[Name of Group]
[Name of Plan]
Summary Plan Description (SPD) Wrap Document

Effective [Month Day], 2024

This document, together with the Member Handbook prepared by **Memorial Hermann Health Solutions, Inc.** (MHHSI) and any Summary of Material Modifications issued by Employer (defined below), is Your Summary Plan Description. If the Member Handbook is not attached, then this Summary Plan Description is not complete and You should contact Your Employer for a complete copy.

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Attachment: Hybrid Plan Member Handbook

1. INTRODUCTION

[Name of Group] ("Employer") maintains the [Name of Plan] ("Plan") for the benefit of its eligible employees and their eligible dependents. Benefits under the Plan are currently provided an administrative services agreement ("Services Agreement") entered into between the Employer and Memorial Hermann Health Solutions, Inc., its third- party administrator.

Plan benefits, including information about eligibility, are summarized in the MHHSI Hybrid Member Handbook ("Handbook") and Provider Directory. These documents are available to members through Memorial Hermann Health Solutions, Inc. ("MHHSI") If a paper copy is needed, contact MHHSI to obtain one free of charge. You must read the Handbook to understand Your benefits.

This document provides You with an overview of the Plan and addresses certain information that may not be included in the attached Handbook. This document, together with the attached Member Handbook provided by MHHSI, is the Summary Plan Description ("SPD") required by the Employee Retirement Income Security Act of 1974 ("ERISA"). This document is not intended to give You any substantive rights to benefits that are not already provided in the attached Handbook.

To facilitate efficient operation of the Plan, the Plan may allow forms (e.g., election forms and notices), whether required or permissive, to be sent and/or made by electronic means.

Plan benefits are provided pursuant to the Employer's employee welfare benefit plan.

Nothing in this document shall be construed as a contract of employment between the Employer and any participant, or as a guarantee of any participant to be continued in the employment of the Employer, nor as a limitation on the right of the Employer to discharge any of its employees with or without cause.

Para asistirle en Español, por favor llame el numero 855-645-8448, de lunes a viernes, 8:00 a.m. hasta 5:00 p.m.

1. GENERAL PLAN INFORMATION

A. ***Plan Name:*** [Name of plan, and if different, the name by which the plan is commonly known].

B. ***Plan Year:*** The 12-month period beginning [e.g., January 1] and ending [e.g., December 31].

C. ***Type of Plan:*** A group health plan (a type of welfare benefits plan subject to the provisions of ERISA).

D. ***Internal Revenue Service Identification Number:*** [Tax ID Number; e.g., 99-9999999]

E. ***Effective Date:*** The effective date of this document is [date]. The original effective was [date]. [This plan has been amended several times since the original effective date.]

F. ***Funding Method:*** The Plan is self-insured. The Employer shares the cost of Employee [and Dependent] coverage under this Plan with the covered Employees. The enrollment application for coverage will include a payroll deduction authorization. This authorization must be filled out, signed and returned with the enrollment application.

G. The level of any Employee contribution is set by the Employer, which reserves the right to change the amount of Employee contributions, including contributions, Co-payments, Out-of-Pocket expenses, Deductibles, and fees, costs, and charges.

H. Claims are sent to MHHSI, which is responsible for paying claims. MHHSI and the Employer share responsibility for administering the Plan. The costs of funding the plan for employees and their families are paid in part by the Employer out of its general assets, and in part by employee after-tax payroll deductions. The Employer provides a schedule of the applicable premiums; contact the Human Resources Manager of Employer if You need another copy. Employee after-tax payroll deductions will be used in their entirety prior to using Employer contributions to pay for premiums under the Plan. Any refund, rebate, dividend, experience adjustment, or other similar payment under the Plan will be allocated, consistent with the fiduciary obligations imposed by ERISA, to reimburse Employer for amount that it has paid.

2. NAMES AND ADDRESSES

A. ***Plan Sponsor:***

[Name of Employer, Employee Organization, Association, or Other]
[Address]
[City, State, Zip Code]
[Phone Number]

B. ***Plan Administrator and Named Fiduciary:***

[Name of Employer, Employee Organization, Association, or Other]
[Address]
[City, State, Zip Code]
[Phone Number]

C. ***Designated Agent for Service of Legal Process:***

[Name and/or title of person designated by the Employer to receive legal documents]
[Address]
[City, State, Zip Code]
[Phone Number]

D. ***Third-Party Administrator***

Memorial Hermann Health Solutions, Inc.
P.O. Box 19909
Houston, TX. 77224-1909
855-645-8448

3. Eligibility and Participation Requirements

A. ***Eligibility and Time Limits:*** In general, to determine whether You or Your spouse and/or dependents are eligible to participate in the Plan and how to enroll, please read the eligibility section in the attached Member Handbook.

B. ***Open Enrollment:*** An open enrollment period is a time established by the Employer when eligible employees and their eligible family members have the option to enroll in the Plan or make changes to current Plan coverage.

C. ***Special Enrollment and Reinstatement:*** In certain circumstances, enrollment may occur outside the open enrollment period. These circumstances, rights, and enrollment timelines are described in the attached Member Handbook.

D. ***Termination of Coverage:*** Coverage shall terminate as described in the attached Member Handbook.

E. ***Continuation of Coverage:*** An explanation of continuation coverage, including information about qualifying events, beneficiaries, premiums, notice and election requirements and procedures, and duration of coverage is described in the attached Member Handbook.

F. ***Post Retirement Coverage:*** Retiree coverage is not available, except as indicated in the attached Member Handbook.

4. Summary of Plan Benefits

A. ***Health Benefits:*** The Employer has contracted with Memorial Hermann Health Solutions, Inc**.** (MHHSI**)** to administer certain health care benefits on the Employer's behalf. A summary of the benefits provided under the Plan are set forth in the attached Member Handbook. The Member Handbook describes the types of benefits, scope of coverage, prerequisites to being covered and other details regarding the benefits. As noted above, You must read the Member Handbook to understand Your benefits.

B. ***Denial, Loss or Recovery of Benefits:*** As described in the attached Member Handbook, Your ability to incur expenses to be paid by the Plan ends when Your coverage ends. Please also review the attached Member Handbook for any continuation of coverage rights that You or a dependent may have under the Plan. The attached Member Handbook also describes when the Plan may recover overpaid benefits or erroneously paid benefits through its right to subrogation and reimbursement.

C. ***Exclusions and Limitations:*** The Plan includes certain exclusions and limitations that may result in the denial of a claim or a loss or reduction of a benefit. Please read the attached Member Handbook carefully to understand these limitations. Other situations may also lead to a reduction or limitation (e.g., timeline to file a claim), which are described in the attached Member Handbook.

5. How the Plan is Administered

A. ***Plan Administration:*** The Plan Administrator is the Employer. As the Plan Administrator, the Employer is responsible for satisfying certain legal requirements under ERISA with respect to the Plan (e.g., distributing SPDs and filing an annual report about the Plan with the government). The authorized party on behalf of the group for benefit administration is the person who acts on behalf of the Plan Administrator.

B. ***Plan Operations and Authority of the Third-Party Administrator.*** The Plan is self-insured. The Plan is administered by both the Employer and Memorial Hermann Health Solutions, Inc., and the Employer has delegated responsibility for determinations regarding covered benefits and the amount and manner of the payment of benefits, including the appeal of denied claims, to Memorial Hermann Health Solutions, Inc.

C. ***Claims Procedures:*** Refer to the attached Member Handbook for details on obtaining preauthorization, approvals, procedures for filing claims, notification of benefit determinations, grievance procedures for the review and appeal of denied claims, refund of overpayments, and subrogation. Please note that certain procedures (e.g., appealing a denied claim) have specific time limits. If You do not take action on time, You may lose certain rights (e.g., the right to file suit in a state or federal court if You fail to appeal a denied claim on time).

D. ***Questions***: If You have any general questions about the Plan (e.g., whether You are eligible to participate), please contact the Plan Administrator of the Employer. If You have questions about benefits, the provider network, or general plan benefit information, please contact MHHSI.

6. Termination of the Plan

The Employer reserves the right to terminate the Plan at any time in its discretion. The Plan may be terminated by a written instrument duly adopted by the Employer or any of its delegates.

7. Statement of ERISA Rights

As a participant in the Plan, You are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits
Examine, without charge, at the Employer's principal office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Employer may make a reasonable charge for the copies.

Receive a summary of the Plan's annual Form 5500, if any is required by ERISA to be prepared, in which case the Employer, as Plan Administrator, is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage
Continue health care coverage for Yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or Your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing Your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries
In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate Your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of You and other Plan participants and beneficiaries. No one, including Your employer, Your union, or any other person, may fire You or otherwise discriminate against You in any way to prevent You from obtaining a (pension, welfare) benefit or exercising Your rights under ERISA.

Enforce Your Rights
If Your claim for a welfare benefit is denied or ignored, in whole or in part, You have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps You can take to enforce the above rights. For instance, if You request a copy of Plan documents or the latest annual report from the plan and do not receive them within 30 days, You may file suit in a Federal court. In such a case, the court may require the Employer, as Plan Administrator, to provide the materials and pay You up to $110 a day until You receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If You have a claim for benefits that is denied or ignored, in whole or in part, You may file suit in a state or Federal court. In addition, if You disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, You may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if You are discriminated against for asserting Your rights, You may seek assistance from the U.S. Department of Labor, or You may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If You are successful, the court may order the person You have sued to pay these costs and feeds. If You lose, the court may order You to pay these costs and fees, for example, if it finds Your claim is frivolous.

Assistance with Your Questions
If You have any questions about Your Plan, You should contact the Plan Administrator of the Employer. If You have any questions about this statement or about Your rights under ERISA, or if You need assistance in obtaining documents from the Plan Administrator, You should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in Your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about Your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Attachment

Hybrid Plan Member Handbook

INTRODUCTION

This Member Handbook includes a description of the Plan sponsored by [*Employer Name*], hereinafter referred to as the Employer. No oral interpretations can change this Member Handbook. The Plan described is designed to protect Covered Persons against certain catastrophic health expenses. *[Employer Name]* (Employer), established the Plan, effective *[effective date of plan year]*, for the purpose of providing Covered Persons with health care and other welfare benefits described in this document. The terms and conditions for eligibility to participate in the Plan and receive benefits from the Plan are explained in this document. This document is to be provided to Covered Persons who are receiving benefits under the Plan. The right to a copy of this document and other rights afforded to Covered Persons under the Employee Retirement Income Security Act ("ERISA") is explained above in the "Statement of ERISA Rights" section of the SPD Wrap Document. Covered Persons are encouraged to study this document and understand the types of benefits to which they are entitled, the eligibility requirements for participating in the Plan, including the timely payment of contributions, the conditions necessary to receive a benefit under the Plan, the amount of the benefits provided under the Plan, and the Covered Person's share of the cost of the benefits.

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DEFINED TERMS

The following terms have special meanings and when used in this Plan will be capitalized.

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

Acquired Brain Injury
Acquired Brain Injury means a neurological insult to the brain, which is not hereditary, congenital, or degenerative and 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.

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

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

- **Community Reintegration Services** means services that facilitate the continuum of care for an affected individual as they transition into the community.

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

- **Neurobehavioral Treatment** means interventions that focus on behavior and the variables that control behavior.

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

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

- **Neurophysiological Treatment** means interventions that focus on the functions of the nervous system.

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

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

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

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

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

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

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

Active Employee - An Employee who is on the regular payroll of the Employer and who is performing the duties of his or her job with the Employer on a full-time basis, unless absence is due to a health status-related factor.

Agreement - The written agreement between Plan Sponsor and Memorial Hermann Health Solutions, Inc. to provide administrative services in support of the Plan.

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

Ambulance Service –Transportation by a specially designated 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 specialized institution that meets all of the following requirements:

- It is permanently established, equipped and operated solely to accommodate the performance of outpatient surgery by Physicians who are legally authorized to perform surgery;
- It has at least two operating rooms and at least one recovery room; is equipped to perform diagnostic lab and x-ray procedures in connection with surgery; has resuscitation equipment for emergencies resulting from surgery, a blood bank and other blood supplies;
- It has the full-time services of Registered Nurses for patient care in operating and recovery rooms;
- It has a written agreement with one or more Hospitals in the area for immediate acceptance of patients who develop complications or require post-operative confinement; and
- It has an organized medical staff supervising its operations as required by established policy and maintains adequate medical records for all patients.

Annual Open Enrollment Period - The period designated by the Plan Sponsor in each year during which Eligible Employees and Dependents may enroll in the Plan.

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

Calendar Year - January 1st through December 31st of the same year.

Chemical Dependency - 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.

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

- Affiliated with a Hospital with an established system for patient referral;
- Accredited as such a facility by the Joint Commission;
- 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 the state of 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.

COBRA - The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

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

Complaint – Any dissatisfaction expressed either orally or in writing by a complainant to an insurer regarding any aspect of their operation including 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.

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

Cosmetic and Reconstructive Surgery - **Cosmetic Surgery** is 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. **Reconstructive Surgery** is surgery to correct abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infections, 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. **Note: 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 Covered Person has finished a series of treatments without a lapse in treatment or has been medically discharged.

Covered Charges - The expenses incurred for Covered Services.

Covered Person - Any eligible Employee or eligible Dependent whose primary residence is covered under this Plan.

Covered Services - Medically Necessary health services, including Prescription Drug services, specified and described in the Medical Benefits and Prescription Drug Benefits sections of this Member Handbook which are available when rendered by a Provider and for which the Covered Person is entitled to receive benefits.

Custodial Care - Care provided primarily to meet a Covered Person's 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 - Annually set amounts of covered expenses Covered Persons 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, You will pay benefits for other Covered Charges above the Covered Person's reached Deductible amount. The Deductible does not include any Copayments applicable for the rest of the Plan Year. All charges must be incurred while the Covered Person(s) is covered under this Member Handbook.

Family Deductibles
If applicable, the Family Deductible is a cumulative amount all family members enrolled in this Plan must pay for each Plan 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 a Plan Year. Once this Family Deductible Limit is satisfied for that Year, We provide coverage for all Covered Charges for all family members who are enrolled in the same Plan.

Dependents (Eligible Dependents) - An Employee's lawful spouse, an Employee's Dependent Child through the age of 26; and; an Employee's Domestic Partner who may be the same or opposite gender of the Eligible Employee who meet the eligibility requirements as described in the Enrollment section of this Member Handbook. Children over the age of 26 may also be Dependents under the circumstances described in the Enrollment section of this Member Handbook.

Dependent Child - A Dependent other than an Employee's lawful or common law Spouse or Domestic Partner. A Dependent Child may be a natural child, an eligible foster child, a stepchild, a child placed for adoption, an adopted child (including a child for whom the Employee or the Employee's Spouse is a party in a suit in which the adoption of the child is sought), a child with a medical support order, a child of any age who is medically certified as disabled, or a child of a Domestic Partner.

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 Eligible Employee 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 Covered Person by filing an affidavit of Domestic Partnership and obtaining a certificate of Domestic Partnership from their local registrar.

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 Plan begins for the Covered Person and/or their dependents. This Plan is effective at 12:01 am on the noted Effective Date.

Eligible Employee - An Employee who meets the eligibility criteria for enrollment in the Plan, as established by the Plan Sponsor.

Employee - A person who is an Active, regular Employee of the Employer, regularly scheduled to work for the Employer in an Employee/Employer relationship.

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

ERISA - The Employee Retirement Income Security Act of 1974, as amended, and the regulations and other regulatory authority issued thereunder by the appropriate governmental authority.

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

(1) its use is mainly limited to laboratory and/or research; or
(2) 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; or
(3) 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; or
(4) reliable evidence shows that the consensus of the opinion among experts is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with the stated means of treatment of diagnosis; or
(5) reliable evidence shows that it is not generally approved or used by Physicians in the medical community; or
(6) it does not have final approval from the appropriate governmental regulatory body.

Reliable evidence means only: 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.

External Review - A review by a person or a third party that is not associated with or affiliated with the Employer or MHHSI. An External Review may be conducted to review adverse determinations and appeals of adverse determinations.

Family - The covered Employee and the family members who are covered as Dependents under the Plan.

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.

Foster Child - An unmarried child under the limiting age shown in the Dependent Eligibility Section of this Plan for whom a covered Employee has assumed a legal obligation. All of the following conditions must be met: the child is being raised as the covered Employee's; the child depends on the covered Employee for primary support; the child lives in the home of the covered Employee; and the covered Employee may legally claim the child as a federal income tax deduction.

A covered Foster Child is not a child: temporarily living in the covered Employee's home; one placed in the covered Employee's home by a social service agency which retains control of the child; or whose natural parent(s) may exercise or share parental responsibility and control.

Generic Drug - A drug that has the same active ingredient as the Brand Name Drug and is allowed to be produced after the Brand Name Drug's patent has expired. Generic Drugs are shown on the Prescription Drug Formulary (the list of covered Prescription Drugs) which is available at https://healthplan.memorialhermann.org/members/resource-center/pharmacy-benefit-information/.

