

[929 Gessner, Suite 1500]
Houston, TX 77024
[1-877-988-1918]



SMALL[EMPLOYER]GROUP[CONSUMER CHOICE]
[NEW PLAN NAME]
A HEALTH MAINTENANCE ORGANIZATION

EVIDENCE OF COVERAGE YEAR: []

THIS HEALTH CARE EVIDENCE OF COVERAGE IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. YOU SHOULD CONSULT WITH YOUR EMPLOYER TO DETERMINE WHETHER YOUR EMPLOYER IS A SUBSCRIBER TO THE WORKER'S COMPENSATION SYSTEM.

Si necesita ayuda en español para entender este documento, puede solicitarla sin costo adicional, llamando al número de servicio al cliente que aparece al dorso de su tarjeta de identificación o en el folleto de inscripción.

THIS EVIDENCE OF COVERAGE IS NOT A MEDICARE SUPPLEMENT POLICY. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the Company.

[This Texas Consumer Choice Benefits Health Maintenance Organization Evidence of Coverage, either in whole or in part, does not provide state-mandated health benefits normally required in evidences of coverage in Texas. This standard health benefit plan may provide a more affordable health plan for you although, at the same time, it may provide you with fewer health plan benefits than those normally included as state-mandated health benefits in Texas. Please consult with your insurance agent to discover which state-mandated health benefits are excluded in this Evidence of Coverage.]

In consideration of your complete and accepted application and timely payment of required premiums, Memorial Hermann Health Plan Inc. ("MHHP") agrees with you and the Employer Group ("Group"), to provide coverage for benefits and services, in accordance with the terms, conditions, rights, and privileges set forth in this You and/or your enrolled dependents are covered under and are subject to all the conditions and provisions noted in throughout this Evidence of Coverage.

In consideration of Your completed and accepted Enrollment Form and timely payment of required premiums, Memorial Hermann Health Plan, Inc. ("MHHP") agrees to provide or arrange to provide coverage for the benefits and services specified in this Evidence of Coverage, in accordance with and subject to the terms stated herein and all applicable local, state and federal laws.

Important Notices

1. The initial rates agreed upon by the Group and MHHP are effective during the initial year from and after the effective date of this Evidence of Coverage. We may change the premium rates from time to time, but no more frequently than quarterly. Any changes to rates must have effective dates of January 1, April 1, July 1, or October 1. We will give the Group written notice of any premium rate change at least 60 days prior to the change, with the exception of retroactive premium rate increases related to fraud or the intentional misrepresentation of a material fact.
2. The coverage provided under this Evidence of Coverage is health maintenance organization (HMO) coverage and not indemnity insurance. As an HMO, MHHP contracts with only certain providers; therefore, with certain exceptions as explained herein, you, the Covered Employee, and Your Covered Dependents are required to use those providers in order to receive the coverage described. Those providers will determine the form of Treatment to be provided. MHHP does not intend that all alternative forms and methods of Treatment will be eligible for coverage. If You or Your Covered Dependents elect to receive Treatment from a Non-Participating Provider, or receive a form of Treatment not authorized by MHHP, You may be required to pay for the services provided out of Your own pocket.
3. MHHP is a named fiduciary to review claims under this Evidence of Coverage. The Group delegates to MHHP the discretion to determine whether You and Your Covered Dependents are entitled to the benefits of this Evidence of Coverage. In making these determinations, MHHP has the authority to review claims in accord with the procedures contained herein and to construe this Evidence of Coverage to determine if You and Your Covered Dependents are entitled to its benefits. If Group is subject to the Employee Retirement Income Security Act, a federal law, this Evidence of Coverage may be governed by the provisions of that law.

IMPORTANT NOTICE

To obtain information or make a complaint:

You may call Memorial Hermann Health Plan, Inc.'s toll-free telephone number for information or to make a complaint at:

[1-877-988-1918]

You may also write to Memorial Hermann Health Plan, Inc. at:

Memorial Hermann Health Plan,
Inc.
[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 EVIDENCE OF COVERAGE:

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 Plan, Inc.'s para obtener información o para presentar una queja al:

[1-877-988-1918]

Usted también puede escribir a Memorial Hermann Health Plan, Inc.:

Memorial Hermann Health Plan, Inc.
[929 Gessner, Suite 1500
Houston, TX 77024]

Usted puede comunicarse con el Departamento de Seguros de Texas para obtener información sobre compañías, 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 compañía 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.

Contact Information

Address: [929 Gessner, Suite 1500 Houston, TX 77024]
 Website: [www.healthplan.memorialhermann.org]
 Member Services: [1-877-988-1918]
 Provider Directory:
[\[http://healthplan.memorialhermann.org/members/\]](http://healthplan.memorialhermann.org/members/)
 Complaints & Grievances: [1-877-988-1918]
 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: [713-338-4873] [or [1-877-988-1918]]
 Or write to: [Memorial Hermann Claims Department
 P.O. Box 660303 Dallas, TX 75266-0303]

[For Dental Benefits contact [FCL Dental]]

[Website:] [www.fclidental.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 Evidence of Coverage from Memorial Herman Health Plan, Inc., regulated by the Texas Department of Insurance.

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

This health benefit Evidence of Coverage replaces any others previously issued to You and/or Your Dependents, as of the stated or amended Effective Date. This Evidence of Coverage describes Your Benefits, rights and responsibilities covered under this Evidence of Coverage. We encourage You to read this entire Evidence of Coverage 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 Evidence of Coverage, 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 Evidence of Coverage. "MHHP," "We," "Us," "Our" and "the Company" means Memorial Hermann Health Plan, Inc. "You", "Your", "Yourself", "Evidence of Coverage Holder" or "Member" means You the Subscriber and/or Your enrolled Dependent.

This Evidence of Coverage 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 Evidence of Coverage. Capitalized words found throughout the document are defined in the "Definitions" section.

MHHP has issued an Agreement to the Group identified on Your identification card. The benefits and services listed in this Evidence of Coverage will be provided for Members for a covered Illness, Injury, or condition, subject to all of the terms and conditions of the Group's Agreement.

We are entering into this Evidence of Coverage with You based on the answers submitted by You and all other Members on Your signed Enrollment Form. In consideration for the payment of the premiums stated in this Evidence of Coverage, MHHP 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 Evidence of Coverage, you will receive covered services considered by us to be:

- Medically necessary
- Provided by a Participating Provider
- Listed as a Covered Service
- Not in excess of any benefit limitations as described in the Service of Benefit section of this Evidence of Coverage
- Received while your Evidence of Coverage is in force.

[High Deductible Health Plan and Health Savings Accounts

This Evidence of Coverage of Evidence of Coverage 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 MMHP 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 Plan, Inc. Provider Network

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

The MHHP HMO network consists of a broad number of physicians, hospitals and other allied health professionals. Those that have partnered with MHHP are considered Participating or Preferred, In-network Providers. Those not contracted with MHHP 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 MHHP 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 MHHP 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 as Provider status may change from time to time. It is also possible that a Provider may be contracted with MHHP 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

MHHP 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. Please note that MHHP does not cover benefits or treatment serviced by Out-of-Provided Care Providers except for Medically Necessary Emergency Care. Care obtained outside Our Network means the Member will have higher out-of-pocket costs and pay a higher Copayment and/or Deductible than if they had stayed In-Network. These additional costs may be significant.

MHHP will pay a lower level of Benefits to Out-of- Network Providers based on a lower Allowable Charge, and/or penalties may apply. 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. Emergency care for Out of Network Providers will be paid at the usual and customary rate or at an agreed upon rate.

If Medically Necessary Covered Services are not available In-Network, MHHP, on the request of an In-Network Provider and within a reasonable period, shall allow referral to an Out-of-Network Provider and fully reimburse the **Out-of-Network** Provider at the usual and customary rate or at an agreed rate. Before denying a request for a referral to an Out-of-Network Provider, MHHP will provide for a review conducted by a specialist of the same or similar type of specialty as the Provider to whom the referral is requested.

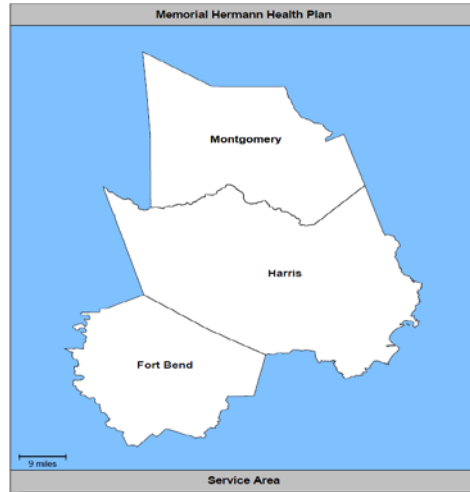
It is the Member's responsibility to check and verify that the service(s) wanted are In-Network from the provider and location where they are seeking care.

Emergency and Non-Emergency Care

Emergency services performed in the Emergency department of a Hospital, 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

MHHP coverage is available only to Subscribers who legally live or work in Our Evidence of Coverage Service Area and dependents covered under this Evidence of Coverage. To become or remain a MHHP Subscriber, You must reside or work in one or more of the following Texas counties: Fort Bend, Harris, or Montgomery.



Your coverage will end 30 days after you move out of or no longer work in the Service Area. Please contact Member Services for more information.

II. DEFINITIONS

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

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** is services designed to address modalities of comprehension and expression, including understanding, reading, writing and verbal expression of information.
- **Cognitive Rehabilitation Therapy** is services designed to address therapeutic cognitive activities, based on an assessment and understanding of the individual’s brain-behavioral deficits.
- **Community Reintegration Services** are services that facilitate the continuum of care as an affected individual transitions into the community.
- **Neurobehavioral Testing** is 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** is interventions that focus on behavior and the variables that control behavior.

- **Neurocognitive Rehabilitation** is 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** is services designed to address neurological deficits in informational processing and to facilitate the development of higher level cognitive abilities.
- **Neurofeedback Therapy** is 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** is an evaluation of the functions of the nervous system.
- **Neurophysiological Treatment** is interventions that focus on the functions of the nervous system.
- **Neuropsychological Testing** is 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** is interventions designed to improve or minimize deficits in behavioral and cognitive processes.
- **Post-acute Care Treatment Services** are 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** are services that facilitate the continuum of care beyond the initial neurological insult through rehabilitation and community reintegration.
- **Psychophysiological Testing** is an evaluation of the interrelationships between the nervous system and other bodily organs and behavior.
- **Psychophysiological Treatment** is interventions designed to alleviate or decrease abnormal physiological responses of the nervous system due to behavioral or emotional factors.
- **Remediation** is the process of restoring or improving a specific function.
- **Services for Acquired Brain Injury** is the work of testing, treatment and providing therapies to an individual with an acquired brain injury.
- **Therapy for Acquired Brain Injury** is 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 MHHP or negotiated as the maximum amount the plan will pay for all Provider services covered. For services rendered by Out of Network providers, plan may pay a Usual & Customary (UCR) rate 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.

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

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

Authorization (Authorized) - A determination by MHHP 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.

Basic Health Care Services - Health care services that the commissioner determines an enrolled population might reasonably need to be maintained in good health.

Benefits – Coverage for health care services, treatment, procedures, equipment, drugs, devices, items or supplies provided under this Evidence of Coverage. A schedule of all health care services that are available to enrollees under the basic, limited, or single health care service 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 HMO or its 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 legal spouse has been granted legal custody or appointed as 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 Evidence of Coverage 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 MHHP of charges for Covered Services that have been incurred by a Member during the time period when covered under this Evidence of Coverage. 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.

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 a health maintenance organization regarding any aspect of the their 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.

Entire Contract and Changes – The entire contract between the Group and Us is as stated in the Agreement and the Evidence of Coverage including the endorsements, application, and the attached papers, if any. No change in the Agreement or Evidence of Coverage shall be effective until approved by one of Our officers. This approval must be noted on or attached to the Evidence of Coverage. No agent may change the Agreement or waive any of its provisions.

Copayment (Copay) – The specific dollar amount or percentage 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 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 Evidence of Coverage 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 Evidence of Coverage, who You have listed on the Enrollment Form, and for whom premium payments have been made.

Covered Expenses - Expenses incurred for Covered Services received from Participating Providers that do not exceed the Negotiated Rate.

Covered Services - Medically Necessary services or supplies that are listed in the benefit sections of this Evidence of Coverage, 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 Evidence of Coverage.

- 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 Evidence of Coverage 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 Evidence of Coverage starts paying Benefits. When the Evidence of Coverage 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 Evidence of Coverage 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 in the Eligibility & Enrollment section.

