense, including Deductibles, coinsurance, and copayments, that is covered at least in part by any plan covering the person. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense that is not covered by any plan covering the person is not an allowable expense. In addition, any expense that a health care provider or physician by law or in accord with a contractual agreement is prohibited from charging a covered person is not an allowable expense.

The following are examples of expenses that are not allowable expenses:

(1) The difference between the cost of a semi-private hospital room and a private hospital room is not an allowable expense, unless one of the plans provides coverage for private hospital room expenses.

(2) If a person is covered by two or more plans that do not have negotiated fees and compute their benefit payments based on the usual and customary fees, Allowed Amounts, or relative value schedule reimbursement methodology, or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an allowable expense.

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

(4) If a person is covered by one plan that does not have negotiated fees and that calculates its benefits or services based on usual and customary fees, Allowed Amounts, relative value schedule reimbursement methodology, or other similar reimbursement methodology, and another plan that provides its benefits or services based on negotiated fees, the primary plan's payment arrangement must be the allowable expense for all plans. However, if the health care provider or physician has contracted with the secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the primary plan's payment arrangement and if the health care provider's or physician's contract permits, the negotiated fee or payment must be the allowable expense used by the secondary plan to determine its benefits.

(5) The amount of any benefit reduction by the primary plan because a covered person has failed to comply with the plan provisions is not an allowable expense. Examples of these types of plan provisions include second surgical opinions, prior Authorization of Admissions, and preferred health care provider and physician arrangements.

(d) "Allowed amount" is the amount of a billed charge that a carrier determines to be covered for services provided by a non-preferred health care provider or physician. The Allowed amount includes both the carrier's payment and any applicable Deductible, copayment, or coinsurance amounts for which the Member is responsible.

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

(f) “Custodial parent” is the parent with the right to designate the primary residence of a child by a court order under the Texas Family Code or other applicable law, or in the absence of a court order, is the parent with whom the child resides more than one-half of the calendar year, excluding any temporary visitation.

Order Of Benefit Determination Rules

When a person is covered by two or more plans, the rules for determining the order of benefit payments are as follows:

a) The primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other plan.
b) Except as provided in (c), a plan that does not contain a COB provision that is consistent with this Policy is always primary unless the provisions of both plans state that the complying plan is primary.
c) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage must be excess to any other parts of the plan provided by the Policyholder. 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.
d) A plan may consider the benefits paid or provided by another plan in calculating payment of its benefits only when it is secondary to that other plan.
e) If the primary plan is a closed panel plan and the secondary plan is not, the secondary plan must pay or provide benefits as if it were the primary plan when a covered person uses a non-contracted health care provider or physician, except for emergency services or authorized referrals that are paid or provided by the primary plan.
f) When multiple contracts providing coordinated coverage are treated as a single plan under this subchapter, this section applies only to the plan as a whole, and coordination among the component contracts is governed by the terms of the contracts. If more than one carrier pays or provides benefits under the plan, the carrier designated as primary within the plan must be responsible for the plan’s compliance with this subchapter.
g) If a person is covered by more than one secondary plan, the order of benefit determination rules of this subchapter decide the order in which secondary plans’ benefits are determined in relation to each other. Each secondary plan must take into consideration the benefits of the primary plan or plans and the benefits of any other plan that, under the rules of this Policy, has its benefits determined before those of that secondary plan.
h) Each plan determines its order of benefits using the first of the following rules that apply:
    1. Nondependent or Dependent. The plan that covers the person other than as a dependent, for example as an employee, member, Policy holder, subscriber, or retiree, is the primary plan, and the plan that covers the person as a dependent is the secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a dependent and primary to the plan covering the person as other than a dependent, then the order of benefits between the two plans is reversed so that the plan covering the person as an employee, member, Policy holder, subscriber, or retiree is the secondary plan and the other plan is the primary plan. An example includes a retired employee.
    2. Dependent Child Covered Under More Than One Plan. Unless there is a court order stating otherwise, plans covering a dependent child must determine the order of benefits using the following rules that apply.