Genetic Information - Information about genes, gene products and inherited characteristics that may derive from an individual or a family member. This includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories and direct analysis of genes or chromosomes.

Grace Period – The amount of time, after the Premium is due, during which payment can still be made without coverage lapsing.

Habilitative Care Benefits - Health care services that help a person to develop skills and functioning for daily living that they are incapable of developing on their own. These services may include Physical and Occupational Therapy and Speech-Language Pathology.

Hospital - An institution that meets all of the following requirements:

- it is operated in accordance with the laws of the jurisdiction in which it is located pertaining to hospitals and is either accredited by The Joint Commission or certified under Medicare;
- it is primarily engaged in providing, on an Inpatient basis, diagnostic and therapeutic facilities for the diagnosis, medical care and treatment of sick and injured persons under the supervision of a staff of Physicians for compensation from its patients and on an Inpatient basis;
- it is not primarily a place for Custodial Care or a nursing or convalescent home but it does provide all services on its premises under the supervision of a staff of Physicians; and
- it continuously provides twenty-four (24) hour a day nursing service by or under the supervision of Registered Nurses (RN's) on the premises.

Illness - A bodily disorder, disease, physical sickness or mental health condition. Illness includes pregnancy, childbirth, miscarriage or Complications of Pregnancy.

Individual Treatment Plan - A written plan for treatment of a Covered Person developed and implemented through a cooperative process between the Covered Person and the health care practitioner and that identifies desired treatment outcomes and strategies for achieving such outcomes.

Infertility - The inability to:

- Conceive after sexual relations without contraceptives for the period of one (1) year; or
- Maintain a pregnancy until fetal viability.

Infusion Therapy - The administration of Prescription Drugs 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 Plan, it shall also include drugs administered by aerosol (into the lungs) and by feeding tube.

Injury - An accidental bodily injury caused by unexpected external means while covered under the Plan. The injury must result in loss directly and independently of all other causes. All bodily injuries caused by one Accident shall be considered as one Injury.

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.

Legal Guardian - A person recognized by a court of law as having the duty of taking care of the person and managing the property and rights of a minor child.

Maintenance Prescription Drugs – Prescription Drugs taken for an extended period of time to treat a long term or chronic medical condition. When You get a long-term supply (90-day supply) of these Drugs, Your Cost-Sharing may be lower. These Drugs may also be eligible for Medication Synchronization plans.

Medical Care Facility - A Hospital, a facility that treats one or more specific ailments or any type of Skilled Nursing Facility.

Medical Emergency/Emergency Medical Condition – A medical condition provided in a Hospital emergency facility, freestanding emergency medical care facility, or comparable emergency facility to evaluate and Stabilize a medical condition of recent onset and severity, including severe pain, that would lead a prudent layperson possessing an average knowledge of medicine and health to believe that the person's condition, sickness or Injury is of such a nature that failure to get immediate medical care could result in:

(1) Placing the Covered Person's health in serious jeopardy;
(2) Causing serious impairment to bodily functions;
(3) Causing serious dysfunction of any bodily organ or part;
(4) Causing serious disfigurement; or
(5) In the case of a pregnant woman, causing serious jeopardy to the health of the fetus.

Medical Synchronization – A unique patient program designed to make it easier for a patient to pick up all their maintenance medication refills at the Pharmacy in a single convenient visit. To utilize this feature, the patient must request a network Pharmacy to adjust their medications and coordinate the refilling of their medication to one convenient monthly medication pickup date. The pharmacist may refer to this option as a "Medication Synchronization program or plan' and will work with the patient on their medication regimen and tailor the program to their needs. This will also allow the Copayments to be prorated based on the synchronized days' supply and most pharmacies perform this service at no cost to the patient. For questions about this process, please call Customer Service at 855-645-8448.

Medically Necessary (Medical Necessity) - Services or supplies are those that MHHSI determines to be **all** of the following:

(1) Appropriate and necessary for the symptoms, diagnosis or treatment of the medical condition;
(2) Provided for the diagnosis or direct care and treatment of the medical condition;
(3) Within standards of good medical practice within the organized medical community;
(4) Not primarily for the patient's convenience, the Physician's or another provider's convenience; and
(5) The most appropriate procedure, supply, equipment or service which can be safely provided must satisfy the following requirements:
    - There must be valid scientific evidence demonstrating that the expected health benefits from the procedure, supply, equipment or service are clinically significant and produce a greater likelihood of benefits, without a disproportionately greater risk of harm or complications, for the patient with the particular medical condition being treated than other possible alternatives; and
    - Generally accepted forms of treatment that are less invasive have been tried and found to be ineffective or are otherwise unsuitable; and
    - For Hospital stays, acute care as an Inpatient is necessary due to the kind of services the patient is receiving or the severity of the medical condition, and that safe and adequate care cannot be received as an outpatient or in a less intensified medical setting.

Medicare - The Health Insurance for the Aged and Disabled program under Title XVIII of the Social Security Act, as amended.

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

Memorial Hermann Health Solutions, Inc. (MHHSI) - The third-party administrator that provides administrative services to Plan Sponsor with respect to the Plan. MHHSI is also the Claims Administrator.

Negotiated Rate - The rate of payment that MHHSI has negotiated with a Participating Provider for Covered Services.

Network Provider – See Participating Provider.

Newborn - A recently born 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 Hospital (out-of-network) - A Hospital that has not entered into a Participating Provider agreement with MHHSI at the time services are rendered**.**

Non-Participating Physician (out-of-network) - A Physician who does not have a Participating Provider agreement in effect with MHHSI at the time services are rendered.

Non-Participating Provider (out-of-network) - A provider who does not have a Participating Provider agreement in effect with MHHSI 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 - The Covered Charges that a Covered Person incurs under the Plan.

Out-of-Pocket Maximum - The maximum amount, as shown on the Schedule of Benefits, of un-reimbursable expenses (including any applicable Deductible Amount and Coinsurance), that must be paid by a Covered Person for Covered Services in one (1) Benefit Period. The Out-of-Pocket Maximum does not include certain amounts indicated on the Schedule of Benefits.

Partial Hospitalization - An outpatient program specifically designed for the diagnosis or active treatment of a mental health condition or Chemical Dependency when there is reasonable expectation for improvement or when it is necessary to maintain a patient's functional level and prevent relapse. This program shall be administered in a psychiatric facility that is accredited by the Joint Commission on Accreditation of Health Care Organizations and shall be licensed to provide partial hospitalization services, if required, by the state in which the facility is providing these services. Treatment lasts less than 24 hours, but more than four hours a day and no charge is made for room and board.

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

Participating Provider (in-network) - A Participating Physician or other health care provider that has a Participating Provider agreement in effect with MHHSI at the time services are rendered. Participating Providers agree to accept the Negotiated Rate as payment in full for Covered Services.

Pharmacy - A state and federally licensed establishment where the practice of pharmacy occurs, that is physically separate and apart from any health care provider's office, and where Prescription Drugs and devices are legally dispensed under Prescriptions to the general public by a pharmacist who is licensed to dispense such Prescription Drugs and devices under the laws of the state in which such pharmacist practices.

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.

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.

Physician - A doctor that is 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 Plan that are within the scope of his or her licensure.

Plan - An employee welfare benefit plan as such term is defined by ERISA. The set of benefits under the Plan are described in this Member Handbook, in the Summary of Benefits and in written Plan amendments, if any.

Plan Sponsor - As defined by ERISA, (i) the Employer in the case of an employee benefit plan established or maintained by a single employer; (ii) the employee organization in the case of a plan established or maintained by an employee organization; or (iii) in the case of a plan established or maintained by two or more employers or jointly by one or more employers and one or more employee organizations, the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the plan.

Plan Year - The contract period of twelve (12) consecutive coverage months, with the effective date on the first of the month of the first month of coverage. The Plan Year can start on the first day of any month and continue through the last day of the 12th month of coverage.

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 o 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 onset through rehabilitation and community reintegration.

Preauthorization (Prior Authorization) - A determination by MHHSI that health care services proposed to be provided to a Covered Person are Medically Necessary and appropriate. Sometimes called Prior Authorization, prior approval, or precertification. Your health insurance or Plan may require Preauthorization for certain services before You receive them, except in an emergency. Preauthorization is not a promise that Your health insurance or Plan will cover the cost.

Preferred Drug - A drug included on the Plan's Prescription Drug Formulary. A Preferred Drug is usually covered under the Plan without the need for Preauthorization.

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

Premium – The amount that must be paid for Your health Benefit coverage.

Prescription - A written or verbal order from a licensed health care practitioner to a pharmacist for a drug or device to be dispensed. Any oral prescription must promptly be recorded in writing by the Pharmacy from which it is dispensed.

Prescription Drug Formulary – A list of specific Prescription Drugs that are covered under this Summary Plan Description.

Prescription Drugs - Drugs, biologicals or compounded prescriptions that are required by law to have a label stating "Caution – Federal Law Prohibits Dispensing Without a Prescription," and which are approved by the federal Food and Drug Administration (FDA) for safety and effectiveness, subject to the Prescription Drug Exclusions and Limitations.

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

Primary Care Provider - A Physician or other health care provider who is a general caregiver and includes general and family practitioners, internists, pediatricians, obstetricians and gynecologists; or who is designated by MHHSI as a Primary Care Provider. A Primary Care Provider cannot be a Specialty Care Provider. An enrollee with a chronic, disabling, or life-threatening illness may apply to MHHSI to use a non-Primary Care Physician as their PCP.

Prior Authorization – The Plan requires You (or yYour Physician) to get Prior Authorization for certain Drugs. This means that You will need to get approval from the Plan before eYou fill Your Prescriptions. If You don't get approval, the Plan may not cover the Drug.

Qualified Beneficiary - Refers, under the COBRA continuation of coverage law, to an individual covered by a group health plan, including this Plan, on the day before a qualifying event who is either an Employee, the Employee's spouse, or an Employee's Dependent child.

Qualifying Life Event – A change in Your situation – like getting married, having a baby, or losing health coverage – that can make You eligible for a Special Enrollment Period, allowing You to enroll in health insurance outside the Annual Open Enrollment Period.

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.

Service Area - The geographical area designated by Us in which We provide Coverage. The Service Area consists of:
Brazoria, Ft. Bend, Galveston, Harris, Montgomery, Walker, Waller, and Wharton counties.

Sickness – Any of the following, whether or not diagnosed, treated, or requiring treatment by a Health Care Provider: ill health, disease, pregnancy and bodily or mental infirmity or disorder, including Mental/Nervous Problems. All Sicknesses that are due to the same cause or related cause shall be considered as one Sickness.

Skilled Nursing Facility - An institution or distinct part of an institution that is licensed or approved under state law and primarily provides skilled nursing care and related services as a Skilled Nursing Facility, extended care facility, or nursing care facility approved by The Joint Commission, the Bureau of Hospitals of the American Osteopathic Association, or as otherwise determined by MHHSI to meet the reasonable standards applied by either one of those authorities that provides:

- Bedded 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
- Preauthorization for all patients.

Special Enrollment Period - A time outside the yearly Open Enrollment Period when You can sign up for health insurance. You qualify for a Special Enrollment Period if You've had certain life events, including losing health coverage, moving, getting married, having a baby, or adopting a child.

Specialty Care Provider or **Specialist** - A Physician or other health care provider who is classified as a specialist by the American Boards of Medical Specialties or who is designated by MHHSI as a Specialty Care Provider. A Specialty Care Provider cannot be a Primary Care Provider.

Specialty Drugs - High-cost Prescription Drugs that meet any of the following criteria:

- Are used in limited patient populations or indications;
- may be self-injected;
- have limited availability, require special dispensing, or delivery and/or patient support is required; and/or
- complex reimbursement procedures are required.

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

Spouse - The Employee's husband or wife, through lawful or common law marriage.

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 Summary Plan Description is issued (also known as a Member).

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 health professional licensed, certified, or otherwise entitled to practice in this state and acting within the scope of the health professional's license, certification, or entitlement to a patient at a different physical location than the health professional using telecommunications or information technology.

Telemedicine Medical Service – A health care service delivered by a Physician licensed in this state, or a health professional acting under the delegation and supervision of a Physician licensed in this state, and acting within the scope of the Physician's or health professional's license to a patient at a different physical location than the Physician or health professional using telecommunications or information technology.

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.

Urgent Care Clinic - A clinic, with extended office hours, that provides Urgent Care and minor Emergency Care to patients on an unscheduled basis and 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.

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.

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 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, Yours - Refers to the Employee who is a Covered Person under the Plan.

CONTACT INFORMATION

Address:	P.O. Box 19909, Houston, TX 77224-1909
Website:	https://healthplan.memorialhermann.org/
Customer Service:	855-645-8448
Email:	MHHPCustomerService@apex4health.com
Provider Directory:	https://healthplan.memorialhermann.org/members/
Preauthorization for Medical Claims:	855-645-8448
Complaints:	855-645-8448
For Benefits, Claims Status or Authorization Requirements: Or write to:	855-645-8448 Memorial Hermann Medical Claims Department P.O. Box 19909 Houston, TX 77224-1909

For Prescription Drug Benefits contact Navitus Health Solutions

Website:	http://www.navitus.com/
Customer Service, Preferred Drug List & Utilization Review:	866-333-2757
Appeals of Utilization Review:	866-333-2757
Appeals of Utilization FAX Line:	855-668-8551
For Non-Participating Pharmacy Claim Forms & Claim Submissions, write to:	Navitus Health Solutions, LLC P.O. Box 999 Appleton, WI 54912-0999
For Mail Orders, write to:	Costco Mail Order Pharmacy 260 Logistics Ave., Suite B Jefferson, IN 47130-9839
Customer Service:	1-800-607-6861
Website:	https://www.costco.com/pharmacy/home-delivery

For Mental Health Benefits contact Memorial Hermann Health Plan

Website:	https://liveandworkwell.com/content/en/member.html
Customer Service:	855-645-8448
For Claim Forms & Submissions, Claims write to:	Memorial Hermann Health Plan P.O. Box 19909 Houston, TX 77224-1909

Participating Provider Network Information

Participating Provider network name:	**Memorial Hermann Health Solutions, Inc. ("MHHSI")**
Address:	**P.O. Box 19909** **Houston, TX 77224-1909**
Telephone:	**855-645-8448**
Web Site:	**https://healthplan.memorialhermann.org**

MHHSI Provider Network* MHHSI providers must be used by all residents of the MHHSI Service Area to receive Participating Provider benefits. This includes all Employees who work within the MHHSI Service Area. In order to receive Participating Provider benefits, all Covered Dependents who reside outside the MHHSI Service Area must use providers in the MHHSI Provider Network when visiting the MHHSI Service Area except during emergency situations. To find a MHHSI Provider Network, visit https://healthplan.memorialhermann.org or call the MHHSI Customer Service number shown above.

For Covered Dependents who reside outside the Service Area and for Covered Dependents who are visiting outside the MHHSI Service Area, the PHCS network is available:

PHCS

Preferred Provider Organization

HMO network name:	Private Healthcare Systems, Inc. (PHCS)
Address:	115 Fifth Avenue 7th Floor New York, NY 10003
Telephone:	(212) 780-2000
Website:	https://www.multiplan.us

Private Healthcare Systems (PHCS) Network *

* PHCS Network providers are considered Participating Providers only outside of the MHHSI Service Area. In order to receive Participating Provider benefits, all Covered Persons who reside outside the MHHSI Service Area must use providers in the MHHSI Provider Network when visiting the MHHSI Service Area except during emergency situations. To find a PHCS Network provider, visit https://www.multiplan.com/webcenter/portal/ProviderSearch.

Note: PHCS Network providers that are located in the MHHSI Service Area are considered Non-Participating Providers for all Covered Persons.

Non-Participating Providers Who Provide Benefits at Participating Provider Facilities; Circumstances When Covered Services Provided by Non-Participating Providers will be Paid at the Participating Provider Level

Although health care services may be, or have been, provided to a Covered Person at a participating (in-network) health care facility, other professional services may be, or have been provided at or through the facility by physicians and other health care practitioners who are Non-Participating Providers. In this case, the higher (Participating Provider) PPO benefit payment will be made to those Non-Participating Providers.

Under the following circumstances, the In-Network benefit payment will be made for certain Non-Participating Provider services:

1. If a Covered Person has no choice of Participating Providers in the specialty that the Covered Dependent is seeking within the HMO service area.
2. If a Covered Person is outside the HMO service area and has a Medical Emergency requiring immediate care.
3. If a Covered Person receives Physician, anesthesia services, or other facility-based services by a Non-Participating Provider at a HMO Participating Provider facility.

If a Participating Provider recommends the Covered Person go to a Non-Participating Provider, this care will be covered as if that Provider were a Participating Provider, subject to any preauthorization requirements that may apply.