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 Eligible Employee for an extended period of time; and
- has shared financial assets and obligations with the Eligible Employee for an extended period of time.
- and has established a domestic partnership with the Evidence of Coverage holder 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 Evidence of Coverage begins for the Member and/or their dependents. This Evidence of Coverage 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 Eligibility & Enrollment section.

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 in serious jeopardy.
- Serious impairment to bodily function.
- Serious dysfunction of any bodily organ or part.
- Serious disfigurement of such person.
- For a pregnant woman, result in serious jeopardy to the health of the fetus.

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

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

Evidence of Coverage - this document, including the Enrollment Form, Schedule of Benefits and any amendments/endorsements to this document, entitling a Subscriber and any applicable Dependents to the specified health coverage contained herein.

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 or 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.

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 MHP identifies as a Generic Drug based on a nationally recognized pricing source.

Grievance – A written expression of dissatisfaction with MHP 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 inpatient 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 the Company.

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 Evidence of Coverage, 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.

MHHP, We, Our and Us – Memorial Hermann Health Plan, Inc. MHHP is a health maintenance organization 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 MHHP 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 Copayment), 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 Copayment), which must be paid by a family for Covered Services in one (1) Benefit Period. When the Evidence of Coverage 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 Evidence of Coverage 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 Evidence of Coverage, forms and amendments (if any).

Policy – Includes an individual, blanket, or franchise insurance agreement or Agreement, or Evidence of Coverage issued by a health maintenance organization.

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 Evidence of Coverage.

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

Referral – An authorization given to one Participating Provider from another Participating Provider (usually from a PCP to a Participating Specialist) in order to arrange for additional care for a Member.

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 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 Evidence of Coverage the Service Area consists of: Fort Bend, Harris, and Montgomery counties.

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.

Small Employer - a person who employed an average of at least two employees but not more than 50 employees on business days during the preceding calendar year and who employs at least two employees on the first day of the plan year.

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 Evidence of Coverage is issued (also known as a Member, or an Evidence of Coverage holder).

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, MHHP – Memorial Hermann Health Plan and anyone to whom We legally delegate performance on our behalf under this Evidence of Coverage .

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.

Waiting Period – a required period of continuous, full-time employment that must be completed before an Eligible Employee is eligible for MHHP 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 – a Covered Employee of the Group who is covered by this Plan.

Year – “Benefit Year” or “Evidence of Coverage 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.
- This Evidence of Coverage does not provide coverage when you use an Out of Network Provider, except for an Emergency. 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 Evidence of Coverage 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 Cost Share	[Schedule of Benefits]
[Individual Deductible:]	[\$0-7,150]
[Family Deductible:]	[\$0-14,300]
Individual Out-of-Pocket Maximum:	[\$0-7,150]
Family Out-of-Pocket Maximum:	[\$0-14,300]
[Individual Prescription Drug Out-of-Pocket Maximum:]	[\$0-7,150]
[Family Prescription Drug Out-of-Pocket Maximum:]	[\$0-14,300]
Copayment:	[0-50]%
Maximum out of Pocket:	[Copayment applies first, then Deductible], Copayment applies

[Schedule of Benefits]

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

[Schedule of Benefits]

	Routine Care Services	[\$[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]	
	Diagnostic Test X-Ray	[\$[0-100] Copay][,] [0-50%] [after Deductible][Deductible Waived]	
	Imaging (CT/PET Scans, MRIs)	[\$[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]	
	Ambulatory Surgical Center	[\$[0-100] Copay][,] [0-50%] [after Deductible][Deductible Waived]	
	Emergency Room Services	[\$[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]	[For [first] [0-10] [Urgent Care] Visits, [Deductible] and [Copayment] [Waived]]
	Inpatient Hospital Services	[\$[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]	
If you have outpatient surgery	Facility Fee (e.g. Ambulatory Surgery Center)	[\$[0-100] Copay][,] [0-50%] [after Deductible][Deductible Waived]	
	Physician/Surgeon Fees	[\$[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	[\$[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]	
	Mental/Behavioral Health & Substance Abuse Inpatient Services	[\$[0-100] Copay][,] [0-50%] [after Deductible][Deductible Waived]	[Applies to [first] [0-10] [days][visits]] [of admission]]
If you are pregnant	Prenatal and Postnatal Care	[\$[0-100] Copay][,] [0-50%] [after Deductible][Deductible Waived]	
	Physician Delivery Services	[\$[0-100] Copay][,] [0-50%] [after Deductible][Deductible Waived]	

	Inpatient Facility Services	[\$[0-100] Copay][,] [0-50%] [after Deductible][Deductible Waived]	[Applies to [first] [0-10] [days][visits]]
	Postpartum	[\$[0-100] Copay][,] [0-50%] [after Deductible][Deductible Waived]	
	Education Services	[\$[0-100] Copay][,] [0-50%] [after Deductible][Deductible Waived]	
Oral Contraceptives	All FDA Approved Prescriptions and Devices	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	
Contraceptive services and devices	All FDA approved devices	[\$[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] [Maximum of [60-100] visits per Year]	[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]	
	Physical Therapy/Occupational Therapy	[\$[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]	[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]	
	Skilled Nursing Care	[\$[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]	
	Prosthetic & Orthotic Devices	[\$[0-100] Copay][,] [0-50%] [after Deductible][Deductible Waived]	
	Hospice Service	[\$[0-100] Copay][,] [0-50%] [after Deductible][Deductible Waived]	
If your child has developmental needs	Autism Spectrum Disorder	[\$[0-100] Copay][,] [0-50%] [after Deductible][Deductible Waived]	
	Early Intervention Services	[\$[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]	
Vision Care	Eye Exam with PCP	[\$[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]	
	[Glasses/Contacts]	[\$[0-100] Copay][,] [0-50%] [after Deductible][Deductible Waived]	[1 pair of eyeglasses OR 1 pair of contact lenses per year]
	Pediatric Vision Needs	[\$[0-100] Copay][,] [0-50%] [after Deductible][Deductible Waived]	
Other Professional Services	Anesthesia	[\$[0-100] Copay][,] [0-50%] [after Deductible][Deductible Waived]	
	Speech & Hearing Exams	[\$[0-100] Copay][,] [0-50%] [after Deductible][Deductible Waived]	
	Speech & Hearing Therapy & Hearing Aids	[\$[0-100] Copay][,] [0-50%] [after Deductible][Deductible Waived]	[Hearing aids limited to 1 pair every [10-40] months]
	Radiation Therapy	[\$[0-100] Copay][,] [0-50%] [after Deductible][Deductible Waived]	
	Infusion Therapy	[\$[0-100] Copay][,] [0-50%] [after Deductible][Deductible Waived]	
	Allergy Immunotherapy / Injections	[\$[0-100] Copay][,] [0-50%] [after Deductible][Deductible Waived]	
	Administration of covered injectable prescription drugs	[\$[0-100] Copay][,] [0-50%] [after Deductible][Deductible Waived]	
Other Professional Services Continued			

	Dialysis	[\$[0-100] Copay][,] [0-50%] [after Deductible][Deductible Waived]	
	Telehealth or Telemedicine Services	[No Charge][\$[0-100] Copay][,] [0-50%] [after Deductible][Deductible Waived]	

Pharmacy Services			
[30 Day Retail [and Mail] Pharmacy Service]	[Generic Drugs]	[\$[0-300] Copay][,] [0-50%] [after Deductible][Deductible Waived]	
	[Brand Name Formulary Drugs]	[\$[0-300] Copay][,] [0-50%] [after Deductible][Deductible Waived]	

	[Brand Name Non-Formulary Drugs]	[\$[0-300] Copay][,] [0-50]% [after Deductible][Deductible Waived]	
	[Specialty Drugs]	[\$[0-300] Copay][,] [0-50]% [after Deductible][Deductible Waived]	[Specialty Drugs are subject to Utilization Review]
[90 Day Mail] Service Supply	[Generic Drugs]	[\$[0-300] 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]	
	[Brand Name Non-Formulary Drugs]	[\$[0-300] Copay][,] [0-50]% [after Deductible][Deductible Waived]	
	[Specialty Drugs]	[Not Covered]	

[Dental Schedule of Benefits]

	<u>Pediatric</u>	<u>Famil y/Adul</u> <u>t</u>
Annual Deductible:	[\$0 - 1500]	[\$0 - 1500]
Annual Maximum:	[\$0 - 5000]	[\$0 - 5000]

Maximum Out-of-Pocket Benefit: [Out of pocket maximum for an Evidence of Coverage with one covered child is \$350. The out of pocket maximum for an Evidence of Coverage with two or more covered children is \$350 per individual child or \$700 combined for all children.]

[Dental Schedule of Benefits]

Category	Services You May Need	In-Network	Exclusion s & Limitation s
Diagnostic & Preventive Services	Oral Exams	[Adult][Children][\\$0-100 Copay][After Deductible] [0-50%]	[Up to 2 per year]
	Bitewing X-ray - 2 single film or 4 film		[1 per year]
	Full mouth or Panoramic X-ray		[1 per 36 months]
	Sealant		[1 per year]
Minor Restorative, Periodontal & Surgical	Cleanings/Prophylaxis	[Adult][Children][\\$0-100 Copay][After Deductible] [0-50%]	[Up to 2 per year]
	Topical Fluoride Treatment		[Up to 2 per year]
	Filings - Amalgam or Resin Composite Restoration - 1 or 2 surface		[Up to 2 per year]
	Periodontal scaling and root planning (deep cleaning)		[1 per quadrant every 36 months]
	Periodontal maintenance		[Up to 4 per year]
Extractions	[Up to 2 per		

	Surgical incision and drainage of abscesses -intra oral soft tissue Emergency care for pain relief		year] [1 per year]
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[Dental Schedule of Benefits Continued]

Category	Services You May Need	In-Network	Exclusions & Limitations
Major Restorative, Endodontic, & Prosthodontic Services	Endodontics Resin Onlays, Inlays and Crowns Partial Dentals Including Repair and Adjustments Complete Dentures Including Repair and Adjustments Root Extraction/Canal Treatment	[Adult][Children][\\$0-100 Copay][After Deductible] [0-50%]	[1 per year] [1 per 36 months] [1 per 36 months] [1 per year]
Medically Necessary	Implants and 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	[Adult][Children][\\$0-100 Copay][After Deductible] [0-50%]	[1 per year]

[Pediatric Dental Schedule of Benefits]

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

The following services are subject to a \$7 office visit Co-payment per visit in addition to the Copayments

listed below, in order to cover administrative and supply expenses.

Dental Procedure Code	Diagnostic Services	Copayment
D0120	Periodic oral evaluation -Limited to 1 every 6 months	\$4
D0140	Limited oral evaluation - problem focused - Limited to 1 every 6 months	6
D0150	Comprehensive oral evaluation, new or established patient - Limited to 1 every 6 months	5
D0210	Intraoral – complete series of radiographic images - 1 every 60 (sixty) months	11
D0220	Intraoral - periapical first radiographic image	2
D0230	Intraoral - periapical each additional radiographic image	2
D0240	Intraoral - occlusal radiographic image	3
D0250	Extraoral – first film	4
D0260	Extraoral – each additional film	3
D0270	Bitewing – single radiographic image - 1 set every 6 months	3
D0272	Bitewings – two radiographic images -1 set every 6 months	3
D0273	Bitewings – three radiographic images -1 set every 6 months	3
D0274	Bitewings – four radiographic images - 1 set every 6 months	5
D0277	Vertical bitewings – 7 to 8 radiographic images - 1 set every 6 months	5
D0330	Panoramic radiographic image – 1 film every 60 (sixty) months	9
D0340	Cephalometric x-ray;	28
D0350	Oral / Facial Photographic Images;	13
D0391	Interpretation of Diagnostic Image	25
D0415	Bacteriologic Studies for Determination of Pathologic Agents	0

D0425	Caries susceptibility Tests	0
D0460	Pulp Vitality Test	0
D0470	Diagnostic casts	0
Dental Procedure Code	Preventive Services	Copayment
D1120	Prophylaxis – Child - Limited to 1 every 6 months	6
D1201	Topical Application of Fluoride (including prophylaxis) – Child	6
D1203	Topical Application of Fluoride (excluding prophylaxis) – Child	1
D1206	Topical fluoride varnish - 2 in 12 months	6
D1208	Topical application of fluoride (excluding prophylaxis) – child - Limited to 2 every 12 months	1
D1310	Nutritional Counseling for the Control of Dental Disease	0
D1330	Oral Hygiene Instruction	0
D1351	Sealant per tooth (for children under 14) - unrestored permanent molars - 1 sealant per tooth every 36 months	20
D1352	Preventative resin restorations in a moderate to high caries risk patient - permanent tooth - 1 sealant per tooth every 36 months;	20
D1510	Space Maintainer – fixed – unilateral	109
D1515	Space Maintainer – fixed – bilateral	144
D1520	Space Maintainer - removable – unilateral	135
D1525	Space maintainer - removable – bilateral	172
D1550	Re-cement or re-bond Space Maintainer	23
Dental Procedure Code	Minor Restorative Services	Copayment
D2140	Amalgam - one surface, primary/permanent	35
D2150	Amalgam - two surfaces, primary/permanent	45