A. For a dependent child whose parents are married or are living together, whether or not they have ever been married:
   i. The plan of the parent whose birthday falls earlier in the calendar year is the primary plan; or
   ii. If both parents have the same birthday, the plan that has covered the parent the longest is the primary plan.

B. For a dependent child whose parents are divorced, separated, or not living together, whether or not they have ever been married:
   i. If a court order states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to plan years commencing after the plan is given notice of the court decree.
   ii. If a court order states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of (h)(2)(A) must determine the order of benefits.
   iii. If a court order states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of (h)(2)(A) must determine the order of benefits.
   iv. If there is no court order allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:
      a. The plan covering the custodial parent;
      b. The plan covering the spouse of the custodial parent;
      c. The plan covering the noncustodial parent; then
      d. The plan covering the spouse of the noncustodial parent.

C. For a Dependent child covered under more than one plan of individuals who are not the parents of the child, the provisions of (h)(2)(A) or (h)(2)(B) must determine the order of benefits as if those individuals were the parents of the child.

D. For a dependent child who has coverage under either or both parents' plans and has his or her own coverage as a dependent under a spouse's plan, (h) (5) applies.

E. In the event the dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parents' plans, the order of benefits must be determined by applying the birthday rule in (h)(2)(A) to the dependent child's parent(s) and the dependent's spouse.

3. [Active, Retired, or Laid-off Employee. The plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the primary plan. The plan that covers that same person as a retired or laid-off employee is the secondary plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the plan that covers the same person as a retired or laid-off employee or as a dependent of a retired or laid-off employee does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule does not apply. This rule does not apply if (h) (1) can determine the order of benefits.]
4. [COBRA or State Continuation Coverage. If a person whose coverage is provided under COBRA or under a right of continuation provided by state or other federal law is covered under another plan, the plan covering the person as an employee, member, subscriber, or retiree or covering the person as a dependent of an employee,

member, subscriber, or retiree is the primary plan, and the COBRA, state, or other federal continuation coverage is the secondary plan. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule does not apply. This rule does not apply if (h) (1) can determine the order of benefits.]

5. Longer or Shorter Length of Coverage. The plan that has covered the person as an employee, member, Policy holder, subscriber, or retiree longer is the primary plan, and the plan that has covered the person the shorter period is the secondary plan.
6. If the preceding rules do not determine the order of benefits, the allowable expenses must be shared equally between the plans meeting the definition of plan. In addition, this plan will not pay more than it would have paid had it been the primary plan.

Effect On The Benefits Of This Policy
When this Policy is secondary, it may reduce its benefits so that the total benefits paid or provided by all plans are not more than the total allowable expenses. In determining the amount to be paid for any claim, the secondary plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any allowable expense under its plan that is unpaid by the primary plan. The secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim equal 100 percent of the total allowable expense for that claim. In addition, the secondary plan must credit to its plan Deductible any amounts it would have credited to its Deductible in the absence of other health care coverage.

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

Compliance With Federal And State Laws Concerning Confidential Information
Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this Policy and other plans. MHHIC will comply with federal and state law concerning confidential information for the purpose of applying these rules and determining benefits payable under this Policy and other plans covering the person claiming benefits. Each person claiming benefits under this Policy must give MHHIC any facts it needs to apply those rules and determine benefits.

Discrimination

MHHIC may not refuse to insure or provide coverage to an individual, refuse to continue to insure or provide coverage to an individual, limit the amount, extent, or kind of coverage available for an individual, or charge an individual a rate that is different from the rate charged to other individuals for the same coverage because of the individual's race, color, religion, or national origin, age, gender, marital status, or geographic location disability or partial disability.

Facility of Payment

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

Governing Law

This entire Policy is governed by the laws of the State of Texas.