If a Covered Person has a Medical Emergency and needs immediate medical care, this care will be covered at the Participating Provider benefit level shown in the Schedule of Benefits.

Effective January 1, 2022, the No Surprises Act (NSA) established new federal protections against surprise medical bills. Surprise medical bills arise when a contract holder inadvertently receives care from an Out-of-Network Hospital, Physician, or other Providers they did not choose. Surprise billing protections apply to most Emergency services, including those provided in Hospital Emergency Rooms, freestanding emergency departments, and urgent care centers that are licensed to provide Emergency care. The federal law also applies to air ambulance transportation (emergency and non-emergency), but not ground ambulance. Emergency care includes screening and stabilizing treatment sought by patients who believe they are experiencing a medical emergency or active labor.

Please refer to the Complaints and Appeals section of this document for help if You experience a surprise medical bill.

ELIGIBILITY, FUNDING, EFFECTIVE DATE AND TERMINATION PROVISIONS

A Covered Person should contact MHHSI to obtain additional information, free of charge, about Plan coverage of a specific benefit, particular drug, treatment, test or any other aspect of Plan benefits or requirements.

To verify eligibility for Plan benefits, contact MHHSI and obtain a verification of eligibility for Plan benefits **before** the charge is incurred.

ELIGIBILITY

Eligible Employees who reside or work in the MHHSI Service Area and their Dependents are eligible for coverage under this Plan. If You are enrolled in Medicare, You are not eligible to be enrolled in this Plan.

Types of Coverage

The Employee 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.

- Employee Coverage - for only one person, the Employee.
- 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.

Who is Eligible to Enroll in the Plan

An Eligible Employee (or "Employee") means an individual employed by the Employer 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 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
    - another health benefit plan;
    - 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 Covered Persons of the same family (such as husband and wife or parent and child) both qualify as Eligible Employees of the Employer, each may enroll separately as a Covered Employee. An Employee must reside, live or work in the Service Area to enroll in the Plan. Dependents are not required to reside with the Subscriber.

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 person may not be an Eligible Dependent for more than one Eligible Employee. If two Employees of a group share the same Dependent but are enrolling separately under the plan, only one Employee may enroll that Dependent,

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, such a child may stay eligible for Dependent health benefits past the Plan'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 and depends on You for most of his or her support and maintenance.

A disabled Dependent is eligible to enroll beyond the limiting age regardless of the date of disability if he or she has been medically certified as disabled and dependent on their parent. A child does not have to be previously enrolled or found disabled prior to the limiting age for the child to be considered an eligible Dependent.

For the child to stay eligible, You must send MHHSI written proof that the child is incapacitated or developmentally disabled and depends on You for most of his or her support and maintenance (statement of Dependent Child's disability). You have 31 days from the date the child reaches the age limit to do this. MHHSI or the Plan Sponsor 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.

FUNDING

Cost of the Plan. The Employer shares the cost of Employee [and Dependent] coverage under this Plan with the covered Employees. The level of any Employee contribution is set by the Employer, which reserves the right to change the amount of Employee contributions, including contributions, Co-payments, Out-of-Pocket expenses, and Deductibles, and fees, costs, and charges.

ENROLLMENT

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

Otherwise, an Eligible Employee is qualified to apply for enrollment during the Initial Enrollment Period, which is defined as the 31 days before the first of the month following completion of the Waiting Period (if applicable as defined below). **The Initial Enrollment Period** also refers to the 31-day period during which an Eligible Employee or Eligible Dependent first qualifies to enroll for coverage.

The Waiting Period is a period of continuous, full-time employment that must be completed before an Eligible Employee may apply for coverage. The length of the Waiting Period may be zero, one or two calendar months and is determined by the Plan Sponsor on the Plan Sponsor'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.

Annual Open Enrollment
An Eligible Employee may apply for enrollment during the Annual Open Enrollment Period. The Annual Open Enrollment Period is defined as a period of at least thirty-one (31) days consisting of an entire calendar month beginning on the first day of the month and ending on the last day of the month. If the month is less than a 31-day month, the 31-day enrollment period shall continue into the next month.

If an Eligible Employee does not apply within the 31 days of the Initial Enrollment, Annual Open Enrollment or Special Enrollment Periods (the latter as described below), 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 and should be included on the Eligible Employee's Enrollment Form.

Initial Enrollment Period for Dependents 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. 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.

Late Enrollees and Exceptions to Late Enrollees
As defined above, 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 as stated below. You or Your Dependents will not be considered a Late Enrollee if You or Your Dependents did not enroll for coverage within the Initial Enrollment Period and one or more of the following applies:

1. the individual:
    a. was covered under another health benefit plan or self-funded employer health benefit plan at the time the individual was eligible to enroll; and
    b. 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; and

c. 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; the death of a spouse or divorce; and
d. 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;

2. 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;
3. 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;
4. 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;
5. 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);
6. the individual has a change in family composition due to marriage, birth of a child, adoption of a child, or because the individual becomes a party in a suit for the adoption of a child;
7. an individual becomes a dependent due to marriage, birth of a newborn child, adoption of a child, or because the individual becomes a party in a suit for the adoption of a child; and
8. the individual described in subparagraphs 5, 6 and 7 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 the individual 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 period 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 PPO 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 either 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, placement for adoption, or is a party to a suit in which the Eligible Employee seeks to adopt.

Coverage Start

Coverage for an Eligible Employee and his or her Eligible Dependents is effective once MHHSI receives a properly completed application, and the Plan Sponsor pays MHHSI 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 and his or her Eligible Dependents, or any person who has continued group coverage under applicable federal or state law, on the Effective Date.
- 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 date of the Special Enrollment event;
- For an Eligible Employee or Eligible Dependent who submits an Enrollment Form during the Open Enrollment Period, on the first day of the month of the Open Enrollment period.

Adding Dependents to Your 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 Covered Person or a dependent's Newborn child(ren) is eligible for coverage. MHHSI must be notified within 31 calendar days from the date of birth to add the Newborn as a Covered Dependent and continue coverage beyond the first 31 days after the Newborn's birth. An additional premium will apply.

- Adopted Children

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

- Court Ordered Dependent

If a court has ordered an Employee to provide coverage for an Eligible Dependent (including spouse), the Eligible Dependent(s) will be eligible for coverage. MHHSI must be notified within 31 calendar days of court order to add the Eligible Dependent(s) as a Covered Dependent. An additional premium 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 Dependent. Coverage will become effective on the first day of the month following the date the Enrollment Form 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.

For Late Enrollees who apply outside of the Plan Sponsor'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 shall not be covered by the Plan and has no right to any of the benefits provided under the Plan. The Plan Sponsor and/or the Covered Employee must notify MHHSI within 31 days of any change that

affects an individual's eligibility under the Plan, including whether a Covered Dependent meets the criteria set above.

Termination of Coverage

Your coverage ends without notice from MHHSI 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 Plan Sponsor notifies MHHSI that the Covered Person is no longer eligible. The Plan Sponsor will be liable to MHHSI for any premium, including premium for Dependent coverage, for the period of coverage until the end of the calendar month in which the Plan Sponsor provides MHHSI 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 MHHSI, subject to the grace period set forth in the Agreement.

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, Your coverage will end fifteen (15) days after written notice from MHHSI.

Your Dependent(s)' coverage will also end the date Your coverage terminates.

The Parties may terminate the Services Agreement and this Member Handbook as follows, which serves to terminate all Covered Persons' coverage:

- By MHHSI for Non-Payment of Premium. Upon ten (10) days prior written notice as provided in the monthly premium notice sent to Plan Sponsor, MHHSI may terminate this Agreement, if Plan Sponsor does not pay its monthly Premium (as that term is defined in the Services Agreement) in full within 30 days from the due date on the first (1st) day of the month. The Agreement and this Member Handbook shall automatically terminate, as of the last day for which Premium was paid, without the need for further notice. If the Agreement is terminated for non-payment of Premium, MHHSI shall only provide a twelve (12) month claims run-out period.
- By MHHSI for Failure to Maintain Small Group Size. Upon thirty (30) days prior written notice to Plan Sponsor if the Employer has fewer than two (2) full-time employees for more than three (3) consecutive months.
- Early Termination by Plan Sponsor. Plan Sponsor must provide MHHSI at least thirty (30) days' prior written notice of its intent to terminate the Agreement as of the end of a calendar month. In the case of an early termination, Plan Sponsor shall owe an early termination fee equal to the greater of: (a) six (6) months Premium based on the Covered Person census on the date the termination notice is received by MHHSI or
  (b) the balance of the Premium owed under the Agreement for the Plan Year. Plan Sponsor shall pay the early termination fee to MHHSI within thirty (30) calendar days of the termination effective date. If Plan Sponsor pays such early termination fee within the 30-day deadline, MHHSI shall provide Plan Sponsor with a claims run-out period of 24 months from the date of termination. If Plan Sponsor pays the early termination fee after the 30-day deadline or fails to pay the fee in full, MHHSI shall provide Plan Sponsor with a claims run-out period of twelve (12) months from the termination effective date.
- Upon written notice to the other Party if either Party becomes insolvent, is adjudicated as bankrupt, its business comes into possession or control, even temporarily, of any trustee in bankruptcy, has a receiver appointed for it, or makes a general assignment for the benefit of creditors; or
- At the end of any Plan Year upon thirty (30) days written notice by either Party of the Party's intent not to renew the Agreement.

Additionally, if Plan Sponsor does not agree to a fee adjustment made by MHHSI, Plan Sponsor may terminate the Agreement and this Member Handbook by providing written notice to MHHSI within thirty (30) days of the fee adjustment notice. Such termination will be effective thirty (30) days after the termination notice is received by MHHSI.

An Employee may disenroll and terminate coverage under the Plan during a time other than the open-enrollment period, provided he or she has secured other coverage comparable to the Plan, whether individually or through a spousal benefit plan in which he or she is eligible to participate, and with the approval of the Plan Sponsor. The determination of comparability will rest with the Plan Sponsor, and its decision is final. The determination will be made on a case-by-case basis. The disenrollment must comply with United States Department of Labor regulations, and United States Internal Revenue Service/Department of the Treasury regulations. Pursuant to the referenced Federal regulations, current participation in the Cafeteria Plan or Flexible Spending Benefit Plan would preclude a move to other health insurance coverage until the next Plan open-enrollment period.

When coverage under this Plan stops, Covered Persons will receive a certificate that will show the period of creditable coverage under this Plan. MHHSI maintains written procedures that explain how to request this certificate. Please contact MHHSI for a copy of these procedures and further details.

When Employee Coverage Terminates (See Also: Termination of Coverage on page 21 above).
Employee coverage will terminate on the earliest of the following dates (except in certain circumstances, a covered Employee may be eligible for COBRA continuation coverage; for a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the section entitled Continuation Coverage Rights under COBRA):

(1) The date the Plan is terminated.
(2) The last day of the calendar month in which the covered Employee ceases to be eligible for coverage under this Plan. This includes death or termination of Active Employee status of the covered Employee. (See the section entitled Continuation Coverage Rights under COBRA.) It also includes an Employee on disability, leave of absence or other leave of absence, unless the Plan specifically provides for continuation during these periods.
(3) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.

Continuation During Family and Medical Leave. Regardless of the established leave policies mentioned above, this Plan shall at all times comply with the Family and Medical Leave Act of 1993 (FMLA) as promulgated and with regulations issued by the Department of Labor.

During any leave taken under the Family and Medical Leave Act, the Employer will maintain coverage under this Plan on the same conditions as coverage would have been provided if the covered Employee had been continuously employed during the entire leave period.

If Plan coverage terminates during the FMLA leave, coverage will be reinstated for the Employee and his or her covered Dependents if the Employee returns to work in accordance with the terms of the FMLA leave. Coverage will be reinstated only if the person(s) had coverage under this Plan when the FMLA leave started and will be reinstated to the same extent that it was in force when that coverage terminated. For example, Waiting Periods will not be imposed unless they were in effect for the Employee and/or his or her Dependents when Plan coverage terminated.

Rehiring a Terminated Employee. A terminated Employee who is rehired will be treated as a new hire and be required to satisfy all eligibility and enrollment requirements. However, if the Employee is returning to work directly from COBRA coverage, this Employee does not have to satisfy any employment Waiting Period provision.

Employees on Military Leave. Employees going into or returning from military service may elect to continue Plan coverage as mandated by the Uniformed Services Employment and Reemployment Rights Act under the following circumstances. These rights apply only to Employees and their Dependents covered under the Plan immediately before leaving for military service.

(1) The maximum period of coverage of a person under such an election shall be the lesser of:
   (a) The 24-month period beginning on the date on which the person's absence begins; or
   (b) The day after the date on which the person was required to apply for or return to a position of employment and fails to do so.

(2) The cost of COBRA continuation coverage under the Plan is 102% of the full contribution under the Plan, except a person on active duty for 30 days or less cannot be required to pay more than the Employee's share, if any, for the coverage.

(3) An exclusion or Waiting Period may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of service. However, an exclusion or Waiting Period may be imposed for coverage of any Illness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of uniformed service.

When Dependent Coverage Terminates. A Dependent's coverage will terminate on the earliest of the following dates (except in certain circumstances, a covered Dependent may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the section entitled Continuation Coverage Rights under COBRA):

(1) The date the Plan or Dependent coverage under the Plan is terminated.
(2) The date that the Employee's coverage under the Plan terminates for any reason including death. (See the section entitled Continuation Coverage Rights under COBRA.)
(3) The date a covered Spouse loses coverage due to loss of dependency status. (See the section entitled Continuation Coverage Rights under COBRA.)
(4) On the last day of the calendar month that a Dependent child ceases to be a Dependent as defined by the Plan. (See the section entitled Continuation Coverage Rights under COBRA.)
(5) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.

ANNUAL OPEN ENROLLMENT PERIOD

Every year, there is an Annual Open Enrollment Period when covered Employees, their covered Dependents and Qualified Beneficiaries under COBRA are able to change some of their benefit choices, based on which benefits and coverages are available and right for them.

Benefit choices made during the Annual Open Enrollment Period will become effective the first day of the first month of the Plan Year and remain in effect for twelve months unless there is a Special Enrollment event or a change in family status during the year (birth, death, marriage, divorce, adoption) or loss of coverage due to loss of a Spouse's employment. To the extent previously satisfied under the prior benefit option, Waiting Periods will be considered satisfied when changing to another benefit option under the Plan.

A Covered Person or Qualified Beneficiary who fails to make an election during the Annual Open Enrollment Period will automatically remain enrolled in the same benefit plan (or an equivalent plan if the specific benefit plan is no longer available under the Plan) most recently elected by the Covered Person or Qualified Beneficiary.

Covered Persons and Qualified Beneficiaries will receive detailed information regarding Annual Open Enrollment from their Employer.

MEDICAL BENEFITS

Medical benefits apply when Covered Charges are incurred by a Covered Person for care of an Injury or Sickness and while the Covered Person is eligible to receive benefits under the Plan.

DEDUCTIBLE

Deductibles are defined as set amounts of Covered Charges that Covered Persons must pay before the Plan will pay for any benefits for such charges annually. Only Covered Charges incurred by the Covered Person can be used to meet the Deductible. The Deductible amount is shown in the Covered Person's Schedule of Benefits.

Once Your Deductible is met, You will only be responsible for Copayments and Coinsurance amounts, up to Your Out-of-Pocket Maximum. The Deductible does not include any Copayments applicable for the rest of the Plan Year. All charges must be incurred while the Covered Person(s) are covered under this Plan.

Family Deductibles If applicable, the Family Deductible is defined as a cumulative amount the Employee and Dependents enrolled in the same Plan shall meet for each Plan Year. Although the Employee and Dependents incur Covered Charges independently based on the individual deductible amount, each paid expense contributes to the cumulative Family Deductible.

The Family Deductible can be met by a combination of Covered Persons with no single individual within the family contributing more than the individual Deductible limit amount in a Plan Year. Once this Family Deductible limit is satisfied for that Plan Year, the Plan provides coverage for all Covered Charges for all Covered Persons who are enrolled in the same Plan.

COINSURANCE

Coinsurance refers to the sharing of eligible Covered Charges for Covered Services between the Plan and a Covered Person. The sharing is expressed as a pair of percentages, a percentage that the Plan pays, and a Covered Person percentage that You pay. Once the Covered Person has met any applicable Deductible amount, Your percentage will be applied to the Covered Charges for Covered Services to determine Your financial responsibility. The Plan's percentage will be applied to the Covered Charges for Covered Services to determine the benefits provided by the Plan.

COPAYMENT (COPAY)

A Copayment is the specific dollar amount a Covered Person must pay when specified Covered Services are rendered, as shown on the Schedule of Benefits. The Copayment may be collected directly from a Covered Person by a Participating Provider. Copayments do not count towards any Deductible.