D2160	Amalgam - three surfaces, primary/permanent	56
D2161	Amalgam - four or more surfaces, primary/permanent	69
D2330	Resin one surface – anterior	44
D2331	Resin two surfaces – anterior	57
D2332	Resin three surfaces – anterior	69
D2335	Resin-based composite - four or more surfaces, or involving incisal angle (anterior)	82
D2910	Re-cement ore re-bond inlay, onlay, veneer or partial coverage restoration	26
D2920	Re-cement or re-bond crown	26
D2929	Prefabricated porcelain crown - primary tooth - Limited to 1 every 60 months	55
D2930	Prefabricated stainless steel crown - primary tooth – Under age 15 - Limited to 1 per tooth in 60 months	83
D2931	Prefabricated stainless steel crown - permanent tooth - Under age 15 - Limited to 1 per tooth in 60 months	93
D2940	Protective Restoration	27
D2951	Pin retention - per tooth, in addition to restoration	25
Dental Procedure Code	Major Restorative Services	Copayment
D2390	Composite resin crown – anterior	97
D2391	Resin – one surface, posterior	53
D2392	Resin – two surface, posterior	63
D2393	Resin – three surface, posterior	74
D2510	Inlay - metallic – one surface – An alternate benefit will be provided	325
D2520	Inlay - metallic – two surfaces – An alternate benefit will be provided	365

D2530	Inlay - metallic – three surfaces – An alternate benefit will be provided	395
D2543	Onlay - metallic - three surfaces – Limited to 1 per tooth every 60 months	405
D2544	Onlay - metallic - four or more surfaces – Limited to 1 per tooth every 60 months	436
D2610	Inlay – porcelain/ceramic – one surface	275
D2620	Inlay – porcelain/ceramic – two surfaces	311
D2630	Inlay – porcelain/ceramic – three or more surfaces	351
D2642	Onlay – porcelain/ceramic – two surfaces	324
D2643	Onlay – porcelain/ceramic – three surfaces	329
D2644	Onlay – porcelain/ceramic – four or more surfaces	371
D2650	Inlay – composite/resin – one surface (laboratory processed)	224
D2651	Inlay – composite/resin – two surfaces (laboratory processed)	270
D2652	Inlay – composite/resin – three surfaces (laboratory processed)	292
D2710	Crown – resin (laboratory)	207
D2720	Crown – resin with high noble metal	407
D2721	Crown – resin with predominantly base metal	395
D2722	Crown – resin with noble metal	401
D2750	Crown - porcelain fused to high noble metal - Limited to 1 per tooth every 60	407
D2751	Crown - porcelain fused to predominately base metal – Limited to 1 per tooth every 60 months	395
D2752	Crown - porcelain fused to noble metal – Limited to 1 per tooth every 60 months	401
D2780	Crown - 3/4 cast high noble metal – Limited to 1 per tooth every 60 months	407
D2790	Crown - full cast high noble metal– Limited to 1 per tooth every 60 months	407

D2791	Crown - full cast predominately base metal – Limited to 1 per tooth every 60 months	395
D2792	Crown - full cast noble metal– Limited to 1 per tooth every 60 months	401
D2950	Core buildup, including any pins when required – Limited to 1 per tooth every 60 months	125
D2952	Cast post and core in addition to crown	156
D2954	Prefabricated post and core, in addition to crown– Limited to 1 per tooth every 60 months	128
D2981	Inlay Repair necessitated by restorative material failure	30
D2982	Onlay Repair necessitated by restorative material failure	30
D2983	Veneer Repair necessitated by restorative material failure	30
D2990	Resin infiltration/smooth surface - Limited to 1 in 36 months	30
Dental Procedure Code	Endodontic Services	Copayment
D3110	Pulp cap – direct (excluding final restoration)	35
D3120	Pulp cap – indirect (excluding final restoration)	35
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.	65
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development days of the pulpotomy;	45
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration) - Limited to primary incisor teeth for members up to age 6 and for primary molars and cuspids up to age 11 and is limited to once per tooth per lifetime	50
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth excluding final restoration). Incomplete endodontic treatment when you discontinue treatment. - Limited to primary incisor teeth for members up to age 6 and for primary molars and cuspids up to age 11 and is limited	50

	to once per tooth per lifetime;	
D3310	Endodontic therapy/Anterior root canal (excluding final restoration)	184
D3320	Endodontic therapy/Bicuspid root canal (excluding final restoration)	226
D3330	Endodontic therapy/Molar root canal (excluding final restoration)	305
Dental Procedure Code	Periodontal Services	Copayment
D4210	Gingivectomy or gingivoplasty – per quadrant	179
D4211	Gingivectomy or gingivoplasty – per tooth	51
D4212	Gingivectomy or gingivoplasty - with restorative procedures, per tooth - Limited to 1 every 36 months	51
D4240	Gingival flap procedure, including root planing - four or more teeth – Limited to 1 every 36 months	220
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant – Limited to 1 every 36 months	132
D4260	Osseous surgery (including elevation of a full thickness flap and closure), four or more contiguous teeth or tooth bounded spaces per quadrant – Limited to 1 every 36 months;	220
D4261	Osseous surgery (including elevation of a full thickness flap and closure), one to three contiguous teeth or tooth bounded spaces per quadrant – Limited to 1 every 36 months;	132
D4263	Bone replacement graft - first site in quadrant - Limited to 1 every 36 months	150
D4270	Pedicle soft tissue graft procedure	245
D4273	Subepithelial connective tissue graft procedures, per tooth (including donor site surgery)	75
D4275	Soft tissue allograft - Limited to 1 every 36 months	380

D4277	Free soft tissue graft 1st tooth	245
D4278	Free soft tissue graft-additional teeth	245
D4320	Provisional splinting – intracoronal	131
D4321	Provisional splinting – extracoronal	120
D4341	Periodontal scaling and root planing - four or more teeth per quadrant – Limited to 1 every 24 months	79
D4342	Periodontal scaling and root planing - one to three teeth per quadrant – Limited to 1 every 24 months	45
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis – Limited to 1 per lifetime	35
D4910	Periodontal maintenance procedures (following active therapy) - 4 in 12 months combined with prophylaxis after the completion of active periodontal therapy	41
D7921	Collect - Apply Autologus Product - Limited to 1 in 36 months	45
Dental Procedure Code	Prosthodontic Services - (Removable)	Copayment
D5110	Complete denture - maxillary – Limited to 1 every 60 months	525
D5120	Complete denture - mandibular – Limited to 1 every 60 months	525
D5130	Immediate denture - maxillary – Limited to 1 every 60 months	553
D5140	Immediate denture - mandibular – Limited to 1 every 60 months	553
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	469
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	469
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	595
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	595

D5410	Adjust complete denture – maxillary;	25
D5411	Adjust complete denture – mandibular;	25
D5421	Adjust partial denture – maxillary;	25
D5422	Adjust partial denture – mandibular;	25
D5510	Repair broken complete denture base	407
D5520	Replace missing or broken teeth - complete denture (each tooth)	395
D5610	Repair resin denture base	85
D5620	Repair cast framework	85
D5630	Repair or replace broken clasp	85
D5640	Replace broken teeth - per tooth	55
D5650	Add tooth to existing partial denture	85
D5660	Add clasp to existing partial denture	85
D5710	Rebase complete upper denture, each	163
D5711	Rebase complete lower denture, each	172
D5720	Rebase upper partial denture, each	161
D5721	Rebase lower partial denture, each	163
D5730	Reline complete upper denture (chairside), each	94
D5731	Reline complete lower denture (chairside), each	92
D5740	Reline upper partial denture (chairside), each	82
D5741	Reline lower partial denture (chairside), each	82
D5750	Reline complete upper denture (laboratory), each	165
D5751	Reline complete lower denture (laboratory), each	165
D5760	Reline upper partial denture (laboratory), each	165
D5761	Reline lower partial denture (laboratory), each	165
D5810	Interim Complete Denture Upper, each	201

D5811	Interim Complete Denture Lower, each	201
D5821	Interim Partial Denture Lower, each	161
D5850	Tissue conditioning, upper per unit	60
D5851	Tissue conditioning, lower per unit	60
Dental Procedure Code	Prosthodontic Services - (Fixed)	Copay ment
D6101	Debridement perimplant defect, covered if implants are covered - Limited to 1 every 60 months	158
D6102	Debridement and osseous perimplant defect, covered if implants are covered - Limited to 1 every 60 months	158
D6103	Bone graft perimplant defect, covered if implants are covered	180
D6104	Bone graft implant replacement, covered if implants are covered	22
D6210	Pontic - cast high noble metal	407
D6211	Pontic - cast predominately base metal	395
D6212	Pontic - cast noble metal	401
D6240	Pontic - porcelain fused to high noble metal	407
D6241	Pontic - porcelain fused to predominately base metal	395
D6242	Pontic - porcelain fused to noble metal	401
D6250	Pontic- resin with high noble/predominantly base/noble metal	407
D6251	Pontic- resin with high noble/predominantly base/noble metal	395
D6252	Pontic- resin with high noble/predominantly base/noble metal	401
D6545	Retainer - cast metal for resin bonded fixed prosthesis	245
D6602	Inlay – cast high noble metal, two surfaces	365
D6603	Inlay – cast high noble metal, three or more surfaces	395
D6604	Inlay – cast predominantly base metal, two surfaces	365

D6605	Inlay – cast predominantly base metal, three or more surfaces	395
D6606	Inlay – cast noble metal, two surfaces	365
D6607	Inlay – cast noble metal, three or more surfaces	395
D6610	Onlay – cast high noble metal, two surfaces	405
D6611	Onlay – cast high noble metal, three or more surfaces	436
D6612	Onlay – cast predominantly base metal, two surfaces	405
D6613	Onlay – cast predominantly base metal, three or more surfaces	436
D6614	Onlay – cast noble metal, two surfaces	405
D6615	Onlay – cast noble metal, three or more surfaces	436
D6720	Crown – resin with high noble metal	407
D6721	Crown – resin with predominantly base metal	395
D6722	Crown – resin with noble metal	401
D6750	Crown - porcelain fused to high noble metal	407
D6751	Crown - porcelain fused to predominately base metal	395
D6752	Crown - porcelain fused to noble metal	401
D6780	Crown - 3/4 cast high noble metal	407
D6790	Crown - full cast high noble metal	407
D6791	Crown - full cast predominately base metal	395
D6792	Crown - full cast noble metal	401
D6930	Recement fixed partial denture	39
D6940	Stress Breaker	145
<i>Additional charge of \$125 per unit for multiple crown units (6 or more units of crown and/or bridge in same treatment plan; requires complete rehabilitation planning)</i>		
<i>Dental Procedure Code</i>	<i>Oral Surgery Services</i>	<i>Copayment</i>

D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	42/56
D7210	Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated.	84/105
D7220	Removal of impacted tooth – soft tissue	110/126
D7250	Surgical removal of residual tooth roots (cutting procedure)	94/105
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	86
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	137
D7510	Incision and drainage of abscess - intraoral soft tissue	61
D7953	Bone replacement graft for ridge preservation-per site	18
Dental Procedure Code	Adjunctive General Services	Copayment
D9110	Palliative (emergency) treatment of dental pain – minor procedure	6
D9211	Regional Block Anesthesia (except for diagnostic purposes)	0
D9212	Trigeminal Division Block Anesthesia (except for diagnostic purposes)	0
D9215	Local Anesthesia (except for diagnostic purposes)	0
D9230	Analgesia, anxiolysis, inhalation of nitrous oxide (per 15 minutes)	12
D9310	Consultation (diagnostic service provided by dentist or physician other than practitioner providing treatment)	11
D9430	Office visit during regular hours (\$9 office visit copay not charged)	11
D9440	Office visit after regular hours (\$9 office visit copay not charged)	55
D9941	Fabrication of athletic mouthguard	46
D9950	Occlusion analysis - mounted case	84