Incontestability of the Policy

There will be no contest of the validity of the Policy, except for not paying premiums, after it has been in force for two years. No statement in any Application, except a fraudulent statement, made by the Policyholder or by a Covered Person covered under this Policy will be used in contesting the validity of his or her coverage or in denying benefits after such coverage has been in force for two years during the person's lifetime. There is no time limit with respect to a contest in connection with fraudulent statements.

Limitation on Actions

No action at law or in equity will be brought to recover on the Policy until 60 days after a Covered Person files written proof of loss. No such action will be brought more than three years after the end of the time within which proof of loss is required.

Medicare Eligible Individuals

This Policy is not a supplement to Medicare. The Policy provides benefits according to a Non-Duplication of Medicare clause. When a Member becomes eligible for Medicare benefits, We automatically become the secondary health plan for Members meeting any of the following criteria:

- Members who are eligible for Medicare due to a disability and are under age 65.
- Members following the first 30 months of kidney dialysis treatments for end-stage renal disease.
- Members who have received a kidney transplant within the first 3 months after starting a course of kidney dialysis treatments for end-stage renal disease.
- Members who have enrolled in a self-dialysis training program, and received training for home dialysis for treatment of end-stage renal disease.
- Members enrolled 30 days or more after being diagnosed with Amyotrophic Lateral Sclerosis (ALS).

We remain the primary health plan for Medicare beneficiaries not meeting any of the above listed criteria.

Non-Duplication Of Medicare Benefits
If Medicare is a Member's primary health coverage, We will provide claim payment according to this Policy minus any amount paid by Medicare.

Benefits for Medicaid Eligible Members
Members eligible for Medicaid receive full benefits of this Policy. Benefits will not be reduced due to their eligibility for Medicaid. However, in order to receive benefits the services must be for medical services covered under this Policy, and are subject to all other restrictions of this Policy.

Benefits Provided by the Texas Department of Human Services
When services are paid for or rendered by the Texas Department of Human Services on behalf of a Member, payment for the services will be made directly to the Texas Department of Human Services. In the case of a dependent child, when services are paid or rendered by the Texas

Department of Human Services on behalf of such dependent child, payment for the services will be made directly to the Texas Department of Human Services if:

- The parent who is the Subscriber is:
  - A possessory conservator of the child under an order issued by a court in this state; or
  - Is not entitled to possession of or access to the child, and is required by court order or court-approved agreement to pay child support;
- The Texas Department of Human Services is paying benefits on behalf of the child under Chapter 31 or Chapter 32, Human Resources Code; and
- We are notified through an attachment to the claim for covered benefits when the claim is first submitted to Us that the benefits must be paid directly to the Texas Department of Human Services.

Except as provided here, no benefits are payable for expenses incurred after the date of any termination of coverage. For information about the right to continue coverage, refer to the Continuation provision.

MHHIC's Right to Reimbursement

If another person or entity is, or may be, responsible to pay for or provide health care services to You or Your Covered Dependent and if MHHIC paid for or provided those health care services, then MHHIC is entitled to subrogation rights against such person or entity. MHHIC is also entitled to recover from You or Your Covered Dependent the value of services provided, arranged, or paid for, when You or Your Covered Dependent were reimbursed for the cost of care by another party, including You or Your Covered Dependent's auto insurance for Uninsured Motorist and Underinsured Motorist coverage provided that You or Your immediate family did not pay the premiums for the coverage. MHHIC is also entitled to recover its costs and expenses related to recovery activities, including, but not limited to, attorney's fees and court costs.

By receiving service from MHHIC, You and Your Covered Dependents assign to MHHIC the right to proceed in Your or Your Covered Dependents name to secure right of recovery of its costs, expenses, or the value of services rendered. The value of services rendered which MHHIC is entitled to recover will be limited to the cost of providing such services. MHHIC is entitled to discharge of its subrogation rights on a prorata basis with any other contractual or statutory subrogation holder. Furthermore, MHHIC is entitled to deem the first amounts received by You or Your Covered Dependents as recoupment of the value of health care services or damages to which MHHIC is entitled to subrogate up to the value of MHHIC's claim.