OUT-OF-POCKET MAXIMUM

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

Family Out-of-Pocket Maximum- The maximum amount, as shown on the Schedule of Benefits, of non-reimbursable expenses (including any applicable Deductible amount and Coinsurance), which must be paid by Employee and Dependents for Covered Services in one (1) Plan Year. When more than one (1) Covered Person in a family is enrolled in the Plan, the Individual Out-of-Pocket Maximum is not applicable and only the Family Out-of-Pocket Maximum shall apply.

PLAN LIMITS

Some benefits of this Plan may have limitations that apply only to that benefit. If a Covered Person submits a claim for Covered Services for a benefit for which there is a maximum payment limit, regardless of the Covered Person's satisfaction of the Out-of-Pocket Maximum, the Plan's payment will be subject to the special limits of the particular benefit involved. See the benefits below and the Schedule of Benefits for further information.

BENEFIT PAYMENT

Before this Plan pays for any benefits, the Covered Person must satisfy any applicable Deductible or Copayment. After the Covered Person satisfies any applicable Deductible or Copayment, the Plan will begin paying for Covered Services as described in this section.

In addition, certain services may require Preauthorization. See the Schedule of Benefits for the services requiring Preauthorization and the Section titled "Preauthorization Program and Procedures" for information on how to obtain Preauthorization.

The benefits described in this section will be paid for Covered Charges incurred on the date the Covered Person receives the Covered 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 Schedule of Benefits.

COVERED CHARGES

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

COVERED SERVICES

Ambulance and Pre-Hospital Emergency Benefits

Pre-Hospital Emergency Medical Services means the prompt evaluation and treatment of an Emergency Medical Condition and/or transportation to a Hospital. The Plan covers Pre-Hospital Emergency Medical Services for the treatment of an Emergency Medical Condition, when such services are provided by an ambulance service licensed by 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 Services. An appropriate licensed person must render the services.

The Plan does not cover travel or transportation expenses unless connected to an Emergency Medical Condition or due to a facility transfer approved by MHHSI, even if prescribed by a Physician. The Plan also does not cover non-ambulance transportation such as van or taxicab.

Hospital/Inpatient Benefits

All admissions (including, but not limited to, elective or non-emergency, emergency, but excluding pregnancy) must be authorized as outlined in the Care Management section below. In addition, at regular intervals during the Inpatient stay, MHHSI 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 Medical 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, radiology services, laboratory and other diagnostic tests, drugs, medications, biologicals, anesthesia and oxygen services, Inpatient private 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 Charges 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 that are regularly provided and billed by the Hospital.
- Services are provided only for the number of days required to treat the Covered Person's Illness or Injury.
- Concurrent care.

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

Outpatient Hospital Services

Benefits for the following outpatient services and treatments are available and may require authorization. For Cost-Sharing amounts and to determine if authorization is required, please refer to the Schedule of Benefits. These services include:

- ambulatory Surgery;
- diagnostic procedures, including laboratory, radiology, including therapeutic radiology, and imaging;
- rehabilitation and radiation therapy; and
- infusion therapy.

Payments of Outpatient Hospital Covered Charges are 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 benefit and all associated cost-sharing.
- 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.

Medical and Surgical Benefits

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

Surgery

The Covered 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 MHHSI 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 Covered 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 Covered Person.
- Treatment provided for reconstructive surgery following cancer surgery.
- Surgery performed on a Covered Person 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.

Bariatric Surgery – Subject to Preauthorization by MHHSI.

Incidental Procedure

An incidental procedure is one carried out at the same time as a more complex primary procedure and that requires little additional Physician resources and/or is clinically integral to the performance of the primary procedure. The Covered 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. Surgical treatment for complications resulting from non-Covered Services is not covered.

Unbundled Procedure

Unbundled procedures occur 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 MHHSI. The Covered Charge includes the re-bundled procedure. The Plan will provide benefits according to the proper comprehensive procedure code for the re- bundled procedure, as determined by MHHSI.

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 Covered Charge includes all procedures performed at the same surgical setting. Procedure(s) that 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 covered services and supplies provided to a Covered Person but only if all the following conditions are met:

- The transplant procedure is not experimental/investigational in nature.
- Donated human organs or tissue or an FDA-approved artificial device is used.
- The transplant procedure is preauthorized as required under the Plan.
- The Covered Person meets all of the criteria established in pertinent written medical policies.
- The Covered Person meets all of the protocols established by the Hospital in which the transplant is performed.

Benefits are payable for Hospital and Professional services for a:

- Covered Person who is a recipient of the FDA-approved organ or tissue.
- Covered Person who donates the FDA-approved organ or tissue.
- FDA-approved organ or tissue donor who is not a Covered Person, but if the FDA-approved organ or tissue recipient is a Covered Person.

Covered services and supplies "related to" an organ or tissue transplant include, but are not limited to x-rays, laboratory testing, chemotherapy, radiation therapy, prescription drugs, procurement of organs or tissues for a living or deceased donor, and complications arising from such transplant.

Benefits are payable only after benefits have been paid for the Covered Person's expenses, and then only to the extent benefits are available under the recipient's Plan.

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 that is found by MHHSI to be Experimental, Investigative or not a generally accepted medical practice.
- Charges for transplant of animal organs to a human recipient.
- Charges for non-FDA-approved mechanical devices designed to replace human organs. Use of an FDA-approved mechanical heart to keep a patient alive until a human donor heart becomes available, or a kidney dialysis machine are Covered Services when Medically Necessary.
- Charges incurred for keeping a donor alive for a transplant operation.
- Charges for personal comfort or convenience items.
- Alcohol, drug, or tobacco usage

Assistant Surgeon

An assistant surgeon is a Physician, 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 Covered 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 Medically Necessary surgical services. Coverage is also provided for other forms of anesthesia services as defined and approved by MHHSI. 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 MHHSI determines otherwise.

Benefits for anesthesia will be determined by applying the Coinsurance to the Covered 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 with an in-network Provider are covered subject to any applicable Copayments, Coinsurance and Deductible amounts, but are not mandatory in order to receive Benefits.

Oral Surgery Benefits

Coverage is provided for dental care and treatment including surgery and dental appliances required to correct Accidental Injuries of the jaw, cheeks, lips, tongue, roof or floor of mouth, and of sound natural teeth. (For the purposes of this section, sound natural teeth include those that are capped, crowned or attached by way of a crown or cap to a bridge. Sound natural teeth may have fillings or a root canal.) Coverage includes:

- Incision and drainage of abscess and treatment of cellulitis.
- Incision of accessory sinuses, salivary glands, and salivary ducts.
- Excision of exostoses or tori of the jaws and hard palate.
- Excision of tumors or cysts (excluding odontogenic cysts) of the jaws, gums, cheeks, lips, tongue, roof and floor of mouth.
- Extraction of impacted teeth.
- Medically necessary extractions in preparation for radiation treatment.
- 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.
- Anesthesia when rendered in a Hospital setting and for associated Hospital charges when conditions require 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.

Biomarker Testing

Biomarker testing allows providers to use information about a person's specific genetic variations to inform better diagnosis, prognosis, and therapy selection for cancer or rare disease patients. Coverage for biomarker testing to diagnose, treat, manage, or monitor a medical condition is provided if clinical use of the test for the condition:

- is evidence based;
- is scientifically valid;
- informs the patient's outcome or provider's clinical decision; or
- predominantly addresses the acute or chronic issue for which the test is being ordered, except that a test may include some information that cannot be immediately used in the formulation of a clinical decision.

The Plan provides coverage in a manner that limits disruption of care, including limiting the number of biopsies and biospecimen samples.

Pregnancy and Reproductive Benefits

Pregnancy

Pregnancy care and Newborn benefits are available to a Covered Person whose coverage is in effect at the time such services are furnished in connection with her pregnancy. This Plan pays for pregnancies the same way it would cover an Illness, except for any exceptions listed below. The charges the Plan covers for delivery and newborn child are explained below.

Surgical and Medical Services

The Plan covers the following surgical and medical services for expecting Covered Persons when supported by a medical doctor (MD):

- Initial office visit and visits during the term of the pregnancy.
- Diagnostic Services.
- Delivery, including necessary pre-natal and post-natal care. Birthing centers are only covered if supported by physician back up coverage 24 hours a day.
- Abortion performed due to medical emergency. For purposes of this section, "medical emergency" means a life-threatening physical condition aggravated by, caused by, or arising from a pregnancy that, as certified by a physician, places the Covered Person in danger of death or a serious risk of substantial impairment of a major bodily function unless an abortion is performed.

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 not covered.

Facility Services

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

An authorization is required for a Hospital stay in connection with childbirth for the covered mother or covered well newborn child only if the mother's length of stay exceeds forty-eight (48) hours following a vaginal delivery or ninety-six (96) hours following a caesarean section. 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 Plan as any other medical condition. Such complications include conditions, requiring Hospital care, whose diagnoses are distinct from the pregnancy, but are adversely affected by the pregnancy. Diagnoses include but are not limited to:

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

Newborn Care

If a Newborn is covered at birth as a Dependent, surgical and medical services rendered by a Physician for treatment of illness, prematurity, post-maturity, or congenital condition of a Newborn and circumcisions are included. Services of a Physician for Inpatient well baby care immediately following delivery until discharge are covered. Newborns are covered for the administration of a Newborn screening test. Coverage is provided for the cost of the test kit used to perform the screening in the amount required by Health Safety Code §33.019.

Hospital services, including services related to circumcision during the Newborn's post-delivery stay and treatment of illness, prematurity, post-maturity, or congenital condition of a newborn are covered. Charges for well-baby and well-childcare benefits will be provided consistent with those benefits listed in this Member Handbook. 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 Covered Person with Employee only coverage, the child is granted 31 days of automatic 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 the coverage of an Eligible Employee with Family coverage.

Newborns are covered for a screening test for hearing loss from birth through the date the child is 31 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.

Diagnosis of Infertility

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

- In-vitro gamete 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
- Prescription Drug, infusion, or hormonal therapy

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, salpingectomy, 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 Drug contraceptives or contraceptive devices approved by the FDA are covered.

Dental

Dental care for an Accidental Injury to natural teeth is covered under this Plan.

In addition, this Plan 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. MHHSI determines 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 Covered Person 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 Covered Person's Physician or by the dentist providing the dental care.

General Provision

- Any medical treatment that is necessary in conjunction with dental care because of the general health and physical limits of the Covered Person as indicated by said Covered Person's Physician or the MHHSI consulting dentist who reviews the request for treatment.

Exclusions

- Any treatment requested or appliance made which in the opinion of the treating dentist is not necessary for maintaining or improving the Covered Person'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 external review.
- Any dental care provided by a Non-Participating Provider general dentist or Specialist except when authorized by MHHSI.
- Dental treatment and expenses incurred for such treatment started prior to the Covered Person's eligibility to receive benefits under this Plan or started after a Covered Person's coverage under this Plan has terminated.

Limitations on Coverage for Dental Care

- General anesthesia and intravenous sedation are excluded.
- Replacement of lost or stolen prosthetic devices are limited as follows: Dentures or appliances will be replaced only after five (5) years have elapsed since such dentures or appliances were provided under any MHHSI program unless the denture becomes unsatisfactory due to Illness or other causes not controlled by ordinary circumstances. Replacement under this Plan will be made only if the existing denture is unsatisfactory and cannot be made satisfactory.
- Mouth guards or TMJ devices require Preauthorization.

Mental Health & Substance Abuse

Mental Health

The Plan covers mental health care services relating to the diagnosis and treatment of mental (including Serious Mental Illness as defined below), nervous and emotional disorders comparable to other similar Hospital, medical and surgical coverage provided under this Plan. Serious Mental Illness as defined by the American Psychiatric Association in the Diagnostic and Statistical Manual (DSM) includes but is not limited to the following psychiatric Illnesses:

- Schizophrenia;
- Paranoia 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 benefits, services for mental health conditions must meet the following conditions of service:

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

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

- A psychiatric center or impatient facility under the jurisdiction of the Texas Department of State Health Services.
- A state or local government-run psychiatric Inpatient facility.
- A part of a Hospital providing Inpatient mental health care services under an operating certificate issued by the Texas Department of State 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 Department of State 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 that are for treatment for abuse of alcohol, drugs, or other chemicals and the resultant physiological and/or psychological dependency that develops with continued use. There shall be no imposition of any quantitative or non-quantitative treatment coverage limits that are more restrictive than those imposed on Benefits for medical or surgical expenses.

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 that 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 accredited by The Joint Commission as alcoholism, substance abuse, or chemical dependence treatment programs. The Plan does not cover Custodial Care, education or training. There shall be no imposition of any quantitative or non-quantitative treatment coverage limits that are more restrictive than those imposed on Benefits for medical or surgical expenses.

Rehabilitative & Habilitative Therapy

Rehabilitative and 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/her license. Rehabilitation and services that, in the opinion of the Covered Person's Physician are Medically Necessary, will not be denied or terminated if 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.

Cardio/Pulmonary Therapy

Cardio/Pulmonary therapy services are covered when performed by a provider licensed and practicing within the scope of his/her license and licensed to practice in the state in which the services are rendered. The therapy must be used to restore pulmonary or cardiac function.

Occupational Therapy

Occupational Therapy services are covered when performed by a provider licensed and practicing within the scope of his/her 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 prior to the receipt of services. Benefits for eligible treatment by an occupational therapist are limited to one (1) visit per day and are payable subject to the maximum benefit limits shown on the Schedule of Benefits, per Covered Person per Year.

Physical Therapy

Covered Persons 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 prior to the receipt of service unless performed under the following circumstances:

- To children with a diagnosed developmental disability pursuant to the Covered Person's plan of care.
- As part of a home health care agency pursuant to the Covered Person's plan of care.
- To a patient in a nursing home pursuant to the Covered Person'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;
- MHHSI determines that additional treatment is likely to result in significant improvement by measurably reducing the Covered Person's impairment; and
- MHHSI authorizes services prior to being delivered.

Hearing Aids/Cochlear Implants/Speech/Language Pathology Therapy

Hearing aids or cochlear implants are covered when Medically Necessary. Coverage includes fitting and dispensing services and the provision of ear molds as necessary to obtain optimal fit of hearing aids, treatment for habilitation and rehabilitation and, for cochlear implants, external speech processor and controller with necessary component and replacement every three (3) years.

Benefits for Covered Charges 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. Services for hearing aids do not require preauthorization when provided by a Participating Provider or when out-of-network Benefits are available in Your Plan. Cochlear implants require preauthorization.

Speech/Language Pathology Therapy services are covered when performed by a provider licensed and practicing within the scope of his/her license and 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 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. Frequency, duration and results of planned treatments are documented with an anticipated length of treatment and quantifiable long and short term goals provided.

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 three (3) years of age, who is certified by the Texas Health and Human Services Commission 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.

Habilitative Services for Children are covered, subject to applicable Plan limits, from age three (3) years through the end of the month in which the Child turns nineteen (19) years of age.

Skilled Nursing Facility

For any eligible condition, the Plan covers Covered Charges for all Medically Necessary 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 Covered Person must be referred to the Skilled Nursing Facility by a Physician.
- Services must be those that are regularly provided and billed by a Skilled Nursing Facility.
- The services must be consistent with the Covered Person'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 Covered Person must remain under the active medical supervision of a Physician treating the Illness or Injury for which the Covered Person 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, the Plan covers such care furnished to a Covered Person under a written home health care plan. Benefits are provided when You or Your 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 60 days. The Plan covers 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; and
- 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 Plan if the Covered Person had been in a Hospital.
- 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; and.
- Home Health services and supplies directly related to Infusion Therapy are included in the Infusion Therapy Benefit and are not payable under this Home Health Care Benefit.

Payment is subject to all of the terms of this Member Handbook and to the following conditions: the Covered Person's Participating Provider 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.

Services must be provided by a home health agency or a visiting nurse association. The services and supplies must be furnished by recognized health care professionals The home health care plan must be set up in writing by the Covered Person's Physician within 14 days after home health care starts and it must be reviewed by the Covered Person's Physician at least once every 60 days.

The Plan does not cover:

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

Hospice Services

Hospices are palliative care 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.

The Covered Person must be suffering from a terminal illness, as certified by the attending Physician and submitted to MHHSI in writing. The Physician must consent to the Covered Person's care by the Hospice and must be consulted in the development of the Covered Person's treatment plan. The hospice must submit a written treatment plan to MHHSI every 30 days.

The Plan does 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 members who are not Covered Persons, except for services related to bereavement counseling

Palliative Care

Palliative care provides services for symptom management or curative treatment of a primary Illness, as well as psychological support in dealing with an Illness. It can include care such as pain management, counseling, and nutrition advice. It can also include helping You to:

- Better understand Your Illness.
- Decide what treatment You do or do not want.
- Communicate more effectively with Your Providers and Your Family.
- Openly discuss Your feelings about Your Illness.

Palliative care services can be provided in a Hospital, Physician's office, Skilled Nursing Facility, or in a Member's home.