D9951	Occlusal adjustment - limited	45
D9952	Occlusal adjustment - complete	193
D9999	Unspecified Adjunctive procedure, by report	9
Other Services		
	Temporary Crown with Permanent Crown	0
	Infection Control Charges	0
	Office or Dental Supplies	0
	Laboratory Expenses	0
	Equipment and Instruments necessary for treatment	0
	Any other general overhead expenses	0
	Acid Edge charge	0
	Duplication of X-rays	0
	Periodontal Probing done with Initial and Periodic Oral Examinations	0
	Use of Bonding Materials (Allbond, Amalgabond or comparable materials – Refer to code 09999)	9
All procedures not included in this CPT Code listing have a Copayment of 75% of the dentist's Usual and Customary charge, including the following services:		
D0160	Detailed and extensive oral evaluation - problem focused, by report;	
D0180	Comprehensive periodontal evaluation - Limited to 1 every 6 months;	
D2542	Onlay - metallic - two surfaces – Limited to 1 per tooth every 60 months;	
D2740	Crown - porcelain/ceramic substrate - 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;	
D2794	Crown – titanium– Limited to 1 per tooth every 60 months;	

D2980	Crown repair, by report;
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
D3352	Apexification/recalcification – interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.);
D3353	Apexification/recalcification - final visit (includes completed root canal therapy, apical closure/calcific repair of perforations, root resorption, etc.);
D3354	Pulpal regeneration (completion of regenerative treatment in an immature permanent tooth with a necrotic pulp) does not include final restoration;
D3410	Apicoectomy/periradicular surgery – anterior;
D3421	Apicoectomy/periradicular surgery - bicuspid (first root);
D3425	Apicoectomy/periradicular surgery - molar (first root);
D3426	Apicoectomy/periradicular surgery (each additional root);
D3450	Root amputation - per root;
D3920	Hemisection (including any root removal) - not including root canal therapy;
D4249	Clinical crown lengthening-hard tissue
D4271	Free soft tissue graft procedure (including donor site surgery);
D4342	Periodontal scaling and root planning-one to three teeth, per quadrant – Limited to 1 every 24 months;
D5281	Removable unilateral partial denture-one piece cast metal (including clasps and teeth) – Limited to 1 every 60 months
D6010	Endosteal Implant (surgical placement of implant body) - 1 every 60 months;
D6012	Surgical Placement of Interim Implant Body - 1 every 60 months
D6040	Epoosteal Implant – 1 every 60 months;

D6050	Transosteal Implant, Including Hardware – 1 every 60 months;
D6053	Implant supported complete denture;
D6054	Implant/abutment supported removable denture partial denture
D6055	Connecting Bar – implant or abutment supported - 1 every 60 months;
D6056	Prefabricated Abutment – 1 every 60 months;
D6057	Custom Abutment - 1 every 60 months
D6058	Abutment supported porcelain ceramic crown -1 every 60 months;
D6059	Abutment supported porcelain fused to high noble metal - 1 every 60 months;
D6060	Abutment supported porcelain fused to predominately base metal crown - 1 every 60 months;
D6061	Abutment supported porcelain fused to noble metal crown - 1 every 60 months;
D6062	Abutment supported cast high noble metal crown - 1 every 60 months;
D6063	Abutment supported cast predominately base metal crown - 1 every 60 months;
D6064	Abutment supported cast noble metal crown - 1 every 60 months;
D6065	Implant supported porcelain/ceramic crown - 1 every 60 months;
D6066	Implant supported porcelain fused to high 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 high noble metal fixed partial denture - 1 every 60 months;
D6070	Abutment supported retainer for porcelain fused to predominately base metal fixed partial denture - 1 every 60 months;
D6071	Abutment supported retainer for porcelain fused to noble metal fixed partial denture - 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 high noble metal fixed partial denture - 1 every 60 months;
D6077	Implant supported retainer for cast metal fixed partial denture - 1 every 60 months;
D6078	Implant/abutment supported fixed partial denture for completely edentulous arch - 1 every 60 months;
D6079	Implant/abutment supported fixed partial denture for partially edentulous arch - 1 every 60 months;
D6080	Implant Maintenance Procedures -1 every 60 months;
D6090	Repair Implant Prosthesis -1 every 60 months;
D6091	Replacement of Semi-Precision or Precision Attachment -1 every 60 months;
D6095	Repair Implant Abutment -1 every 60 months;
D6100	Implant Removal -1 every 60 months; D6190 Implant Index -1 every 60 months;
D6190	Implant Index Radiographic/surgical implant index, by report -1 every 60 months
D6214	Pontic – titanium – Limited to 1 every 60 months;
D6245	Pontic - porcelain/ceramic – Limited to 1 every 60 months;
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;

D6548	Retainer - porcelain/ceramic for resin bonded fixed prosthesis -1 every 60 months;
D6740	Crown - porcelain/ceramic -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;
D6973	Core buildup for retainer, including any pins - 1 every 60 months
D6980	Fixed partial denture repair, by report;
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;
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;
D7311	Alveoloplasty in conjunction with extractions-one to three 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 exostosis;
D7910	Suture of recent small wounds up to 5 cm;
D7971	Excision of pericoronal gingiva;
D9220	Deep sedation/general anesthesia - first 30 minutes;
D9221	Deep sedation/general anesthesia - each additional 15 minutes;
D9241	Intravenous conscious sedation/analgesia - first 30 minutes; and,
D9242	Intravenous conscious sedation/analgesia - each additional 15 minutes.

	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))	
D9940	Occlusal guard, by report - 1 in 12 months for patients 13 and older	
LIST OF EXCLUSIONS AND THINGS WE DO NOT COVER		
Dental Procedure Code	Exclusions & Services	
D0310	Sialography	
D0320	Temporomandibular joint (TMJ) arthrogram, including injection	
D0321	Other temporomandibular joint (TMJ) radiographic images, by report	
D0322	Tomographic survey	
D0416	Viral culture	
D0418	Analysis of saliva (example chemical or biological analysis of saliva for diagnostic purposes)	

D0425	Caries test
D0431	Adjunctive pre-diagnostic test
D0472	Oral Pathology lab (Accession of tissue, gross examination, preparation and transmission of written report)
D0473	Oral Pathology lab (Accession of tissue, gross and microscopic examination, preparation and transmission of written report)
D0474	Oral Pathology lab (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-situ-hybridization, including interpretation
D0480	Oral Pathology lab
D0481	Electron microscopy - diagnostic
D0482	Direct immunofluorescence
D0483	In-direct immunofluorescence
D0484	Consultation on slides prepared elsewhere
D0485	Consultation including preparation of slides from biopsy material supplied by referring source
D0486	Accession Transepithelial (Laboratory accession of transepithelial cytologic sample, microscopic examination, preparation and transmission of written report)
D0502	Other oral pathology procedures, by report
D1310	Nutritional Counseling
D1320	Tobacco counseling
D1330	Oral Hygiene Instruction
D1555	Removal of fixed space maintainer

D2410	Gold Foil 1 surface
D2420	Gold Foil 2 surface
D2430	Gold Foil 3 surface
D2799	Provisional Crown
D2955	Post Removal
D2970	Temporary Crown
D2975	Coping
D3460	Endodontic Implant
D3470	Intentional reimplantation
D3910	Surgical procedure for isolation of tooth
D3950	Canal preparation
D4230	Anatomical crown exposure 4 or more teeth
D4231	Anatomical crown exposure 1-3 teeth
D4320	Splinting intracoronal
D4321	Splinting extracoronal
D5810	Complete denture upper (interim)
D5811	Complete denture lower (interim)
D5820	Partial denture upper (interim)
D5821	Partial denture lower (interim)
D5862	Precision Attachment
D5867	Replacement Precision Attachment
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
D6051	Interim Abutment
D6199	Unspecified Implant Procedure, by report
D6253	Provisional Pontic – further treatment or completion of diagnosis necessary prior to final impression.
D6793	Provisional retainer Crown
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 Osteotomy/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	Arthroscopy surgical: synovectomy
D7876	Arthroscopy surgical: discectomy
D7877	Arthroscopy surgical: debridement
D7880	TMJ Appliance (Occlusal orthotic device, by report)
D7899	TMJ Therapy
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 – Lateral, with bone or bone substitutes
D7952	Sinus Augmentation of Vertical
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
D9230	Analgesia, anxiolysis, inhalation of nitrous oxide
D9248	Non-intravenous conscious sedation
D9410	House/extended care facility call
D9420	Hospital Call
D9450	Case presentation
D9630	Other drugs and or medicaments
D9920	Behavior Management
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
D9972	External bleaching - per arch
D9973	External bleaching - per tooth

D9974	Internal bleaching - per tooth
D9975	External bleaching - per arch
<ul style="list-style-type: none"> 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 	
<ul style="list-style-type: none"> Services and treatment which are not dentally necessary or which do not meet generally accepted standards of dental practice 	
<ul style="list-style-type: none"> Any services that are considered strictly cosmetic in nature including, but not limited to, charges for personalization or characterization of prosthetic appliances 	
<ul style="list-style-type: none"> Services related to the diagnosis and treatment of Temporomandibular Joint Dysfunction (TMJ) 	
<ul style="list-style-type: none"> 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 	
<ul style="list-style-type: none"> Services and treatment resulting from Your failure to comply with professionally prescribed treatment 	
<ul style="list-style-type: none"> Any charges for failure to keep a scheduled appointment 	
<ul style="list-style-type: none"> Office infection control charges 	
<ul style="list-style-type: none"> State or territorial taxes on dental services performed 	
<ul style="list-style-type: none"> Service charges submitted by a dentist, which are for the same services performed on the same date for the same Insured Person by another dentist; 	
<ul style="list-style-type: none"> Service charges provided free of charge by any governmental unit, except where this exclusion is prohibited by law; 	
<ul style="list-style-type: none"> Those performed by a dentist who is compensated by a facility for similar covered services performed for Insureds; 	
<ul style="list-style-type: none"> Duplicate, provisional and temporary devices, appliances, and services; 	
<ul style="list-style-type: none"> Plaque control programs, oral hygiene instruction, and dietary instructions; 	
<ul style="list-style-type: none"> Gold foil restorations 	
<ul style="list-style-type: none"> 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	
· 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.	

<ul style="list-style-type: none"> Services and treatment not prescribed by or under the direct supervision of a dentist, except in those states where dental hygienists are permitted to practice without supervision by a dentist. In these states, we will pay for eligible covered services provided by an authorized dental hygienist performing within the scope of his or her license and applicable state law;
<ul style="list-style-type: none"> Services and treatment which are experimental or investigational;
<ul style="list-style-type: none"> Services and treatment which are for any illness or bodily injury which occurs in the course of employment if a benefit or compensation is available, in whole or in part, under the provision of any law or regulation or any government unit. This exclusion applies whether or not you claim the benefits or compensation;
<ul style="list-style-type: none"> Services and treatment performed prior to your effective date of coverage;
<ul style="list-style-type: none"> Services and treatment incurred after the termination date of your coverage unless otherwise indicated;
<ul style="list-style-type: none"> Telephone consultations;
<ul style="list-style-type: none"> Services or treatment provided as a result of intentionally self-inflicted injury or illness;
<ul style="list-style-type: none"> Services or treatment provided as a result of injuries suffered while committing or attempting to commit a felony, engaging in an illegal occupation, or participating in a riot, rebellion or insurrection;
<ul style="list-style-type: none"> Charges for copies of your records, charts or x-rays, or any costs associated with forwarding/ mailing copies of your records, charts or x-rays;
<ul style="list-style-type: none"> Charges for which the member would have no obligation to pay in the absence of this or any similar coverage;
<ul style="list-style-type: none"> Charges which are for specialized procedures and techniques;
<ul style="list-style-type: none"> Treatment of services for injuries resulting from war or act of war, whether declared or undeclared, or from police or military service for any country or organization;
<ul style="list-style-type: none"> Hospital costs or any additional fees that the dentist or hospital charges for treatment at the hospital (inpatient or outpatient);
<ul style="list-style-type: none"> Cone Beam Imaging and Cone Beam MRI procedures;
<ul style="list-style-type: none"> Orthodontic care for dependent children age 19 and over;
<ul style="list-style-type: none"> Internal and external bleaching;

The provider directory specifies whether a dentist is a **General Dentist** or not. All procedures might not be performed by the Participating Provider you select. The Copayments shown apply to those Participating Provider General Dentists who do perform these services and are not applicable for services performed by a Participating Provider who is not a General Dentist (Specialty Dentist). Therefore, you are encouraged to discuss the availability of the scheduled services with your Participating Provider General Dentist.