You and Your Covered Dependents will cooperate fully in the exercise of these rights of subrogation, to the extent they comply with applicable law, and will take no action or refuse to take any action that would prejudice the rights of MHHIC. You or Your Covered Dependents may not settle, compromise or release a claim against a third party unless (1) the rights of MHHIC are expressly reserved in the settlement, compromise or release and You advise the MHHIC in writing within such period of time as is reasonably necessary to protect MHHIC's rights, (2) MHHIC is paid in full, or (3) MHHIC has given a written waiver of claim after notice. MHHIC reserves the right to select its own representation; including legal representation, in pursuit of its subrogation rights herein; You or Your Covered Dependents will distribute to MHHIC any subrogation, subject to any limitations under the Texas Civil Practices and Remedies Code.

Notices and Other Information

Any notices, documents, or other information under the Policy may be sent by United States Mail, postage prepaid, addressed as follows:

- If to Us: To Our last address on record with the Policyholder.
- If to the Policyholder: To the last address provided by the Policyholder on an enrollment or change of address form actually delivered to Us.
- If to a Covered Person: To the last address provided by the Covered Person on an enrollment or change of address form actually delivered to Us.

Payment of Premiums - Grace Period

Premiums are to be paid by You to Us. They are due on each premium due date. You may pay each premium other than the first within 30 days after the monthly premium due date. Those days are known as the Grace Period. You are liable to pay premiums to Us from the first day the Policy is in force in order for this Policy to be considered in force on a premium-paying basis. You will be liable for the monthly payment of the premium for the time the Policy stays in effect. If any premium is not paid by the end of the monthly Grace Period, coverage will terminate at the end of the Grace Period. Any due Premium may be deducted from the claims payment.

Reinstatement

If a renewal premium is not paid before the expiration of the period granted for the Member to make the payment, a subsequent acceptance of the premium by Us or any agent authorized by Us to accept the premium, without requiring in connection with the acceptance an application for reinstatement, reinstates the Policy. However, if We or an authorized agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the Policy will be reinstated on approval of the application by Us or, if the application is not approved, on the 45th day after the date of the conditional receipt unless We before that date have notified the Member in writing of Our disapproval of the application. The reinstated Policy covers only loss resulting from an accidental injury sustained after the date of reinstatement and loss due to sickness that begins more than 10 days after the date of reinstatement. In all other respects the Member and We have the same rights under the reinstated Policy as each party had under the Policy immediately before the due date of the defaulted premium, subject to any provisions endorsed in the Policy or attached to the Policy in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than 60 days before the date of reinstatement.

Right of Recovery

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

Discrimination

MHHIC may not refuse to insure or provide coverage to an individual, refuse to continue to insure or provide coverage to an individual, limit the amount, extent, or kind of coverage available for an individual, or charge an individual a rate that is different from the rate charged to other individuals for the same coverage because of the individual's race, color, religion, or national origin, age, gender, marital status, or geographic location disability or partial disability.

Premium Rate Changes

We have the right to prospectively change premium rates as of any of these dates:

- Any premium due date but no more frequently than annually;
- Any date that the extent or nature of the risk under the Policy is changed:
    - By amendment of the Policy; or
    - By reason of any provision of law or any government program or regulation;
    - At the discovery of a clerical error or misstatement as described in the General Provisions section of this Policy.

<u>We will give You 60 days' written notice when a change in the premium rates is made. However, We will not change the premium schedule for this Plan on an individual basis, but only for all Members in the same class and covered under the same plan as You. Additionally, We may change the premium rates no more frequently than annually.</u>

Statements

No statement will void the coverage, or be used in defense of a claim under this Policy, unless it is contained in a writing signed by a Covered Person, and We furnish a copy to the Covered Person All statements will be deemed representations and not warranties.