Centers of Excellence Features

A "Center of Excellence" is a Provider that has entered into an agreement with MHHSI to provide health benefit services for specific procedures. A Covered Person 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 Covered Person 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 Member Handbook.

Other Benefits & Services

Treatment for Diabetes - Equipment and Supplies

The Plan covers:

- 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 that 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 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

Covered Persons 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 Covered Person'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 Covered Person was covered under this Plan.

Benefits will be provided for Covered Charges for Inpatient Hospital care for a minimum of 48 hours following a mastectomy and 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 Charges for the following:

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

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

Acquired Brain Injury

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

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

Post-acute Care Treatment includes coverage for the reasonable expenses related to periodic reevaluation of the care of a Covered Person 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; or
- 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, Teledentistry Services
Telehealth, Telemedicine, and Teledentistry services are covered at the same extent that we would provide coverage for an in-person setting.

Telehealth service is a health service, other than a telemedicine medical service, delivered by a health professional licensed, certified or otherwise entitled to practice in this state and acting within the scope of the health professional's license, certification or entitlement to a patient at a different physical location than the health professional using telecommunications or information technology.

Telemedicine medical service is a health care service delivered by a Physician licensed in this state, or a health professional acting under the delegation and supervision of a physician licensed in this state and acting within the scope of the physician's or health professional's license to a patient at a different physical location than the physician or health professional using telecommunications or information technology.

Teledentistry Dental Service is a health care service delivered by a dentist, or a health professional acting under the delegation or supervision of a dentist, acting within the scope of the dentist's or health professional's license or certification to a patient at a different physical location than the dentist or health professional using telecommunications or information technology.

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.

For additional information regarding Urgent Care benefits, please see the No Surprises Act (NSA) and what it means to you on page 60 of this Member Handbook.

Attention Deficit/Hyperactivity Disorder
The diagnosis of and treatment for attention deficit/hyperactivity disorder is covered when rendered or prescribed by a Physician as Medically Necessary.

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 Covered Person's Primary Care Provider. 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 or the state in which the services are rendered;
- 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.

ASD benefits are subject to the Deductible and Coinsurance amounts that are applicable to the benefits obtained. (Example: A Covered Person obtains speech therapy for treatment of ASD. Covered Person will pay the applicable Deductible or Coinsurance amount shown on the Schedule of Benefits for speech therapy.)

Cleft Lip and Cleft Palate Services
The following services for the treatment and correction of cleft lip and cleft palate are covered as Medically Necessary:

- 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 as Medically Necessary.

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 MHHSI. The equipment and supplies are subject to the Covered Person's medical Deductible and Coinsurance.

Durable Medical Equipment, Orthotic Devices, Prosthetic Appliances, Devices and Services
Durable Medical Equipment
Durable Medical Equipment is covered when the equipment is prescribed by a Physician prior to obtaining the equipment and is Medically Necessary. The equipment must not be provided mainly for the comfort or convenience of the Covered Person or others. Prior Authorization is required for DME over $500. 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:

(1) Benefits for the rental of Durable Medical Equipment will be based on the rental Covered Charge (but not to exceed the purchase Covered Charge).
(2) At MHHSI'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 Covered Charge.
(3) Benefits based on the Covered Charge for standard equipment will be provided toward any deluxe equipment when a Covered Person selects deluxe equipment solely for his/her comfort or convenience.
(4) Benefits for deluxe equipment based on the Covered Charge for deluxe equipment will only be provided when documented to be Medically Necessary.
(5) 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.
(6) 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 MHHSI.

Orthotic Devices, Prosthetic Appliances & Devices
Benefits as specified in this section will be available for the purchase of prosthetic devices, Orthotic Devices and professional services related to the fitting and use of those devices that equals the coverage provided under federal laws for the aged and disabled.

Benefits are limited to the most appropriate model of prosthetic device or Orthotic Device that adequately meets the Medical Necessity of the Covered Person as determined by the Covered Person's treating Physician, podiatrist, prosthetist, or orthotist. These benefits will be subject to the following:

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

Benefits for prosthetic appliances and devices and prosthetic services of the limbs are the same as for non-limb with the addition of:

- A Covered Person may choose a prosthetic appliance or device that is priced higher than the benefit payable under this Plan 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 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).

The Plan also covers any services or supplies in connection with routine foot care, including the removal of warts, corns, or calluses, or the cutting and trimming of toenails, in connection with diabetes, circulatory disorders of the lower extremities, peripheral vascular disease, peripheral neuropathy, or chronic arterial or venous insufficiency as Medically Necessary.

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. Covered Persons should check their provider directory or contact a customer service representative at the number listed on his/her ID card to verify that a sleep laboratory is accredited.

Clinical Trials

Benefits are provided to a Covered Person 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 National Institutes of Health;
  - The Centers for Disease Control and Prevention;
  - The Agency for Health Care Research and Quality;
  - The Centers for Medicare & Medicaid Services;
  - Cooperative group or center of any of the entities described above, including:
    - The National Institutes of Health
    - The Department of Defense
    - The Department of Veteran Affairs;
    - The Department of Energy;
    - The Centers for Disease Control and Prevention;
    - The Agency for Health Care Research and Quality;
    - The Centers for Medicare & Medicaid Services;
  - 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, the Department of Veterans Affairs or the Department of Defense 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 study or investigation is a drug trial that is exempt from having such an investigational new drug application; or
- The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration.

Clinical Trial Limitations

The Plan is 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 MHHSI. The Plan is

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.

Treatment received from Foreign Country Providers
Benefits for services and supplies received from Foreign Country Providers are covered for Medical Emergencies and other urgent situations where treatment could not have been reasonably delayed until the Covered Person was able to return to the United States.

The Plan does not accept assignments of benefits from Foreign Country Providers. The Covered Person can file a claim with the Plan for services and supplies from a Foreign Country Provider, but any payment will be sent to the Covered Person. The Covered Person is responsible for paying the Foreign Country Provider. The Covered Person is also responsible at his or her own 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 Plan and will not be more than would be paid if the service or supply had been received in the United States.

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

Well Woman Examinations

- One (1) routine annual visit per Plan Year to an obstetrician/gynecologist. Additional visits recommended by the Covered Person's obstetrician/gynecologist may be subject to the Deductible amount, Copayment or Coinsurance percentage shown on the Schedule of Benefits, if not a preventive service.
- One (1) routine pap smear, cervical and ovarian cancer screening per Benefit Period for early detection including:
    - blood, laboratory and Diagnostic Services in connection with evaluating the pap smear.
    - the provider's charge for administration of the test, for any covered female 18 years of age or older, not to exceed one (1) every 3 years for a:
        - CA 125 blood test; and
        - conventional pap smear screening, a screening using liquid-based cytology methods, or any other test or screening 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 (HPV) and ovarian cancer.
- Mammograms are covered for the screening of breast cancer. Diagnostic imaging includes imaging examination using mammography, ultrasound imaging, or magnetic resonance imaging. Diagnostic imaging is designed to evaluate an abnormality detected by a patient and it is also designed to evaluate an individual with dense breast tissue. Diagnostic imaging is also designed to evaluate:
    - A subjective or objective abnormality detected by a physician or patient in a breast;
    - An abnormality seen by a physician on a screening mammogram;
    - An abnormality previously identified by a physician as probably benign in a breast for which follow-up imaging is recommended by a physician.
    - We cover mammograms for the screening of breast cancer as follows:
        - 2-D and all low-dose mammography, including digital mammography and breast tomosynthesis (3d mammography) annually for women aged 35 and over.
        - all Preventive mammograms are covered at no cost to You when obtained from a Network Provider.
    - We cover diagnostic mammograms as follows:
        - 2-D and all low-dose mammography including digital mammography and breast tomosynthesis (3D mammography). The 35-year and older age requirement does not apply to diagnostic imaging screenings.
        - all diagnostic mammograms are covered at no cost to You when obtained from a Network Provider.

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 five (5) years.
- Annual counseling on sexually transmitted infections for all sexually active women.
- Annual screening and counseling for human immune-deficiency virus infection for all sexually active women.
- Prescription FDA-approved contraceptive methods, sterilization procedures and patient education and counseling for all women with reproductive capacity, including injectable drugs and implants, intra-uterine devices, diaphragms, and the professional services associated with them.
- Comprehensive lactation support and counseling by a trained provider during pregnancy and/or in the postpartum period and rental and Prior Authorization required for purchase of breastfeeding equipment not to exceed $500.
- 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.

Physical Examinations and Testing

Routine Wellness Physical Exam
You are eligible for a physical examination once every Plan Year. Eye and ear screenings for children are covered through age 17, to determine the need for vision and hearing correction complying with established medical guidelines. Coverage is also available for one annual hearing screening for Covered Persons between the ages of 18 and 21: and one annual vision screening (risk assessment) up through the age of 21. 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 and Wellness Care Services 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 and Wellness Care Services benefit. These higher tech services may be covered under the Plan when the tests are Medically Necessary.

Adult Immunizations
The Plan will cover adult immunizations 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
The Plan covers immunizations for children and adolescents recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. Coverage for covered persons from birth through the date of the child's sixth birthday includes immunization against: diphtheria, haemophilus influenza type b, hepatitis, measles, mumps, pertussis, polio, rubella, tetanus, varicella, rotavirus, and any other immunization that is required for the child by law.

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

Well Baby & Well Child Care
Well baby care routine examinations will be covered for infants under the age of 24 months for whom no diagnosis is made. Routine examinations ordered after the infant reaches 24 months will be subject to the routine wellness physical exam benefit as described above.

Prostate Cancer Screening
One (1) physical rectal exam and one (1) prostate-specific antigen (PSA) test per Plan Year, is covered for Covered Persons fifty (50) years of age or older and asymptomatic or if the Covered Person 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 Covered Person's Physician for follow-up treatment within sixty (60) days after either visit if related to a condition diagnosed or treated during the visits.

Aortic Aneurysm Screening
A one-time screening for an abdominal aortic aneurysm (AAA) with ultrasonography is covered for men aged 65 to 75 years who have a history of smoking.

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). Routine screening for low-risk patients is not covered.

Colorectal Cancer Screening

Colorectal cancer exams, preventive services, and lab tests with an "A" or "B" grade from the United States Preventive Services Taskforce (USPSTF) are covered for members starting at age 45. Coverage for a follow-up colonoscopy, if the results of the initial colonoscopy test or procedure were abnormal, is also covered. The follow-up colonoscopy will be subject to the regular plan benefits (applicable deductible and coinsurance).

Selected generic Physician prescribed colonoscopy preparation and supplies for colonoscopies covered under the Preventive and Wellness Care Services benefit will be covered at no cost to You when obtained from a Participating Provider pharmacy. Routine colorectal cancer screening will not mean services otherwise excluded from benefits because the services are deemed by MHHSI to be Experimental and/or Investigational. Brand-name colonoscopy preparation and supplies will be covered at no cost to the Covered Person when a Participating Provider prescribes brand-name colonoscopy preparation and supplies because of Covered Person's inability to tolerate selected generic colonoscopy preparation and supplies.

Lung Cancer Screening

A lung cancer screening is covered for adults aged 60 to 80 years who have a 20 pack per year smoking history and currently smoke or have quit within the past 15 years. The covered screening is performed with a low dose computed tomography (CT) every year. Screenings are discontinued once a person has not smoked for 15 years or has a health problem that limits life expectancy or the ability to have lung surgery.

Nicotine Dependence Treatment

We will cover Prescription Drugs that have been approved by the U.S. Food and Drug Administration for the management of nicotine dependence The Plan's various nicotine treatment options are noted on the 2024 formulary.

Bone Mass Measurement

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

- a woman 65 or older or postmenopausal who is not receiving estrogen replacement therapy; or
- an individual with: vertebral abnormalities; primary hyperparathyroidism; or has a history of bone fractures; or
- receiving long-term glucocorticoid therapy; or
- being monitored to assess the response to or efficacy of an approved osteoporosis Drug therapy.

The list of covered preventive/wellness services changes from time to time. To check the current list of recommended Preventive and 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/.

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 Covered Person'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 Covered Charge that MHHSI determines and only those Prescription Drugs that MHHSI determines 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.
- Drugs to aid smoking cessation.
- Insulin.
- Insulin syringes prescribed and dispensed for use with insulin.
- Continuous blood glucose monitor (CGM) is covered through Your Pharmacy Benefit. Please check the Formulary for any restrictions and tier information. Preferred continuous glucose monitors are DexCom G6/G7 and FreeStyle Libre/Libre 2/Libre 14, all other CGMs are excluded.
- 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 Covered Person for a chronic, disabling, or life-threatening illness if the Prescription 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 Prescription Drug is prescribed in:
    - Prescription Drug reference compendium approved by the Texas Commissioner of Insurance; or
    - Substantially accepted peer-reviewed medical literature.
- Orally administered anticancer medication that is used to kill or slow 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.
- Prescription eye drop refills to treat a chronic eye disease or condition dispensed on or before the last day of the prescribed dosage period and:
  - not earlier than the 21st day after the date a Prescription for a 30-day supply of eye drops is dispensed;
  - not earlier than the 42nd day after the date a Prescription for a 60-day supply of eye drops is dispensed; or
  - not earlier than the 63rd day after the date a Prescription for a 90-day supply of eye drops is dispensed.

Conditions of Service

The Prescription Drug or medicine must be:

- Prescribed in writing by a Physician and dispensed within one (1) year (or less) 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 Covered Person'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 Prescription Drug or medicine must not be used while the Covered Person 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).

Specialty Drugs

Prescription Drugs designated on the Drug Formulary as Specialty Pharmacy Drugs must be dispensed from one of the Participating Specialty Pharmacy Providers. Specialty Prescription Drugs dispensed by a Participating Specialty Pharmacy Provider will be subject to the Formulary Copayment for Specialty Prescription drugs as specified in the Schedule of Benefits. Failure to obtain Specialty Prescription Drugs from the Participating Specialty Pharmacy Provider may result in denial of coverage for the Specialty Prescription Drug. Drugs on the health plan Formulary and Specialty Pharmacy Drugs may require prior Authorization and may be

subject to other coverage requirements or may be on a limited distribution list. To be covered under Your health Plan, You have two convenient options to fill Your Specialty Pharmacy Prescriptions as a Memorial Hermann Health Plan Member. You can fill Your Specialty Pharmacy Prescriptions at Memorial Hermann Specialty Pharmacy or at Lumicera Health Services.

For more information on the specialty pharmacies and how to see if Your medications are covered or to get started, visit the FAQ document on Our website https://healthplan.memorialhermann.org/members/pharmacy-benefit-information/pharmacy-benefit-faq.

Step Therapy
The main goal of step therapy is to promote safer, more cost-effective treatment by encouraging a "step" approach in evaluating Prescription Drug use. To receive the maximum plan benefit, You may first need to try a proven, cost-effective option before engaging in a newer treatment that may be higher-cost and higher-risk.

Some Prescription Drugs require step therapy. This means that You must try one or more other Prescription Drugs before a step therapy drug is covered. The other Prescription Drugs are called prerequisite drugs. They are equally effective, have FDA approval and may cost less. They treat the same condition as the step therapy drug. If You don't try the other Prescription Drugs first, You may need to pay full cost for the step therapy drug.

Step therapy is not required for Prescription Drugs that are being used to treat stage-four advanced metastatic cancer, as long as the Drugs are FDA-approved and its use is consistent with best practices for the treatment of stage four advanced, metastatic cancer or an associated condition and supported by peer-reviewed, evidence-based literature.

If Your doctor determines that a first-line prerequisite drug is not right for You, then Your Prescription Drug benefit will cover second-line drugs, which are often less-preferred and more expensive.

To request a Drug with step therapy requirements, You or Your doctor can contact the Prior Authorization Department at Navitus Health Solutions at: 1-866-333-2757 or go online at http://www.navitus.com. For more information, You or Your doctor can call 1- 866-333-2757. If MHHSI does not deny an exception request before 72 hours, the request is considered granted. When the prescribing Provider believes that the denial of the request makes death or serious harm probable and MHHSI does not deny the request before 24 hours, the request is considered granted.

If You have questions about step therapy or prior authorization, please call the Pharmacy Program number on the back of Your Memorial Hermann Health Solutions ID card.

Preferred Drug (Prescription Drug Formulary) Program
In order to continue providing an affordable Pharmacy benefit, MHHSI has developed a Preferred Drug program. The program is designed to help manage rapidly escalating Prescription Drug costs while remaining flexible and sensitive to Covered Persons' medical needs.

Preferred Generic Drugs are Drugs on the Formulary that require the lowest Copayment. Preferred Name Brand Prescription Drugs are also on the Formulary and may require an increased Copayment or Coinsurance. If the Member requires the use of Generic-equivalent Drugs and the Member receives a Name Brand Prescription Drug when a Generic equivalent is available, then the Member will pay no more than the Generic Copayment plus the difference between the cost of the Generic Drug and the cost of the Name Brand Prescription Drug, even when the Prescription is written "dispense as written."