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Specialty Dentists – Should you need a Specialty Dentist, you may be referred by your Participating Provider General Dentist, or you may refer yourself to any Participating Provider Specialty Dentist from our directory. Upon identification of yourself as a MHHP Member, Your Co-payment will be the following percentage of the Participating Provider Specialty Dentist's usual fee: Endodontist (root canals) 80%, Oral Surgeon (tooth extractions) 75%, Orthodontist 75%, Periodontist (gum problems) 75%, Pediatric Dentist (children's dentist) 75%.

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Missed Appointments – A missed appointment without 24 hours notice may result in a missed appointment charge made by the Participating Provider General and Specialty Dentists. Please discuss this with your selected dentist.

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Children Under 5 Years of Age – Children under 5 years of age may be referred to a pediatric dentist. Please discuss this with your selected Participating General Dentist.

IV. ELIGIBILITY & ENROLLMENT

Subscribers, who reside or work in the MHHP Service Area and their dependents are covered under this Evidence of Coverage. If you are enrolled in Medicare, You are not eligible to purchase or be enrolled in this Evidence of Coverage.

Types of Coverage

The Evidence of Coverage holder 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 Evidence of Coverage holder.
- Family Coverage - for You, Your Spouse and/or Your Dependent Child or coverage for multiple children who 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 Evidence of Coverage covers only individuals under the age of 21.

Who is Eligible

An Eligible Employee (or “Employee”) means an individual employed by the Group who works on a full-time basis and who usually works at least 30 hours a week. An Employee includes a sole proprietor, a partner, and an independent contractor, if the sole proprietor, partner or independent contractor is included as an employee under the Group’s Health Benefit Plan.

An Eligible Employee does not include:

- An employee who works on a part-time, temporary, seasonal, or substitute basis or
- An employee who is covered under a. another Health Benefit Plan;
 - a self-insured employee welfare benefit plan that provides health benefits and that is established in accordance with the Employee Retirement Income Security Act of 1974;
 - the Medicaid program if the employee elects not to be covered;
 - another federal program, including the CHAMPUS program or Medicare program, if the employee elects not to be covered; or
 - a benefit plan established in another country if the employee elects not to be covered.

If two members of the same family (such as husband and wife or parent and child) both qualify as Eligible Employees of the Group, each may enroll separately as a Covered Employee. An Employee must reside, live or work in the Service Area.

Eligible Dependents

A Dependent means an Employee’s:

- Lawful spouse
- Child(ren)
- Domestic Partner who may be the same or opposite gender of the Eligible Employee.

A Subscriber must reside or work in the Service Area.

A person may not be a Covered Dependent for more than one Eligible Employee.

Special Needs/Dependent Children Over 26

You or your spouse 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 Evidence of Coverage, such a child may stay eligible for Dependent health benefits past this Evidence of Coverage’s age limitation of 26 for eligible Dependents. The child will stay eligible as long as the child is and remains unmarried and incapable of earning a living, if:

- a) the child's condition started before he or she reached this Evidence of Coverage’s age limit;
- b) the child became covered under this Evidence of Coverage or any other policy or contract before the child reached the age limit and stayed continuously covered or covered after reaching such limit;
- c) 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 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.

It is the responsibility of the Employee to apply for coverage for Dependents.

Enrollment

Any person who qualifies as an Eligible Employee of the Group on the day prior to the Evidence of Coverage Effective Date, or any person who has continued group coverage with the Group under applicable federal or state law, is eligible immediately. The Enrollment Form for this Employee should be submitted with the Application.

Otherwise, an Eligible Employee is qualified to apply for the Plan during the Initial Enrollment Period, which is the 31 days before the first of the month following completion of the Waiting Period. The Waiting Period is a required period of continuous, full time employment that must be completed before an Eligible Employee may apply for MHHP coverage. The length of the Waiting Period may be one or two calendar months and is selected by the Group on the Group's application.

Exception to the Waiting Period

An exception to the Waiting Period will be made under certain circumstances for an Eligible Employee who has previously completed the Waiting Period, and then ceased to be eligible due to termination of employment. If this individual returns to an Eligible Employee status within six (6) months after the date of termination, the employee is eligible on the first day of the month following the date of return. The Eligible Employee must apply within 31 days of the date of the return.

Special Enrollment

An Employee who is Eligible, but who has not elected to enroll during an Initial Enrollment Period or during the Annual Open Enrollment Period, may apply for enrollment within the 31 days following the date he or she first acquires an Eligible Dependent, whether by marriage, birth, adoption or placement for adoption.

Annual Open Enrollment

An Eligible Employee may apply for enrollment during the Annual Open Enrollment Period. If an Eligible Employee does not apply within the 31 days of the Initial Enrollment, Annual Open Enrollment or Special Open Enrollment Periods as outlined above, he or she becomes a Late Enrollee.

Enrollment at Time of Employee Enrollment

If a person meets the above definition of Eligible Dependent on the date the Eligible Employee is qualified to apply for the Plan, then the Eligible Dependent qualifies to apply at the same time that the Eligible Employee applies, and should be included on the Eligible Employee's Enrollment Form.

Initial Enrollment Period for Dependent Only

An Eligible Dependent is qualified to apply for the Plan during the Initial Enrollment Period, which is the 31 days following the date he or she meets the above definition of an Eligible Dependent.

Late Enrollees

As defined, a Late Enrollee is an Eligible Employee or Dependent who submits his or her written application for enrollment after the expiration of the Initial Enrollment Period, a Special Enrollment Period, or after the expiration of the Annual Open Enrollment Period. There are exceptions to this definition which will not be considered a Late Enrollee if he or she did not enroll for coverage within the Initial Enrollment Period and:

- the individual:
 - was covered under another health benefit plan or self-funded employer health benefit plan at the time the individual was eligible to enroll;
 - declined in writing to enroll, at the time of initial eligibility, stating that coverage under another health benefit plan or self-funded employer health benefit plan was the reason for declining enrollment;
 - has lost coverage under another health benefit plan or self-funded employer health benefit plan as a result of: termination of employment; reduction in the number of hours of employment; termination of the other plan's coverage; termination of contributions toward the premium made by the employer; or the death of a spouse or divorce; and
 - requests enrollment not later than the 31st day after the date on which coverage under the other health benefit plan or self-funded employer health benefit plan terminates;
- the individual is employed by an employer who offers multiple health benefit plans and the individual elects a different health benefit plan during an open enrollment period;
- a court has ordered coverage to be provided for a spouse under a Covered Employee's plan and the request for enrollment is made not later than the 31st day after the date on which the court order is issued;
- a court has ordered coverage to be provided for a child under a Covered Employee's plan and the request for enrollment is made not later than the 31st day after the date on which the Employer receives the court order or notification of the court order;
- the individual is a child of a Covered Employee and has lost coverage under Chapter 62, Health and Safety Code, Child Health Plan for Certain Low-Income Children or Title XIX of the Social Security Act (42 U.S.C. §§1396, et seq., Grants to States for Medical Assistance Programs), other than coverage consisting solely of benefits under Section 1928 of that Act (42 U.S.C. §1396s, Program for Distribution of Pediatric Vaccines);
- the individual has a change in family composition due to marriage, birth of a child, adoption of a child, or because a Member becomes a party in a suit for the adoption of a child;
- an individual becomes a dependent due to marriage, birth of a newborn child, adoption of a child, or because a Member becomes a party in a suit for the adoption of a child; and
- the individual described in subparagraphs 4, 5 and 6 of this subsection requests enrollment no later than the 31st day after the date of the marriage, birth, adoption of the child, loss of the child's coverage, or within 31 days of the date a Member becomes a party in a suit for the adoption of a child.

Special Enrollment Periods for Eligible Employees and Dependents

Eligible Employees who do not enroll themselves and/or their Eligible Dependents during the Initial Enrollment Period because they were covered by another Health Benefit Plan may do so within 31 days after that other coverage terminates, if the following requirements are met:

- If the other coverage was COBRA continuation under another plan, that continuation must have been exhausted before the Eligible Employee may enroll the affected persons under this Plan.
- If the other coverage was not COBRA continuation, then any employer contribution toward the cost of the coverage must have terminated or that coverage must itself have been terminated because of a loss of eligibility by the person through whom coverage was obtained. Loss of eligibility for coverage includes loss of coverage as a result of:
 - divorce;
 - death;
 - termination of employment or reduction in hours of employment;
 - loss of dependent status;
 - loss of eligibility for HMO or other group coverage as a result of ceasing to meet Service Area requirements;
 - employer contributions toward that coverage have been terminated;
 - exhaustion of COBRA continuation coverage period maximum; or
 - exhaustion of plan lifetime maximum benefit limit.

In addition, the Eligible Employee must have declined enrollment for Employee and/or Dependent coverage during the Initial Enrollment Period by means of a written statement that the reason for declining enrollment was other coverage. However, a written statement may be required only if the consequences of failing to provide such a statement were explained to the Employee at the time of Initial Enrollment.

An Eligible Employee who did not enroll during the Initial Enrollment Period may enroll for Employee and/or Dependent coverage within 31 days after he or she marries or acquires a Dependent Child or Children by birth or adoption or when the Employee is a party in a suit to adopt a child.

An Eligible Employee who did not enroll his or her spouse during an Initial Enrollment Period may enroll that spouse within 31 days after the Eligible Employee acquires a Dependent Child or Children by birth or adoption or when the Employee is a party in a suit to adopt a child. If the Eligible Employee does not apply to enroll an Eligible Dependent within 31 days of when he or she qualifies as an Eligible Dependent, such dependent becomes a Late Enrollee. An Eligible Dependent whose coverage was canceled by request while still entitled to coverage is also considered a Late Enrollee if requesting to be covered again.

An Eligible Employee who did not enroll during an Initial Enrollment Period may enroll within 60 days after coverage under a Medicaid plan is terminated as a result of loss of eligibility for such coverage. An Eligible Dependent whose state assistance (Medicaid or SCHIP) is terminated due to loss of eligibility may enroll within 60 days after the state coverage is terminated as a result of loss of eligibility for such coverage.

An Eligible Employee or Eligible Dependent who did not enroll during an Initial Enrollment Period may enroll within 60 days after becoming eligible for Medicaid or SCHIP premium assistance subsidy (including coverage under any waiver or demonstration project conducted under or in relation to such a state plan).

Special Enrollment of an Eligible Dependent Spouse

A spouse who is an Eligible Dependent but was not enrolled in the Plan at the time the Eligible Employee enrolled or during the Initial Enrollment Period may enroll during the 31 days following the date a dependent Child becomes newly eligible whether through birth, adoption or placement for adoption.

If the Eligible Employee does not apply to enroll an Eligible Dependent within 31 days of when he or she qualifies as above, he or she becomes a Late Enrollee. An Eligible Dependent who was canceled by request while still entitled to coverage is also considered a Late Enrollee if requesting to be covered again.

Coverage Start

Coverage for an Eligible Employee and his or her Eligible Dependents is effective once We receive a properly completed application, and the Group pays Us the required premium.

Coverage under the Plan becomes effective:

- For any person who qualifies as an Eligible Employee on the day prior to the Effective Date of the Evidence of Coverage and his or her Eligible Dependents, or any person who has continued group coverage under applicable federal or state law, on the Effective Date of the Evidence of Coverage .
- For Eligible Employees and their Eligible Dependents who apply during their Initial Enrollment Period, on the first day of the month following the end of the Waiting Period;
- For an Eligible Employee or Eligible Dependent spouse who applies during a Special Enrollment Period, on the first day of the month following the end of the Special Enrollment Period;
- For an Eligible Employee or Eligible Dependent who submits an Enrollment Form during the Open Enrollment Period, on the first day of the month following the Open Enrollment period.

Adding Dependents to Your Evidence of Coverage

For a person who becomes an Eligible Dependent after the date the Eligible Employee's coverage begins, coverage for the Eligible Dependent will become effective in accordance with the following provisions:

- *Newborn Children*

A Member or a dependent's Newborn child(ren) is eligible for coverage., MHHP must be notified within 31 calendar days of birth to add the Newborn as a Covered Dependent. An additional premium will apply.

- *Adopted Children*

A Member or a dependent's Newborn child(ren) is eligible for coverage., MHHP must be notified within 31 calendar days of birth to add the Newborn 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. MHHP 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*

Notification and premium payment must be received within 31 days of the date the grandchild first qualifies as an Eligible Dependent. Coverage will become effective on the first day of the month following the date the application for coverage is received.

- *Other Dependents*

A written Enrollment Form 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 Enrollment Form for coverage is received, approved and any required premium is paid.