Renewal Privilege – Termination

All periods of covered benefits hereunder will begin and end at 12:01 am. Central Standard Time.

The Policyholder may renew this Policy for a term of one (1) calendar year. All renewals are subject to the payment of premiums then due, computed as provided in this Policy's **Premium Rates** section and to the provisions stated below.

We have the right to non-renew this Policy on the renewal date following written notice to the Policyholder, and, if required, to the Commissioner of the Texas Department of Insurance, for the following reasons:

- Subject to 180 days advance written notice, We cease to do business in the individual health benefits market;
- Subject to 90 days advance written notice, We cease offering and non-renew a particular type of Health Benefits Plan in the individual market provided We act uniformly without regard to any Health Status-Related Factor of Covered Persons or persons who may become eligible for coverage and We offer the Subscriber on a guaranteed issue basis the option to purchase any other individual health benefit plan available at the time of the discontinuance.

During or at End of Grace Period - Failure to Pay Premiums: If any premium is not paid by the end of its grace period, the Policy will end as described in the Grace Period provision.

Termination by Request - If You want to replace this Policy with another individual Health Benefits Plan (subject to MHHIC restrictions), You must give us notice of the replacement within 30 days after the effective date of the new Plan. This Policy will end as of 12:01 a.m. on the effective date of the new Plan and any unearned premium will be refunded. If You want to end this Policy and do not want to replace it with another Plan, You may write to Us, in advance, to ask that the Policy be terminated at the end of any period for which premiums have been paid. Then the Policy will end on the date requested.

This Policy will be renewed automatically each year on the Renewal Date, unless coverage is terminated on or before the Renewal Date due to one of the following circumstances:

- You have failed to pay premiums in accordance with the terms of the Policy, or We have not received timely premium payments; (Coverage will end as described in the Grace Period provision.)
- You have performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the Policy; (Coverage will end as of the effective date.)
- You become covered under another individual Health Benefits Plan; (Coverage will end at 12:01 a.m. on the date the individual Health Benefits Plan takes effect, provided We receive notice of the replacement within 30 days after the effective date of the new plan.)
- Another reason prescribed by rules adopted by the Commissioner.

Termination of Dependent Coverage

If You fail to pay the cost of Dependent coverage, Your Dependent coverage will end. It will end on the last day of the period for which You made the required payments, subject to the Grace Period provisions, unless coverage ends earlier for other reasons.

A Dependent's coverage ends when the Dependent is no longer a Dependent, as defined in the Policy. Coverage ends at 12:01 a.m. on the date the first of these events occurs. Also, Dependent coverage ends when the Policyholder's coverage ends.

Third Party Liability

No benefits are payable for any Illness, Injury, or other condition for which a third party may be liable or legally responsible by reason of negligence, an intentional act, or breach of any legal obligation on the part of such third party. Nevertheless, We will advance the benefits of this Policy to You subject to the following:

- You agree to advise MHHIC, in writing, within 60 days of any Member's claim against the third party and to take such reasonable action, provide such information and assistance, and execute such paper as We may require facilitating enforcement of the claim. You also agree to take no action that may prejudice Our rights or interests under this Policy. Failure to provide notice of a claim or to cooperate with Us, or actions that prejudice Our rights or interests, will be material breach of this Policy and will result in You being personally responsible for reimbursing Us.
- We will automatically have a lien, to the extent of benefits advanced, subject to the maximum recoverable amount allowed under the Texas Civil Practices and Remedies Code, Chapter 140, upon any recovery that any Member receives from the third party, the third party's insurer, or the third party's guarantor. Recovery may be by settlement, judgment or otherwise. The lien will be in the amount of benefits paid by Us under this

Policy for the treatment of the Illness, disease, Injury or condition for which the third party is liable, subject to the maximum recoverable amount allowed under the Texas Civil Practices and Remedies Code, Chapter 140.

Workers' Compensation

The health benefits provided under this Policy are not in place of, and do not affect requirements for coverage by Workers' Compensation.