Prescription Drugs, which are Non-Preferred or Non-Formulary, may not be covered by Us or may require the larger Coinsurance or Copayment, depending on the Plan selected, and may have a prior Authorization requirement or other restrictions.

Prescription Drug Formulary
This Plan includes coverage for Prescription Drugs. The **Prescription Drug Formulary** is the list of Prescription Drugs covered under this Plan. 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. MHHSI reviews the Prescription Drug Formulary at least once per year. A **Non-Formulary Prescription Drug** is a Prescription Drug that is not included in the Prescription Drug Formulary and therefore not usually covered under this Plan.

Information about Your Prescription Drug Formulary is available to You to print and discuss with Your doctor. You can review and print formulary information immediately from the website at: https://healthplan.memorialhermann.org/members/pharmacy-benefit-information/ .

You may also contact MHHSI at the telephone number on Your ID card to ask whether a specific Prescription Drug is included in Your Prescription Drug Formulary.

Copayments vary based upon the tier level a particular Drug has been placed on by the Health Plan. **Please check the Formulary or Drug list for the latest updates or changes along with any special requirements (indicated under the Special Code) and Tier categories.** Utilize the legend at the bottom of each page if Your Drug or product contains a special code or indicator under the tier category and to view any additional restrictions or notes on a Drug.

- Tier 1: Low cost, high value Generics and select Brands
- Tier 2: Preferred Brands and select Generics
- Tier 3: Non-Preferred Brands and Non-Preferred Generics
- Tier 4: Specialty Drugs, indicated on the Formulary with a "MSP" or "SP" symbol
- Tier 5: Medical Benefit products covered to meet benchmark requirements, indicated on the formulary with a "M" symbol
- Tier 6: Preventive Drug list as required by ACA requirements, indicated on the Formulary with a "$0" symbol
- EXC: Drugs or products that are a Plan Benefit exclusion from coverage.
- NC: Drugs or products that are not covered on the Formulary but You can request coverage through a prior Authorization request.

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 Your Physician, if appropriate. The Covered Person's Physician always has the final decision on drug selection. If the Covered Person's Physician prescribes a Non-Preferred Brand Name Drug even after the Covered Person 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. Additionally, if the negotiated or usual and customary cost of the Generic Drug is less than the Copayment, You will only be required to pay the lower of the two amounts.

A **Preferred Brand Name Drug** is a Brand Name Drug that appears on the Prescription Drug Formulary as a Preferred Brand Name Drug and that is made available to Covered Persons at a lower Copayment amount compared to **Non-Preferred Brand Name Drugs**. A Non-Preferred Brand Name Drug appears on the Prescription Drug Formulary as a Non-Preferred Brand Name Drug and is available to Covered Persons at a higher Copayment amount compared to Preferred Brand Name Drugs.

The Drug Formulary contains a Therapeutic Interchange List of products that are not covered with the alternative that is preferred or covered on the Plan. We recommend using this list to discuss treatment options with Your health care Provider or Physician.

If a Prescription Drug is on Your Prescription Drug Formulary, this does not guarantee that Your Physician or other authorized prescriber will prescribe the Prescription Drug for a particular medical condition or mental illness.

An Exception Request is a request that the Plan cover a Prescription Drug that is not on Your Prescription Drug Formulary.
You, Your designee, or Your prescribing Physician (or other prescribing provider) have the right to submit an Exception Request to MHHSI.

Standard Exception Request. Under a Standard Exception Request, MHHSI will make a determination and notify You or Your designee and Your prescribing Physician (or other prescribing provider) no later than 72-hours from receipt of Your request for review. If MHHSI grants Your Exception Request and agrees to cover the Non-Formulary Prescription Drug, the coverage will remain in place for the length of the Prescription, including any refills, as long as You remain enrolled under this Plan.

Expedited (Urgent) Exception Request. You, Your designee, Your prescribing Physician (or other prescribing provider) may request an Expedited Review of an Exception Request based on exigent circumstances. Exigent circumstances exist when You, or Your unborn child, are suffering from a health condition that may seriously jeopardize Your life, health, or ability to regain maximum function or when You are undergoing a current course of treatment using a Non-Formulary Prescription Drug.
MHHSI will make a determination on an Expedited Exception Request and notify You or Your designee and Your prescribing Physician (or other prescribing provider) of the coverage determination no later than 24-hours following receipt of the request. If MHHSI grants Your Exception Request based on Your exigent circumstances, the Non-Formulary Prescription Drug will be covered for the duration of Your exigent circumstances, as long as You remain enrolled in this Plan.

An Expedited Exception Request must include:

- Information related to the existence of the exigency and a description of the harm that could reasonably occur to the Covered Person, or unborn child, if the requested Non-Formulary Prescription Drug is not provided in the 24-hour timeframe; and
- Justification supporting the need for the Non-Formulary Prescription Drug to treat the Covered Person'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.

External Appeals of Denied Exception Requests. If MHHSI denies either Your Standard Exception Request or Your Expedited Exception Request for coverage of a Non-Formulary Prescription Drug, You, Your designee, or Your prescribing Physician (or other prescribing provider) may request that Your Exception Request and the denial be reviewed by an independent, external review organization. The External Review Organization must make a determination on Your Exception Request and notify You, Your designee, and Your prescribing Physician (or other prescribing provider) of their coverage determination no later than 72- hours from receipt of Your review request if the original request was a Standard Exception Request, and no later than 24-hours from receipt of the request if the original request was an Expedited Exception Request. If the External Review Organization approves the Non-Formulary Prescription Drug through the external review process, coverage of the Non-Formulary Prescription Drug will be for the same duration as described above under Standard Exception Request and under Expedited Exception Request.

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, MHHSI will notify Your Physician or pharmacist. The Plan, with the guidance and information provided by MHHSI, reserves the right to limit benefits to prevent over-utilization of Prescription Drugs.

Certain Prescription Drugs may require Preauthorization. For information on which specific Prescription Drugs require Preauthorization, call the toll-free number shown in the contact information section in the Introduction to this Member Handbook. If a Covered Person fills a Prescription for a drug that requires Preauthorization, the Covered Person will receive a letter informing him/her of the requirement, and of how to obtain approval for any refills.

If MHHSI denies a request for Preauthorization of a Prescription Drug that is not part of the Prescription Drug Formulary, the Covered Person or the Covered Person's prescribing Physician may file an appeal with MHHSI by following the procedures described under "Adverse Determination Process and Time Frames" in the "Complaints and Appeals" section of this Member Handbook.

MHHSI 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 Plan not later than the 30th day before the date on which the provision of Prescription Drugs or intravenous infusions will be discontinued.

Generic Drugs

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

Retail Pharmacies

Participating Retail Pharmacies

When a Covered Person has a prescription filled, they must present their ID card. The Pharmacy will calculate the Copayment, Coinsurance and Deductible responsibilities, if any. Covered Persons 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.

Covered Persons 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.

Maintenance Drugs

Maintenance Prescription Drugs are Drugs taken for an extended period to treat a long term or chronic medical condition. When You get a long-term supply (90-day supply) of these Drugs, Your Cost Sharing may be lower. These Drugs may also be eligible for Medication Synchronization plans.

When a Member receives a partial supply of a Maintenance Drug, We will prorate any Cost Sharing amount charged if the Pharmacy or the Member's prescribing Physician notifies Us that:

- the quantity dispensed is to synchronize the dates that the Pharmacy dispenses the Member's Prescription Drugs.
- the synchronization of the dates is in the best interest of the Member; and
- the Member agrees to the synchronization.

The proration must be based on the number of days' supply of the Drug actually dispensed.

Oral Contraceptive Drugs

HB 916 enacts coverage requirements for health benefit plans that provide benefits for Prescription contraceptive Drugs. Your Plan provides for an enrollee to obtain:

- a three-month supply of the covered Prescription contraceptive Drug at one time the first time the enrollee obtains the Drug; and
- a 12-month supply of the covered Prescription contraceptive Drug at one time each subsequent time the enrollee obtains the same Drug.

Contraceptive Drugs are limited to only one 12-month supply during each 12-month period.

Mail Service Program

Prescription Drugs may be purchased through the Costco Mail Order Pharmacy mail order 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. Maintenance Drugs (defined as an ongoing prescription) can be purchased through the mail, subject to the Deductible, Copayment, Coinsurance 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 order Pharmacy customer service department for availability of the Prescription Drug or medication.

The prescription must include the Prescription Drug name, dosage, directions for use, quantity, number of refills (if permitted), the Physician's or other prescribing provider's name and phone number, the patient's name and address, and be signed by a Physician or other prescribing provider. Submit the Prescription with the appropriate payment for the purchase, and a properly completed order form. Covered Persons need only pay any applicable Deductible, Copayment or Coinsurance, or Prescription Drug Deductible, if any. The first mail service pharmacy prescription order must also 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 Member Handbook.

For more information, please visit: https://www.costcohealthsolutions.com/pages/Members_MailOrder.aspx.

Prescription Drug Exclusions and Limitations

Covered Charges for Prescription Drugs are subject to and treated as part of any benefit maximums in the Plan and to any other exclusions or limitations contained in this Plan. The following are not covered under Prescription Drug benefits of the Plan:

- Any covered drugs or charges for which benefits are available under the Medical Benefit section of this Plan, unless otherwise specified on the Formulary.
- Drugs, medications, and supplies not requiring a prescription, except insulin and certain over-the-counter (OTC) products listed on the Formulary.
- Non-medical substances or items, with the exception that Drugs to aid smoking cessation are covered.
- Dietary supplements, cosmetics, health or beauty aids, unless otherwise specified on the Formulary.
- Any over-the-counter vitamin, mineral, herb or botanical product that 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, unless otherwise specified on the Formulary.
- Drugs taken while the Covered Person is in a Hospital, Skilled Nursing Facility, rest home, sanitarium, convalescent Hospital or similar facility.
- Drugs not approved by the Food and Drug Administration (FDA) for use in humans or for the condition, dose, route, duration and frequency being treated.
- Any Prescription Drug labeled "Caution, limited by federal law to investigational use" or non-FDA approved investigational.
- 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, unless otherwise specified on the Formulary.
- Anorexiants or drugs associated with weight loss, except as provided under Preventive and Wellness Care Services.
- 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 Plan.
- 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” but may still need to meet prior Authorization or other Utilization Management criteria and may have higher cost share.
- Prescription Drugs with a non-prescription (over the counter) chemical and dose equivalent, except insulin and certain OTC products listed on the Formulary.
- Replacement of lost or stolen Prescription Drugs except as approved by the Plan, other limitations may exist.
- 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 Member Handbook 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 an orally administered drug.
    - Charges for immunization agents related to travel or not approved by the ACIP,
    - 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 provider, 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 controlled substances as a replacement for a previously dispensed controlled substance that was lost, misused, stolen, broken or destroyed.
    - Drugs or medications not requiring a prescription, except insulin.
    - 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:
        - An Inpatient 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 without a Preauthorization
        - Hypodermic needles or syringes, except insulin syringes.
        - Other non-medical substances, regardless of their intended use.
    - Charges for over-the-counter vitamins.
    - Charges for any drug used to treat 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.
    - 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 MHHSI is legally required to pay it, MHHSI will.
    - Charges for drugs covered under Home Health Care or Hospice Care section of this Member Handbook.
    - 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.

    - 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 a Medical Emergency.
- Experimental or Investigational Drugs or products that have not been proved as safe and effective or is not supported by peer-reviewed literature or compendia.

MEDICAL EXCLUSIONS AND LIMITATIONS

Note: All exclusions related to Prescription Drugs are shown in the Prescription Drug Plan section above.

The following are services, supplies and treatments that are not covered under this Plan. The Plan will not cover 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. Preauthorization required when used as a substitute
- The amount of any charge which is greater than the Covered Charge, except as provided under the Hospital Based Providers provision.
- 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.
- 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 and Reconstructive Surgery except as otherwise stated in this Member Handbook; complications of Cosmetic and Reconstructive 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 Member Handbook.
- Services or supplies, the primary purpose of which is educational in 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 Member Handbook.
- Experimental or Investigational treatments, procedures, hospitalizations, drugs, biological products or medical devices, except as otherwise stated in this Member Handbook.
- Extraction of teeth, except as otherwise stated in this Member Handbook.
- Services or supplies for or in connection with:
    - Refraction exams to determine the need for (or changes of) eyeglasses or lenses of any type;
    - 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, with the exception of dental coverage, provided by one of the following Covered Persons 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 this Member Handbook; and c) ovulation predictor kits. See also the separate Exclusion addressing sterilization reversal.
- Services or supplies related to herbal medicine.
- Services or supplies related to hypnotism.
- Services or supplies related to medicinal marijuana.
- Elective abortions when prohibited by law.
- 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.
- Services or supplies necessary while the Covered Person is in the custody of Law Enforcement.
- 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. This 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 Member Handbook.
- Charges for missed appointments.
- Charges for nicotine dependence treatments and management drugs unless otherwise stated in the Preventive and Wellness Care Services section of this Member Handbook.
- Any charge identified as a non-Covered Charge or which are specifically limited or excluded elsewhere in this Member Handbook, or which are not Medically Necessary, except as otherwise stated in this Member Handbook.

- Services or supplies that are not furnished by an eligible provider.
- Services related to outpatient Private Duty Nursing care, except as provided under the Home Health Care section of this Member Handbook.
- Services or supplies related to rest or convalescent cares.
- 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 and Wellness 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 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 another practitioner 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 Medical Condition; 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 Plan 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 a Medical Emergency and except as provided below with respect to a full-time student.
  Exception: Subject to MHHSI's 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 MHHSI are not covered under the Plan.
- Travel to obtain medical treatment, drugs or supplies is not covered. In addition, the Plan 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 and 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 Member Handbook.
- Transportation, travel except as otherwise listed in this Member Handbook
- Vision therapy except as otherwise listed in this Member Handbook.
- 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 a 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 under Bariatric Surgery in the Medical Benefits section of this Member Handbook.
- Wigs, toupees, hair transplants, hair weaving or any drug if such drug is used in connection with baldness except for hair loss following chemotherapy/radiotherapy up to 1 per lifetime or a maximum dollar amount of $500.
- Complications from services, supplies and treatment for services that are not covered under this Plan.

PREAUTHORIZATION PROGRAM AND PROCEDURES

This Plan 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 Center 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 Plan 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 Covered Person'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 MHHSI;
- The services are not Experimental and Investigational; and
- The services are determined by MHHSI to be eligible under this Plan.

Preauthorization may be undertaken:

- At least three (3) calendar days (but preferably 10 days advance notice) 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 MHHSI determines 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

To initiate Preauthorization, instruct Your Physician to call the MHHSI Preauthorization Center at the telephone number shown in the Contact Information section in the Introduction to this Member Handbook **at least 3 calendar days (but preferably 10 days' advance notice)** prior to any admission or scheduled date of a proposed service requiring Preauthorization. If the MHHSI Preauthorization 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.

- Preauthorization may not be required for particular health care services if Your Physician or Provider meets exemption criteria for certain health care services.

If the proposed health care services involve Inpatient care which would require Preauthorization, MHHSI 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 MHHSI's written medically accepted screening criteria and review procedures. If the proposed health care services are to be provided while You are in Inpatient in a health care facility at the time the services are proposed, MHHSI 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, MHHSI 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 Covered Person, but in no case to exceed one hour from receipt of the request. The determination will be provided to the provider of record. If MHHSI issues an adverse determination in response to a request for post-stabilization treatment or a request for treatment involving a life-threatening condition, MHHSI will provide to the Covered Person or individual acting on behalf of the Covered Person, and the Covered Person's provider of record, a notification regarding external review of adverse determinations.

Preauthorization is required for charges incurred in connection with:

- Elective Inpatient services
- Mental health & substance abuse outpatient services – MH/SA intensive (extended) or residential services, Applied Behavioral Analysis (ABA) therapy and non-behavioral health providers neuropsychiatric testing.
- Non-emergency outpatient surgeries & diagnostic procedures
- ABA in cognitive therapy
- Skilled Nursing Facility admission
- Durable Medical Equipment of $500 or more
- Non-Participating Provider services for hearing aids
- Cochlear implants
- Genetic testing
- Home health care
- Hospice care
- Certain Prescription Drugs including Specialty Drugs and certain injectable drugs
- Services and/or Prescription Drugs to enhance fertility
- Complex imaging services
- Prosthetics and Orthotic devices
- All Non-Participating Provider services (out-of-network services) unless due to a medical emergency

Non-compliance may result in a penalty. Services and supplies which are not preauthorized by MHHSI may be subject to reduced benefits. For more information regarding the services for which MHHSI requires Preauthorization, consult MHHSI's website at https://healthplan.memorialhermann.org/ or contact Customer Service.