In no event will an Eligible Dependent's coverage become effective prior to the Eligible Employee's Effective Date of Coverage.

Late Enrollees who apply outside of the Group's Open Enrollment Period, coverage will be effective on the first day of the month following the next Annual Open Enrollment Period provided that the Late Enrollee is an Eligible Employee or an Eligible Dependent on that date and further provided that he or she applies or re-applies during that Annual Open Enrollment Period.

Notification of Eligibility Change

Any person who does not satisfy the eligibility requirements is not covered by the Plan and has no right to any of the benefits provided under the Plan. The Group and/or the Covered Employee must notify MHHP within 31 days of any change that affects an individual's eligibility under the Plan, including whether a Covered Dependent meets the Eligible Dependent criteria set forth under "Who Is Eligible".

Change to Group Evidence of Coverage

We may modify the Group Evidence of Coverage on any Anniversary Date provided: the modification is uniform among all small or large employers, as applicable, covered by the Group Evidence of Coverage; and We notify the Commissioner of Insurance and each affected Group no later than the 60th day before the date such modification is effective.

Termination of Coverage

Employee & Dependents

Your coverage ends without notice from us on the earliest of:

- The last day of the month after the date You no longer meet the definition of an Eligible Employee; however coverage will remain in force until the end of the calendar month in which the Group notifies Us that the Member is no longer eligible. The Group will be liable to Us for any premium, including premium for Dependent coverage, for the period of coverage until the end of the calendar month in which the Group provides Us such notice;
- The last day of the month in which You exceed the maximum number of months of paid personal or medical Leave of Absence (LOA) for which Your employer provides continuing eligibility for coverage under this Plan.
- the end of the last period for which premium payment has been made to Us;
- the date the Evidence of Coverage terminates;
- in the event of fraud or intentional misrepresentation of material fact by You or Your Covered Dependent, except as described under Incontestability, or fraud in the use of services or facilities, sixteen (16) days after written notice from MHHP.

Covered Dependent coverage will also end the date Your coverage terminates.

Group's Agreement

The coverage of all Members shall terminate if the Group Agreement is terminated. If We terminate the Group Agreement, We will notify the Group of cancellation. In addition, the Group Agreement and any associated Evidence of Coverage may be terminated by the Group on any Renewal Date. In either situation, it is the Group's responsibility to notify all Covered Employees. The Agreement or this Evidence of Coverage may be terminated by Us:

- For non-payment of required premium (after the expiration of the 30 day Grace Period);
- On the date of fraud or intentional misrepresentation of a material fact by the Group, after not less than 15 days written notice, except as indicated in the Time Limit on Certain Defenses provision;
- On any Renewal Date for any of the following reasons. We must give the Group written notice of cancellation at least 30 days in advance if termination is due to:
 - failure to comply with the terms of this Plan;
 - failure to maintain the required minimum participation for a period of at least 6 consecutive months;
 - relocation of a majority of the Group's Eligible Employees to a location outside of the Service Area;
 - relocation of the Group's primary business location to a location outside the Service Area, unless the majority of the Group's eligible employees remain in Texas; or
 - Enrollees no longer residing, living, or working the Service Area, or area for which MHHP is authorized to do business, provided coverage is terminated uniformly without regard to the health status of an enrollee.
- On any Renewal Date if We discontinue this small or large employer group Health Benefit Plan, as applicable. We must give the Group and the Commissioner of Insurance written notice of cancellation at least 90 days prior to the discontinuation and make available to the small or large group employer, as applicable, all plans that we make available to new small or large group employer business, as applicable, in the state.
- On any Renewal Date if We are also canceling all small or large group employer Health Benefit Plans, as applicable, in the state or in a geographic Service Area. We must give the Group and the Commissioner of Insurance written notice of cancellation at least 180 days in advance and again at least 30 days in advance of the date on which termination of coverage is effective.

This Evidence of Coverage is a part of the Group Agreement as if fully incorporated therein and any direct conflict between the Group Agreement and the Evidence of Coverage will be resolved according to the terms which are most favorable to the Member.

State Continuation Provisions

If Your coverage terminates, You will have the right to continue under the Group Evidence of Coverage as outlined below. The Group is responsible to provide You with information on Your options. No evidence of insurability is required. In order to be eligible for this option You must have been continuously covered under the Evidence of Coverage for at least 3 consecutive months prior to termination and coverage must have terminated for any reason other than involuntary termination for cause. Involuntary termination for cause does not include termination for any health-related cause.

Your written application and payment of the first premium must be received by the Employer within 60 days after the later of date the group coverage would otherwise terminate or the date We or the Employer gives You notice of Your right to continue coverage.

There is no right of continuation if:

- the termination of coverage occurred because You failed to pay any required premium;
- The Group Evidence of Coverage is terminated;

Continuation of Coverage

For Members

You choose to continue coverage under the Group Evidence of Coverage, continuation will be permitted for the applicable period shown below. The premium rate will not exceed 102% of the Group premium. The premium will be payable in advance to the Group on a monthly basis.

Continuation will not terminate until the earliest of:

- For any Member not eligible for continuation coverage under Title X, Consolidated Omnibus Reconciliation Act of 1985 (29 U.S.C. Section 1161 et seq.) (COBRA), nine months after the date the Member elects to continue the coverage;
- For a Member eligible for continuation coverage under COBRA, six additional months following any period of continuation coverage provided under COBRA;
- The date You fail to make timely premium payments;
- The date on which You are covered for similar benefits under another group or individual policy; or
- The date the Group Evidence of Coverage terminates.

Additional Continuation Rights for Certain Covered Dependents

If coverage terminates as the result of Your death, retirement, or divorce, a Covered Dependent's coverage can continue. A dependent who qualifies for this will have the right to continue under the Group Evidence of Coverage as outlined below. No evidence of insurability is required. In order to be eligible the Covered Dependent must have been covered under the Plan for at least one year, unless the Covered Dependent is an infant under one year of age. There is no right of continuation if:

- Continuation is required under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). Please check with Your employer.
- If coverage terminates due to any of these circumstances:
 - The Group Evidence of Coverage is canceled; or
 - The Covered Dependent fails to make timely premium payments.

If the Covered Dependent chooses to continue coverage under the Group Evidence of Coverage, continuation will be permitted for a maximum of three years. The premium will be payable in advance to the Group on a monthly basis. Continuation will not terminate until the earliest of the following dates:

- Three years after the date coverage would have terminated because of the Employee's death, retirement or divorce;
- The date the Covered Dependent fails to make timely premium payments;
- The date the Group Evidence of Coverage terminates.

COBRA Continuation

Most employers who employ 20 or more people on a typical business day are subject to the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). If the Group is subject to the federal law which governs this provision, Members may also be entitled to a period of continuation of coverage under this Act. Check with the Group for details. COBRA coverage is available to You and/or Your Eligible Dependents under the following circumstances:

- If You terminate or are terminated from Your employment for reasons other than gross misconduct, or if Your hours are reduced, You and Your Covered Dependents can continue coverage for up to 18 months.
- If the Social Security Administration determines that You or any of Your Eligible Dependents were Disabled when You lost Your job or were Disabled within 60 days after the job loss, You and Your Eligible Dependents may be eligible for 29 months of continuation.
- If You have family coverage, and Your Eligible Dependents lose coverage because either 1) You die or are divorced, or 2) You become eligible for Medicare, Your Eligible Dependents may continue coverage up to 36 months.
- A child who is no longer an Eligible Dependent may also continue coverage up to 36 months.
- Covered retirees and widows of retirees may have longer continuation rights if a Group files a Chapter 11 bankruptcy petition.
- You must tell the Group if You divorce, or if Your Dependent Child is ineligible within 60 days of the date it happens. The person losing coverage will then be notified of the right to buy continued coverage. He or she will then have 60 days to elect the coverage and pay the required premium, and another 45 days to pay the premium covering the time period before election.

If the terminated Member is a minor, his or her parent or guardian may act on his or her behalf to elect COBRA continuation coverage.

Second Qualifying Event

If your family has another qualifying event (such as a legal separation, divorce, etc.) during their initial 18 months of COBRA continuation coverage (or 29 months, if the disability provision applies), your spouse and Dependent children can receive up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months from the original qualifying event. Such additional coverage is only available if the second qualifying event would have caused your spouse or Dependent children to lose coverage under the Plan had the first qualifying event not occurred. A qualified beneficiary must give timely notice to the Plan Administrator in such a situation.

Continuation of Coverage During a Military Leave

Another Federal law, the Uniformed Service Employment and Reemployment Rights Act (USERRA) requires that employers provide employees who are members of the military with military leave during the course of their employment. Employers must provide a cumulative total of 5 years, and in certain circumstances, more than 5 years, of military leave.

Extension of Benefits

If a Member is Totally Disabled on the date of termination of the Evidence of Coverage, coverage will be extended. Benefits will continue to be paid under the terms of the Evidence of Coverage

for Eligible Expenses due to the disabling condition. Extension of Benefits will continue until the earlier of:

- a) the date payment of the maximum benefit occurs
- b) the date the Member ceases to be Totally Disabled, or
- c) the end of 90 days following the date of termination.

This Extension of Benefits is not applicable if the Evidence of Coverage is replaced by another carrier providing substantially equivalent or greater benefits.

Notification Requirements

The Covered Dependent must notify the Group within 15 days of the Covered Employee's death, retirement, or divorce. The Group will immediately provide written notice to the Covered Dependent of the right to continue coverage and will send the election form and instructions for premium payment.

Within 60 days of the Covered Employee's death, retirement, or divorce, the Covered Dependent must give written notice to the Group of the desire to exercise the right of continuation or the option expires. Coverage remains in effect during the 60-day period provided premium is paid.

V. HOW YOUR EVIDENCE OF COVERAGE WORKS

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

The Participating Provider Plan pays a portion of Covered Expenses after Members meet the applicable Copayments and Deductibles each Year. This section describes Deductibles and Copayments and discusses steps Members should take to ensure that You receive the highest level of inpatient and outpatient benefits available under this Plan. See the Section of this Plan titled "Definitions" for a definition of Covered Expenses and Covered Services.

The inpatient and outpatient benefits described in the following sections are provided for Covered Expenses incurred by Members while covered under this Plan. An expense is incurred on the date You receive the service or supply for which the charge is made. These benefits are subject to all provisions of this Plan, which may limit benefits or result in benefits not being payable. Either the Member or the provider of service must claim benefits by sending MHHP properly completed claim forms itemizing the services or supplies received and the charges.

This section shows the maximum Covered Expense for each type of provider. No benefits are payable unless the Member's coverage is in force at the time services are rendered, and the payment of benefits is subject to all the terms, conditions, limitations and exclusions of this Plan.

Service Providers

Primary Care Physician

Your Primary Care Provider (PCP) is a health care professional who meets State requirements and is trained to give You basic medical care. The term "PCP" will be used throughout this Evidence of Coverage. Generally, You will get Your routine or basic care from Your PCP. Your PCP will also coordinate the covered services You need including X-rays, lab tests, therapies, specialists, hospital admission, and follow up care. Your PCP also contacts other plan Providers for updates about Your care and/or treatment. When all parties are informed of Your medical condition, You receive the most effective and necessary treatment. The following providers may act as a PCP:

- Internist/Internal Medicine
- Family Practitioner
- General Practitioner
- Geriatrician
- Pediatrician
- Other provider as specifically designated by Us

A Member may select, in addition to a PCP, an obstetrician or gynecologist to provide health care services within the scope of the professional specialty practice of a properly credentialed obstetrician or gynecologist. A family physician, internal medicine physician, or other qualified physician may be selected to provide obstetrical or gynecological care. A Member who selects an obstetrician or gynecologist may do so without a referral from the primary care physician or prior Authorization or precertification from the HMO.

In addition, an enrollee with a chronic, disabling, or life-threatening illness may apply to the health maintenance organization's medical director to use a nonprimary care physician specialist as the enrollee's primary care physician.

Choosing a PCP

Your Provider Directory contains a list of providers who are participating in Our network. If You don't have Your copy of the Provider Directory, You can request an up-to-date copy from Member Services which will include provider their qualifications. You can also see the Provider Directory at <http://healthplan.memorialhermann.org/members/> or download it from Our website.

Changing your PCP

You may change Your PCP for any reason, at any time. To choose another PCP from Our network, call our Member Service department at the number shown on your Member ID Card. A PCP change request received by the last working day of the month will be effective on the first day of the month following Your request.