Subject to the notice requirements and prior to the issuance of an adverse determination, if MHHSI questions the Medical Necessity or appropriateness or the Experimental or Investigational nature of a service, MHHSI will give the Physician who ordered it a reasonable opportunity to discuss with MHHSI's physician Your treatment plan and the clinical basis for MHHSI's 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; and notice of the external review process with instructions. If You have a life-threatening condition or if MHHSI is denying the provision of prescription drugs or intravenous infusions for which You are receiving benefits under this Plan, 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 MHHSI discontinues 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 admission due to an Emergency Medical Condition or procedure, MHHSI must be notified within 48 hours of the admission or procedure or as soon as reasonably possible. MHHSI may take into account whether or not Your condition was severe enough to prevent You from notifying MHHSI, or whether or not a member of Your family was available to notify MHHSI for You.

There are penalties for some services if preauthorization is not performed as outlined in the Summary Plan Description. Note: These penalties are not counted toward the Deductible, Prescription Drug Deductible, if any, or Your Out-of-Pocket Maximum.

Non-Urgent Preauthorization

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

Concurrent hospitalization care authorization determinations will be issued no later than 24 hours after the request is received by MHHSI.

Preauthorization Renewal Process

Your Physician or other health care Provider may request a renewal of an existing prior Authorization at least 60 days before it expires. We must issue a determination, "if practicable," before the existing prior Authorization expires.

Preadmission Review

If Preauthorization is not performed, MHHSI 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 a Covered Person's Provider would like to request an approval of benefits for additional treatment while a Covered Person is undergoing a course of treatment for an Illness or Injury for which MHHSI has approved benefits and the Covered Person 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 Covered Person requests an extension of benefits less than 24 hours prior to the end of the initially prescribed and previously approved course of treatment, depending on the benefits, the request will be handled as if it were a new request for benefits, rather than an extension of benefits.
- If MHHSI receives a request for additional benefits at least 24 hours prior to the end of the initially prescribed and previously approved course of treatment, MHHSI must notify the Covered Person and the requesting Provider of its decision regarding the request within 24 hours of receipt of the request if the request is for urgent care benefits.
- If MHHSI denies a request for additional benefits, in whole or in part, MHHSI must explain the reason for the adverse benefit decision and this Member Handbook provisions upon which the decision was based no later than the third calendar day after the date the request is received.
- Covered Persons may appeal the adverse benefit decision according to the rules for an appeal of an Urgent, Preadmission or Concurrent Care benefit decision, depending on the circumstances, within thirty (30) calendar days of the adverse benefit decision.

Reduction or End of Benefits

If after approving a request for benefits in connection with a Covered Person's Illness, Injury, disease or other condition, MHHSI decides to reduce or end these benefits, in whole or in part:

- MHHSI must notify You sufficiently in advance of the reduction in, or end of benefits to allow a Covered Person 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 Plan provisions upon which, the decision was made.
- To keep the benefits MHHSI has already approved, a Covered Person must successfully appeal MHHSI's decision to reduce or end those benefits. A Covered Person must appeal to MHHSI at least 24 hours prior to the reduction in, or end of, benefits.
- If a Covered Person 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 Covered Person was appealing an urgent care adverse benefit decision.
- If MHHSI receives an appeal for benefits at least 24 hours prior to the reduction in, or end of, benefits, MHHSI must notify the Covered Person of its decision regarding the appeal within 24 hours of receipt of the appeal. If MHHSI denies an appeal of the decision to reduce or end the Covered Person's benefits, in whole or in part, MHHSI must explain the reason for the adverse benefit decision and the Plan provisions upon which the decision was based.
- Covered Persons may further appeal the adverse benefit decision according to the rules for appeal of an urgent care adverse benefit decision.
- MHHSI may not deny or reduce payment to a physician or provider for those services based on medical necessity or appropriateness of care unless the Physician or Provider has materially misrepresented the proposed services or has failed to perform the proposed services.

Continued Stay Review

MHHSI also will determine if a continued Hospital or Skilled Nursing Facility stay is Medically Necessary. MHHSI will provide notice of the 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 Covered Person and the provider of record. If MHHSI is approving or denying post-stabilization care subsequent to Emergency Medical Condition treatment, or care related to a life-threatening condition, MHHSI 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 MHHSI issues an adverse determination in response to a request for post-stabilization treatment or a request for treatment involving a life-threatening condition, MHHSI will provide the Covered Person, and the Covered Person's provider of record, notification relating to external review of adverse determinations.

Retrospective Review

If neither Preauthorization, nor preadmission review nor continued stay review was performed, MHHSI will use Retrospective Review to determine if a scheduled or an admission related to a Medical Emergency 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 this Member Handbook. If it is determined that a Hospital stay or any other service was not Medically Necessary, the Covered Person is responsible for payment of the charges for those services. MHHSI will provide notice of an adverse determination in writing to the Covered Person 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 MHHSI may extend the

30-day period for up to 15 more days if: MHHSI determines that an extension is necessary due to matters beyond its control; and MHHSI notifies the Covered Person and the provider of record, within the initial 30-day period, of the circumstances requiring the extension and the date by which MHHSI expects to make a determination. If the period is extended because of the Covered Person'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 MHHSI sends the notice of the extension to the Covered Person or the provider until the earlier of: the date the Covered Person or the provider responds to the request; or the date by which the specified information was to have been submitted.

Persons not involved in the previous decisions regarding the Covered Person'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 Covered Person's claim, will review Medical Necessity appeals. A Covered Person must exhaust all internal appeal opportunities prior to requesting an external appeal conducted by an external review organization, except for adverse determinations involving denial of Prescription Drugs, intravenous infusions, or life-threatening circumstances. The internal appeal process is also deemed to be exhausted, allowing the Covered Person to request an external appeal without completing the internal Appeal process, if MHHSI fails to strictly comply with all requirements of the internal appeal process, except in cases where the non-compliance was de minimus, or minimal.

CLAIMS PROCEDURES

How to File a Claim for Benefits

MHHSI and its Participating Providers have entered into agreements that eliminate the need for a Covered Person to file a claim themselves for benefits. Participating Providers will file claims for Covered Persons either by mail or electronically.

Prescription Drug Claims

Most Covered Persons 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 Pharmacy 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 MHHSI, may require the signature of the dispensing pharmacist. The claim form should then be sent to MHHSI's Pharmacy Benefit Manager, whose telephone number should be found on Your ID card. Benefits will be paid to the Covered Person based on the Covered 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 Participating Provider. If yes, this Provider will file Your claim with MHHSI.

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 for Participating Providers will be processed at the Negotiated Rate. For processing charges on the rental, purchase and necessary repairs/maintenance of wheelchairs, braces, crutches, etc. the invoice must be:

- 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 Plan except where specifically stated under the benefit for Infusion Therapy.

Claims Questions

Your claim(s) will be processed according to the terms of this Member Handbook and as required by law. Covered Persons may write MHHSI at the claims address noted on the Contact Page or call Customer Service at the telephone number shown on their ID card.

Payment of Claims Not Paid to Providers

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, the Plan may pay benefits up to $1,000 to someone related to You or a beneficiary by blood or marriage whom MHHSI deems to be equitably entitled to such benefits. The Plan will be discharged to the extent of any such payments made by MHHSI in good faith.

Assignment of Claim Payments: MHHSI will recognize any assignment made under the Plan, if:

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

The Plan and MHHSI 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 MHHSI will make prompt payments to the provider for any benefits payable under this Plan. Payment for services provided by a Non-Participating Provider is payable to You unless assignment is made as described above.

Payment to a Possessory or Managing Conservator

Benefits paid on behalf of a Dependent Child may be paid to a person other than the enrolled Employee as a possessory or managing conservator. The enrolled Employee can also be paid benefits if an order is issued by a court of competent jurisdiction in this or any other state that 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 MHHSI, 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 Employee where the Employee has paid any portion of a medical bill that would be covered under the terms of the Plan.

Claims Provisions

A Covered Person's (referred to as "claimant" in this section) right to make a claim for any benefits provided by this Plan is governed as follows:

- *Notice of Loss*
  A claimant should send a written notice of claim to MHHSI within 20 days of a loss. No special form is required to do this. The notice need only identify the claimant. When MHHSI receives the notice, MHHSI 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 MHHSI received the notice of claim. If the form is received within such time, it should be completed, as instructed, by all persons required to do so.

- *Proof of Loss*
  In the case of a claim for a loss, other than a claim for a loss of time for disability, written proof of the loss must be provided to MHHSI not later than the 90th day after the date of the loss; and in the case of a claim for loss of time for disability:
  - Written proof of the loss must be provided to MHHSI not later than the 90th day after the beginning of the period for which the Plan is liable; and
  - Subsequent written proof of the continuance of the disability must be provided to MHHSI at intervals as reasonably required by MHHSI.

  Failure to provide written proof of a loss within the time prescribed does not validate or reduce a claim if:
  - It was not reasonably possible to provide written proof of the loss within that time;
  - Written proof of the loss is provided as soon as reasonably possible; and
  - Unless the claimant does not have the legal capacity to provide proof of loss, proof of loss is provided not later than the first anniversary of the date the proof of loss is otherwise required.

  When You file proof of loss, You may direct MHHSI, 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, MHHSI will determine to pay either the Covered Person or the provider.

- *Payment of Claims*
  All benefits payable under the Plan must be paid not later than the 30th day after the date proof of loss is received.

If You have any questions about any of the information in this section, You may call MHHSI's Customer Service at the telephone number shown on Your ID card.

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.

If You call for information about a claim, MHHSI can better help You if You have the claim number or Member number, patient's name and date of service readily available.

COMPLAINTS AND APPEALS

Complaints

MHHSI wants to know when a Covered Person is unhappy about the care or services received under this Plan. If a Covered Person wants to register a Complaint about MHHSI or a health care provider, please refer to the procedures below.

A Complaint is an oral or written expression of dissatisfaction with MHHSI or with a provider's services. Covered Persons may call Customer Service to register a Complaint. Complaints apply to any issue not relating to a Medical Necessity or Experimental or Investigational determinations by MHHSI. Complaints may concern contractual benefit or referral denials, or issues or concerns You have regarding our administrative policies or access to providers.

To file a Complaint, please contact us at:

Memorial Hermann Health Solutions, Inc.
P.O. Box 19909
Houston, TX 77224-1909
Attn: Appeals and Grievances
Customer Service: 855-645-8448

A letter will be sent within five (5) days acknowledging the date of receipt of the Complaint. A response will be mailed to the Covered Person within thirty (30) business days. MHHSI 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 (1) business day after MHHSI receives the Complaint.

Appeal of Complaint Resolution

A Covered Person who is not satisfied with the resolution of the Complaint has the right to file a written request for appeal. MHHSI will send an acknowledgment letter to the Covered Person no later than five (5) business days after the date the written request for appeal is received. MHHSI will complete its review of the appeal no later than thirty (30) calendar days after the date the written request for appeal is received.

An appeal of a Complaint relating to an ongoing Emergency Medical Condition 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 Covered Person's request for appeal is received. Such appeals will be reviewed 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.

The No Surprises Act (NSA) and what it means to You:

Effective January 1, 2022, the No Surprises Act (NSA) established new federal protections against surprise medical bills. Surprise medical bills arise when a contract-holder inadvertently receives care from an Out-of-Network Hospital, Physician, or other Providers they did not choose. Doctors and Hospitals are not allowed to bill patients more than the In-Network Cost-Sharing amount for surprise bills.

Surprise billing protections apply to most Emergency services, including those provided in Hospital Emergency Rooms, freestanding emergency departments, and urgent care centers that are licensed to provide Emergency care. The federal law also applies to air ambulance transportation (emergency and non-emergency), but not ground ambulance. Emergency care includes screening and stabilizing treatment sought by patients who believe they are experiencing a medical emergency or active labor.

Beginning January 1, 2022, Providers will need to find out a patient's insurance status and then submit the surprise Out-of-Network bill directly to the patient's health plan. Providers are encouraged to include information about whether the NSA protections apply on the claim. Health plans will need to respond within 30 days, advising the Provider of the applicable In-Network Cost-Sharing amount for the claim. The health plan will send payment to the Provider and will send the contract-holder a notice, an Explanation of Benefits, (EOB), that it has processed the claim and indicating the In-Network Cost-Sharing amount the patient owes the Out-of-Network Provider. It is at this point that the Out-of-Network Provider is allowed to send the patient a bill for no more than the In-Network Cost-Sharing amount.

The NSA gives consumers the right to appeal health plan decisions to incorrectly deny or apply Out-of-Network Cost-Sharing to surprise medical bills, first to the health plan, and then, if the plan upholds its decision, to an independent external reviewer.

For information about the new federal protections against surprise medical bills, or to submit a Complaint, You may refer to: https://www.cms.gov/nosurprises/consumers.

For more help:

- Call the No Surprises Help Desk at 1-800-985-3059 (available 8 am to 8 pm EST, 7 days a week)
- Get help in a language other than English. Information about how to access these services is available through the No Surprises Help Desk.
- Call the No Surprises Help Desk to get this information in an accessible format, like large print, Braille, or audio, at no cost to you.

To initiate an independent dispute resolution, (IDR), please refer to: https://www.cms.gov/nosurprises/consumers/medical-bill-disagreements-if-you-are-uninsured.

- You are eligible to use the dispute resolution process if:
  - You are either uninsured or You are self-pay (You have insurance but didn't use it to pay for Your health care item or service).
  - Services were received on or after January 1, 2022
  - You have a good faith estimate from Your Provider
  - You have a bill dated within the last 120 calendar days (about 4 months)
  - The difference between the good faith estimate and the bill from any single Provider or facility is at least $400

NOTE: THERE IS A $25 NON-REFUNDABLE ADMINISTRATIVE FEE TO START THIS PROCESS

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 accordance with its 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 billed charge.

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 insurance company 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 Plan 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 Plan 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 determines 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 billed charge.

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

The following are examples of expenses that are not Allowable Expenses:

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

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

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

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

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

(d) "Allowed amount" is the amount of a billed charge that a carrier determines to be covered for services provided by a non-preferred health care provider or physician. The Allowed amount includes both the carrier's payment and any applicable Deductible, Copayment, or Coinsurance amounts for which the Covered Person 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 Plan 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 Medical 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 decides 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, contract 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. MHHSI 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 MHHSI 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, MHHSI 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. MHHSI 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.

Third Party Liability and Rights of Subrogation

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, MHHSI will advance the benefits of this Plan to You subject to the following:

- By receiving benefits under this Plan, You and Your Covered Dependents assign to MHHSI the right to proceed in Your or Your covered Dependents' name to secure rights of recovery of the Plan's costs, expenses, or the value of services rendered. The value of services rendered that MHHSI is entitled to recover will be limited to the cost of providing such services. MHHSI, on behalf of the Plan, is entitled to discharge its subrogation rights on a pro-rata basis with any other contractual or statutory subrogation holder.
- 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 the Plan paid for or provided those health care services, then MHHSI, on behalf of the Plan, is entitled to subrogation rights against such person or entity. The Plan 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 are reimbursed for the cost of care by another party, including Your 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. MHHSI, acting on behalf of the Plan, is also entitled to recover its costs and expenses related to recovery activities.
- You agree to advise MHHSI, in writing, within 60 days of Your or Your covered Dependent's claim against the third party and to take such reasonable action, provide such information and assistance, and execute such paper as MHHSI may require facilitating enforcement of the claim. You also agree to take no action that may prejudice the Employer's rights or interests under this Plan. Failure to provide notice of a claim or to cooperate with MHHSI, or actions that prejudice the Plan's rights or interests, will be a material breach of this Plan and will result in You being personally responsible for reimbursing MHHSI, acting on behalf of the Plan.
  The Plan 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 Covered Person 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 MHHSI 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.
- 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 the Plan or MHHSI. You or Your covered Dependents may not settle, compromise or release a claim against a third-party unless (1) the rights of

the Plan and MHHSI are expressly reserved in the settlement, compromise or release and You advise MHHSI in writing within such period of time as is reasonably necessary to protect the Plan's and MHHSI's rights, or (2) the Plan is paid in full up to the benefits paid by the Plan for that injury, or (3) MHHSI has given a written waiver of claim after notice. MHHSI, acting on behalf of the Plan, 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 MHHSI, acting on behalf of the Plan, any subrogation recoveries, which are limited to the lesser of one-half of the gross recovery minus attorney fees, if applicable, and the total cost of benefits paid, provided or assumed under this Plan as a direct result of the tortious conduct of the third party minus attorney fees, if applicable.

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

Recovery from another plan under which the Covered Person is covered. This right of refund also applies when a Covered Person recovers under an uninsured or underinsured motorist plan (which will be treated as third party coverage when reimbursement or subrogation is in order), homeowner's plan, renter's plan, medical malpractice plan or any liability plan.

Rights of Plan Administrator. The Plan Administrator has a right to request reports on and approve of all settlements.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

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 Plan Sponsor is subject to the Federal law that governs this provision, Covered Persons may also be entitled to a period of continuation of coverage under this Act. Check with the Plan Sponsor 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 Eligible 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/widowers of retirees may have longer continuation rights if an Employer files a Chapter 11 bankruptcy petition.
- You must tell the Plan Sponsor 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 Covered Person 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.

Notification Requirements
Under federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), certain Employees and their families covered under this Plan will be entitled to the opportunity to elect a temporary extension of health coverage (called "COBRA continuation coverage") where coverage under the Plan would otherwise end. This notice is intended to inform Covered Persons, in summary fashion, of their rights and obligations under the continuation coverage provisions of COBRA, as amended and reflected in final and proposed regulations published by the Department of the Treasury. This notice is intended to reflect the law and does not grant or take away any rights under the law.

The Plan Administrator which is responsible for the proper administration of COBRA continuation coverage under the Plan, has selected the Claims Administrator (MHHSI) to perform certain administrative services related to COBRA continuation coverage for the Plan. Complete instructions on COBRA, as well as election forms and other information, will be provided by the Claims Administrator or its designee to Covered Persons who become Qualified Beneficiaries under COBRA.

What is COBRA continuation coverage? COBRA continuation coverage is the temporary extension of group health plan coverage that must be offered to certain Covered Persons and their eligible family members (called "Qualified Beneficiaries") at group rates. The right to COBRA continuation coverage is triggered by the occurrence of a life event that results in the loss of coverage under the terms of the Plan (the "Qualifying Event" as further defined below). The coverage must be identical to the Plan coverage that the Qualified Beneficiary had immediately before the Qualifying Event, or if the coverage has been changed, the coverage must be identical to the coverage provided to similarly situated Active Employees who have not experienced a Qualifying Event (in other words, similarly situated non-COBRA beneficiaries).

Who can become a Qualified Beneficiary? In general, a Qualified Beneficiary can be:
(1) Any individual who, on the day before a Qualifying Event, is covered under a Plan by virtue of being on that day either a

covered Employee, the spouse of a covered Employee, or a Dependent child of a covered Employee. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

(2) Any child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, and any individual who is covered by the Plan as an alternate recipient under a qualified medical support order. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

The term "covered Employee" includes not only common-law employees (whether part-time or full-time) but also any individual who is provided coverage under the Plan due to his or her performance of services for the employer sponsoring the Plan (e.g., self-employed individuals, independent contractor, or corporate director). However, this provision does not establish eligibility of these individuals. Eligibility for Plan Coverage shall be determined in accordance with Plan eligibility provisions.

An individual is not a Qualified Beneficiary if the individual's status as a covered Employee is attributable to a period in which the individual was a nonresident alien who received from the individual's Employer no earned income that constituted income from sources within the United States. If, on account of the preceding reason, an individual is not a Qualified Beneficiary, then a spouse or Dependent child of the individual will also not be considered a Qualified Beneficiary by virtue of the relationship to the individual. A Domestic Partner is not a Qualified Beneficiary.

Each Qualified Beneficiary (including a child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage) must be offered the opportunity to make an independent election to receive COBRA continuation coverage.

What is a Qualifying Event? A Qualifying Event is any of the following if the Plan provided that the Covered Person would lose coverage (i.e.: cease to be covered under the same terms and conditions as in effect immediately before the Qualifying Event) in the absence of COBRA continuation coverage:

(1) The death of a covered Employee.

(2) The termination (other than by reason of the Employee's gross misconduct), or reduction of hours, of a covered Employee's employment.

(3) The divorce or legal separation of a covered Employee from the Employee's spouse. If the Employee reduces or eliminates the Employee's spouse's Plan coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a Qualifying Event even though the spouse's coverage was reduced or eliminated before the divorce or legal separation.

(4) A covered Employee's enrollment in any part of the Medicare program.

(5) A Dependent child's ceasing to satisfy the Plan's requirements for a Dependent child (for example, attainment of the maximum age for dependency under the Plan).

If the Qualifying Event causes the covered Employee, or the covered spouse or a Dependent child of the covered Employee, to cease to be covered under the Plan under the same terms and conditions as in effect immediately before the Qualifying Event, the persons losing such coverage become Qualified Beneficiaries under COBRA if all the other conditions of COBRA are also met. For example, any increase in contribution that must be paid by a covered Employee, or the spouse, or a Dependent child of the covered Employee, for coverage under the Plan that results from the occurrence of one of the events listed above is a loss of coverage.

The taking of leave under the Family and Medical Leave Act of 1993 ("FMLA") does not constitute a Qualifying Event. A Qualifying Event will occur, however, if an Employee does not return to employment at the end of the FMLA leave and all other COBRA continuation coverage conditions are present. If a Qualifying Event occurs, it occurs on the last day of FMLA leave and the applicable maximum coverage period is measured from this date (unless coverage is lost at a later date and the Plan provides for the extension of the required periods, in which case the maximum coverage date is measured from the date when the coverage is lost.) Note that the covered Employee and family members will be entitled to COBRA continuation coverage even if they failed to pay the employee portion of premiums for coverage under the Plan during the FMLA leave.

What factors should be considered when determining to elect COBRA continuation coverage? You should take into account that a failure to continue the Covered Person's group health coverage will affect the Covered Person's rights under federal law. The Covered Person should take into account that the Covered Person has special enrollment rights under federal law (HIPAA). You have the right to request special enrollment in another group health plan for which the Covered Person is otherwise eligible (such as a plan sponsored by the Covered Person's spouse's employer) within 30 days after Plan coverage ends due to a

Qualifying Event listed above. You will also have the same special right at the end of COBRA continuation coverage if the Covered Person gets COBRA continuation coverage for the maximum time available to the Covered Person.

What is the procedure for obtaining COBRA continuation coverage? The Plan has conditioned the availability of COBRA continuation coverage upon the timely election of such coverage. An election is timely if it is made during the election period.

What is the election period and how long must it last? The election period is the time period within which the Qualified Beneficiary must elect COBRA continuation coverage under the Plan. The election period must begin no later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and ends 60 days after the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event, or the date notice is provided to the Qualified Beneficiary of her or his right to elect COBRA continuation coverage. If coverage is not elected within the 60-day period, all rights to elect COBRA continuation coverage are forfeited.

Note: If a covered Employee who has been terminated or experienced a reduction of hours qualifies for a trade readjustment allowance or alternative trade adjustment assistance under a federal law called the Trade Act of 2002, and the Employee and his or her covered Dependents have not elected COBRA coverage within the normal election period, a second opportunity to elect COBRA coverage will be made available for themselves and certain family members, but only within a limited period of 60 days or less and only during the six months immediately after their group health plan coverage ended. Any person who qualifies or thinks that he and/or his family members may qualify for assistance under this special provision should contact the Claims Administrator for further information.

The Trade Act of 2002 also created a new tax credit for certain TAA-eligible individuals and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. If the Covered Person has questions about these new tax provisions, the Covered Person may call the Health Coverage Tax Credit Consumer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at http://www.doleta.gov/tradeact.

Is a covered Employee or Qualified Beneficiary responsible for informing the Claims Administrator of the occurrence of a Qualifying Event? Yes. In the event of a Qualifying Event by reason of divorce, legal separation, or a Dependent child attaining the age of 26, the Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the Qualified Beneficiary has timely notified the Claims Administrator that a Qualifying Event has occurred. For Qualifying Events by reason of a reduction in hours, separation of employment, death, commencement of a proceeding in bankruptcy with respect to the Employer, the Employer will notify the Claims Administrator of the Qualifying Event within 30 days following the date coverage ends.

IMPORTANT:
To notify the Claims Administrator, as required for certain Qualifying Events (divorce, legal separation of the employee and spouse, or a Dependent child attaining age 26), the Qualified Beneficiary, or someone on behalf of the Qualified Beneficiary must notify the Claims Administrator in writing within 60 days after the Qualifying Event occurs. To timely comply with this notification procedure, follow the instructions below. If these procedures are not followed or if the notice is not provided in writing to the Claims Administrator or its designee during the 60-day notice period, any spouse or Dependent Child who loses coverage will not be offered the option to elect continuation coverage. You must send this notice to the Claims Administrator.

PROCEDURES FOR NOTIFYING CLAIMS ADMINISTRATOR OF A QUALIFYING EVENT

Any notice that the Covered Person provides must be ***in writing***. Oral notice, including notice by telephone, is notacceptable. You must mail, fax or hand-deliver the Covered Person's notice to the person, department or firm listedbelow, at the following address:

Memorial Hermann Health Solutions
P.O. Box 19909
Houston, TX 77224-1909

If mailed, the Covered Person's notice must be postmarked no later than the last day of the required notice period. Any notice the Covered Person provides must state:

- the **name of the plan or plans** under which the Covered Person lost or are losing coverage,
- the **name and address of the Employee** covered under the plan,
- the **name(s) and address(es) of the Qualified Beneficiary(ies)**, and
- the **Qualifying Event** and the **date** it happened.

If the Qualifying Event is a **divorce or legal separation**, the Covered Person's notice must include **a copy of thedivorce decree or the legal separation agreement**.

Be aware that there are other notice requirements in other contexts, for example, in order to qualify for a disabilityextension.

Once the Claims Administrator or its designee receives *timely notice* that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each of the Qualified Beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. Covered Employees may elect COBRA continuation coverage for their spouses, and parents may elect COBRA continuation coverage on behalf of their children. For each Qualified Beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that Plan coverage would otherwise have been lost. If the Covered Person or the Covered Person's spouse or Dependent children do not elect continuation coverage within the 60-day election period described above, the right to elect continuation coverage will be lost.

Is a waiver before the end of the election period effective to end a Qualified Beneficiary's election rights? If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, if a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the Claims Administrator or its designee, as applicable.

Is COBRA coverage available if a Qualified Beneficiary has other group health plan coverage or Medicare? Qualified Beneficiaries who are entitled to elect COBRA continuation coverage may do so even if they are covered under another group health plan or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, a Qualified Beneficiary's COBRA coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to Medicare or becomes covered under other group health plan coverage (but only after any applicable preexisting condition exclusions of that other plan have been exhausted or satisfied).

When may a Qualified Beneficiary's COBRA continuation coverage be terminated? During the election period, a Qualified Beneficiary may waive COBRA continuation coverage. Except for an interruption of coverage in connection with a waiver, COBRA continuation coverage that has been elected for a Qualified Beneficiary must extend for at least the period beginning on the date of the Qualifying Event and ending not before the earliest of the followingdates:

(1) The last day of the applicable maximum coverage period.

(2) The first day for which timely payment is not made to the Plan with respect to the Qualified Beneficiary.

(3) The date upon which the Employer ceases to provide any group health plan (including a successor plan) to any employee.

(4) The date, after the date of the election, that the Qualified Beneficiary first becomes covered under any other Plan that does not contain any exclusion or limitation with respect to any pre-existing condition, other than such an exclusion or limitation that does not apply to, or is satisfied by, the Qualified Beneficiary.

(5) The date, after the date of the election that the Qualified Beneficiary first enrolls in the Medicare program (either part A or part B, whichever occurs earlier).

(6) In the case of a Qualified Beneficiary entitled to a disability extension, the later of:

(a) (i) 29 months after the date of the Qualifying Event, or (ii) the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or

(b) the end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension.

The Plan can terminate for cause the coverage of a Qualified Beneficiary on the same basis that the Plan terminates for cause the coverage of similarly situated non-COBRA beneficiaries, for example, for the submission of a fraudulent claim.

In the case of an individual who is not a Qualified Beneficiary and who is receiving coverage under the Plan solely because of the individual's relationship to a Qualified Beneficiary, if the Plan's obligation to make COBRA continuation coverage available to the Qualified Beneficiary ceases, the Plan is not obligated to make coverage available to the individual who is not a Qualified Beneficiary.

What are the maximum coverage periods for COBRA continuation coverage? The maximum coverage periods are based on the type of the Qualifying Event and the status of the Qualified Beneficiary, as shown below:

(1) In the case of a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period ends 18 months after the Qualifying Event if there is not a disability extension and 29 months after the Qualifying Event if there is a disability extension.

(2) In the case of a covered Employee's enrollment in the Medicare program before experiencing a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period for Qualified Beneficiaries other than the covered Employee ends on the later of:

(a) 36 months after the date the covered Employee becomes enrolled in the Medicare program; or
(b) 18 months (or 29 months, if there is a disability extension) after the date of the covered Employee's termination of employment or reduction of hours of employment.

(3) In the case of a Qualified Beneficiary who is a child born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, the maximum coverage period is the maximum coverage period applicable to the Qualifying Event giving rise to the period of COBRA continuation coverage during which the child was born or placed for adoption.

(4) In the case of any other Qualifying Event than that described above, the maximum coverage period ends 36 months after the Qualifying Event.

Under what circumstances can the maximum coverage period be expanded? If a Qualifying Event that gives rise to an 18-month or 29-month maximum coverage period is followed, within that 18- or 29-month period, by a second Qualifying Event that gives rise to a 36-months maximum coverage period, the original period is expanded to 36 months, but only for individuals who are Qualified Beneficiaries at the time of and with respect to both Qualifying Events. In no circumstance can the COBRA maximum coverage period be expanded to more than 36 months after the date of the first Qualifying Event. The Plan Administrator must be notified of the second Qualifying Event within 60 days of the second Qualifying Event. This notice must be sent to the Plan Sponsor in accordance with the procedures above.

How does a Qualified Beneficiary become entitled to a disability extension? A disability extension will be granted if an individual (whether or not the covered Employee) who is a Qualified Beneficiary in connection with the Qualifying Event that is a termination or reduction of hours of a covered Employee's employment, is determined under Title II or XVI of the Social Security Act to have been disabled at any time during the first 60 days of COBRA continuation coverage. To qualify for the disability extension, the Qualified Beneficiary must also provide the Plan Administrator with notice of the disability determination on a date that is both within 60 days after the date of the determination and before the end of the original 18-month maximum coverage. This notice should be sent to the Employer in accordance with the procedures above.

Does the Plan require payment for COBRA continuation coverage? For any period of COBRA continuation coverage under the

Plan, Qualified Beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. Qualified Beneficiaries will pay up to 102% of the applicable premium and up to 150% of the applicable premium for any expanded period of COBRA continuation coverage covering a disabled Qualified Beneficiary due to a disability extension. The Plan will terminate a Qualified Beneficiary's COBRA continuation coverage as of the first day of any period for which timely payment is not made.

Must the Plan allow payment for COBRA continuation coverage to be made in monthly installments? Yes. The Plan is also permitted to allow for payment at other intervals.

What is Timely Payment for payment for COBRA continuation coverage? Timely Payment means a payment made no later than 30 days after the first day of the coverage period. Payment that is made to the Plan by a later date is also considered Timely Payment if either under the terms of the Plan, covered Employees or Qualified Beneficiaries are allowed until that later date to pay for their coverage for the period or under the terms of an arrangement between the Employer and the entity that provides Plan benefits on the Employer's behalf, the Employer is allowed until that later date to pay for coverage of similarly situated non-COBRA beneficiaries for the period.

Notwithstanding the above paragraph, the Plan does not require payment for any period of COBRA continuation coverage for a Qualified Beneficiary earlier than 45 days after the date on which the election of COBRA continuation coverage is made for that Qualified Beneficiary. Payment is considered made on the date on which it is postmarked to the Plan.

If Timely Payment is made to the Plan in an amount that is not significantly less than the amount the Plan requires to be paid for a period of coverage, then the amount paid will be deemed to satisfy the Plan's requirement for the amount to be paid, unless the Plan notifies the Qualified Beneficiary of the amount of the deficiency and grants a reasonable period of time for payment of the deficiency to be made. A "reasonable period of time" is 30 days after the notice is provided. A shortfall in a Timely Payment is not significant if it is no greater than the lesser of $50 or 10% of the required amount.

Must a qualified beneficiary be given the right to enroll in a conversion health plan at the end of the maximum coverage period for COBRA continuation coverage? If a Qualified Beneficiary's COBRA continuation coverage under a group health plan ends as a result of the expiration of the applicable maximum coverage period, the Plan will, during the 180-day period that ends on that expiration date, provide the Qualified Beneficiary with the option of enrolling under a conversion health plan if such an option is otherwise generally available to similarly situated non-COBRA beneficiaries under the Plan. If such a conversion option is not otherwise generally available, it need not be made available to Qualified Beneficiaries.

IF YOU HAVE QUESTIONS

If the Covered Person has questions about the Covered Person’s COBRA continuation coverage, the Covered Person should contact the COBRA Administrator. For more information about the Covered Person’s rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at http://www.dol.gov/ebsa.

KEEP YOUR PLAN ADMINISTRATOR INFORMED OF ADDRESS CHANGES

In order to protect the Covered Person’s family's rights, the Covered Persons should keep MHHSI informed of any changes in the addresses of family members. You should also keep a copy, for the Covered Person’s records, of any notices the Covered Person sends to MHHSI.