Notice of Physician or Provider Termination /Continuity of Care

It is possible that Your PCP may leave or be terminated from Our network of providers and You will have to find a new PCP. For convenience, We recommend that You ask Your former PCP to transfer Your medical records to Your new PCP. We will provider thirty (30) days advance written notice of a provider's impending separation or termination from MHHP.

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.

Special Circumstances

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

Covered Expenses for the services of a Non-Participating Provider will be paid according to the in-network benefit schedule ONLY:

- 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. Ask Your PCP to 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 or services. Please notify Us as soon as possible after obtaining emergency or. 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.

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 most of 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. If You have a chronic, disabling, or life-threatening illness, You may apply to Our medical director to use a non-primary care physician specialist as Your Primary Care Physician. To be eligible to serve as Your Primary Care Physician, a physician specialist must:

- Meet Our requirements for primary care physician participation; and
- Agree to accept the responsibility to coordinate all of Your health care needs.

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 Evidence of Coverage and will not be more than would be paid if the service or supply had been received in the MHHP 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 MHHP more than the MHHP Negotiated Rates. In addition, Participating Providers will file claims with Us for You. A directory of local MHHP Participating Providers is available through Our website, shown in the Contact Information section in the Introduction to this Evidence of Coverage, or by calling Our member service department at the toll free number shown in the Contact Information section in the Introduction to this Evidence of Coverage. You will always be responsible for any expense incurred which is not covered under this Evidence of Coverage.

Emergency Care

Coverage for Emergency and Urgent 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.

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 a referral or authorization first from Your PCP.

- 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 MHHP 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. MHHP 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 Evidence of Coverage.

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 are 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 (1) hour 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 urgent or emergency basis.

Paying for Services

Deductibles

If applicable, Deductibles are annually set amounts of covered expenses. Members must pay before We will pay for 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, MHHP will pay benefits for other Covered Charges above the Member's reached Deductible amount. The deductible does not include any Copayments applicable for the rest of the Evidence of Coverage Year. All charges must be incurred while the Member(s) are covered under this Evidence of Coverage.

Family Deductibles

If applicable, The Family Deductible is a cumulative amount all family members enrolled in the same Evidence of Coverage meet for each Evidence of Coverage Year. 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 an Evidence of Coverage 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 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 Evidence of Coverage 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 Evidence of Coverage 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.

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 Plan. 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) and Copayments for an Evidence of Coverage 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 Evidence of Coverage Year. If other than Individual coverage applies, when members of the same family covered under this Evidence of Coverage have collectively met the family Out-of-Pocket Limit of Deductibles and Copayments for an Evidence of Coverage year as noted in the Schedule of Benefits section, We will provide coverage for 100% of the Allowed Amount for the rest of the Evidence of Coverage 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 and Copayment 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 Preauthorization 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.

MHHP 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 Plan 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 Evidence of Coverage.

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 Plan. All services are paid at the percentages indicated and subject to limits outlined in the Section titled "How Your Evidence of Coverage Works."

Any Benefits listed in this Evidence of Coverage, which are not mandated by State or Federal law, may be deleted or revised.

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 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.

Benefits 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 Evidence of Coverage.

Exceptions:

- Charges incurred prior to pre-transplant evaluation.
- Charges incurred for testing administered to people other than the 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 Copayment 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 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. Coverage includes: (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.)

- 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 Evidence of Coverage 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

MHHP 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 Copayment 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 Evidence of Coverage 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 gravidarum, pre-eclampsia, 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 are 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 well baby and well child care benefits will be provided consistent with those benefits listed in this Evidence of Coverage. 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 Evidence of Coverage 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 an Evidence of Coverage of a Subscriber with a Family Evidence of Coverage.

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 consist 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 Evidence of Coverage 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 Evidence of Coverage.]

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 20. 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 Evidence of Coverage 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 MHHP, covered low vision services will include one comprehensive low vision evaluation every 5 years for follow-up care, four visits in any five-year period.

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

Benefits	Allowable Charge (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 Evidence of Coverage 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 Evidence of Coverage 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 MHHP 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 Worker's 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 MHHP.
- Dental treatment and expenses incurred for such treatment started prior to the Member's eligibility to receive benefits under this Evidence of Coverage, 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 MHHP program unless the denture becomes unsatisfactory due to illness or other causes not controlled by ordinary circumstances. Replacement under this Evidence of Coverage 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 & Limitations

- Replacement of appliances due to theft, loss or breakage.

- Re-treatment by an MHHP dentist when the original treatment was done by a different MHHP dentist or treatment in progress at inception of eligibility unless treatment is continued by an MHHP 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 Evidence of Coverage . 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 inpatient 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. Referrals are not required

for Prevention, wellness and education related services for Occupational Therapy. 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 3 years of age will not be subject to any plan limits for Physical and/or Occupational Therapy, and will not apply to the Plan lifetime maximum benefit limit.

Payment for Medically Necessary early intervention services for treatment of diagnosed developmental delays will be provided to a child under 3 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 Evidence of Coverage 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 Evidence of Coverage 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 Evidence of Coverage 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 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 Evidence of Coverage with MHHP 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 (s) (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 Evidence of Coverage.

Other Benefits & Services

Treatment for Diabetes - Equipment and Supplies

We cover: 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 Evidence of Coverage, 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 Plan 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 Plan.

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
- Protheses 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 Copayment.

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 plan 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 anesthesiologist
- 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 Plan. 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 Plan 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 Copayment 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 Copayment 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 Copayment.

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)

Benefits as specified in this section will be available for the purchase of Orthotic Devices Authorized by the Company. These Benefits will be subject to the following:

- There is no coverage for fitting or adjustments, as this is included in the Allowable Charge for the Orthotic Device.
- Repair or replacement of the Orthotic Device is covered only within a reasonable time period from the date of purchase subject to the expected lifetime of the device. We will determine this time period.
- 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.
- No Benefits are available for supportive devices for the foot, except when used in the treatment of diabetic foot disease and other medically necessary services under the Medicare Benefit Policy Manual noted within this Evidence of Coverage.

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 Evidence of Coverage 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, 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 Copayment 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 described or 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 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 United States Department of Veterans Affairs; or
 - The United States Department of Energy.
 - The study or investigation is conducted under an investigational new drug Application reviewed by the Food and Drug Administration.
 - 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 Plan, at the rates that are established under the Plan, as payment in full for the routine patient care provided in connection with the clinical trial and the treatment is pre-approved by MHHP. 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, MHHP 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 Evidence of Coverage covers Prescription Drugs. A Prescription Drug Formulary is a list of Prescription Drugs covered under this Evidence of Coverage. 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 three-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.

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 Evidence of Coverage. We will cover any approved Prescription Drug at the benefit level until the 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.

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.

We will provide notice of an adverse determination for a concurrent review of the provision of prescription drugs or intravenous infusions for which You are receiving benefits under this Evidence of Coverage not later than the 30th day before the date on which the provision of prescription drugs or intravenous infusions will be discontinued.

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 Evidence of Coverage. 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 Evidence of Coverage .

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 Plan. In addition, reimbursement will not be provided for:

- Drugs, medications and supplies from a Non-Participating Provider.
- 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 Plan.
- 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.
- Anorexiant or drugs associated with weight loss, except as provided under Child and Adult Preventive Care Services.
- Drugs obtained outside the United States.
- Allergy desensitization products, allergy serum.
- All Infusion Therapy is excluded under this Plan 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 an Evidence of Coverage 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."
- 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) 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 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 visits per Benefit Period to an obstetrician/gynecologist. Additional visits recommended by the Member's obstetrician/gynecologist may be subject to the Deductible Amount or Copayment shown on the Schedule of Benefits, if not a preventive service.
- One (1) routine Pap smear, cervical and ovarian cancer 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 mammogram for women age 35 – 39 and
 - One (1) baseline screening mammogram annually for women age 40 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 Copayment 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.
- Prescribed 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 Evidence of Coverage 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 Evidence of Coverage Benefits when the tests are Medically Necessary.

Adult Immunizations

MHHP 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

MHHP 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 or Deductibles when provided in accordance with the recommendations of ACIP and when provided by a Participating Provider.

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 Screenings

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. MHHP'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

MHHP 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 MHHP. 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 Evidence of Coverage except where specifically stated under the benefit for Infusion Therapy.

Claims Questions

Your claim(s) will be processed according to the terms of this Evidence of Coverage, 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 Evidence of Coverage, 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 Evidence of Coverage. 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 Evidence of Coverage.

Claims Provisions

A claimant's right to make a claim for any benefits provided by this Evidence of Coverage 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 Evidence of Coverage holder. 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*
Proof of loss must be sent to Us within one (1) year of the loss, except in the case of legal incapacity. If a notice or proof is sent later than 90 days of the loss, We will not deny or reduce a claim if the notice or proof if it was sent as soon as possible.

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. Evidence of Coverage Evidence of Coverage

- *Payment Of Claims*
We will pay all benefits to which the claimant is entitled as soon as We receive written proof of loss. All benefits will be paid as they accrue.
- *Physical Exams*
We, at our expense, have the right to examine Subscriber. 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.
- In the event of a weather-related catastrophe or major natural disaster, as defined by the commissioner, the claim-handling deadlines imposed under this subchapter are extended for an additional 15 days.

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 Evidence of Coverage number, patient's name and date of service readily available.

X. COMPLAINT, GRIEVANCE & APPEALS

Complaints and Grievances

MHHP 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 referral denials, 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: Complaints
Phone: (713) 338-6535 or 1-888-642-5040
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. MHHP 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 the health maintenance organization receives 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.

Additionally, a Member who is not satisfied with the resolution of the Complaint has the right to appear in person before a complaint appeal panel at the site at which the Member normally receives health care services or at another site agreed to by the Member, or the Member may address a written appeal to the complaint appeal panel. We will send an acknowledgment letter to the Member no later than five (5) business days after the date the written request for appeal is received. We will complete this appeals process no later than thirty (30) calendar day after the date the written request for appeal is received.

An appeal of a Complaint relating to an ongoing Emergency or denial of continued Hospitalization shall be concluded in accordance with the medical or dental immediacy of the case and no later

than one (1) business day after the Member's request for appeal is received. At the request of the Member, We will provide, instead of a complaint appeal panel, a review by a physician or provider who has not previously reviewed the case and is of the same or a similar specialty as the physician or provider who would typically manage the medical condition, procedure, or treatment under consideration for review in the appeal.

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 determination.
- If the Member has questions or needs assistance putting the Appeal in writing, the Member may call Our Member Service Department at 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 an Informal Reconsideration of Our coverage decision when they concern Medical Necessity determinations. MHHP 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 determination, within 180 days of receipt of the adverse determination. There are several methods for initiating an internal Appeal:

- Verbally: Member Services at 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: Complaints

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 Evidence of Coverage 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 determinations based on Agreement limitations or exclusions. Administrative Appeals should be submitted in writing to:

Memorial Hermann Health Plan
929 Gessner Road, Suite 1500
Houston, TX 77024
Attn: Administrative Appeals

MHHP 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. The Internal Appeal process is not required for denial of prescription drugs, intravenous infusions or life threatening circumstances.

After a binding decision in favor of an enrollee relating to a health care service already provided, MHHP 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 Utilization Review Organization (IRO) after final internal adverse Determinations, except where the final internal adverse Determination was based on eligibility, including rescission, or the application of a Evidence of Coverage 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 determination, file a written request with the Texas Department of Insurance.

XI. PREAUTHORIZATION PROGRAM AND PROCEDURES

This Evidence of Coverage 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 Preauthorization.

Preauthorization 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 Evidence of Coverage 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 Evidence of Coverage.

Preauthorization 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 Preadmission 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 Process and Time Frames

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 MHHP Review Center at the telephone number shown in the Contact Information section in the Introduction to this Evidence of Coverage 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 MHHP 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.

If the proposed health care services involve inpatient care which would require preauthorization, We will review the request and issue a length of stay for the admission into a health care facility based on the recommendation of Your physician or provider and Our written medically accepted screening criteria and review procedures. If the proposed health care services are to be provided while You are an inpatient in a health care facility at the time the services are proposed, We will review the request and issue a determination indicating whether proposed services are preauthorized within 24 hours of the request by the physician or provider.

If the proposed medical care or health care services involve post-stabilization treatment, or a life-threatening condition, We will issue and transmit a determination indicating whether proposed services are preauthorized within the time appropriate to the circumstances relating to the delivery of the services and the condition of the Member, but in no case to exceed one hour from receipt of the request. The determination will be provided to the provider of record. If We issue an adverse determination in response to a request for post-stabilization treatment or a request for treatment involving a life-threatening condition, We will provide to the Member or individual acting on behalf of the Member, and the Member's provider of record, a notification regarding Independent Review of Adverse Determinations.

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 Evidence of Coverage, 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. If We discontinue the provision of prescription drugs or intravenous infusion, You will receive the notice no later than the 30th day before the date on which the provision of prescription drugs or intravenous infusions will be discontinued.

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.

Non-Urgent Preauthorization

When You submit a request for benefits for services not included in Post-Stabilization Treatment or Life Threatening Condition authorization or Concurrent Hospitalization Care authorization, a determination will be issued and transmitted not later than the third calendar day after the date the request is received by MHHP.

Preadmission 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 MHHP 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 MHHP 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 MHHP denies a request for additional benefits, in whole or in part, We must explain the reason for the adverse benefit decision and the Evidence of Coverage 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, MHHP decides to reduce or end these benefits, in whole or in part:

- MHHP 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 Evidence of Coverage provisions upon which the decision was made.
- To keep the benefits MHHP has already approved, a Member must successfully appeal MHHP's decision to reduce or end those benefits. A Member must appeal to MHHP 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 MHHP 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 MHHP 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 Evidence of Coverage 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.
- MHHP may not deny or reduce payment to a physician or provider for 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 MHHP issues an Adverse Determination in response to a request for post-stabilization treatment or a request for treatment involving a life-threatening condition, MHHP 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 Preadmission 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 Evidence of Coverage. 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.

Adverse Determination Process and Time Frames

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 Preauthorization 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.

We will provide notice of an adverse determination as follows:

(1) with respect to a patient who is hospitalized at the time of the adverse determination, within one working day by either telephone or electronic transmission to the provider of record, followed by a letter within three working days notifying the patient and the provider of record of the adverse determination;

(2) with respect to a patient who is not hospitalized at the time of the adverse determination, within three working days in writing to the provider of record and the patient; or

(3) within the time appropriate to the circumstances relating to the delivery of the services to the patient and to the patient's condition, provided that when denying poststabilization care subsequent to emergency treatment as requested by a treating physician or other health care provider, the agent shall provide the notice to the treating physician or other health care provider not later than one hour after the time of the request.

We will provide notice of an adverse determination for a concurrent review of the provision of prescription drugs or intravenous infusions for which You are receiving benefits under this Evidence of Coverage not later than the 30th day before the date on which the provision of prescription drugs or intravenous infusions will be discontinued.

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, denials of continued stays for hospitalized members, and denials for the provision of prescription drugs or intravenous infusions for which You are receiving benefits under this Evidence of Coverage:

- 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 or have been denied the provision of prescription drugs or intravenous infusions for which You are receiving benefits under this Evidence of Coverage, 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 Evidence of Coverage and complications from services, supplies and treatment for services that are not covered under this Evidence of Coverage . MHHP 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 Evidence of Coverage; 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 Evidence of Coverage.
- Care or treatment by means of dose intensive chemotherapy, except as otherwise stated in this Evidence of Coverage.
- 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 Evidence of Coverage .

- Experimental or Investigational treatments, procedures, hospitalizations, drugs, biological products or medical devices, except as otherwise stated in this Evidence of Coverage.
- Extraction of teeth, except as otherwise stated in this Evidence of Coverage.
- Services or supplies for or in connection with:
 - Except as otherwise stated in this Evidence of Coverage 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 Evidence of Coverage 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.
- 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 Evidence of Coverage ; 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 Evidence of Coverage.
- Charges for missed appointments.

- Charges for nicotine dependence treatments and management drugs unless otherwise stated in the Preventive Care section of this Evidence of Coverage. Any charge identified as a Non-Covered Charge or which are specifically limited or excluded elsewhere in this Evidence of Coverage, or which are not Medically Necessary and Appropriate, except as otherwise stated in this Evidence of Coverage.
- 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 Evidence of Coverage 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 Evidence of Coverage.
- 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.
- Prescription Drugs or new dosage forms that are used in conjunction with a treatment or procedure that is determined to not be a Covered Service.
-
- Drugs used solely for the purpose for weight loss.
- Life Enhancement Drugs for the treatment of sexual dysfunction, (e.g. Viagra).
- Prescription Drugs dispensed outside of the United States, except as required for Emergency treatment.
- 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 Evidence of Coverage.
- 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.
- Services or supplies related to Routine Foot Care except:
 - An open cutting operation to treat weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions;
 - The removal of nail roots; and
 - Treatment or removal of corns, calluses or toenails in conjunction with the treatment of metabolic or peripheral vascular disease.
- 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 Evidence of Coverage.
- 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 Evidence of Coverage and under military health coverage and who receive care in facilities of the Uniformed Services.

- Provided outside the United States other than in the case of Emergency and except as provided below with respect to a full-time student.

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 benefits coverage; foreign travel; school admissions; or attendance including examinations required for participation in athletic activities.
- Transplants, except as otherwise listed in this Evidence of Coverage.
- Transportation, travel.
- Vision therapy.
- 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 Evidence of Coverage .
- 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 MHHP. 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 plan, 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 MHHP 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 plan, and change your Primary Care Provider for any reason.
- Have your medical information kept confidential by MHHP and Your doctor. MHHP 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 MHHP 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 MHHP 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 MHHP policies that affect Your rights and responsibilities.

You have the responsibility to:

- Review and understand the information You receive about Your health benefit plan 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 Plan.
- 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 Plan.
- Voice Your opinions, concerns or complaints to MHHP Consumer Service and/or Your healthcare professional.
- Notify MHHP 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 plan 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 plan's benefits that is accessible and appropriate for You.

If You have any trouble getting information from our plan 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 Evidence of Coverage, and tell them that You want to file a complaint.

Action Against Party Liable

By receiving service from MHHP, You and Your Covered Dependents assign to MHHP 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 MHHP is entitled to recover will be limited to the cost of providing such services. is entitled to discharge of its subrogation rights on a prorata basis with any other contractual or statutory subrogation holder. Furthermore, MHHP 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 MHHP is entitled to subrogate up to the value of MHHP's claim.

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 Plan. 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 MHHP from strictly applying the express benefits, limitations, and exclusions of the Plan at any other time or for any other Member.

Amendments

We may make amendments to the Evidence of Coverage upon 60 days' notice to the Evidence of Coverage holder and as noted below. An amendment will not affect benefits for a service or supply furnished before the date of change; and no change to the benefits under this Evidence of Coverage will be made without approval.

Only Our officers have authority to waive any conditions or restrictions of the Evidence of Coverage, to extend the time in which a premium may be paid, to make or change an Evidence of Coverage, or to bind Us by a promise or representation or by information given or received. No change in the Evidence of Coverage is valid unless the change is shown in one of the following ways:

- It is shown in an endorsement on it signed by one of Our officers.
- If a change has been automatically made to satisfy the requirements of any state or federal law that applies to the Evidence of Coverage, as provided in the section of this Evidence of Coverage called **Conformity With Law**, it is shown in an amendment to it that is signed by one of Our officers.
- If a change is required by Us, it is accepted by the Evidence of Coverage holder, as evidenced by payment of a premium on or after the Effective Date of such change.
- If a written request for a change is made by the Evidence of Coverage holder, it is shown in an amendment to it signed by the Evidence of Coverage holder and by one of Our officers.

Assignment

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

Clerical Error – Misstatements

No clerical error or programming or systems error by the Evidence of Coverage holder or by Us in keeping any records pertaining to coverage under this Evidence of Coverage 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 Evidence of Coverage holder 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 Evidence of Coverage's **Incontestability** section, the true facts will be used in determining whether coverage is in force under the terms of this Evidence of Coverage.

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 Evidence of Coverage. 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 "Preauthorization Program and Procedures" in the section of Your Evidence of Coverage entitled "How the Plan 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 Evidence of Coverage 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 Evidence of Coverage.

Cooperation with MHHP

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 MHHP. You or Your Covered Dependents may not settle, compromise or release a claim against a third party unless (1) the rights of MHHP are expressly reserved in the settlement, compromise or release and You advise the MHHP in writing within such period of time as is reasonably necessary to protect MHHP's rights, (2) MHHP is paid in full up to the benefits paid by MHHP for that injury, or (3) MHHP has given a written waiver of claim after notice. MHHP 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 MHHP any subrogation without offset for attorney's fees or other costs of representation.

Coordination Of This Plan'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 Evidence of Coverage 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 benefits policies, excluding disability income protection coverage; individual and group health maintenance organization evidences of coverage; individual accident and health benefits policies; individual and group preferred provider benefit plans and exclusive provider benefit plans; group benefits contracts, individual benefits 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 plan" means, in a COB provision, the part of the Evidence of Coverage 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 Evidence of Coverage providing health care benefits is separate from this plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with like benefits, and may apply other separate COB provisions to coordinate other benefits.

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

(c) "Allowable expense" is a health care expense, including deductibles 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 or copayment for which the insured 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 plan 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 contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide out-of-network benefits.
- 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 plan, 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, contract 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, contract 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, Evidence of Coverage 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 Plan

When this plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all plans are not more than the total allowable expenses. In determining the amount to be paid for any claim, the secondary plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any allowable expense under its plan that is unpaid by the primary plan. The secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim equal 100 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 plan and other plans. MHHP will comply with federal and state law concerning confidential information for the purpose of applying these rules and determining benefits payable under this plan and other plans covering the person claiming benefits. Each person claiming benefits under this plan must give MHHP any facts it needs to apply those rules and determine benefits.

Facility of Payment

A payment made under another plan may include an amount that should have been paid under this plan. If it does, MHHP may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under this plan. MHHP 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 Evidence of Coverage is governed by the laws of the State of Texas.

Incontestability of the Evidence of Coverage

There will be no contest of the validity of the Evidence of Coverage, except for not paying premiums, after it has been in force for two years. No statement in any Application or Enrollment Form, except a fraudulent statement, made by the Evidence of Coverage holder or by a Covered Person covered under this Evidence of Coverage 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 Evidence of Coverage 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 Plan is not a supplement to Medicare. The Plan 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 to Part B of Medicare 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.

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 Plan minus any amount paid by Medicare.

Benefits for Medicaid Eligible Members

Members eligible for Medicaid receive full benefits of this Plan. 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 Plan, and are subject to all other restrictions of this Plan.

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.

MHHP'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 MHHP paid for or provided those health care services, then MHHP is entitled to subrogation rights against such person or entity. MHHP 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. MHHP is also entitled to recover its costs and expenses related to recovery activities, including, but not limited to, attorney's fees and court costs.

Notices and Other Information

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

- If to Us: To Our last address on record with the Evidence of Coverage holder.
- If to the Evidence of Coverage holder: To the last address provided by the Evidence of Coverage holder 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 Evidence of Coverage is in force in order for this Evidence of Coverage 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 Evidence of Coverage stays in effect. If any premium is not paid by the end of the Grace Period, coverage will end as of the end of the period for which premium has been paid? You may be responsible for the payment of charges incurred for services or supplies received during the Grace Period.

Right of Recovery

If the amount of the payments made by MHHP 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

MHHP 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 quarterly;
- Any date that the extent or nature of the risk under the Evidence of Coverage is changed:
 - By amendment of the Evidence of Coverage; 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 Evidence of Coverage.

We will give You 60 days written notice when a change in the premium rates is made. However, We may change the premium rates from time to time, but no more frequently than quarterly.

Statements

No statement will void the coverage, or be used in defense of a claim under this Evidence of Coverage, 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 Evidence of Coverage holder may renew this Evidence of Coverage for a term of one (1) calendar year. All renewals are subject to the payment of premiums then due, computed as provided in this Evidence of Coverage's **Premium Rates** section and to the provisions stated below.

We have the right to non-renew this Evidence of Coverage on the renewal date following written notice to the Evidence of Coverage holder 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;

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 Evidence of Coverage will end as described in the Grace Period provision.

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

This Evidence of Coverage 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 Evidence of Coverage, 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 Evidence of Coverage; (Coverage will end as of the effective date.)
- with respect to a Covered Person other than a Dependent, termination of eligibility if You are no longer a Resident, (We will give You at least 30 days written notice that coverage will end.)
- 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, unless coverage ends earlier for other reasons.

A Dependent's coverage ends when the Dependent is no longer a Dependent, as defined in the Evidence of Coverage. Coverage ends at 12:01 a.m. on the date the first of these events occurs. Also, Dependent coverage ends when the Evidence of Coverage holder'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 Plan to You subject to the following:

- You agree to advise MHHP, 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 Plan. 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 Plan 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 Plan 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 Evidence of Coverage are not in place of, and do not affect requirements for coverage by Workers' Co